Systemic Consultations in Intellectual Disability Services: Experiences of Care Staff

Volume 1

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Acknowledgements

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Abstract

This research used interviews and Interpretative Phenomenological Analysis (IPA) methodology to explore the experiences of care staff who attended systemic consultations within an Intellectual Disability (ID) service. A systematic literature review revealed limited research in the area of systemic approaches used with people with IDs and their networks. Research questions encompassed 'How do care staff experience systemic consultations that they have attended in ID services?', 'What do care staff find helpful in systemic consultations?', and, 'What do care staff find unhelpful in systemic consultations?'. Seven participants were interviewed, and interview data was transcribed and analysed using IPA. Five superordinate themes emerged; 'Not knowing what to expect; it was something different', 'Our relationships improved', 'An outside person shone a new light enabling us to think and work differently', 'Making sense of what we have achieved', and 'They made us feel validated'. The research findings highlighted important clinical implications. These included a need for the context to be 'warmed' and relational reflexivity (Bunham, 2005) to be applied in order to help care staff prepare for systemic consultations and feel supported. Future research directions are also discussed in order to develop the evidence-base for systemic approaches within ID services.

1. Introduction

1.1 Overview

This research focuses on understanding the experiences of care staff who support people with an Intellectual Disability (ID) in the community (i.e., work in residential, supported living, and/or day centre provisions) of attending systemic consultations. The research uses qualitative methodology of interviews, and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009). This first chapter sets the wider context of issues involved in the provision of support for people (or person) with IDs (PWIDs). This section will go on to discuss systemic approaches, the research project's systemic focus and relevant systemic concepts, followed by exploring the general evidence-base for systemic approaches. Systemic approaches in ID services will then be discussed, considering their utility and application with families and the wider network. The evidence-base for systemic approaches in IDs will then be investigated via a systematic literature review. Following synthesis of the evidence-base, a conclusion and rationale for the current research will be offered along with research questions.

1.2 Setting the context

PWIDs often have complex needs and require support from others to engage in activities of daily living. Cooper, Smiley, Morrison, Williamson, and Allan (2007) found a prevalence rate of 40.9% of mental health problems in PWIDs. There are also high reported rates of behaviour that challenges (e.g., 16-41% in adults with ID) (BPS, 2011a). This indicates a need for effective health and social care services within the field of IDs.

With a long history of marginalisation, the rights of PWIDs have in recent years been acknowledged and supported by important government agendas encouraged via legislation. 'Valuing People' (DoH, 2001) and 'Valuing People Now' (DoH, 2009) outlined policy for supporting PWIDs to uphold their rights

and promote choice and inclusion. Supporting PWIDs to become independent also became a priority. Further recent developments have seen the implementation of 'Transforming Care' (DoH, 2012), which has pushed further for PWIDs to move out of hospitals and into the community. This followed a serious case review of the 'Winterbourne View scandal' (South Gloucestershire Safeguarding Adults Board, 2012), where undercover filming revealed emotional and physical abuse of PWIDs from care staff. It found that PWIDs were inappropriately placed in hospitals and assessment and treatment units. Therefore, this current research comes at a time where care staff and health and social care professionals may be under increased pressure to support PWIDs to find and sustain suitable accommodation. This may therefore lead to more referrals to ID teams, and therefore offering effective and acceptable evidence-based interventions is increasingly important.

1.3 What can evidence-based interventions offer in IDs?

Research in psychological therapies for PWIDs is significantly behind research for individuals without IDs. NICE (2015) guidelines recommend Positive Behavioural Support for the preferred intervention for PWIDs where there is behaviour that challenges. Positive Behavioural Support is a values-based approach grounded in applied behavioural analysis (Carr et al., 2002). It identifies antecedents, behaviours, and consequences, and develops various proactive and reactive strategies to reduce behaviour that challenges (Carr et al., 2002). Clinical practice indicates further helpful approaches where empirical evidence is not yet well-developed. However, "absence of evidence for efficacy is not evidence of a lack of efficacy" (Roth & Parry, 1997, p. 372). It is important that other interventions are researched further to add to the empirical evidence regarding their effectiveness. This current research focuses on exploring the experiences of care staff where systemic approaches were used, specifically, systemic consultations using a reflecting team model (Anderson, 1987).

1.4 Key Definitions

This section clarifies key terms relevant to the research.

1.4.1 Intellectual Disability

Intellectual Disability (ID) is defined by the BPS (2000, p.4) as "significant impairment[s]" of "intellectual functioning" and "adaptive/social functioning" which occur before adulthood. The DSM-V (APA, 2013) furthers categorises severity according to individuals' levels of adaptive functioning on conceptual, social and practical domains.

1.4.2 Care staff

Within this research, 'care staff' refers to paid staff members who support PWIDs in a variety of tasks of daily living, including aspects of self-care, mobility, leisure, employment and voluntary work, financial, practical, health, psychological, and social needs. Care staff often support PWIDs in their own homes, group homes, supported living, residential placements, and/or day centres. Therefore, the care staff referred to in this research are specifically paid staff members supporting PWIDs in the community (not hospitals or rehabilitation units).

1.4.3 System

'System' refers to a group of people who are connected, and in systemic therapy the relationships and connections within and between systems are the focus of intervention (Vetere & Dallos, 2003). Systems often organise themselves around a problem ('problem-determined systems'; Andersen & Goolishian, 1988). However, Fredman (2014) recognised that PWIDs have a network of many people around them including family, friends, health and social care professionals, care staff, etcetera, and her approach was to enable the strengths and resources of the network (system) in generating a 'resource-full' community. System and network are used interchangeably.

1.4.4 Systemic therapy

Systemic therapy (ST) is used interchangeably with 'systemic family therapy' and 'systemic approaches', as also reflected in the literature and practice. ST is used as an 'umbrella' term for a number of different systemic models, ideas, and concepts, understanding difficulties as within relationships and patterns of communication within systems (Dallos & Draper, 2005).

1.4.5 Defining Systemic Consultation

The term 'systemic consultation' has not been clearly defined per se in the literature. 'Systemic consultation' fits under the above 'umbrella term' of 'systemic therapies', however, more specifically refers to a number of integrated systemic models and likely to use a reflecting team in the room (Andersen, 1991) (section 1.5.2.3). Woodward, Clarke and Viljoen (2016) writing about their work within ID services, discussed the use of the term 'systemic consultations' further. Woodward et al. (2016) reflected that their use of 'consultation' opposed to 'systemic therapy' related to practitioners not being qualified as systemic psychotherapists. Rather, that 'systemic ideas and interventions' underpinned consultations.

Within Clinical Psychology literature, there has been another form of supporting the wider network via 'team formulation'. To assist in emphasising important elements of systemic consultation, I will compare systemic consultation with team formulation. Formulation is an important part of the work of Clinical Psychologists which offer an understanding of difficulties associated with service users (BPS, 2011b). The BPS (2011b) define formulation based on Johnstone and Dallos (2006), stating that formulations are grounded in psychological theory, encapsulate main difficulties and how they may be connected and perpetuated, guide intervention(s), and can be continually reviewed. The BPS (2011b) also recommends using formulation with MDTs, and Johnstone (2011) described its usefulness with teams who felt stuck or challenged by clients. Furthermore, it is useful in formulating transference and countertransference, and "facilitating

culture change in teams and organisations" towards psychosocial understandings (BPS, 2011b, p. 9). The purpose of team formulations in this respect is somewhat similar to systemic consultations; however, use of systemic models in systemic consultations may help more specifically clinicians and/or care staff to understand difficulties more relationally. Systemic consultations can be attended by a variety of people within a service user's network including the service user and/or their family, whereas, team formulations, appear specific to MDTs, and/or paid care staff.

Johnstone (2014) discussed different approaches to team formulation where psychosocial understanding of difficulties presented to a service is collaboratively developed with a MDT. These included Clinical Psychologists reviewing notes devising provisional formulations, Clinical Psychologists facilitating collaborative formulation with teams, and team formulation meetings being establishing within teams and at service levels (Johnstone, 2014). Team formulation can also be informal, 'chipping in', via already established MDT meetings etcetera (Christophides, Johnstone, & Musa, 2012). Team formulations are likely to integrate a number of psychological modalities, whereas systemic consultations give precedence to systemically-informed psychological theories. Systemic consultations also often focus on difficulties brought by attendees to a particular consultation, rather than the referral as a whole as in team formulation.

Team formulations are typically delivered in a group format, whereas systemic consultations often use a reflecting team (Andersen, 1991) (see section 1.5.2.3). The set-up of a reflecting team offers an observer perspective where the reflecting team are more removed and therefore may be more able to notice dynamics within the system. Reflections in systemic consultations are offered via reflecting team members talking to each other in front of a system which promotes more positive connotations (Andersen, 1990), more likely to lead to change. This set-up in systemic consultations may also influence the receiving of

information by the system/MDT, where delivery of suggestions as conversations between reflecting team members may feel less threatening and more tentative, than suggestions offered in conversation with the MDT in team formulation, which may accentuate an 'expert' role of Clinical Psychologists. Underpinning philosophy of social constructionism within systemic consultations also allows for every person's view to be valid and the focus is on generating alternative ways of seeing things, whereas team formulation may be more focussed on developing one overall understanding.

Furthermore, the interview style within systemic consultations of circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; see section1.5.2.1) can be seen as interventions in themselves (see Tomm, 1985). Interventions can also be developed by attendees facilitated by the lead therapist's questions. Suggestions for interventions may also be offered by reflecting team members and/or a lead therapist via the offering of multiple perspectives, and introduction of difference(s). Systemic consultations are also underpinned by the stance that a system already has many resources, and consultations can enable these.

1.5 Systemic approaches

This section will introduce systemic theory and then discuss systemic concepts relevant to the research.

1.5.1 Introduction of systemic approaches

Systemic theory cannot be attributed to a main theorist or research group. Instead, systemic ideas were developed by different individuals and groups of thinkers, leading to different schools of systemic family therapy. Dallos and Draper (2005) identified three phases of STs. The first phase ran between 1950 and 1970. This phase brought a relational way of thinking about difficulties, a focus on systems, understanding homeostasis of systems, open and closed systems, triangulation and conflict detouring, and, functionality. The second phase focussed on developments through the mid-1970s to mid-1980s. This

second phase moved towards understanding of individuals' constructions and their influences on patterns of communications within systems (shaped by constructivism), along with understanding of shared meanings. Bateson (1972) and the Milan school of thought (e.g., Selvini, Boscolo, Cecchin, & Prata, 1980) were influential. There was also a shift towards second-order cybernetics, a move away from the expert position. The third phase (mid-1980s to 2000) was influenced by social constructionism (Gergen, 1985) and developed systemic understanding towards personal meanings and beliefs and recognised the influence of context and different layers of belief levels on 'problem-determined' systems (Anderson & Goolishian, 1988) and therapists. The third phase also saw the therapist as part of the system and introduced the reflecting team (Andersen, 1987; 1991) (section 1.5.2.3). It is beyond the scope of this project to elaborate further, however, readers are directed to Dallos and Draper (2005) for more details on phases, key ideas and theorists that contributed towards the development of ST.

1.5.2 Relevant systemic concepts

This research project focuses on the phase of ST where a shift occurred with therapists moving from a removed, expert position, to a position where they were seen as part of the system. A shift had also happened enabling recognition of resources and strengths already present in systems to help to solve difficulties. This phase was known as second-order cybernetics. It saw new ways of working corresponding to these ideas, with the emergence of the 'reflecting team' (Andersen, 1987; 1991). Systemic concepts relevant to this research will be now outlined. Concepts will include important principles of Milan STs, social constructionism, the reflecting team format, and narrative approaches.

1.5.2.1 Relevant principles from Milan STs

Circularity is a key concept from systems theory. Instead of understanding interactions as cause and effect within linear relationships, interactions in relationships are understood as circular where behaviours influence each other

(Watzlawick, Beavin, & Jackson,1967). The Milan team, influenced by Bateson specified that "information is a difference" and "difference is a relationship (or a change in the relationship)" (Selvini, Boscolo, Cecchin, & Prata, 1980, p.4).

Circularity invites therapists to explore relationships using circular questions as a way of eliciting difference (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985). Questions may link up individuals' actions by asking, for example, what a certain individual does in response to a behaviour displayed by an individual in the system.   Selvini et al. (1980) introduced questions within a dyadic relationship (between two people), or within a triadic relationship (between three people) where one individual is required to comment on the relationship between the two others in the system. Within second-order cybernetics, the focus shifted to the meanings attributed to the behaviours and hence circularity in patterns resulting from these attributed meanings (Dallos & Draper, 2005).

Another principle from the Milan school of thought was neutrality, which was defined as a non-biased stance towards each member of the system, not being allied to any one individual (Selvini, Boscolo, Cecchin, & Prata, 1980). However, this term gained negative connotations seeing therapists as reducing their accountability and appearing detached (Jones, 1993). Curiosity (1987) was therefore devised by Ceccin (1987) to supersede neutrality.   Curiosity's social constructionist philosophy (Gergen, 1985) means that each way of understanding the same situation is equally valid. Ceccin (1987) connected curiosity and circularity, reporting that when one is looking for a linear explanation, curiosity is lost as the explanation is found. However, looking for patterns of interactions and circularity, curiosity is retained as multiple descriptions and explanations are sought. Ceccin (1987) also described curiosity being supported by understanding the system is how they are at that moment in time for a logical reason. This stance led to interview questions enabling production of multiple descriptions and explanations of situations.

Hypothesising could be used to uphold a curious position (Ceccin, 1987). Hypothesising is linked to ideas about patterns of interactions that may describe and/or explain 'problem' situation(s) used in STs to direct therapists' interventive interviewing (Jones, 1993). Ceccin (1987) proposed that curiosity subsides when hypotheses cannot be created as this indicates 'stuckness' through understanding the family's stories as rigid explanations. Circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985) are asked to test out hypotheses and elicit difference.

Positive connotation is also linked with the Milan team (Boscolo, Cecchin, Hoffman, & Penn, 1987). It allows description of patterns sustaining problems in a way that understands the problem as serving an important function for the system, for example, a protective function, or a way of bringing the system members closer together (Jones, 1993). Positive connotation offers ways for system members to understand problems driven by positive and often shared desires. It also introduces systemic understanding of the problem, understanding each person's role in the interactions sustaining the problem, and hence decreasing blame on an 'identified patient'.

1.5.2.2 Social constructionism

Social constructionism (Gergen, 1985) influenced STs during the third phase by aiding understanding of experiences within a person's social and cultural contexts (Dallos & Draper, 2005). Dallos and Draper (2005) give an overview that social constructionist theories influenced by Marxist analysis also propose differences in power within societies, and power held by individuals within higher social economic classes is sustained resulting in oppression in lower soico-economic groups. Anderson and Goolishian (1988) proposed that language influences reality, therefore language can also maintain social differences.

A social constructionist philosophy (Gergen, 1985) underpins 'curiosity' (Cecchin, 1987), and a view that there are multiple realities and each person's

view is equally valid. Adopting this stance also connects with a shift from the expert position to a 'not knowing' approach (Anderson & Goolishian, 1992). The phase of first-order cybernetics saw therapists as expert and separate from the system that they were observing. Second-order cybernetics recognised therapists as part of the system, and holding curiosity (Cecchin, 1987) could develop alternative descriptions and explanations of the 'problem' rather than give one view as correct and the truth (summarised by Dallos & Draper, 2005).

1.5.2.3 The reflecting team format

The 'reflecting team' format was pioneered by Andersen (1987; 1990), underpinned by social constructionism, and inspired by Bateson's ideas (1972). The emergence of the reflecting team led to a shift in STs. Andersen (1987; 1990) reported that the 'reflecting team' came out of a supervisory team observing a family therapy session and giving their reflections in front of the family to help prevent the therapist joining with the negative outlook of the family in 1985. Andersen (1990) reported hesitancy prior to this session in speaking in front of a family due to fears of negative thoughts about the family affecting the way they spoke about the family. However, speaking in front of the family helped therapists use more positive language (Andersen, 1990), and was acceptable to the family, reflecting team and interviewer.

Andersen (1987; 1990) described guidelines for ST using a reflecting team. This involved the reflecting team observing the family therapy session from behind a one-way screen, whilst the lead therapist interviewed the family, using circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985). The reflecting team were then highlighted through the one-way screen and could be heard by the lead therapist and family (the 'interview-system') whilst they made reflections on what they had heard. Andersen (1987; 1990) proposed that reflections were made offering tentatively additional descriptions and explanations of the 'problem' whilst validating family members' descriptions and explanations (holding a 'both-and' position). The descriptions and explanations

were based on positive meanings and in a range acceptable to a family system. To obtain change, differences needed to be "unusual but not too unusual" (Andersen, 1990). Andersen (1990) proposed reflections last between five and ten minutes and occur once or more during the session.

The reflecting team process was underpinned by a number of concepts. One of these was inspired by Bateson's (1972) definition of information as "any difference which makes a difference" (p. 381). Andersen (1990) explained that individuals describe themselves in relation to differences they perceive between themselves and their context. As there are many differences, the description does not comprise all possible differences, and therefore, different people describe the same situation differently. Therefore, Bateson's idea (1972) can be understood as change being elicited by identifying appropriate differences.

1.5.2.4 Narrative approaches

Dallos and Draper (2005) linked the process of the reflecting team to narrative therapy. White and Epston (1990) understood dominant 'problem-saturated' narratives as leading to difficulties. Therefore narrative therapies focussed on enabling individuals to develop alternative new stories and narratives about themselves to understand their experience (White & Epston, 1990). The reflecting team talk about difficulties in alternative ways and therefore propose new narratives (Dallos & Draper, 2005). Harvey (1992, as cited in Dallos & Draper) considered the responses of other people important in enabling change in narratives, therefore affirmation by therapists and family could be considered important within therapy. Narrative therapies also draw on 'externalising', which uses language to reduce blame on an individual by extracting them from the problem and talking about the problem externally from individuals and relationships (White & Epston, 1990).

1.6 Systemic approaches and the general evidence-base

This section gives an overview of the evidence for effectiveness of STs, and highlights some of the methods and difficulties in measuring effectiveness of STs.

1.6.1 Evidence for the effectiveness of STs

Carr (2014) synthesised the existing evidence-base for STs used with 'adult-focused problems' through database and manual searches including meta-analyses and systematic reviews. Carr (2014) stated that the predominant 'adult-focused problems' discussed in the article are those where controlled trial studies were available as part of literature search results. These problems were "relationship distress, psychosexual problems, intimate partner violence, anxiety disorders, mood disorders, alcohol problems, schizophrenia and adjustment to chronic illness" (Carr, 2014, p. 159), where existing evidence supported systemic interventions.

Carr's (2014) review showed promising results for STs, and furthermore reported briefly on some cost-effectiveness studies (e.g., Crane & Christenson, 2012). Carr (2014) stated his position in relation to the article's purpose "to permit the strongest possible case to be made for systemic evidence-based practices with a wide range of adult-focused problems and to offer useful guidance to therapists, within the space constraints of a single article" (Carr, 2014, p. 159). With this in mind, and no reference to a systematic literature search, Carr's (2014) search strategy may have been biased, for example, including articles where STs were effective and excluding articles not supporting effectiveness. Further concerns about the reviewed research also included Carr's (2014) own concerns regarding the tendency for research trials to use samples that may not represent those who use healthcare services.

Carr (2014) recommended inclusion of clinical samples using healthcare services in future research to assess clinical effectiveness of STs. Carr (2014) also reflected that there is less research available evaluating STs informed by

narrative and social constructionist approaches, and the majority of controlled trials are within CBT, psychoeducation, and structural and strategic modes.

NICE guidelines currently recommend STs for a range of conditions including schizophrenia, bipolar disorder, OCD, depression, and alcohol problems (Carr, 2014). However, NICE guidance omits recommendations for STs for 'panic disorder with agoraphobia' and PTSD despite the evidence available for them (Carr, 2014).

1.6.2 Measuring change in STs

Historically, there has been paucity in using standardised outcome measures to measure effectiveness of STs. This may relate to many existing standardised measures focusing on first-order change (e.g., symptoms) rather than second-order change (e.g., change in relationships). Aiming for first-order change corresponds well when difficulties are understood as within individuals, informing individual therapeutic intervention and goals. However, systemic epistemology understands difficulties as within relationships, between people, and/or associated within the system and environment, rather than located within an individual (Vetere & Dallos, 2003). Therefore, traditional outcome measures can be redundant due to difference in intervention focus and goals. Further difficulties of measuring second-order change may include dilemmas regarding who self-reports change if an intervention includes more than one person, and who defines the difficulty and how, given underpinning social constructionist philosophy.

There has been recent development of a systemic outcome measure; the Systemic Clinical Outcome and Routine Evaluation (SCORE) (Stratton, Bland, Janes, & Lask, 2010), refined as SCORE-15 (Stratton et al., 2014). The SCORE-15 is a self-report questionnaire for each family member to complete; statements about family functioning (connected with theory and practice) require a response on a likert scale to represent how well they describe their family. It

also contains qualitative questions about the family and requires a severity rating of difficulties along with a rating regarding their beliefs about the helpfulness of ST. Furthermore, Hamilton and Carr (2016) conducted a systematic review of available assessment measures of family functioning and found five measures (including SCORE) clinically appropriate (see Hamilton & Carr, 2015). These measures are specific to family members and have not yet been adapted and/or validated for use with wider system members (e.g. care staff) to the author's knowledge.

1.7 Systemic approaches in ID

Many PWIDs require support with multiple tasks of everyday living. Due to this, PWIDs are often supported by a network of people including family members, care staff, and, health and social care professionals. Furthermore, Haydon-Laurelut (2011) discussed the social construction of disability, and often PWIDs are referred for help with dominant 'problem-saturated' narratives (White & Epston, 1990). These narratives can often reflect PWIDs' experiences of disempowerment and marginalisation (Haydon-Laurelut, 2011). Therefore STs are well placed within this population. Kaur, Scior, and Wilson (2009) reported that STs were first highlighted as important in an ID context in 1967 by Russel-Davis. Despite this, it appears that STs have been applied more in ID contexts within the last 15-20 years. This section considers the usefulness and application of systemic approaches with families, how systemic approaches may be useful with the wider network, and will then discuss some applications documented in the literature.

1.7.1 Usefulness and application of systemic approaches within the family system
It is highlighted in the literature that transitions within the family lifecycle (Carter & McGoldrick, 1988) could be "out of synchrony" compared to families without PWIDs (Vetere, 1993; Goldberg et al., 1995; Baum, 2006a), for example, PWIDs moving out of home later than expected in the family lifecycle. Vetere (1993) reported that families' initial experiences of grief and loss of the

anticipated 'healthy child' that first arises with diagnosis of ID, can be reactivated at expected transition points. Stages of grief include shock, protest, disorganisation and reorganisation (Parkes, 1972). During reactivation of grief, relationships within and around families with PWIDs can be affected (Vetere, 1993) resulting in protest and blaming of themselves and/or healthcare professionals as responsible for the ID. Vetere (1993) noted that not all families reach acceptance, and 'infantilisation' can occur where PWIDs are continually positioned in a child role (Black, 1982, as cited in Vetere, 1993).

Acknowledging these difficulties, Vetere (1993) drew factors of families with healthy coping from research. She identified these factors as families with good social support, problem solving and conflict resolution abilities, equalities and working together in parenting, practical resources, orientation of aims in the present, an even balance on the opinions and needs of all members of the family, and, a focus on positives.

Vetere (1993) recommended a structural family therapy approach (Minuchin, 1974), and discussed aims of therapy including accepting diagnosis, expanding support networks, processing grief, balancing family needs, and enabling families to assist their child in developing skills (see Vetere, 1993). Goldberg et al. (1995) also recognised these grief processes, and used a reflecting team format (Andersen, 1987), with families with PWIDs, with a focus on helping families connect with their loss, and work through grief as a family in order to transition to the next stage of the family lifecycle (Goldberg et al., 1995).

Foster (1988) recommended a brief family therapy model, whereas, Fidell (2000) discussed applying different models of STs that are helpful to families at the time. Fidell (2000) also discussed a social constructionist understanding of IDs given the wider historical marginalisation discourses applied to PWID and their lack of power within systems.

Baum and Lynnggaard (2006) appear to be raising the profile of systemic work in the field of IDs, bringing together practitioners using systemic approaches to write a book 'Intellectual Disabilities: A Systemic Approach'. Within this, Baum and Walden (2006) described how they set up and evaluated systemic consultations within their ID service. They used a reflecting team format (Andersen, 1987; 1991; section 1.5.2.3); where up to three reflecting team members were present with the lead therapist and system. A 'four-part session' of a 30 minute pre-session (reflexive hypothesising with the lead therapist and reflecting team members), a 90-120 minute main session with the family, including the lead therapist interviewing the family drawing on systemic approaches including Milan (Boscolo, Cecchin, Hoffman, & Penn, 1987), post-Milan (Cecchin, Lane, and Ray, 1992), structural (Minuchin, 1974), and narrative methods (Freedman & Coombs, 1996), ending with a 30 minute discussion between clinicians.

Rhodes (2003) integrated behavioural and systemic approaches to create a model to help families with behaviour that challenges. Rhodes (2003) proposed that behavioural interventions alone would be likely lead to 'symptom substitution' and therefore 'second order' change was needed prior to behavioural interventions. Rhodes (2003), drawing on strengths of behavioural and systemic models, devised an integrated approach; 'behavioural assessment', 'mediation analysis' (assessment of the family's stressors and transitions); family therapy for families who may have become 'stuck'; behavioural intervention. Family therapy techniques were presented in more detail and included interventive interviewing (Tomm, 1988), circular questions (Tomm, 1985), questioning of continued beliefs from families of origin, reinforcing exceptions, and 'collapsing time' (MacKinnon, 1988).

1.7.2 Why systemic approaches may be useful within the wider network

As early as 1993, Vetere, suggested the importance of STs in working beyond families with PWID, drawing attention to the many health and social care, and education professionals, that may work with PWIDs.

Care staff are often an important part of PWIDs' network, with many PWIDs being supported by care staff in residential and supported living environments, their own homes, day centres, and in the community, and help PWIDs access resources. Care staff also hold power in the construction of narratives about PWIDs. Therefore, these interactions and relationships are an important part of understanding and intervening in difficulties that may arise and hence important to include care staff in systemic work. Furthermore, care staff are able to generalise their knowledge in working with other PWIDs they support.

Traditionally, psychological approaches that care staff may have been involved in are likely to have included Positive Behaviour Support interventions (Carr et al., 2002), and this is the current recommended intervention (NICE, 2015). However, there are several documented reasons in the literature for working systemically with care support staff. These include increased changes within the system (e.g., care staff/managers/clients leaving the home or starting) leading to problems emerging due to differences in beliefs, values etcetera (Haydon-Laurelut, Bissmire, & Hall, 2009), 'organisational cultures' limiting progress (Rhodes et al., 2014), difficulties in implementation of recommendations, and care staff being more knowledgeable about clients than professionals due to their day-to-day interactions with clients (Rikberg Smyly, 2006). Additionally often PWIDs do not have the power to make the changes as the changes are needed within the system (Haydon-Laurelut, Bissmire, & Hall, 2009). Rikberg Smyly (2006) reflected combining numerous perspectives from people in the PWID's network is an important part of what STs can offer. She saw this as important to empower people in the network to create "new situations, new actions, and new stories about the clients as well as themselves" (Rikberg Smyly, 2006, p. 147).

Dominant Western societal discourses about ID are that ID can be located within a person; ID is diagnosed, within a person, as a medical condition (e.g., using the DSM-V (APA, 2013)). This diagnosis therefore focuses on deficits attributed to a person. ID services predominantly based within the National Health Service (NHS) in the UK, can further perpetuate societal beliefs that ID can be located within a person. There has however been some shift through 'Transforming Care' (DoH, 2012) urging for people labelled with ID to be supported in the community as opposed to hospitals (see section 1.2).

The influence of individualistic societal beliefs on understanding of ID can be understood within the Coordinated Management of Meaning (CMM) model (Pearce & Cronen, 1980). I will first outline the CMM model and then situate understanding of ID using this model. CMM theorises that conversations and construction of meaning are influenced by a number of contextual levels. Within the CMM hierarchical model, Pearce and Cronen (2004) set out contexts of beliefs embedded within, and, having potential to influence one another (see Figure 1).

Levels of beliefs
Societal beliefs/discourses
Culture
Family beliefs
Personal/professional lifescript
Relationship
Episode
Speech act
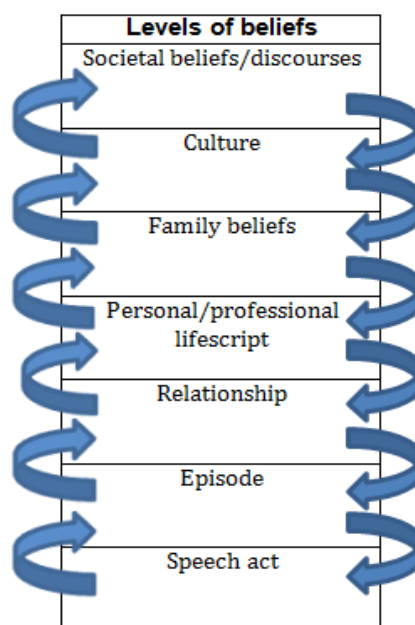
Figure 1
CMM hierarchical model (Pearce, 2004)

CMM (Pearce & Cronen, 2004) proposes that cultural and societal beliefs influence a person's family beliefs, which in turn influence that person's personal and/or professional lifescript (beliefs). These personal and/or professional beliefs contain individuals' beliefs about themselves and another person (the 'relationship'), and within this sits the immediate context (e.g. a systemic consultation) and exchange between individuals (termed the 'speech act').

Individualistic, medicalised societal beliefs about ID may influence a person's cultural, family, and personal/professional beliefs. These personal/professional beliefs of ID being a medicalised condition and within a person may be held by many members of a person's wider network. These may influence 'episode[s]' and 'speech act[s]', for example, interventions offered (episodes) and the language (speech acts) used about a person (e.g., "the PWID is challenging"). These beliefs contrast with systemic approaches where difficulties can be viewed as socially constructed and understood within relational patterns and meaning-making. Therefore, a systemically-trained clinician may hold personal/professional beliefs of a relational nature, influencing contextual levels of relationship, episode, and speech act (e.g., offering an intervention for a family, and/or the wider system), and using language that is coherent with their personal/professional beliefs (e.g., use of circular questions; narrative therapies). Systemic approaches (which can be conceptualised as the 'episode') therefore can be used to help the wider network around the person identified with an ID to understand difficulties relationally and therefore influence their personal and professional beliefs. This may ultimately influence future relationships, episodes, and 'speech acts', where 'speech acts' may be more coherent with a relational understanding, creating incoherence with individualistic deficit-based understandings, and therefore helping to reduce 'problem-saturated' narratives (White & Epston, 1990) associated with the person labelled with an ID (see section 1.5.2.4).

1.7.3 Systemic work with the wider network: A summary of possible applications

This section will outline systemic approaches discussed in the literature for working with the wider network. Most of the models documented appear to be underpinned by social constructionism (Gergen, 1985), use a reflecting team format (Andersen, 1987), are strengths-based, and therapists take a 'non-expert' collaborative approach.

1.7.3.1 Network training

Jenkins and Parry (2006) devised a 'network training' model which involved a systemic approach working with the network around PWIDs. This model was originally based around functional analysis (Clements, 1992) and adapted to integrate systemic theory and practice (Jenkins & Parry, 2006). The model brings everyone together in the support network of the PWID. It is based on a training day facilitated by two facilitators and a half day review six weeks later. Jenkins and Parry (2006) reported that the approach is based on Milan systemic principles of hypothesising, circularity, and curiosity (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980; Watzlawick, Beavin, & Jackson,1967; Ceccin, 1987) and is used where referrals are assessed to be in crisis, experiencing difficulties with communication within the network, organisational difficulties, or a complex system involved. Aims are to enable improvement in support of PWIDs through working with the system, with a focus on enabling sharing information, enhancing communication and consistency, developing a shared understanding incorporating different perspectives, and supporting the system to become unstuck. Jenkins and Parry (2006) reported initial good informal feedback, and it is yet to be formally evaluated.

1.7.3.2 Systemic consultation with clinicians

Rhodes et al. (2011) developed a systemic consultation model as a 'tertiary supervisory' intervention to enable clinicians working within a behavioural approach to think more systemically. The aim was to help with change where systems become stuck due to difficult interactions within the system or complex

interpersonal difficulties. The clinician seeking help presents to a team of six about their case. A sociogram is drawn and questions asked by the team. Rhodes et al. (2011) detailed five phases in the systemic consultations grounded in reflective ST approaches as in Andersen (1995). Firstly the clinician explained the reason for their attendance, what was limiting behavioural intervention and their goals for systemic consultation. The clinician was then asked by the 'chairperson' about 'settings' involved (e.g., professionals, schools). The reflecting team then interview the clinician asking for demographic information for a genogram. The team then hypothesise taking a curious perspective, asking questions regarding interactions, relationships, and coinciding/preceding events to the onset of the behaviour that challenges. Reflective conversations are held within the reflecting team observed by the clinician. Reflections highlight strengths of the clinician, tentative themes, and understandings of the case. The clinician is then invited to comment on reflections, and a letter sent. Rhodes et al.'s (2011) model appears to focus on involvement of a reflecting team and conceptualises how behavioural and systemic approaches can work together. This approach could have wider implications, for example, it could be suitable for more people involved in the PWID's support system. Rhodes et al. (2011) described an account of their clinical work using systemic consultation, in which they were able to facilitate thinking of the relational aspects of the case and potential reasons behind difficulties parents had in implementing a behavioural programme. This approach has recently been formally researched (Fennessy et al., 2015; Rhodes et al., 2014) and detailed within the systematic literature review.

1.7.3.3 Systemic approaches with care staff teams

Haydon-Laurelut, Bissmire, and Hall (2009) presented their work within a model of systemic consultation with staff teams in ID services. They discussed initial self-reflexive hypothesising upon referral. Haydon-Laurelut et al. (2009) also recommended negotiating with management regarding who to invite to consultations to ensure commitment to change. A 'non-expert' position was

adopted by therapists as care staff working with PWIDs know them well. Therefore, a collaborative approach where the care staff's knowledge, beliefs, and resources are worked with is more likely to enable change through collaboration. Haydon-Laurelut et al. (2009) however recognised it was often necessary to shift into an expert position (e.g., to give information about care plans techniques) which they felt was a concern when taking a systemic approach. Haydon-Laurelut et al. (2009) discussed the importance of 'warming the context' (Burnham, 2005) due to methods used within systemic consultations being 'unusual' compared to those normally used in meetings with professionals, encompassing transparent explanations of methods and techniques. They discussed using methods of 'appreciative inquiry' (Cooperrider & Srivastva, 1990), engaging staff in conversations focussed on their strengths and skills of managing things well. Haydon-Laurelut et al. (2009) discussed the importance of providing opportunity for each staff member to give their views, being heard by their colleagues and the consultation team. They also considered initially investigating the lifecycle of the organisation through eliciting information though interviewing staff in consultations. Reflections were given in a format consistent with Andersen (1987) which along with the interview methods gave opportunity for staff to engage in self-reflexivity (Burnham, 2005).

Rikberg Smyly (2006) applied literature in the field of systemic work with organisations (Campbell, Coldicott, & Kinsella, 1994; Huffington & Brunning, 1994; Campbell, 2000) to working in 'group homes'. She highlighted the significance of therapists' roles in STs as "enabl[ing] others to solve [a problem]" (p.162-163), taking a 'non-expert' facilitative position. Rikberg Smyly (2006) documented helpful areas for therapists to take into account. These areas were defined as 'agency life-cycle stage' 'beliefs, attitudes, and expectations of the staff team' and 'encouraging participative conversations', and are outlined below.

Agency life-cycle stage: Here, the focus is on changes in the organisation or the 'group home', including changes in staffing (e.g., difficulties recruiting and/or

maintaining a consistent staff team), organisational structures (including anticipated tasks of care staff), and the addition and/or departure of PWIDs. Rikberg Smyly (2006) also explained that depending on the details of these changes, it is important to think about which system members to work with (e.g., support staff; managers; 'other relevant stakeholders') at which stage.

Beliefs, attitudes, and expectations of the staff team: This topic considers the different underlying beliefs behind behaviours held by individuals within the network. These include beliefs about help-seeking which can be informed by previous experiences with services and thus may be important to explore. Reder and Fredman (1996) also discussed beliefs about help-seeking and the importance of attending to this from early on in therapy. This appears especially important within IDs where PWIDs are often referred for help with beliefs from others that the 'problem' is located within the PWID (Haydon-Laurelut, 2011). Given this is different to a relational systemic approach, conversations about help-seeking beliefs may be even more important. Rikberg-Smyly (2006) also described wider beliefs within this, including beliefs among staff about disabilities, current difficulties and resolutions previously tried, and, knowledge of PWIDs' past and communication with others in their network.

Encouraging participative conversations: Including many people encompassed by the problem from the network, is reported to be most beneficial. Rikberg Smyly (2006) reported that this was important to limit the '"outside-expert" stance to reduce the power associated with collecting information from individuals separately. This is important to aid communication of each person's story helping the system to co-construct meaning, by coming to an understanding of changes required (Rikberg Smyly, 2006).

1.7.3.4 Issues in applying STs in ID settings
Baum and Walden (2006) reported dilemmas in setting up systemic consultations such as organising sessions for each person to attend, where

consultations were held, inclusion of PWIDs, different ideas about who needs help (i.e., often families presenting views that the individual with an ID needed to be "fixed"), and a need to include the wider network (e.g., care staff). They also discussed their methods of evaluation focussing predominantly on attainment of goals, and reflected on the difficulty of measuring the types of change worked towards within systemic approaches in an ID population. Baum's evaluation is more formally documented in Baum (2006b) and discussed within the systematic literature review. Adaptations for PWIDs included such as a slower pace of therapy and using drawings and role-play have also been considered (Fidell, 2000; Vetere, 1993). Dilemmas of advocating for PWIDs and upholding curiosity have also been considered (Anslow, 2014).

1.8 Evidence-base of systemic approaches in ID

Research in STs in IDs is still in its infancy with limited process and outcome research. The majority of literature is descriptive; describing techniques and adaptations and describing case examples (e.g., Haydon-Laurelut & Nunkoosing, 2010). Non-peer-reviewed research will be described and critically analysed, followed by presentation of the systematic literature review and a critical review of these.

1.8.1 Non-peer-reviewed studies

Perspectives of STs have been studied using Interpretative Phenomenological Analysis (IPA). An unpublished thesis (Arkless, 2004) conducted interviews with six PWIDs, and ten family members of PWIDs, about their experiences of STs. Arkless' (2004) study found three major themes with both samples; 'relationship to help, value of therapy and having a voice versus being silenced'. The interview schedule used by Arkless (2004) contained questions relating to 'general information', 'relationship to help', 'view of the problem', 'process/techniques of therapy', 'changes', 'service development' and 'process of interview'. Participants were recruited across five community learning disability teams. Due to the number of settings participants were recruited across, there may have

been more variance between systemic approaches practised. The research was ethically sound and Arkless (2004) provided transparency through stating her stance (Elliot, Fischer, & Rennie, 1999). Some PWIDs were interviewed with another family member which may have inhibited participants' accounts. There was variance between the points of therapy that participants were interviewed at which may have elicited some differences (e.g., anxiety about ending).

Petrie (2011) interviewed four PWIDs about their experiences of the reflecting team (Andersen, 1987) in family therapy. Petrie does not outline methodological details, therefore its strengths and limitations are difficult to appraise. Petrie (2011) discussed four main themes from using IPA to analyse the data: 'feeling excluded'; 'feeling heard'; 'having strengths recognised' and the 'therapeutic relationship'. Petrie (2011) reported feelings of exclusion related to the reflecting team format being unusual and breaking social norms of conversation. Positive aspects of the reflecting team included being complimented, with Petrie (2011) reporting that these parts were one participant's key memory of the therapy. Petrie (2011) provides strong clinical implications of the research; recommending that practitioners explain the reflecting team format further and give a choice to whether this is used.

I evaluated a learning disability service's systemic consultations investigating service usage before and after systemic consultations, and experiences of two multidisciplinary team (MDT) members (Johnson, 2015). There were different patterns of service usage shown in the small sample size and due to uncertainty regarding the data accuracy, it was difficult to provide firm conclusions. Interviews were analysed using principles from a thematic analysis approach, and revealed interesting themes of 'differing expectations'; 'positive techniques' 'uncertainty regarding forum composition'; 'strengthening the network', and 'enabling for the client'. Service recommendations included discussing and repeating the rationale for using systemic consultations, discussing professionals' roles within consultations, offering a choice of who to invite and whether a

reflecting team is used or not (consistent with Anslow, 2014, and, Petrie, 2011), providing systemic training for professionals, and checking adaptations made for PWIDs are appropriate. As this was a service evaluation and had a small sample size, it was limited in recommendations beyond the service.

1.8.2 Systematic literature review

A systematic review of the literature was carried out to identify empirical quantitative and qualitative research in the field of systemic interventions in IDs. Search terms used were broad due to the current limited evidence-base. The search was carried out on 27th October 2015 on databases AMED, HMIC, PsycINFO, and CINAHL, using search terms (learning disab* OR mental retard* OR intellectual disab*) AND (systemic family therap* OR systemic therap* OR family therap* OR system* consult* OR reflect* team). Results were reviewed, and articles excluded if they concerned a different form of systemic therapy (i.e., non-psychological, e.g., dentistry), were duplicates, or unavailable in English. Further exclusion criteria included articles outside of empirical research including descriptive (e.g., describing clinical work) and theoretical articles, and/or if STs were mentioned briefly. Figure 2 displays the assessment process.
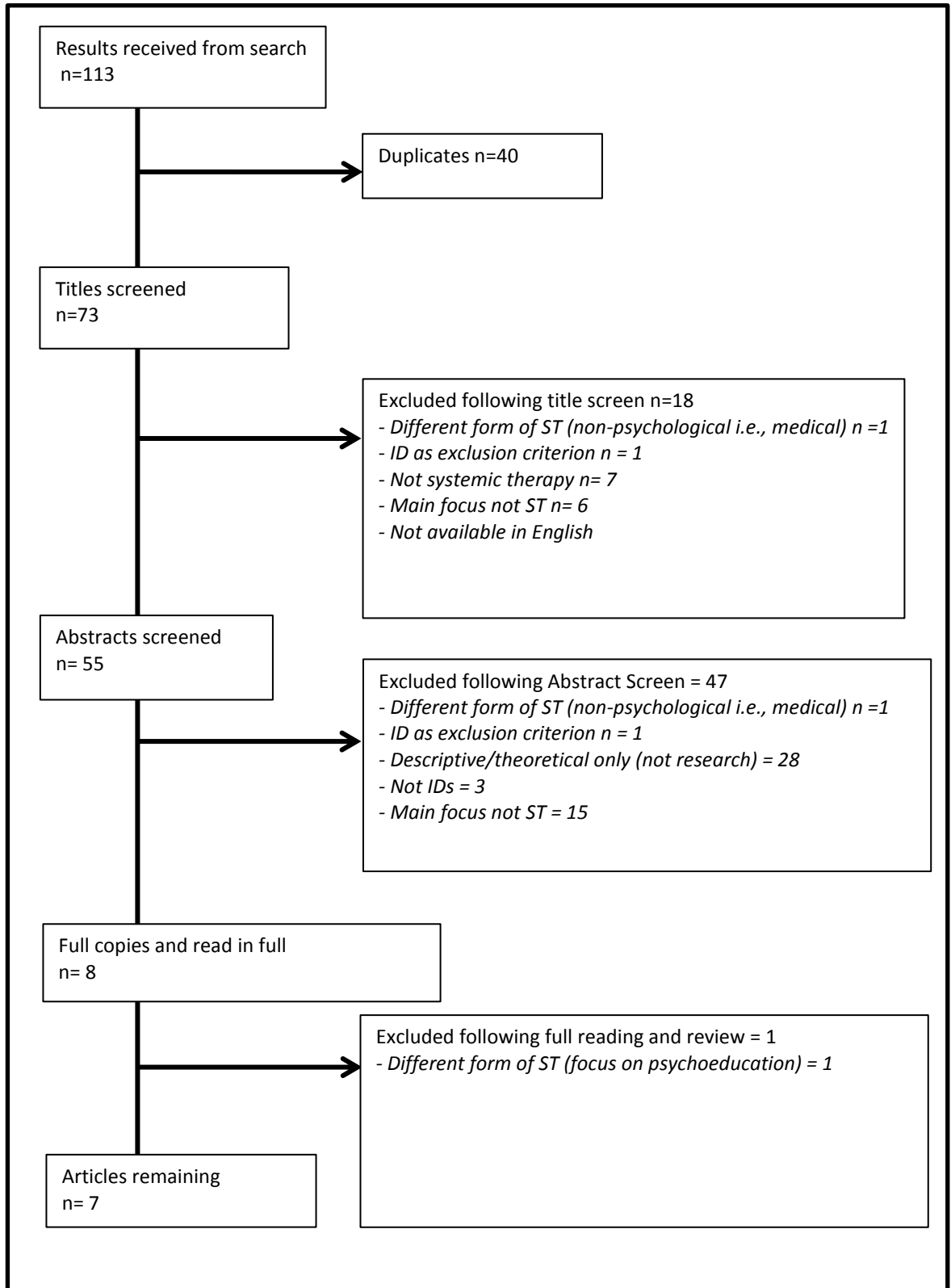
Figure 2
Literature Search Process

Seven key articles were retrieved and reference lists and citation searches from these along with a key text (Baum & Lynggaard, 2006) and Doctoral dissertation (Arkless, 2004) were screened for key missing articles. No further empirical peer-reviewed research was found. All seven key articles were reviewed and critically appraised. I have presented descriptions and critiques of the articles in sections 1.8.2.1-1.8.2.4, dividing the findings into sections according to the focus of research. Qualitative research is evaluated against quality and validity criteria proposed by Yardley (2015). The first section critiques an article on the use of systemic approaches within ID services, the second and third include critique of research on systemic consultations in ID services (the second with families and the wider network, and third using systemic consultations as a supervisory model), and fourth section on research analysing topics of vulnerability and protection within STs. The systematic literature review closes with synthesis of findings in section 1.8.2.5. A table is also provided in Appendix A summarising the studies and their strengths and weaknesses.

1.8.2.1 Use of systemic approaches in IDs

One study investigated the use of systemic approaches in NHS ID services; Kaur, Scior and Wilson (2009). Fifteen participants responded on behalf of 14 services to questionnaires covering use of STs, models of STs, supervision, resources, training, and evaluation. Kaur et al. (2009) found that 55 clinicians were delivering STs across the 14 services, and a mean of 46% of referrals were worked with systemically. Most clinicians were Clinical Psychologists, and seventeen trained to diploma/masters level in STs. Seven services had designated 'family therapy clinics'. STs mostly included PWIDs and their support network, and the next common structure excluded PWIDs. Services varied between an individual therapist working independently and teams of two or more clinicians. A range of social constructionist, narrative, Milan, post-Milan and brief solution-focussed models were used and most commonly an integrative approach.

All participants viewed determining an evidence-base for STs in ID services as important, however, experienced barriers in evaluation. Barriers included limited formal systemic training, time constraints, uncertainty regarding whose views to obtain, small sample, restricted finances, MDT's limited understanding of systemic work (leading to few cases referred), issues working in different environments, and service outcome measures being unsuitable in evaluating systemic work. Kaur, Scior and Wilson's (2009) research illustrated complexity of evaluating systemic work and urged the importance of collaboration and prioritising evaluation, along with training in systemic approaches across MDTs. Although some services may have been missing, a strength of the study is that it looked across services in the UK. Kaur et al. (2009) identified limitations of a small sample size, homogeneity in professional discipline, and exclusion of other clinicians' views in the service.

1.8.2.2 Systemic consultations with families and the wider network

Three studies evaluated systemic consultations with families and the wider network: Baum (2006b), Anslow (2014), and, Rikberg Smyly, Elsworth, Mann and Coates (2008). All studies used a reflecting team and are detailed and critiqued below.

Baum (2006b) presented findings of an initial service evaluation of family therapy intervention in IDs using a reflecting team format (Andersen, 1990) (detailed further in section 1.7.1) (Baum & Lynnggaard, 2006). Baum (2006b) explored creation of goal-focussed outcome instruments completed by clinicians and found inter-rater reliability. Satisfaction questionnaires were also devised for different members of the network. Nine families were seen for family therapy. Themes of therapy were explored, and they included childhood to adulthood transition, 'life-threatening illness' of three fathers, 'bereavement and loss', 'chronic sorrow', 'triangulation and scapegoating', 'marital difficulties', 'sibling relationships', 'fear of violence', and 'captive' or 'captivated' parents. Models of therapy included Milan ST (Selvini, Boscolo, Cecchin, & Prata, 1980)

and Structural Family Therapy (Minuchin, 1974). Goals were achieved for four families, and could not be reported for five families due to therapy continuing, or families terminating therapy prematurely.

The descriptive data gives insight into some of the themes appearing when working systemically in IDs. It also highlights complexities of data collection when families discontinue, and the lack of standardised outcome monitoring tools for STs within IDs. Limitations of the research include a small sample, use of non-standardised outcome measures, missing data, and lack of a control group. Outcome forms were completed retrospectively by clinicians, and therefore perspectives of families were missing.

Another study (Anslow, 2014) interviewed five adult participants with IDs about their experiences of STs. Anslow (2014) found superordinate themes via IPA that comprised 'Therapists' focus on strengths and difficulties', 'Differences in meta-cognitive abilities', 'Finding a voice in therapy', 'Frustration with the outcome of therapy' and 'Managing an unusual experience'. Participants differed in their ability to understand different views. 'Finding a voice in therapy' represented powerlessness through communication difficulties with therapists and empowerment that therapists were 'speaking up for them'. Anslow (2014) discussed the dilemma of therapists remaining 'neutral' (Selvini, Boscolo, Cecchin, & Prata, 1980) alongside their advocacy role for PWIDs, and the need for therapists to be aware of this dilemma to reduce effects on other system members. 'Managing an unusual experience' reflected participants' confusion regarding the reflecting team process. 'Frustration with the outcome of therapy' was underpinned by a desire for more 'doing' and requiring continuing help. Ambiguity regarding delineation of outcome was also discussed. 'Frustration with the outcome of therapy' may have also been influenced by interviews being completed soon after a ST session, however, due to second-order change expected within STs (as Anslow discussed) and subsequent visible changes may take longer to develop.

Anslow's research was rigorous and valid, meeting quality criteria proposed by Yardley (2015). Anslow built on Petrie (2011), interviewing participants shortly after a therapy session, and used DVD recordings of their latest session to maximise recall. This was a strength of the research, along with validity where participant and therapist feedback on analyses was sought. It was also ethically sound. Anslow (2014) based her interviews on the Helpful Aspects of Therapy Questionnaire (HATQ) (Llewelyn, 1998). This was following the strengths of Lloyd and Dallos (2008) who evaluated mothers' experiences of solution-focussed brief therapy.

A further study, Rikberg Smyly, Elsworth, Mann and Coates (2008), analysed written data from telephone interviews with 64 participants (5 carers/service users; 39 care staff; 20 professionals) on the helpfulness of initial systemic consultations in an ID service. Data was analysed using content analysis and coded into categories of 'only positive'. 'mainly positive', 'both positive and negative', 'mainly negative' and 'only negative' using unstandardised cut-offs, and themes identified.

Rikberg Smyly, Elsworth, Mann and Coates (2008) found that most participants gave positive responses (86%) and found systemic consultations helpful/useful (97%). There were differences between groups of participants; 100% of carers/service users gave only/mainly positive comments, compared with 90% of care staff, and 75% of professionals gave only/mainly positive comments. Mainly negative comments were given by 25% of professionals. Rikberg Smyly et al. (2008) made sense of this by reflecting on power difference between participant groups. Themes arising from positive feedback included finding systemic consultations helpful/useful, feeling able to voice opinions, enabling 'broadened perspectives', 'a positive focus', helping with next steps/giving ideas, and being 'satisfied with the outcome'. Reflections provided by the reflecting team were the main basis of helpful experiences. Themes from negative

comments included an unfamiliar/uncomfortable structure, feeling 'unprepared', worries about the PWID attending, and being unable to see an outcome or not understanding or remembering systemic consultations. Feeling able to voice opinions arose more for care staff than others and 'a positive focus' and 'feeling unprepared' arose more for professionals and carers/service users than care staff. Rikberg Smyly et al. (2008) recommended that more information should be provided about systemic consultations prior to attending.   The authors highlighted limitations of the research, including, that they evaluated only the initial systemic consultation and families/service users were under-represented.

Strengths of Rikberg Smyly et al. (2008) comprised inclusion of views from different attendees, evaluation of systemic consultations within the same service reducing extraneous variables (e.g., therapist factors of rapport and experience), and credibility checks with another coder. Interviews were not transcribed, and unknown factors may have influenced responses due to interviews conducted via telephone.   Content analysis appeared a reasonable method to manage a relatively large sample of qualitative data. However, this method can limit the level of detail obtained.   Content analysis may miss linguistic and more conceptual elements relying only on the words participants use. Categorising interview data into positive/negative categories may overlook salient parts of participants' experiences (e.g., one negative comment may have outweighed positive comments). Categorisation may also have been biased, grounded in the coders' personal perceptions of positive and negative, rather than the meanings for participants.

These three studies add to the literature regarding the effectiveness of systemic consultations using a reflecting team format. The quality of the research varied. Baum (2006b) added initial themes and outcomes in working within an integrated systemic model using a reflecting team format. Anslow (2014) provided rich data understanding the experiences of adults with IDs of the reflecting team format, and Rikberg Smyly, Elsworth, Mann and Coates (2008)

provided an overview of experiences of attending initial systemic consultations from different perspectives.

1.8.2.3 Systemic consultations used as 'tertiary supervision'

Two studies evaluated effectiveness of systemic consultations as a 'tertiary supervision' model for clinicians (see section 1.7.3.3 for model details (Rhodes et al., 2011)); Fenessey et al. (2015), and Rhodes et al. (2014). The studies are detailed and critiqued below.

Fennessy et al. (2015) evaluated systemic consultations provided to Case Managers in ID services. Twenty-four participants were divided between research and comparison groups. The research group participated in an initial and follow-up systemic consultation, whereas the comparison group received usual supervision only. Grounded Theory was used to analyse transcripts, genograms and 'field notes' from systemic consultations. Themes identified were 'stuck and stressed', 'zooming out', and 'becoming an agent of change'. 'Stuck and stressed' represented Case Managers coming to systemic consultations feeling stuck in their interactions with families, poor communication between services, and incongruence between families asking and rejecting support. Case Managers felt that systemic consultations helped them in 'zooming out', enabling a reflective, overarching view, and reducing reactive support strategies. Some Case Managers felt more hopeful following systemic consultations, and many reported increased confidence and ability to implement new ideas with authority. In contrast, two Case Managers doubted their capacity to influence change.

Using quantitative measures, Fennessy et al. (2015) found additional evidence for effectiveness of systemic consultations. A near significant decrease in stress on the Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) was found after systemic consultations compared to before. The organisational systems questionnaire (OSQ; Billings, Kimball, Shumway &

Korinek, 2007) revealed improvement (near significant) in Case Managers' views of the functioning in their organisation. Case Managers also needed to seek advice from less people following systemic consultations, and the 'flow' of information between network members became more efficient.

Fennessy et al. (2015) reported strength in the validity of their research due to triangulation of data from different sources, however, omitting family members' views may have missed potential different outcomes experienced indirectly. Further limitations include exclusion of clinical significance in quantitative measures. There were strengths to the qualitative part including rigorous data analysis, reports of examples of disconfirming themes, and maintenance of a 'paper trail' (Yardley, 2015). The research was important as according to the authors, it was the first evaluate systemic consultations for Case Managers in ID services.

Rhodes et al. (2014) used thematic analysis based on grounded theory techniques to evaluate the experiences of eleven behaviour support clinicians attending one systemic consultation. The longitudinal study interviewed participants before, immediately afterwards, and two months after the systemic consultation. The format of systemic consultations was in line with Rhodes et al. (2011).

Rhodes et al. (2014) found that participants experienced relationships difficulties with carers before they attended systemic consultations and hoped that systemic consultations could help them to "gain some distance" to become unstuck. Following systemic consultations, clinicians became more focussed on relationships including their role in these, and were able to use skills learned through modelling from consultations. Skills included facilitating carers to focus on relationships, supporting the system in helping themselves, and reflecting on their strengths. Rhodes et al. (2014) also found "barriers to change" including difficulties applying a different approach if contrary to the clinicians'

organisation's approach. Clinicians with less experience could feel overwhelmed due to the difference in the approach not providing structure, eliciting more uncertainty than familiar behavioural approaches. Some participants desired advice and more systemic consultation sessions. Rhodes et al. (2014) made recommendations for more systemic consultations to be offered, for organisation managers to attend, and for training in a systemic approach.

It was unclear who had interviewed participants in Rhodes et al.'s (2014) research, and therefore the relationship between interviewer(s) and participants could not be understood. One can speculate bias in participants' accounts towards reporting positive effects if interviewer(s) was/were part of the reflecting team. A power imbalance may have also been present given that some participants wanted more consultations. The study appeared rigorous and triangulated observations with interview data. An audit trail and checking analyses with reflecting team members was also incorporated, adding strength to the research. Yardley (2015) recommended searching for disconfirming cases; this did not appear to be mentioned, although there were accounts described when there was only one participant who had commented on something specific.

1.8.2.4 Vulnerability and Protection in STs

Pote, Mazon, Clegg, and King (2011) explored themes of vulnerability and protection in four videotapes of three families receiving STs. The format of STs was unclear and therefore it is unknown whether a reflecting team was present. Sessions were attended by PWIDs and their families. Thematic and conversational analyses were used to identify specific themes of vulnerability and protection in therapy extracts. Discussion on vulnerability and protection was found for 25% of ST time. Vulnerability and protection were identified in members of the system endeavouring to protect the PWID from the ID and its 'consequences', 'physical harm', 'peers', 'siblings', 'the world at large', 'emotional distress', and other potential risks. Parents protected siblings from the PWID and monitored them to ensure they did not have a disability. The PWID

protected their family and broader system members from difficult discussions, and protected themselves from negative associations in relation to their view of increasing independence.

Pote, Mazon, Clegg, and King (2011) found through conversational analysis that all system members (PWID, family, and therapist) used strategies to protect each other within conversations. Five different strategies were used with the most frequent being to change the topic and reverse the narrative from positive to negative (by client or family), or negative to positive (more common in therapists 'reframing'). Pote et al. (2011) discussed clinical implications including therapists normalising and enabling talk about protection, and to be aware of the 'triangulation' of protectiveness (all in the therapy room protective towards each other), and for protectiveness to be commented on when displayed in conversations. Self-reflexivity of therapists was also recommended to think about their own feelings of protectiveness.

Strengths of the study critiqued against Yardley (2015) included its rigour, validity checks, transparency in the authors' positions, detailed explanation of analysis method, and exploration of alternative meanings of data outside the 'protection' lens. Limitations included limited explanation of thematic analysis, and inaccessibility engaging with conversational analysis examples due to specialist transcription. A limitation (acknowledged by Pote, Mazon, Clegg, & King, 2011) was caution needing to be applied to the level of interpretation made due to PWIDs' varying communication abilities.

1.8.2.5 Synthesis of systematic literature review

Overall, there were seven key empirical research articles within the area of STs in IDs. Of these articles, one used a quantitative design, two mixed methods, and four qualitative. Across the research, informants varied between therapists, family members, case managers, service users (PWIDs), multidisciplinary

professionals, care staff, and, clinicians trained in behavioural interventions. Therefore, different perspectives were gained.

Research methodology varied across the research including using and analysing standardised and non-standardised self-report questionnaires, interviews, field notes, and extracts from STs. Methods of analysis also varied; from reports of descriptive data, independent t-tests, to qualitative analyses including content, conversational and thematic analysis, grounded theory, and IPA. Some studies had methodological limitations.

Limited articles were obtained from the systematic literature review. This reflects the lack of research completed within STs in IDs. Kaur, Scior, and Wilson (2009) corroborated this. Kaur et al. (2009) found that although systemic approaches were being used within different ID services, there were significant barriers to evaluating systemic work, and called for collaboration for evaluation and raising the profile of STs in IDs. From the wider literature (outside of the systematic literature review), interest is shown in writing about using STs in IDs, with several articles and book chapters dedicated to STs in IDs (section 1.7).

Kaur, Scior, and Wilson (2009) found a range of STs were being used including social constructionist, narrative, post-Milan, brief solution-focussed, and Milan, with the most common approach being integrative. Five articles evaluated systemic consultations using a reflecting team format (Andersen, 1987). In addition to this, integration of systemic approaches were reported in Baum (2006b) (reporting use of primarily structural (Minuchin, 1974), and Milan ST techniques as well using hypothesising, neutrality and circularity (Boscolo, Cecchin, Hoffman & Penn, 1987) and Rhodes et al. (2014) (reported primarily Milan ST; Selvini, Boscolo, Cecchin, & Prata, 1980), integrating structural, solution-focused and narrative models). Due to this integration of models, evaluation STs becomes more complex.

There were different themes that arose within ST sessions (Baum, 2006b), and Pote, Mazon, Clegg, and King (2011) found further evidence for the themes of vulnerability and protection in content and process from therapy extracts.

Within the five articles evaluating systemic consultation models of STs, they all used a reflecting team format (Andersen, 1987; 1990). Differences appeared within how they were used; one stream with families and/or care staff (Baum, 2006b; Rikberg Smyly, Elsworth, Mann, & Coates, 2008; Anslow, 2014), and the other stream providing 'tertiary supervision' to clinicians (Fennessy et al., 2015; Rhodes et al., 2014). This shows wide applicability of the reflecting team method within ID services.

Within the reviewed systemic consultation articles, one focussed on the perspectives of PWID (adults), three on clinicians' perspectives, and one multiple perspectives (carers/service users, care staff, and professionals). Fennessy et al.'s (2015) found a decrease in Case Managers' levels of stress, an increase in efficiency of the system information flow, and Case Managers needing to consult less people for advice following systemic consultations. This was in comparison to no changes within a control group.

Similar themes were reported across studies evaluating perspectives with different clinicians (Case Managers in Fennessy et al., 2015; behaviour support clinicians in Rhodes et al., 2014). Themes included coming to systemic consultations with difficult relationships with carers, feeling 'stuck and stressed', and hoping to 'gain some distance'. Systemic consultations helped clinicians in 'zooming out' and focus more on relationships. They also helped to increase clinicians' confidence implementing change, and use skills learned within systemic consultations. Some 'barriers to change' however were experienced (Rhodes et al., 2014) including newer clinicians feeling overwhelmed by the approach. This theme was similar to Anslow's theme of 'Managing an unusual experience' in her analysis of adults with IDs' perspectives, and Rikberg, Smyly,

Elsworth, Mann & Coates (2008) themes of an unfamiliar structure that was uncomfortable/odd, and feeling unprepared which occurred for some MDT professionals and care staff.

Many of Anslow's (2014) themes corroborated with Rikberg, Smyly, Elsworth, Mann & Coates' (2008) including 'therapists focus on strengths and difficulties' with 'a positive focus', 'finding a voice in therapy' with 'able to express a view', 'finding a voice in therapy' with 'concerns about a service user attending', and 'frustration with the outcome of therapy' with 'no outcome/lack of understanding or memory of the meeting'.

The current evidence-base indicates initial evidence that systemic consultations using a reflecting team method (Andersen, 1987; 1980) can be helpful for a number of different members of systems around PWIDs. However, some uncertainties have presented within the findings relating to reflecting teams being an unfamiliar experience for many. The evidence-base needs to be developed in order to understand effectiveness and acceptability of systemic approaches in ID.

1.9 Conclusions and rationale

Empirical research within STs in IDs is in early stages, evidenced by limited peer-reviewed research. However, initial research provides a promising start within this field. In addition, clinicians have written about the use of STs in IDs, describing their work and theory-practice links. The beginnings of research in an area often start with small case study designs and descriptive data, which is evident in this case. However, there has also been some sound qualitative research into the area of systemic consultations using the reflecting team format, developing some initial knowledge about the experiences of individuals of attending systemic consultations. There are clearly many avenues for further research in this field. Process and outcome research are needed to help develop the evidence-base of STs in IDs. Given the limited research available,

methodological limitations of some studies, and relatively small sample sizes, only tentative conclusions can be made about the effectiveness and acceptability of a systemic approach in ID. Initial research points towards both helpfulness and some uncertainty regarding the format of the reflecting team.

From reviewing the literature, care staff's perspectives appear particularly underrepresented. This current research aimed to explore the experiences of care staff's experiences of systemic consultations to understand these underrepresented perspectives. This is especially important due to the number of PWIDs who are likely to be supported by care staff. This research drew on methodological strengths of existing research using qualitative approaches (Anslow, 2014; Arkless, 2004).

1.10 Research Questions

This study focusses on the following research question:

- How do care staff experience systemic consultations that they have attended in ID services?

Supplementary research questions are also asked:

- o What do care staff find helpful in systemic consultations?
- o What do care staff find unhelpful in systemic consultations?

2. Methodology

In this section, I will begin with outlining why a qualitative design was chosen and detail the chosen methodology of Interpretative Phenomenological Analysis (IPA). I will also outline alternative methodologies I explored initially and detail my stance and epistemology as the researcher and analyst in this research. I will then go on to report on ethical issues, the recruitment process, participants, method of data collection and data analysis. I will conclude with describing the research's adherence with qualitative research standards.

2.1 Qualitative Design

Qualitative designs can generate rich in-depth information, and can be useful when research in particular areas are in their infancy. A quantitative approach did not seem to fit the early stage of research within the field of systemic approaches in ID services. Given the findings from the systematic literature review, a qualitative design was deemed most appropriate for this research.

As highlighted in the systematic literature review (section1.8.2), thus far there has been only one published study known to the author, Rikberg Smyly, Elsworth, Mann, and Coates (2008), that has investigated the experiences of care staff in IDs of systemic approaches, specifically, of the first systemic consultation. Although Rikberg Smyly et al. (2008) separated their results, the study's focus was on care staff, family, and professionals who had attended an initial systemic consultation. Interviews were conducted over the telephone and the method of analysis used was content analysis.

2.2 Interpretative Phenomenological Analysis (IPA)

The current research employed IPA (Smith, 1996; Smith, Flowers & Larkin, 2009). IPA is an idiographic approach (Smith, et al., 1999); it is concerned with in-depth understanding of a person's 'lived experience'. IPA is grounded in phenomenology, hermeneutics, and idiography, which will now be discussed.

Phenomenology: Phenomenology is the study of lived experience. The school of phenomenological philosophy includes the work of Husserl, Heidegger, Merleau-Ponty, and Sartre. Smith, Flowers, & Larkin (2009) described the work of these philosophers and summarised its influence on IPA. Through these philosophers' work, phenomenology sees that understanding of experience occurs through an individual's personal and unique perspective. It understands experience as 'embodied'; understanding one's own experience is through living in their own bodies and encounters with the world and others through this. According to Smith et al. (2009), Merleau-Ponty described the understanding of our own experience being embodied as different to understanding someone else's experience through different means; we can only observe others' behaviour, expression and language and understand from our own embodied experiences. Smith et al. (2009) discuss Husserl's emphasis on the need to 'bracket' our own preconceptions to enable understanding of the experience under examination. However, we are born into a pre-existing world and hence cannot be isolated from this. Sartre (also discussed by Smith et al. (2009)) illustrated experience in relation to absence as well as presence of others. Hence, experiences are relational to the world and others. Reflexivity and 'bracketing' are therefore important in IPA to understand this 'intersubjectivity' termed by Heidegger according to Smith et al. (2009), meaning our being in relation to the world and others.

Hermeneutics: Smith, Flowers, and Larkin (2009, p.21) describe hermeneutics as "the theory of interpretation". Hermeneutics started with interpreting biblical writings, and has since been applied to a variety of texts. Smith et al. (2009) and Smith (2007) credit Schleiermacher, Heidegger, and Gadamer with contributing significantly to hermeneutics. They described Heidegger linking phenomenology and hermeneutics. Hermeneutics views the analyst as discovering explicit and implicit meanings of texts. Hence in IPA, interpretation goes beyond explicit content of participants' utterances. It also recognises that the presence of

analysts' preconceptions and experiences influence interpretations. As interpretation progresses, the analyst is able to identify their preconceptions. Smith et al. (2009) described the implications of this on 'bracketing', which they understand cannot be fully accomplished and is an 'iterative' process, which one must continually go to and fro to understand the analyst's preconceptions. The hermeneutic circle influences IPA; to make sense of data, the analyst constantly moves to and fro between the part and the whole. The part is understood in context of the whole and vice versa. Smith et al. (2009) explain this process permeating through each layer of analysis; from one word as the part, to the sentence it is within as the whole, between one excerpt to the whole text, and, one interview as a part to the research as a whole, etcetera. They describe this as an iterative process and hence non-linear.

Idiography: Smith, Flowers, and Larkin (2009) described idiography as a focus on the 'particular'; IPA is a detailed and in-depth analysis. IPA underpinned by idiography is also concerned with a distinct "experiential phenomena (an event, process or relationship)... understood from the perspective of particular people, in a particular context" (Smith et al. 2009, p.29). This juxtaposes a nomothetic approach where the focus is on understanding general experiences, often using statistical analyses and averages. Smith et al. (2009) explain that IPA uses single case analysis progressing to careful generalisations, still speaking to the particular of the experiences of individual analyses.

Drawing it together in IPA: Smith (2004; 2011) explains that IPA uses a 'double hermeneutic'. From this perspective, "[T]he participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p. 40). Furthermore, positions of both empathy and questioning are taken.

IPA has been successfully used in a number of studies exploring experiences of individuals attending systemic consultations in learning disability services

(Anslow, 2014; Petrie, 2011; Arkless, 2004). This suggests that it is a suitable approach to explore experiences of systemic consultations.

2.3 Exploration of alternative methodologies

I chose IPA after contemplating other research methodologies. I considered Thematic Analysis (guided by Braun & Clarke, 2006) due to its flexible approach. Thematic analysis was used by Rhodes et al. (2014) and Pote, Mazon, Clegg, and King (2011). I had also used Thematic Analysis principles in my small-scale service-related project (Johnson, 2015) (and in a previous project) and hence was familiar with the analysis. However, IPA appeared to complement the research questions more than Thematic Analysis, with the research focus on how care staff make sense of systemic consultations, and IPA specifically examining how a phenomenon is understood from a particular perspective. IPA was able to provide a more in-depth analysis and interpretations at different levels.

I also considered using Grounded Theory (Glaser & Strauss, 1967; Charmaz, 2015). Fennessy et al. (2015) used Grounded Theory, and Rhodes et al. (2014) drew on principles of Grounded Theory within their Thematic Analysis. Grounded Theory is a comprehensive qualitative methodology that can enable theory development. Although a strength of the methodology, I felt that due to limited research in the area, this step may be too soon for the research stage of systemic consultations in ID services. Exploring paid carers' experiences of systemic consultations in-depth appeared more fitting with the current stage of the evidence-base. Therefore, IPA was considered more appropriate to enable understanding of individual perspectives in detail prior to developing theory which may have wider generalisations, and risk overlooking unique alternative perspectives.

2.4 Epistemological position and researcher stance

It is important to state my own stance and relevant experiences to 'own [my] perspective' (Elliot, Fischer, & Rennie, 1999) and be reflexive throughout this

research to enhance validity. This is especially important due to the 'double hermeneutic' in IPA research. The reliance on the analyst to interview and analyse data requires the analyst to discover their preconceptions and understand the influence of these on analysis, 'bracketing' their own experiences as much as possible. IPA recognises that some preconceptions may only appear during the process of analysis (Smith, 2007). Here, I will present my relevant experiences and stance that I was aware of prior to starting the research. Additionally, I kept a reflective journal throughout the research which helped in developing my awareness of my further preconceptions.

My interest in systemic approaches in ID services dates back four years to my Assistant Psychologist post in a Community ID Team. I was fortunate to be invited into a reflecting team in systemic consultations which saw a combination of PWIDs, families, professionals, and care staff. I remember the process of the systemic consultations as different to usual ways of working. I began to make sense of the underpinning reasons for the set-up of systemic consultations. However, some of my understanding did not come until formal systemic teaching in my clinical training. I remember feeling excited about the approach, as if seeing difficulties located within patterns of interactions and understandings people held, and not within the service user, made sense. It felt liberating, non-blaming, and hopeful.

I evaluated systemic consultations in a learning disabilities service for my small-scale service-related project (Johnson, 2015). Within this, I looked at effects of consultations on service usage and experiences of attending systemic consultations for two multidisciplinary team members. My interest developed further and I became more aware of gaps in the literature. I also held a strong desire to contribute to the evidence-base in the field of IDs due to this being sparse compared to other clinical populations.

My epistemological position lies closer to 'social constructionism' than other positions, and contrasts 'positivism'. Burr (2003) defines 'social constructionism' based on Gergen's (1985) assumptions which are described subsequently. Social constructionism takes 'a critical stance toward taken-for-granted knowledge', for example, questioning classifications such as gender, mental health diagnoses, whether these are 'real' distinctions. Social constructionism regards knowledge as constructed between people, with language an essential part of constructions. It understands knowledge as specific to time and culture, and thus is different across time and cultures. It also postulates that constructions influence social action.

A social constructionist position influences my beliefs about how knowledge can be obtained, and therefore influencing research methodologies I chose. I wanted to understand the multiple realities of care staff's experiences of systemic consultations in ID services, to become closer to understanding the essence of this type of experience. My position is strongly linked with qualitative research, with language as a basis for understanding, and hence my methodology of using interviews.

The reflecting team model of systemic consultations is also underpinned by social constructionism. Reflecting on why I feel drawn to this approach, reveals my personal and professional values of openness to multiple points of view. It also fits with my desire to avoid classification where it may be marginalising, and wanting to contribute to challenging negative societal views and increase empowerment in individuals labelled with an ID.

2.5 Ethical issues

Ethical approval was obtained from the NHS Health Research Authority, specifically, the National Research Ethics Service (NRES) Committee Yorkshire and The Humber, South Yorkshire, reference 15/YH/0425 (see Appendix B). The research also received sponsorship in full from the University of Hertfordshire

(ethical protocol number LMS/PG/NHS/00406) (Appendix C). The research also conformed to the BPS Code of Conduct, Ethical Principles and Guidelines (2009).

Informed consent was obtained from all participants. Research information was given verbally and in written form.   Separate information sheets with similar information were devised specifically for participants and their organisations, and consent forms were also completed (Appendices D-F).

Participants were informed that their choice to participate or not would not affect systemic consultations or any relationships with any other professionals. They were informed of their right to withdraw before and after interviews. Confidentiality and anonymity was also discussed with participants (and available on information sheets). A break during interviews was also offered. There was also a debrief following interviews and opportunity for participants to feed-back on the interview process.

Initially, easy-read information sheets and consent forms were devised for service users with IDs whom care staff were attending systemic consultations in relation to, to involve them in the research.   These were developed in consultation with a service user with an ID.   However, following the NRES meeting and careful consideration with supervisors, this was omitted. It was not necessary as interviews focussed on the experience of care staff and not service users with IDs directly. Instead, I planned to include service users with IDs via dissemination of easy-read leaflets comprising research findings. I also planned to feed-back findings to an employed service user representative, and, service user and carer representatives group at the recruitment site.

I had previously worked in the service I recruited from. When I worked there, I had already planned my research methodology. To ensure that I would not later be interviewing participants I had worked with, I did not attend the majority of systemic consultations where there were care staff present. My field supervisor

and I had open conversations with my clinical supervisor and hence felt able to manage the dilemma so that my clinical work and my research would not overlap. This felt important, as interviewing participants where I had been part of systemic consultations could have substantially obstructed how comfortable participants felt giving feedback and hence hinder what could be learned about their experiences. This could not be completely avoided and hence I worked with approximately two care staff members in systemic consultations, and therefore these care staff were not asked to participate.

2.6 Recruitment

Three NHS sites were initially identified for recruitment. The first site was identified as the main site, and the other two were identified in the event of difficulty recruiting from the first site. All participants were able to be recruited from the first site, therefore, the other two sites were not used. Research and Development approval was obtained from the recruitment site (Appendix G). My field supervisor was linked with first site and helped with recruitment. My field supervisor emailed all Psychologists within ID teams who were involved with systemic consultations with research information, inclusion and exclusion criteria (see Table 1), and information sheets and consent forms. Psychologists were asked to contact eligible care staff to discuss the research.

Table 1

Inclusion and Exclusion criteria

Inclusion	**Exclusion**
• Care staff member to have attended at least one systemic consultation	• Managers or care staff with *only* managerial responsibilities and no direct care roles
• Care staff member to be a paid member of staff	• Unpaid and/or family carers
• Care staff member to have attended systemic consultation(s) where a reflecting team was present	• Systemic consultation(s) attended did not have a reflecting team present

My field supervisor also spoke about the research in organisation meetings. She had also kept a list of service users who had attended systemic consultations with names of associated lead therapists; therefore she was able to approach Psychologists in relation to specific systemic consultations they led. Lead therapists (Clinical Psychologists) contacted potential participants via telephone and gave information about the research and completed a 'researcher reply slip' (Appendix H) and obtained consent for myself to contact them. Psychologists were also able to send information sheets and consent forms. I then contacted potential participants to explain more and arrange a research interview if they wished. I sent out a confirmatory email to participants with information sheets and a consent form. Where Psychologists were unable to contact potential participants themselves, my field supervisor did so.

Seventeen potential participants were contacted by Psychologists. Ten care staff members were initially interested in participating and hence I contacted them with their consent. One care staff member declined to participate due to personal reasons and one care staff member did not respond to further correspondence. The first care staff member who I interviewed completed a pilot interview and data was not used in analysis. Interviews were arranged and

completed with the remaining seven participants, and all data from these analysed.

The research site I recruited from had designated systemic consultations where referrals were often made by the MDT or a Psychologist recommending the approach where they thought it may be helpful. Systemic consultations at the service comprised a lead therapist who interviewed attendees (which could be a combination of care staff, the SU, family members, and professionals) and a reflecting team (consisting of between one and three members of staff). All lead therapists were Clinical Psychologists with broad-based training in different models, and three were trained to either postgraduate certificate or diploma level in systemic practice. Clinical Psychologists attended regular specialist systemic supervision. They draw on social constructionist approaches, and techniques from Milan ST, Post-Milan, narrative, structural, and solution-focussed approaches. The person with an ID and members of their system (e.g., family members/care staff/professionals) as appropriate are invited to attend systemic consultations. There is a lead therapist who interviews attendees, following systemic principles, whilst a reflecting team (comprising of qualified and Trainee Clinical Psychologists) listen in and reflect about what they heard, focussing on positives, exceptions, pointing out dilemmas, making connections, introducing small differences, and drawing on the system's resources. Pre-session and post-session hypothesising is also used, guided by the Milan five-part model (Selvini, Boscolo, Cecchin, & Prata, 1980).

2.7 Participants

A purposive and homogenous sample was used, consistent with IPA principles, where "participants are selected on the basis that they can grant us access to a particular perspective on the phenomena under study" (Smith, Flowers & Larkin, 2009, p. 49). Smith et al. (2009) advise between four and ten interviews for studies conducted within professional doctorate degrees; seven participants were therefore recruited, fitting with this advice, and discussion with my

research supervisor. These seven participants were recruited from one Intellectual Disability service that had held systemic consultations. The mean age was 38.86 years (age range 25-60 years). Five participants held managerial responsibilities in addition to their direct care support roles. Systemic consultations attended by participants also had a range of other individuals who attended including a combination of care staff from supported living/group homes and the SU's day centre, family members, and social workers. Participant details are available in Table 2. Four different lead therapists were involved across systemic consultations that were attended by the seven participants.

Table 2

Relevant information for Participants

Participant Number	Pseudonym	Gender	Number of Systemic Consultations attended	Additional managerial responsibilities?
2*	Anne	Female	3-4	No
3	Andrew	Male	8	Yes
4	Lucy	Female	4-5	Yes
5	Emma	Female	2	Yes
6	Susie	Female	unsure; "quite a few"	No
7	Karen	Female	6-10	Yes
8	Jenny	Female	3-4	Yes

*participant numbers start at number 2 due to participant who completed pilot interview originally having the label of participant number 1.

I brought my research proposal to discuss at a Learning Disability Systemic special interest group on 18th March 2015 to inform local clinicians and seek advice regarding recruitment and homogeneity. The discussions enabled me to

understand various contextual factors influencing my research and also to help liberate me from preconceived ideas I had regarding inclusion and exclusion criteria. One specific query I took to the group was regarding what stage to interview care staff. I had previously had concerns that interviewing care staff after they had received different amounts of systemic consultations may result in them being at different stages and may violate homogeneity of the sample. I also wondered whether interviewing care staff prior to discharge from systemic consultations may interfere with the work in the systemic consultations. Clinicians were not concerned about these factors. I was made aware that the ability to reflect on an experience, as happens in research interviews, can actually enhance its effectiveness. It was also brought to my attention that I did not have to be restricted to one member of care staff per systemic consultation due to likely differences and hence richness in experiences between care staff. I thought carefully with my supervisors about the discussions and opened up recruitment to the possibility of interviewing more than one care staff member who attended systemic consultations in relation to the same PWID, and for cases to be open or discharged.

When I had initially proposed this research, I imagined that the paid care staff would include only those who worked with individuals with ID in small group homes, residential services, and/or supported living. I had not thought about the possibility of paid care staff working with individuals in day centres as part of the sample. A paid care staff member who worked in a day centre was put forward to participate. I reflected on my own assumptions; in my own work in systemic consultations in ID services, I had not worked with care staff from a day centre and therefore may have overlooked their involvement. I wondered whether I had only thought about the other care staff because I assumed their relationships may be the most strained due to spending the most time with participants. Discussing with my supervisors, we concluded that perspectives that day centre staff members were likely to be similar enough to provide information about the phenomena being researched and hence maintain homogeneity.

An interview schedule was devised to elicit data from participants. The systematic literature review informed the content of the interview schedule, particularly the 'The Helpful Aspects of Therapy Form' (Llewelyn, 1988) used in Lloyd and Dallos (2008) taken to inform Anslow's (2014) interviews eliciting data for IPA, and the Family Interview Schedule in Arkless (2004). Guidance from Smith, Flowers and Larkin (2009) was also used to develop interview questions to obtain appropriate data for IPA analysis.

A pilot interview using the interview schedule was carried out. This allowed for the schedule to be trialled and feedback ascertained from a member of care staff. Feedback sought included the clarity, quality, structure, length and acceptability of the schedule to inform future interviews. During the pilot interview, the participant spoke about their experience of services generally from the MDT rather than systemic consultations in isolation. Therefore, I adapted the introduction to the interview schedule for future interviews to include more explicitly a recap of the set-up of the systemic consultations. I also ensured I differentiated this from any other work from the MDT if participants had been involved in this. In addition, I incorporated the question 'Can you tell me what you remember about the systemic consultation(s)?' as the first question. This was to help participants bring to mind the systemic consultation(s) and for any potential confusion to be clarified.

I noticed that the participant from the pilot interview may have been eager to portray their service in a good light and I therefore reflected on the potential power imbalance within the researcher-participant relationship. The participant spoke as if I knew the work that had been completed with the service user; I reflected on how this may have affected both my own and the participant's understandings within the interview and also the information the participant shared within the interview. With these aspects in mind, I informed future participants prior to starting interviews that I did not know the service user with

an ID, and neither did I know about the work. I thought about the context where members of care staff may meet health and social care professionals and wondered whether these situations might at times involve members of care staff feeling that their practice is under scrutiny. Further, a conversation with my field supervisor raised my awareness of initial concerns that can bring care staff to systemic consultations. Examples of these include tensions within the staff team and/or concerns regarding practice. I hence emphasised that it was participants' experiences of the systemic consultations that I was interested in, and highlighted confidentiality.

Following the pilot interview, I reviewed the inclusion and exclusion criteria again as I felt that the managerial role of this participant may have influenced his responses. I felt that care staff members who were also managers of a service may provide a different perspective to those without a managerial role. After careful consideration with both of my supervisors, we decided that to purposefully exclude individuals within managerial roles would not reflect the care staff members who attended systemic consultations (since more than half of those identified for potential interviews were in managerial roles). Part of the inclusion criteria ensured that individuals within a managerial role also supported service users directly and thus their experiences in a direct care/support role could be accessed.

Interviews were carried out with the seven final participants at a place of their convenience (e.g., at their work base); they took between 28 and 73 minutes, with a median of 61 minutes. The interview schedule is available in Appendix I.

2.8 Data Analysis

Interview data was transcribed and anonymised. A transcription confidentiality agreement was signed by the transcriber (external service) prior to transcription (Appendix J). I also carried out some of my own transcription. Transcripts were copied into a table as recommended in Smith, Flowers & Larkin (2009) and

numbered by line, with space on the left for 'exploratory comments' and on the right for 'emergent themes'. Guidance from Smith et al. (2009) was used to analyse transcripts using IPA including analysis on a single case basis and then across cases.

I started with single case analysis, and specifically the transcript from the interview with Participant 3 (Andrew). The steps I followed are detailed and were in accordance with Smith, Flowers, and Larkin (2009). I read and re-read the transcript whilst playing the audio recording. I wrote my initial thoughts and reactions down in the right hand column. I then went through the transcript line by line, reading carefully (and listening on the audio recording) and analysed the text on three levels (descriptive; linguistic; conceptual). The descriptive level of analysis was where I analysed the content of the interview data, i.e., what the participant was saying. The linguistic level comprised of analysing details of the participant's language such as words used, metaphors, repetitions of words, and the tone, volume, pitch, speed, and pauses. Conceptual level analysis consisted of analysing at a deeper level which was more inquisitive and interpretative. Analysis comprised of consistently going between the small section of the transcript and the whole transcript which was based in the hermeneutic cycle (section 2.2).

IPA also requires the researcher to 'bracket' their own preconceptions in order to approach the transcript with an open mind and reduced bias in interpretation. IPA does however acknowledge that researchers are unable to withdraw from their own experiences, and hence see the analysis as a co-construction of their own and their participant's understanding, a 'double hermeneutic' (section 2.2). I kept a reflective diary throughout the interview and analysis process to enable identification of my own preconceptions with which I understood participants' experiences through (Smith, Flowers, & Larkin, 2009) and 'bracket' my preconceptions as much as possible.

Following writing down my 'exploratory comments' (see Appendix K for an example) guided by the three levels of analysis, I then proceeded to identify 'emergent themes' and write these down the right-hand column of the transcript. Smith et al. (2009) advise that emergent themes should capture the 'psychological essence' of the data. To identify emergent themes, each exploratory comment was read carefully and thought about in context of the whole transcript. The emergent themes were continually checked against the transcript data to ensure that they were grounded in the data.

Larkin, Watts, and Clifton (2006) discuss some of the reasons why IPA has been understood incorrectly in the literature. Larkin et al. (2006) discuss that many studies have stayed 'narrow', giving a summary of participants' experiences, rather than focussing on deepening interpretations at a conceptual level. Therefore, it was important to be aware of this and ensure I was 'deepen[ing]' my interpretations.

All emergent themes for the single case analysis were then typed up as they appeared from the transcript. The frequency of each emergent theme was noted and themes were sorted into clusters (see example of process in Appendices L-P). Some emergent themes became superordinate themes via subsumption due to their ability to describe a cluster well, and some superordinate themes were developed through 'abstraction'. 'Polarization', 'Contextualization', 'Numeration', and 'Function' strategies (see Smith et al., 2009) were also used to organise emergent themes and develop names of superordinate and subordinate themes when relevant. Superordinate and subordinate themes were confirmed by continually going back to the transcripts to ensure themes were grounded in the data.

The process outlined above was completed for each transcript. I then conducted analysis 'across cases', again guided by Smith et al. (2009). For this, I considered all of the superordinate and subordinate themes that I had found for each case. I

used similar techniques as in the single case analyses (e.g., abstraction) to cluster the themes and develop names for final superordinate and subordinate themes that were able to catch experiences across cases. As IPA is an 'iterative' process, continual development of theme names took place. I revisited the transcript data, my clusters of emergent themes and themes for each participant, to ensure that the final themes across cases were grounded in the data.

2.9 Quality and Validity

Guidelines specific to qualitative research for ensuring quality and validity of analysis were adhered to from Elliot, Fischer, and Rennie (1999), and Yardley (2015). I outlined these guidelines to illustrate how the current research meets these. As IPA is interested in a phenomenon from a certain perspective, triangulation of data from different perspectives of others involved in systemic consultations (e.g., SU; family members) was not the aim. However, triangulation was adhered to discussing the data regularly with my supervisors, and in a peer supervision group. My research supervisor also checked my analysis fully for two interviews, from the process of exploratory comments and emergent themes, to clustering and final themes. Participant feedback on analyses was considered, however, it was deemed to be unsuitable due to the complexity of IPA methodology. Cases were examined for disconfirmation of themes in order for alternative experiences to be considered. Yardley (2015) reports that searching for disconfirming cases can be important as disconfirmation could be representative of more individuals who did not participate in the research. I kept a 'paper trail' throughout my analyses, consisting of transcripts, exploratory comments and emergent themes alongside transcripts, and drafts of clusters of themes in order for the process of my analyses to be followed if needed. I have also inserted sections from my analysis journey for one participant in the appendices (Appendices K-P).

Ethical requirements were met and I took an open and reflexive approach throughout. Yardley (2015), and included in Elliot, Fischer, and Rennie (1999) discussed ensuring research is sensitive to the context which comprises providing demographic details for each participant. Some important information is given in Table 2 to situate the sample. Some information is however given across participants (e.g., age range) and some demographic details were unable to be provided, in order to protect participants' confidentiality. As a research interviewer, I was able to be sensitive to the context through my clinical experience in working with care staff in ID services. The research meets the 'Commitment and rigour' principle; I have engaged in in-depth analysis throughout, which IPA lends itself well to. The research is coherent and transparent; describing my methodology in-depth, and stating my epistemological stance and my relationship to the research topic. I have also continued to reflect throughout the process keeping a reflective journal, identifying my preconceptions and attempting to 'bracket' these. 'Impact and importance' validity criteria were also met; research was carried out following a comprehensive literature review which identified a 'gap' in the literature. The research was likely to be worthwhile to add to the evidence-base for systemic approaches in ID services, and provide useful clinical applications.

3. Results

3.1 Summary of Themes

This section will detail the superordinate and subordinate themes that arose overall for participants' experiences of attending systemic consultations. I will first present a table of themes (Table 3), followed by descriptions of these. I also present extracts[1] from participants' accounts to ground the reader in participants' experiences and so that the validity of the research is transparent. The term Service User (SU) is used to refer to PWIDs that the referral had been made to systemic consultations in relation to, as this term was used by participants. A table mapping the overall themes for each person can be found in Appendix Q.

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[1] Please note that pseudonyms are used and identifying information removed to protect confidentiality. Extracts have been edited to demonstrate key points and ensure easier reading, whilst participants' meanings have endeavoured to be retained.

Table 3

Superordinate and subordinate themes across participants

Superordinate Themes	Subordinate Themes
Not knowing what to expect; it was something different	Uncertainty about the process
	Making sense of who they are for and who should attend
Our relationships improved	From difficult relationships to more open communication and working together
	Enabling understanding from another's perspective
	Valuing gains from sharing of information
	Enabling consistency was important
An outside person shone a new light enabling us to think and work differently	An outside person enabled us to think outside the box
	Valuing learning and putting it into practice beyond the explicit
Making sense of what we have achieved	Making sense of the outcome: Uncertainty Vs it helped us all
	Some factors out of our control got in the way
They made us feel validated	Feeling validated
	Appreciating the SU's voice being enabled
	An opportunity to talk

3.2 Not knowing what to expect; it was something different

Systemic consultations seemed to be a new and different experience for participants. Participants did not know what to expect, and this feeling continued for some, and disappeared for others as they got to know the process more. This superordinate theme comprised two subordinate themes which will be described; they cover participants' experiences of feeling uncertain about the

process of systemic consultations and making sense of who they are for and who should attend.

3.2.1 Uncertainty about the process

All participants experienced uncertainty about the process. Systemic consultations were largely a new and different experience for participants. Participants varied in the words they used when referring to them. They used words such as 'systemic meetings', 'systemic counselling', 'systemic therapy', 'groups' and 'systemic', and rarely used 'systemic consultation'. This is likely to have represented participants' previous experiences as a lens through which they were making sense of systemic consultations. For example, some participants' use of 'meetings' may have represented their experiences of professional meetings and/or staff meetings as a frame to make sense of systemic consultations. The use of different words in others' accounts, for example, Susie's use of 'systemic counselling', may have represented her comparison of systemic consultations to more therapeutic spaces. This also fitted with Susie's emotional experiences of systemic consultations. This variety appears to highlight shared uncertainty about what participants understood about the process and purpose of systemic consultations.

Andrew seemed to use his previous experiences of attending meetings with other staff and/or professionals to make sense of the systemic consultations. The word "different" was repeated a great deal throughout his interview; it was a different method and format for him, which had pros and cons. Andrew desired an agenda and actions for the "meetings" in order to move things on. Andrew wanted something to "do" between meetings. This made me think that from a Western culture, there appears to be a higher value placed on being 'busy' than on thinking and reflecting. Agendas and action points were familiar for Andrew, and therefore, without this structure and containment, he may have been left with uncertainty about the effectiveness. This is thought about more in the theme of 'making sense of what we have achieved' (section 3.5).

> ...it was a different format in terms of there didn't seem to be an agenda from
> the first sort of point, it was very much open to discussion and erm very
> much getting our feedback on how things seemed to be going and it was very
> much lead or put to us about how erm, what we wanted to discuss and how
> we thought we might find these sessions useful and how we might be able to
> find them useful to work commonly and towards the same goal to support
> the individual. (Andrew; 2: 39-49)

Andrew also struggled to make sense of the reflecting team, feeling that they rarely added anything new, wishing they were more opinionated. On the positive side, he saw systemic consultations as something "innovative" and an opportunity; an opportunity to collaborate with colleagues in a comfortable informal environment inclusive of everyone's views, and lacked hostility. This opportunity will be discussed more in the subordinate theme of 'feeling validated'.

It was interesting that for Lucy, systemic consultations were not what she expected; she experienced them in a different way to Andrew:

> ...it wasn't what I expected... I think I expected it to be a lot more, erm around
> discussion... where it was a lot more hands on, which was actually quite good
> because it means skills that were taught and things that were spoken about in
> the sessions, we then could come back here. (Lucy; 1-2: 23-33)

Karen, Lucy, and Anne, all reported feeling nervous about the systemic consultations. For Karen and Anne, the nervousness was about not knowing what would be expected from them, and this diminished as they got to know the purpose and process of the systemic consultations. Anne was nervous that she would be expected to know a lot about the SU.

> … in the beginning for the first meeting I was feeling, I was not feeling
> comfortable 'cause I didn't knew [SU]so well… it's taking like six months or so
> to know a person, you know, really know (Anne; 7-8: 226-231)

Additionally, Karen and Lucy experienced worry about conflict between them and family members. Karen worried that it may be "another place for us to get into trouble with [SU's family member]", based on her experiences of the SU's family member making a serious complaint. Lucy's anxiety appeared particularly strong; she found systemic consultations nerve-wracking, and had expected them to be a waste of time. It seems she was trying to cope with a lot in her managerial role and directly supporting SUs; systemic consultations needed to be worth her while. Lucy worried about confrontation with the SU and family, and implied that she did not feel reassured or contained by the therapist. Lucy found the rooms used for systemic consultations inconsistent, uncomfortable, and distracting, referring to a "ticking clock". The "ticking clock" may imply incredible tension and uncomfortable silence, perhaps intensified by Lucy's high anxiety.

> …sounds a bit silly really but a lot of the time [Lead Therapist] had to go off
> for ages and try and find…pens and paper…and also whilst that's happening,
> we're all sort of sat there staring at each other like…ahhhh. Like maybe if she
> said oh right I want you to come up with a team building exercise, I don't
> know or just something to talk about… literally we all kind of at times just sat
> there in silence…and I think that was a bit awkward to start… (Lucy; 41:
> 1164-1180)

Susie spoke about systemic consultations being highly emotive as they related to an issue of loss for the SU. She spoke about systemic consultations not being differentiated from other types of work activities by her employer who she felt did not appreciate the emotional impact of the sessions on care staff. Susie felt she had to struggle to get her organisation to notice this in order for her to have some time after consultations to compose herself. Susie explained that more

information about the emotional content of systemic consultations would have been helpful to receive beforehand.

> ...the expectation that we would go to this meeting which could sometimes be quite stressful and then come back to work and be expected to kind of just snap into you know you've been through an hour of something which is quite draining, it might be quite an emotional session. And then just come straight back into work, that maybe we needed just... half an hour's space before we then got on with something else. (Susie; 9-10: 263-273)

Susie also appeared to have had a different experience to what she might have expected in terms of professional advice. Although she valued the reflections, she felt that more ideas of how to move things forward and solutions would have been helpful. This differed from Anne's experiences of feeling that in addition, she did receive professional advice:

> ...it helped me with the advices that they gave me how to react in different situations. (Anne; 15: 490-491)

Jenny appeared to make sense of the process by understanding it as going "off-track". She understood the organisation's attendance at systemic consultations as obtaining strategies to work with the SU, and explained from her management position, that that is most helpful. Jenny had started attending systemic consultations since there had been something upsetting discussed; she viewed her role as coming in to get sessions back on track. The need to focus on strategies was by far more important for Jenny than focussing on processing the emotional experiences of the SU. I felt a sense of the risks attached to the SU's actions as being overwhelming for Jenny, and hence, the focus on strategies seemed even more important, especially given her managerial responsibility. It seemed there were perhaps differences in expectations of what purpose systemic consultations would serve.

...that wasn't the original reason that they'd sent [SU] to systemic and that somewhere along the line that had gone off track. And so I was asked to step in erm and attend the systemic therapies with her. (Jenny; 3: 66-71)

Uncertainty of the process appeared less of a concern for Emma, who did say that she "didn't exactly know 100% what was going to happen" (20: 603-604). Emma came across as more confident, which may have helped her to feel more comfortable in the face of uncertainty.

3.2.2 Making sense of who they are for and who should attend
All except one participant (Susie) appeared to be trying to make sense of who systemic consultations are for and who should attend. Participants varied in how they spoke about difficulties that had brought them; some participants saw the difficulties located within the SU and understood that the SU and changes in their behaviour should be the focus of systemic consultations. However, other participants understood difficulties as being within relationships, and consistency of support for the SU. Others understood them as a combination of difficulties; some located in the SU and some within relationships. Some participants seemed to make sense of who they thought systemic consultations are for and who should attend during the process, starting with seeing the difficulties within the SU and then realising that they could make changes in the SU's support that would help. Some were unsure of who should therefore be attending systemic consultations, and experienced some discomfort with certain combinations of individuals attending.

Andrew appeared to understand that systemic consultations were for everyone in the SU's network to attend consistently. He described an uncomfortable situation when he was left attending one systemic consultation on his own, and therefore questioning the point. At this moment, he changed his language, referring to systemic consultations as 'counselling' (from 'meetings'). This perhaps represented how personal it had felt and an underlying message that he was the one who needed 'help' which was contrary with his view.

I didn't really need the systemic sort of counselling on your own because you're meant to be doing it as a group or as a larger sort of group. (Andrew; 22: 702-704)

For Lucy, she initially understood systemic consultations as for the SU, and care staff's attendance was to support the SU with her difficulties. Anne also had a similar understanding.

…kind of let her maybe talk to other people who aren't just us about her anxieties and it was just about, how can we best support her and what can we do here to support her anxieties in case there's something we're missing and that's why we started going. (Lucy; 6: 171-180)

Lucy experienced the SU's family member's attendance largely as a hindrance, due to making her feel like she was "walking on eggshells"; anxious about how things she said would be heard. Lucy sometimes appeared ambivalent regarding whether the SU and SU's family member should attend. Lucy was fearful of upsetting the SU, and struggled balancing what needed to be said with her desire to protect the SU, leading her to withhold some information. Lucy understood that overall it was helpful for the SU to attend because it enabled her voice; however, she did find herself sometimes wondering whether the SU should be there:

…sometimes I did feel oh maybe we should have some of these conversations with her not being here erm, just because erm, I don't know, again egg shell kind of feeling like you didn't want to upset her and get her upset. (Lucy; 28: 785-794)

Despite Emma and Lucy attending systemic consultations for the same SU, they understood them differently, with Emma seeing them as a "bit of a recap to see how [the SU] was doing" (2: 35-36) and about "her issues around living with

other people…also to do with staff understanding her" (1: 4-6). However, both Emma and Lucy spoke about the systemic consultations as being helpful for them and the SU (see section 3.5.1).

Jenny initially seemed certain that systemic consultations should be for, and, about the SU, and not for, and about, the staff.

> I think for them and also I think you can get caught up in everyone's problems that it then feels like you probably part of the system therapy, or you part of that, which is not the idea. (Jenny; 14: 418-422)

Jenny's beliefs about who systemic consultations were for conflicted with her actual experience. Jenny's awareness appeared to develop from the systemic consultations that it was important for the environment to change around the SU.

Karen was initially unsure why care staff were invited to join systemic consultations as they had initially been set up as family therapy for the SU and family. She felt they had not been explicitly told why they were invited and therefore had been left guessing that it was because they were a significant "part of her system". Initially Karen felt their attendance was not beneficial for them, however, later was able to appreciate that the systemic consultations as involved them:

> …also trying to remember that it's not all about [SU] that's why we were all together. Erm but that took me a while to think about to think about, I think 'cause, because our focus here is on the guys so much. (Karen, 19: 603-607)

3.3 Our relationships improved

Many participants experienced improvements in their relationships; these were relationships between a combination of care staff, the SU, and the SU's family. Some participants also felt that they had gained a professional support network. Improved relationships were associated with a move towards working together,

more open communication, understanding each other's perspectives, sharing information, and enabling consistency. This superordinate theme comprised four subordinate themes 'From difficult relationships to more open communication and working together'; 'Enabling understanding from another's perspective', 'Valuing gains from sharing of information', and 'Enabling consistency was important'.

3.3.1 From difficult relationships to more open communication and working together

This subtheme appeared in five participants' accounts, and was not present for Susie or Jenny. Many participants spoke from a collective position, for example, using "we" and "us" when talking about their experiences. Some participants with managerial positions also took a further removed position, using "staff", at times. I often checked in interviews when the participant was using "staff", if they felt that they too experienced that; on most occasions they did. It seemed the collective position may have been protective; protecting participants against the hostility perceived between themselves and the SU and/or family. For others, it may have represented the collaborative efforts in their roles as care staff, working together to support the SU. It may have also been a way of giving more negative feedback about systemic consultations.

Emma and Karen seemed to experience a shift, perhaps a reparative process, through systemic consultations, from difficult relationships "battling" with family, to now working together and seeing benefits of this. Emma and Karen's experiences highlighted real difficulty in relationships with family at the beginning of systemic consultations. For Karen, this appeared most dominant. She had experienced an especially strained relationship with the SU's family member, reaching an extreme when the family member made a serious complaint. For Karen, it perhaps still felt uncomfortable, with her laughing in a nervous manner as she told me about the complaint. It had also reached a point where there were additional measures taken by the organisation to mediate.

Karen initially felt guarded in systemic consultations due to feeling as if she was "walking on eggshells". The reflecting team had helped her to see that what she was saying did not "sound as bad as [she thought it was] going to sound or maybe as aggressive" (12: 372-373) therefore allowing her to become more open. She experienced the shift in being able to work together with the SU's family member, and this reducing the SU "playing the staff team off against [family member]". An extract from Emma's interview highlights the difference the systemic consultations enabled.

> ...the relationship with... [two family members]. You know that they've obviously changed a lot which has taken a lot off of us 'cause when she'll go home and be 'oh staff have done this' you just know when she's coming home the [family member]'s going to come in and go mad it's like 'ahhh'. But now she won't she'll come in, so I think the relationship is more, we talk more... she's not literally straight away coming down on us like a ton of bricks for how she hasn't got the whole story... whereas before she would question what we did... she'd do it in front of [SU]. So then it was like we had the battle of [SU] playing one off against the other, now that's not we're actually probably working as a team. (Emma; 36: 45: 1379-1396)

Interestingly, despite Emma and Lucy attending systemic consultations with the same SU, Lucy did not talk about improvements in her relationship with the SU's family member. Instead, she seemed to continue to find this relationship difficult and focussed on how uncomfortable she felt with the SU's family member's presence.

Andrew experienced improved relationships between members of the SU's network. Part of this he thought was due to spending time with each other in systemic consultations and improving communication.

> I definitely think they can help aid with communication... 3, 2 care providers, the social worker and, and the family, communication could be blurred... it

was a good opportunity to be able to communicate as a team about how everyone was feeling and, and the best way to support the individual… (Andrew; 31-32: 1015-1022)

Emma presented a noticeably unified staff team which implied their relationships had improved. Emma attributed these improvements to the validating environment that was enabled in systemic consultations, with a respect for difference in opinions.

Lucy and Emma both experienced an improvement in their relationships with the SU. Lucy experienced the SU as now more able to see that care staff are there to help her. It seemed that systemic consultations provided a space where the SU could communicate her perspective and how she wanted staff to react to her, opening up conversations, and care staff to reflect on their approach with the SU.

> …[SU] kind of pretty much said to that member of staff it's pretty much your attitude, which I think was quite difficult for that member of staff to hear. But even as for me, I found it quite awkward to hear as well 'cause was thinking oh I don't want to start up not an argument but bad feeling, if that makes sense?...Erm, but now it's, they work a lot better together… (Lucy; 55-56: 1590-1598)

Some participants (Anne, Lucy, and Emma) also spoke of gaining a support network. They now felt able to easily contact psychologists when consultations had ended.

3.3.2 Enabling understanding from another's perspective

Five participants discussed systemic consultations enabling them to understand others' perspectives. Participants had the opportunity to hear and/or imagine how others experienced something, increasing their understanding, and hence leading to improvements into relationships. This was evident in different

relationships between care staff and the SU, and between care staff and family, and other professionals and/or support staff.

> Well, it's, it's always interesting to erm, to try and put yourself into someone else's shoes and have someone else say well 'what about this?' (Andrew; 9: 264-266)

Andrew, Lucy, Emma, and Susie all experienced an increase in their understanding of the SU's perspectives. For Andrew, he was encouraged to imagine what the SU may be thinking and feeling in certain situations. However, he did not make reference to any increase in understanding from the SU's part, perhaps because the SU did not attend systemic consultations he attended. Lucy, Emma, and Susie experienced "mutual understanding" where they saw the SU as also understanding their perspectives.

> I think she just kind of needs to know they don't mean it that way [SU]... I just want to encourage you and support you the best I can. But sometimes when you speak to me in a certain way as well I think the member of staff they do, sometimes I probably do bite back a little bit but I don't mean to. Then she said 'Oh, okay'. So it was like getting that mutual understanding. (Lucy; 56-67: 1599-1607)

It seems that Lucy's honesty shines through, realising she "bite[s] back", bringing attention to how pressured and difficult the supported living environment may be. The way that Lucy normalises this may also offer a genuine person-to-person understanding to the SU. This differs to some participants' accounts where it feels as if they may have been mindful of presenting an account to me from a professional perspective.

Susie felt enabled through systemic consultations to see something that was previously interpreted as "demanding" differently. She realised that by the SU asking for a drink, she was asking staff to show they cared. She recognised the

service's aims in her own way of thinking that they should always be supporting SUs develop independence, and hence, making a drink would conflict with this. It allowed Susie to reach deeper understanding of the SU's needs and relate personally.

> … I think [SU]'s very physical… she would ask you to do something like say pour her coke which she could probably do for herself, but she sees that as you're doing something for her that shows that we care. So I think people could see that as she's just wanting you to do something but actually when we talked about that in the session it was she saw those things as someone caring for her. (Susie; 20-21: 616-624)

Furthermore, Emma and Karen felt enabled to understand family members' perspectives, and reciprocally, felt that family members were more able to understand theirs. This was likely to be a big step forward for Karen in light of the previously strained relationship. Karen felt able to understand the family member's anxiety about the support the SU will receive when she [the family member] is no longer around as she has had to continually "fight" to obtain support for the SU. Karen spoke about systemic consultations providing an opportunity for her to let the family member know they will continue the 'fight'.

> … [SU's family member]'s quite fearful that if she is not around, what will happen, 'cause she drives things so much and I think that gave us an opportunity to prove sort of well you know we're still going to continue in the same, fighting the same way. (Karen; 25-26: 805-810)

Karen experienced systemic consultations providing opportunity to clarify roles as the family member had been doing a lot for the SU for fear that care staff would not. She was surprised to realise that the family member had insight into how her actions came across as "controlling". It provided opportunity for the family member to build up trust in care staff by them taking on more. Karen,

along with other participants used the word 'opportunity' frequently, suggesting systemic consultations offered something not usually privileged.

Emma felt that systemic consultations provided opportunity for her to give their side of the "story" enabling understanding by the SU's family member. This continued beyond systemic consultations, reducing hostility, and helping care staff and family to work together.

> … it's cut down on the amount of animosity, that [family member] will come to us and be 'right I've just had [SU] on the phone, she's said la la la la la' and it's like right hold on a minute no 'yes that did happen but so did this'. (Emma; 36: 1106-1110)

The theme was not present for Anne and Jenny. For Jenny, it may have been the lens she took regarding her understanding of systemic consultations being only to obtain strategies to support the SU. For Jenny, it feels unclear why this was not raised, however, it may have been related to her focus on the practical strategies and following advice from the psychologists.

3.3.3 Valuing gains from sharing of information

Most participants talked about the value of sharing information in systemic consultations and felt this continued. Consultations appeared to provide a platform for information and ways of working to be shared relating to the SU. Information appeared to have been shared between care staff, family members, and professionals.

Anne, Emma, and Karen, all spoke about finding out useful information from family members during systemic consultations, informing practice. Anne had found out from the SU's family "forbidden words" that could not be used with the SU due to her negative reaction to them (e.g., "hurry up"). The participant's use of the word "forbidden" is strong, indicating the importance of not saying these words. I wondered about reasons behind information not being communicated

previously. Emma found out that the SU had used to go cycling, and Karen discovered that the SU had had a past difficult experience with a friend that resonated with difficulties the SU was reporting in the present. It was identified through the consultations that the difficulty was actually in the past, and hence shaped staff's response. Karen further noticed a shift in general communication between care staff and family from a "need-to-know" basis to being "better at" sharing information. It struck me that Karen may have feared communication with the family member due to anticipating feeling blamed. It seemed that systemic consultations provided space where communication could be experienced differently, eliciting new discoveries and hence improved support.

> ...being able to speak to [family member] and say '[SU]'s said this, we're really worried', erm and then her [family member] was like 'oh you know, this happened [many] years ago do you think it's that?' and then we can you know speak to [SU] about like, like trying to build a timeline over things... that's been really useful because a lot of things we're thinking 'oh what, what's gone on? What's happened?' but actually it's just almost a memory in a way, and without [SU]'s [family member]'s input and sort of deciphering things we wouldn't have come to that. (Karen; 31: 981-994)

Lucy appeared to speak from her managerial position regarding sharing information. She found it helpful to hear about the care staff team's experiences, and it being "really, really good" that information had been shared through an additional intervention stemming from systemic consultations, where the lead therapist had met with the whole staff team. Additionally, Emma felt that having someone from the "outside" and a validating environment where "no-one is wrong" helped care staff who were usually quiet to share their views and ideas. Emma appreciated the different perspectives they brought.

> ...but obviously in this meeting they were asked a question, they answered. So I think it's like right okay there you go, you know you do have an opinion. You can give it and also you know no one, no one is wrong you know because

we all have something different to bring which, I don't know we do have discussions like this at staff meetings but I just think as I say with that outside person again it makes it easier because they're there to 'okay right [participant] did that bit good, so and so did that bit good why can't you combine the two'... (Emma; 23-24: 685-696)

Jenny also spoke about systemic consultations enabling more open conversations between care staff sharing information.

...it's those kind of things um and maybe little signs that were always there but you, you don't always see those tiny signs before but because [you'll] talk about it a lot [in the staff team], someone will say have you noticed she'll move her right leg first... (Jenny; 27: 837- 841)

Jenny also noticed a "ripple effect" as she shared information that had been discussed in systemic consultations in team meetings, and it therefore influenced care staff's practice beyond those who attended consultations. For Jenny, sharing information in consultations also helped professionals to link up outside consultations and enable wider changes in the SU's support (support in the community). Anne felt that it was not helpful that a MDT professional who was working with the SU was not at systemic consultations as they missed out on the information she could have shared. Andrew experienced benefits of sharing information, including practice, between professionals and care staff working with the SU.

And having the opportunity to say you know in this situation I communicate to [SU] in this way and that seems to work better for me. And, erm and, his [family member] sort of agreeing obviously because we've known [SU] longer, we had that experience to then pass on and in that forum... so you were... practice sharing as well... (Andrew; 35: 1140-1150)

It was interesting how this theme did not arise for Susie. For Susie, the most important point to communicate appeared to be the struggle for emotional aspects of systemic consultations to be recognised. It felt unclear why this did not arise for Anne, and may again be related to her focus on the 'practical'.

3.3.4 Enabling consistency was important

Four participants talked about how systemic consultations enabled them to become more consistent in supporting the SU. Consistency was developed between a range of individuals: between care staff, between care staff and family, and between care staff and other services.

Lucy and Emma felt they adopted a more consistent approach as a staff team. Furthermore, Emma felt the approach used within consultations using something concrete (the "board") helped enable this. This "board" contained the SU's likes, dislikes, and support needs. It was the SU's board, implying that the SU had ownership, and therefore providing a communication aid to indicate her preferences to care staff. Lucy also referred to what appeared to be the same "board", viewing it as helpful in supporting consistency. It felt notably more important for Emma.

> But as I say going back to the board, is a pretty good thing 'cause we sit there and be like 'oh with the meetings, we did suggest doing this'... (Emma; 11: 320-322)

Lucy and Emma acknowledged potential difficulties in consistency previously; some attributed to shift patterns. Lucy found that her shift pattern also meant that she could not always attend systemic consultations and found this a disadvantage. Despite this difficulty, it seemed that by sharing information and conversations being facilitated about ways of working in systemic consultations, enabled care staff to be "working from the same page". Furthermore, Emma also recognised the SU's ever-changing needs and felt that it was important for her support to be continually revised and the "board" was used to ground this.

Therefore flexibility within consistency felt important for Emma. Emma recognised the different ways that staff "fit[ted]" with the SU, and therefore sought to match activities of interest for staff with the SU.

> ... like how we work differently... we're all doing the same thing... not for everyday because as I say we all fit in differently but like obviously with [SU] and trying to get her to calm down when she's shouting. (Emma; 44: 1370-1375)

Emma also experienced an increase in consistency between care staff and the SU's family member, which was similar for Karen. Karen spoke about this enabling the SU to get a "more consistent message". This seemed important given Emma and Karen's shared experiences of the SU "play[ing] [care staff and family members] off against each other".

> ... we could have some sort of consistency between what [SU] was hearing at home and, and what she was hearing here. (Karen; 6: 193-195)

For Andrew, a consistent approach appeared to be enabled across the SU's network. Andrew also reflected on how this may feel less confusing for the SU, having significant empathy having thought of difficult experiences the SU had experienced, emphasised by him seeming to step into the SU's shoes with his reference to "I" as he speaks in the first person.

> ...at home and both at the day centre we found that we were working more consistently, so he wasn't getting mixed messages in terms of if I behave in this way, I'm getting a different response from this individual whereas if I behave in this way...I'm getting something different, it was sort of more, more sort of consistent. (Andrew; 39: 1277-1284)

Although this did not appear as a theme for Jenny, she did mention the value in discussing things more as a staff team leading to the "whole team [having] the

same approach". In contrast, consistency was not referred to in Anne or Susie's accounts.

3.4 An outside person shone a new light enabling us to think and work differently

This superordinate theme encompassed two subordinate themes; 'An outside person enabled us to think outside the box' and 'Valuing learning and putting it into practice beyond the explicit'. Participants experienced benefits from an "outside person" enabling them to think differently outside the box"and/or through learning opportunities. Participants experienced psychologists in systemic consultations as being able to take a more removed position and therefore offering different perspectives. Participants had also learned strategies and techniques through different methods, which some spoke about generalising knowledge, enabling application with different SUs.

3.4.1 An outside person enabled us to think outside the box

Four participants spoke about appreciating the psychologists who were external to their service offering a different perspective. They felt that "outsider[s]" could offer something different as they weren't "in the middle of something" like they felt they were.

> I think you've got a totally independent person, seeing it from everybody's point of view, whereas I think sometimes when you're in the middle of something, obviously you know what's going on but someone else coming in going 'well hold on you've been doing it like this, that's good but why don't you try this option' you'd be like 'ahhh okay' there may be something we might have not thought about doing it that way. (Emma; 7-8: 216-224)

Participants welcomed the "fresh pair of eyes" to look at things from a different perspective. Sometimes the "outside person" was experienced as offering "a little bit of a different perspective" and sometimes "they put a whole different light on it". The use of the word "light" may have implied something not only different,

but a more positive, optimistic view. Jenny felt enabled to think differently about her SU who was often in risky situations. Jenny had come to accept the SU for who she is "recognising that there are limitations and working with the positives" (31: 986-987). She was enabled to think about how support could be adapted around the SU; this seemed a difficult journey for Jenny who desperately wanted the SU to change. Jenny reported that it was the first time they had provided support in the community and saw it as a "good step forward."

> …we've realised that erm emotionally she's probably always going to… override her sense of keeping herself safe… so it is about limiting, for example, the amount of money she takes… she'll phone us and we'll hear her moving off base and that's the time we send someone out. So you know it is about bringing in things to keep her as safe as possible from our side erm without taking her liberties away. (Jenny; 31-32: 993-1003)

It seemed that the external person, for Andrew, was felt not only independent to the service, but "impartial", implying they did not take sides with anyone:

> …interesting to hear from someone who was completely impartial… could think… without having any past experience or possible… emotional ties to the individual or anything like that. (Andrew; 9-10: 293-297)

Although for Andrew it was generally helpful, he also experienced drawbacks; feeling frustrated with a psychologist's reflections suggesting the SU go with professionals to look at potential new accommodation. Andrew felt this was unhelpful given his collaborative careful consideration with the network based on knowing the SU who may become "overwhelmed".

> I thought, you know that is really good we hadn't thought about that, you know if we didn't have someone external sort of, you know informing us or, or making us think in a different way. Erm, there were times as well where she might suggest things or make us think about things where I did think,

you know that, that probably wouldn't work knowing the individual. Erm and I did think at times you know, you don't know the individual so I can understand where you're coming from… (Andrew; 10: 309-320)

3.4.2 Valuing learning and putting it into practice beyond the explicit

Five participants spoke about how they had learned from systemic consultations. Their learning varied from certain strategies to use with the SU, incorporate person-centred techniques, supporting the SU put in their own strategies, and mediate difficult situations. The types of learning varied: participants appeared to learn through strategies suggested to them, being facilitated to collaboratively work out solutions, and, through modelling of techniques used by psychologists in systemic consultations. Some participants also spoke about applying learning beyond the SU they had attended systemic consultations in relation to, incorporating it into their work with other SUs as well.

Anne learned strategies through gaining direct advice from psychologists about "how to handle" situations, and, through modelling how the psychologists were with the SU.

> … it's helping me as staff how to handle her how to handle her in… this way how to react to different situation if she's talking for example in [public] about [private topic] how to stop her… change the subject to say we'll talk home or it's too early… from that meeting I learned how to you know stop her when we are in public and she's talking loudly and you know not to grab attention… (Anne; 4: 98-118)

Jenny, Karen, Lucy, and Emma discussed collaboratively developing strategies/tools in systemic consultations. Emma and Lucy experienced the SU as learning coping strategies to help with her anxiety, and how they could support her to put these into place. Additionally, Jenny discussed being able to update behavioural support plans with strategies. Karen's extract highlights how

the learning has helped both care staff and the SU's family member to manage difficulties.

> I think our ability to deal with those problems have been helped a lot by some of the tools from the systemic therapy, on both sides". (Karen; 27: 856-859)

Furthermore, Karen recounted a "visual cue" that care staff could refer to, which was flexible, and could be updated according to the SU's support. Karen continued to use this with the SU. This visual cue appeared akin to the "board" (section 3.3.4) that Emma and Lucy referred to respectively. This concrete grounding for the SU to be more involved in their support seemed a helpful learning opportunity. Emma was thinking about setting up a board with other SUs. Emma demonstrates her enthusiasm for the unexpected gains of this learning opportunity:

> … obviously having the tools that we were given for… we still use the board with her as well… it's a brilliant thing that possibly we could then carry that on with other people, because I can think of everybody we support, we could make one for. So that's always a bonus. (Emma; 32-33: 987-994)

Furthermore, Emma and Lucy learned through modelling of psychologists. Emma described breaking things down for the SU, and facilitating an open conversation between the SU and a staff member where there was tension. She appeared to encourage both parties to give their views in a calm environment. Lucy learned to give the SU time to talk, facilitated regular one-to-one meetings, and invited the SU into a staff team meeting. Lucy also learned to use more person-centred techniques in her work with the SU, using her favourite colour.

> … okay so if these professionals are kind of working this way, maybe that's how we should start thinking and how we should start doing things… we said 'oh maybe we should do it in purple'… it's just that kind of shadowing and

role modelling from this group which I think's been rubbed off on our team which is really positive. (Lucy; 10: 282-296)

Additionally, Lucy had noticed the SU had also learned an additional coping strategy of reflecting through writing owing to what she was encouraged do in systemic consultations:

> ...she seems to reflect on things more so she now has a reflective diary 'cause she's very good at writing, so she writes things down and I kind of think that from these sessions that's where that would have come... (Lucy; 50: 1410-1415)

Emma also introduced an important perspective regarding seeing systemic consultations as a "recap". She felt strongly that systemic consultations should be held regularly (like SU's annual life reviews), for reviewing and recapping support for the SU. Emma spoke passionately about her feelings that systemic consultations should be available for all SUs. Emma also found systemic consultations helpful in inducting new staff and was keen for as many staff to attend as possible. Emma's account varied, with her speaking about systemic consultations as a "recap", "opposed to... anything new", and also talking about varied learning opportunities offered by them. It seemed these contradictions implied that Emma had experienced both; systemic consultations as a "recap" and a learning opportunity.

> ... I do think you need to do it yearly. Because it's that, it's like passing your driving test, right, when you dri-, learn to drive your hands are at 10 to 2 there is no way on this planet you are ever, ever going to go back, you're then cross your arms there's no way that everybody is going to sit there you've been driving 20 years with your hands at 10 to 2, but you're still driving safely you just learn to cope differently. (Emma; 38: 1171-1180)

Using this metaphor, Emma may be referring to the automaticity of driving. In a driving test one is very aware of one's actions and taking a 'textbook' approach. After this, things become automatic and you are not thinking about them as much but "you're still driving safely", akin to her practice as a care staff member. She appears to imply systemic consultations could be like a refresher course bringing care staff more awareness and how to do things 'correctly'.

3.5 Making sense of what we have achieved

This superordinate theme contained two subordinate themes 'Making sense of the outcome: Uncertainty Vs it helped us all' and 'Some factors out of our control got in the way'. The themes appeared to link with the subtheme detailed in section 3.2.2; 'Making sense of who they are for and who should attend'. Some participants appeared more uncertain than others regarding what changes occurred and how. Obstacles were also brought up by two participants that had got in the way of change.

3.5.1 Making sense of the outcome: Uncertainty Vs it helped us all

Uncertainty about the outcome emerged for three participants; Anne, Karen, and Jenny. It concerned participants' uncertainty regarding what changes had happened as a direct result of systemic consultations, and/or how they had occurred. In addition, Emma felt that she had learned things through experience outside of systemic consultations. In contrast, the other participants had spoken about how systemic consultations had helped all those who attended in some way.

At the beginning of Karen's interview, she reported that she was initially unable to see benefits of attending systemic consultations for her and her staff team.

> I can see the benefits for [SU] for us being there, I still didn't find it, that our participation was that beneficial. Except for making roles and things clear. Erm yeah, but I think for [SU] it was very beneficial. (Karen; 1-2: 28-33)

During the interview process, many benefits transpired for Karen, which centred around improved relationships between her and the SU's family member. The process of the interview encouraging Karen to discuss her experiences of consultations appeared to bring to light the benefits for her. Karen's awareness of these also appeared more apparent as we progressed; "I thought it's quite useful… over time I guess" (13: 389-391). From Karen's managerial position, her understanding of benefits may have been based on something more tangible; this could also be implied from her desire for written feedback and her use of the word 'evidence-based'.

> It would have been quite good to sort of maybe get erm an ending feedback, sort of something written down… everything's so evidence-based here, that, that, I think that could have been quite useful… (Karen; 34: 1086-1091)

I was able to connect with Karen's views as I have thought about this being able to measure changes in systemic work for a long time. An extract from my reflective diary following the interview is below:

> Another thing I noticed was about measuring the outcome; how did care staff know things were working whilst they were in it? It may be difficult because it is hard to measure; how do you measure the change in someone's understanding and/or change in relationships, and is this even valued as much in society as more visible outcomes such as a reduction in behaviour that challenges? (Clair)

For Anne, she was certain that systemic consultations helped "everyone". However, the changes that Anne had experienced accompanied uncertainty regarding whether these had occurred with time as she got to know the SU more, or as a result of systemic consultations, or, more likely, a combination.

...yeah it's not only the systemic consultation 'cause spending time with the person, you know, getting involved, activities, and everything supporting the service user helps as well. (Anne; 15: 479-482)

For Jenny, there seemed to be a feeling of hopelessness, she wasn't sure what they had achieved. She seemed to have resigned to accepting that the SU would always have these difficulties and be an "unmanaged risk". She desperately wanted the SU to be safe, however, believed strategies would fail. Although Jenny stated that the SU "should have the freedom", this may have been a dilemma for Jenny, due to her care for her to be safe, and responsibility held within her managerial position. It seemed that systemic consultations could not help Jenny in what she really wanted; knowing that the SU was completely safe. Jenny may have held a lot of hope that systemic consultations could help, and hence, this may partly be why she felt so disappointed.

Researcher:	And what do you think you were hoping to achieve that you didn't?
Jenny:	Uh well it's still ongoing at the moment... I still think we don't have many strategies. And I don't know whether erm practically we ever will.
Researcher:	What kind of strategies would you like?
Jenny:	See her safe I think... but the reality is... she has the freedom and she should have the freedom to come and go as she erm chooses... her emotions will always override her ability to think logically at that moment... she will always be an unmanaged risk.
	(Extract from Jenny's interview; 18: 544-557)

Jenny's position appeared to have shifted, where she gained some acceptance and could see some hope through systemic consultations helping her to think differently; towards adapting the support around her instead (section 3.4.1).

In contrast, Lucy, Emma, Susie, and Andrew felt that systemic consultations had helped everyone who attended them (i.e., a combination of care staff, the SU, and the SU's family members).

> …to be able to go and still get support, you know and talk about things that have been happening. Yeah so it's almost like staff support as well, because if we were going without [SU], we, it might be that we've been tackling some difficult issues, so it would also give us time. (Susie; 9: 253-259)

> You know it's helping [the SUs] and helping us in turn, enabling us to work with them better and enabling them to get their opinions across to us (R-Yeah). So I do think it should be a thing that everybody should have. (Emma; 46: 1431-1436)

3.5.2 Some factors out of our control got in the way

This subordinate theme arose for two participants (Andrew and Jenny) who felt there were important factors that got in the way of systemic consultations being as effective as they could have been. Whilst one other participant (Anne) acknowledged that some changes couldn't always be maintained as they often "depend[ed] on [the SU's] mood and the day", giving an example of the SU's disrupted sleep affecting her anxiety. This subordinate theme was not present for Lucy, Emma, Susie, and Karen.

Andrew appeared hesitant regarding whether changes lasted. He experienced staff not attending systemic consultations as frustrating, for different reasons, including the need for the process to be discussed again. He also spoke about the disadvantage of staff that had not been present not knowing previous discussions. Andrew found that consistency of staff attending was key to a consistent approach with the SU. Andrew's perspective was interesting however, as he came across as very understanding for individuals' absence, aware of high staff turnover, to an extent which he perhaps did not feel able to provide his genuine emotional responses, which may have been frustration. This may be

linked to Andrew's professionalism and considered dialogue, and/or, alternatively, more related to increased understanding of others' perspectives (section 3.3.2).

> I think this did contribute as well to attendance and possibly consistent approach as well, and, and the sort of team sort of environment is that from his supported living setting because it was incredibly hard setting for them, them to work in at the time. Errr, that you did have quite a high staff turnover from their point of view... you did have a lot of new faces... I think the [MDT professional] changed in that time as well, erm so that was a bit hard and I think contributed to some of the consistency as well... because you did have different people coming into the process at different times... Yeah so, no I think yeah consistency worked and as long as the team was consistent obviously... (Andrew; 40-42: 1287 1359)

Jenny's experience of factors getting in the way was different; she saw obstacles as inherent within the SU. Jenny felt that the SU's poor memory, acquiescence, and emotional reactions often took precedence over plans made in advance and/or the SU's logical judgements of situations. This linked with Jenny's sense of hopelessness in the SU ever being able to change (section 3.5.1).

> ...it's not because of the therapy or what's been done there. I think it's just the nature of the person... I think it is about [SU's] inability to remember what's happened and so really often the things we have discussed never get put into place because she won't remember that or she can't remember saying agreeing to it or and so that's that's the problem... we would probably have a total different result if we had someone that could remember. (Jenny; 17: 532-542)

3.6 They made us feel validated

Most participants felt validated through systemic consultations. This superordinate theme comprised subordinate themes focussing on participants' experiences of feeling validated within systemic consultations, appreciating the

SU's voice being enabled, along with flexibility to meet the SU's needs, and participants' experiences of systemic consultations being an "opportunity" to talk.

3.6.1 Feeling validated

The subordinate theme of 'feeling validated' emerged for all except one participant (Jenny). Some participants spoke about being asked for their views and feeling that these were valued, and some recounted receiving positive feedback from the reflecting team. Others discussed how the SU felt validated.

Anne, Andrew, and Lucy all spoke about being encouraged to give their opinions. Andrew felt valued through this, and experienced the topics for systemic consultations as collaboratively agreed. He commented that the psychologists made him feel that his views had been "taken on board". Similarly, Anne, experienced being asked for her views as helping her to feel involved. This felt important for Anne, given her view of herself as "just a support worker", and therefore may have helped her to increase her confidence. Lucy additionally appreciated the encouragement for other care staff to give their views. For Andrew, who used his experiences of other meetings as a means to make sense of systemic consultations (section 3.2.1), this was a difference that he valued. He felt the environment was "calming", in contrast to other meetings that could become "hostile" and one person could "dominat[e] the meeting". Emma too experienced a calm, informal, and validating environment where "nothing was too small" to bring. Andrew spoke about how this validating approach also enabled him to want to contribute more. Andrew's use of language, (e.g., "very very" comfortable; "never dismissed"; "always valued") may imply the strength of his experiences of systemic consultations, especially compared to other meetings.

> I found myself being very, very sort of comfortable and, and listened to and, and able to, to sort of voice my opinion and you felt that you know you wanted to do that more erm because you were never dismissed, you, you,

your opinions were always valued and, and validated and always taken on board… (Andrew; 30: 956-965)

Additionally Lucy, and Susie, appeared to find the reflecting team empowering. Susie reported that it was helpful to receive positive feedback about their work with the SU. Lucy appeared to speak from her managerial position, referring to the reflecting team empowering staff. She appeared enthusiastic about the reflecting team and found that it helped care staff to give their views which she valued.

> … they pick out like good points that people have said, which I think then kind of empowers the care staff, 'cause they say 'oh I said that' and they're quite proud of themselves, they'll kind of either come up with answers, or for example just, just hearing again the ideas that have been mentioned to kind of reinforce in our minds this is what we should be doing. (Lucy; 22: 615-625)

Lucy also felt that the SU was empowered, being able to see the SU's confidence grow through witnessing her speak up in meetings. Lucy recounted one systemic consultation where everyone attending was asked to highlight positives about the SU. This seemed to be something different for care staff to do given their main contact with the SU was in a pressured day-to-day environment, where the focus may have been on practicalities. It appeared to give a space for positives to be said and heard, and help the SU build a more positive narrative.

> …building [SU]'s confidence… so sometimes we'd go around the group and we'd say nice things about [SU] what worked well with [SU] what's good for [SU], what we find as staff, and I think for [SU] it was nice for her to hear that as well 'cause sometimes I think that she thinks quite negatively and maybe think that well maybe she's a bit sick of us because she's obviously here 24/7… (Lucy; 26-27: 741-758)

Karen too spoke about how her SU (and herself) appeared to feel validated by a member of the reflecting team. Her focus was on the importance of the SU hearing "it from someone else", highlighting how someone from outside of the SU's care staff team was important in making this reflection. Karen appeared to share the emotion with the SU which came to light as she recounted how the SU had received this reflection; "beaming". This part of the interview was interesting as Karen also spoke about other positive things that she saw in the SU. This heart-warming connection that Karen appeared to have with the SU through this reflection, may have unlocked further positive stories about the SU.

> …one of the ladies reflected back and said 'you know [SU] what I heard you saying is that you're an independent adult now', she does say that a lot but I don't think we always validate that Erm and [SU] just started beaming you know 'cause she heard it from someone else. (Karen; 16: 484-490)

Additionally for Karen, the reflecting team's comments enabled a shift for her from being guarded to becoming more open, as she realised from reflections that what she was saying was not as "bad" or "aggressive" as she had thought it sounded. Karen's account felt like the reflecting team had almost become a 'sounding board'.

> When the, the other lady's just sort of feeding back to us because (long pause) I think because of the relationship and because of the like almost always thinking like 'oooh should I say that, shouldn't I say that', it was nice to have that feedback sometimes to hear how things have come across. And, and I think in some ways that allowed future sessions to be more open. 'Cause in the beginning maybe it was, I was quite guarded about what I was saying, and then I realised well actually when they're reflecting back, it doesn't sound as bad as I think it's going to sound or maybe as aggressive maybe. (Karen; 12: 362-374)

3.6.2 Appreciating the SU's voice being enabled

Some participants experienced systemic consultations as person-centred and enabling of the SU's voice. This theme contrasted with some doubts held by Lucy regarding the SU's attendance at systemic consultations (section 4.3.2).

> I mean like I say I think for [SU] it was just having somewhere to go, erm just a, a vehicle almost for saying what she wants to say at the time. (Karen; 17: 531-534)

Karen, Lucy, and Emma, experienced systemic consultations enabling the SU to express their views, and be heard, in doing so. Lucy experienced the SU as being able to express her views on how she wanted staff to speak to her about certain topics (e.g. doing "chores).

> …it was her opportunity to speak for herself and she was saying 'well no actually, it doesn't work like that. I like it when you do this' so she likes it rather than saying erm, 'can you do this for me', like… really quickly we'll go and do it together and then we'll go and do something more motivating after like cooking a meal or something. (Lucy; 14: 411-422)

Lucy appeared to feel enabled to take a step back, where she realised that as staff they can unintentionally overshadow the SU's voice. Karen had also found that the SU's voice could be overshadowed by her family member, and hence appreciated systemic consultations enabling the SU the space to express her views.

Emma experienced systemic consultations and the "board" as person-centred. She recalled the lead therapist reassuring the SU in the first consultation by explaining to her that the meetings were about her. Emma seemed struck by how the SU was involved in systemic consultations, where she compared this to "family meetings" where the SU was excluded.

...it's sort of going in when, and when we have family meetings but this included [SU] 'cause it was about her... that was the main thing that she felt that she was included in every part of her care. You know we're not sort of [family member] and staff are talking about it or... it was basically centred round [SU], [SU] was in the middle and it was up to her to put out those things that she wanted this done or that done, and we work with her as much as we can to get you know as and what she wanted. (Emma; 7: 201-212)

Karen and Susie further discussed how systemic consultations were adapted to the SU's needs. Karen remembered the SU being given a choice to observe the meeting within a consultation when she was distressed. Susie really valued the flexibility in systemic consultations, where the service wasn't dependent on the SU attending, and therefore they (care staff) could receive support. Susie compared this to experiences of the SU being referred for a different type of therapy, which she experienced as the "door shut[ting]". The metaphor of the door being "shut" appeared to represent both the discharge of the SU from the service, and also Susie feeling 'shut out', excluded from feedback or support. In comparison, she viewed systemic consultations as open meetings Furthermore, Susie appeared to refer to consultations as "systemic counselling" which may have related to her experience of also being able to receive support.

...it's for [SU] it's much more tailored than the [other] therapy which was something that she went to and then the door's shut and you don't know there, we can't work with SU with that unless she decides to come out and talk to us about it... (Susie; 8: 222-227)

3.6.3 An opportunity to talk
Five participants felt that systemic consultations enabled space and time to talk. They experienced this as an opportunity (a word used by many participants) as they often felt unable to do this in their usual work places. It seemed something that was not prioritised in services, which connected with my thoughts discussed

in section 3.2.1 with Western cultural values being placed on being 'busy'; an emphasis on the 'practical' and 'doing'.

> …it was a great chance for everyone to get together and to talk through the issues that, that the individual was err, experiencing and how we could do that err, and support him better. (Andrew; 30: 971-984).

The time to talk was valued by Andrew to share with care staff and professionals from different organisations. However, this was also valued by participants (Lucy and Susie) to have the opportunity to talk with the SU and other care staff in the same organisation.

> Well yeah as I said I think the space, having the space [SU] to talk. Yeah because otherwise you get caught up in life don't you that [SU] kind of knows that space is just for her. (Susie; 9: 244-248)

For Jenny, it appeared to open up opportunities to discuss things as a staff team, by bringing back the topics from systemic consultations to discuss with the wider team. She felt that by allowing time for "in-depth" discussions, it allowed her and other staff to notice more about the SU and therefore enhance the support they provided.

> … what I do think indirectly also works is that probably as a [care staff] team we discuss it more you know and and I think that's something 'cause at our [team] meetings… the systemic is always discussed and so it's sharing that information with the rest of the group. And and that's been really positive as well. So that not necessarily in the systemic but the ripple effect out of systemic has been good as well. (Jenny; 26: 809-817)

It was interesting how Jenny experienced this as 'indirect' change, and implies this may be an unexpected change. This connects with Jenny's uncertainty about

the outcomes of systemic consultations (section 3.5.1). Karen also valued the "time to chat" and see different perspectives (connecting to section 3.3.2).

> … and I think something that came out of systemic therapy as well because we were sort of in the room together having that time to chat, erm it's just a bit more patience about things, because seeing things from everyone's side as well. (Karen; 29: 909-914)

A summary of the findings is provided in the next section (Discussion; section 4).

4. Discussion

This chapter will focus on conceptualising the main findings from analysis of seven participants' experiences of systemic consultations. I will first return to my research questions, present a summary of results, and then discuss the results in terms of how they relate to theoretical perspectives and other research. I have introduced some new literature in order to understand the findings. This is due to the nature of IPA allowing for unexpected findings to emerge (Smith, Flowers, & Larkin, 2009). I will then evaluate the methodology and provide self-reflections. Clinical implications and suggestions for further research will follow, and the chapter will close with conclusions.

4.1 Returning to research questions

This study focussed on the following research question:

- How do care staff experience systemic consultations that they have attended in ID services?

Supplementary research questions were also asked:

- What do care staff find helpful in systemic consultations?
- What do care staff find unhelpful in systemic consultations?

4.2 Summary of Results

Five superordinate themes emerged, encompassing thirteen subordinate themes. Overall, there were a range of experiences; some experienced as helpful and some raising uncertainty. The experiences of care staff who participated in the research can be separated according to the categories of what they found helpful and unhelpful. Therefore, results will be summarised according to these categories.

4.2.1 What did care staff find helpful in systemic consultations?

Provision of time and space for care staff to talk to each other and/or others and share information was experienced as helpful. An "outside person" was helpful in enabling thinking 'outside the box' (by providing a different perspective), modelling and, advising on ways of working with the SU and mediating difficult conversations. Additionally, care staff found that the lead therapist facilitating collaborative problem solving was helpful. An "outside person" also helped to enable a validating environment where individuals were encouraged to give their opinions, leading to more open communication. Positive feedback from the reflecting team appeared helpful in empowering care staff and SUs. Flexibility in approach with SUs, such as using something concrete/visual as a focus (e.g., the "board"), and the consultations remaining open despite a SU's irregular attendance were experienced as helpful. Additional efforts to enable expression of the SU's voice were also found helpful. Even though some participants could be concerned about family attending systemic consultations, the joint attendance appeared to often contribute to improved relationships.

4.2.2 What did care staff find unhelpful in systemic consultations?

Interviews revealed that participants did not know what to expect from systemic consultations. This led to uncertainty about the purpose and also for most, uncertainty about who the consultations were for and therefore who should attend. Having limited information about consultations and their purpose prior to attending was unhelpful. Some participants had a different understanding of the purpose of systemic consultations than what they focussed on (e.g., understanding consultations as just for the SU), and some were unaware of the purpose. For some, this led to further uncertainty regarding what can and cannot be discussed, and/or the goals of the intervention. This appeared to link to some participants' experiences of struggling to make sense of what they had achieved through systemic consultations. There were also some factors (inherent cognitive limitations and inconsistency of staff attendance) that some participants felt hindered achievements.

4.3 Understanding the findings in the context of current literature

This study's findings will now be discussed in the context of existing theory and empirical research.

4.3.1 Feeling validated

Participants felt validated through a variety of means. One of these was through comments from the reflecting team (Andersen, 1987; 1990). Andersen (1987; 1990) found that more positive connotations are elicited when reflections are provided in the presence of families, which are seen as essential for change (Jones, 1993). The findings of my research also showed that this could happen for care staff. Some participants experienced empowerment through positive comments from the reflecting team and some felt that it also empowered the SU. In contrast, there was one participant (Andrew) who did not find the reflecting team beneficial, experiencing them as "reiterating" and wished they could be more opinionated. Interview questions did not ask directly about the reflecting team, however, the format was raised explicitly as helpful for three participants.

Helpfulness of the reflecting team's comments was consistent with Anslow (2014) and Petrie (2011) who both interviewed PWIDs about their experiences of the reflecting team. Rikberg Smyly, Elsworth, Mann, and Coates' (2008) findings of 'a positive focus', and Petrie's findings of 'having strengths recognised' also corroborated with this research. Arkless (2004) however found mixed views of SUs and family members, with some finding it confusing and others finding a positive effect.

Anslow (2014) makes sense of her participants' experiences of valuing the positive focus in relation to White and Epston's (1990) narrative techniques of looking for "unique outcomes". This can also be seen in the current research as narrative techniques were part of the collection of skills drawn on in systemic consultations. The reflecting team's positive comments may have enabled some participants (and SUs) to develop new stories about themselves, thickening

positive narratives. Furthermore, this supported Harvey's (1992, as cited in Dallos & Draper) description of others' responses (i.e., affirmation from the reflecting team) being important in enabling new narratives to emerge.

Some participants experienced validation from being asked their views, feeling included and valuing collaboration. This is likely to reflect therapists' stances within a systemic approach of neutrality (Selvini, Boscolo, Cecchin, & Prata, 1980) and/or curiosity (Ceccin, 1987) where each member of the system's view was seen as equally valid by therapists, drawing on social constructionism. Additionally, the experience of collaboration suggests that multiple views were combined to co-construct new narratives. This may be different for care staff who may ordinarily experience adherence to professionals' advice, care plans, etcetera, in the midst of a busy environment, and perhaps less opportunity for collaboration.

Feeling validated through collaboration was consistent with being able to voice opinions reported by Rikberg Smyly, Elsworth, Mann, and Coates (2008) which occurred for professional colleagues, family members/SU and care staff's accounts, with care staff's accounts containing the highest percentage of this theme. However, this finding contrasted with Petrie (2011) finding that PWIDs felt excluded through the reflecting team. This inconsistency may reflect the difference in research focus where Petrie's focus was on the reflecting team (2011), and my current research, focussed on experiences of systemic consultations as a whole. Alternatively, or, in addition, it may reflect differences between sample population as Petrie (2011) referred to specific contributing factors related to PWIDs (e.g., communication styles). Additionally, Arkless (2004) found "having a voice versus being silenced" as a master theme in SUs' and family members' accounts of their experiences of ST; some participants felt enabled to speak up, however others did not for different reasons (e.g. a family member being present). One participant in my research reported withholding some information for fear of conflict with the SU and/or family members, and

another described initially having these feelings, however, feeling more enabled to express her views following reflecting team feedback. Therefore, the research overall reveals mixed findings.

Within the current research, care staff found systemic consultations enabling of the SU's voice. The SU appeared to be at the centre of discussions and many adaptations were made to include the SU. This is consistent with Fredman (2014) who positions the PWID/SU at the centre of the network. This is encouraging due to disempowerment and marginalisation that PWIDs often experience (Haydon-Laurelut, 2011). However one needs to ensure that by offering a voice to the service user, that care staff are not silenced losing 'curiosity' (Ceccin, 1987) in relation to other system members.

Many participants viewed systemic consultations as an opportunity to talk. It appeared that time to talk was not privileged amidst the business of organisations. Western cultural beliefs about the importance of 'doing' rather than reflection, which may then influence the beliefs held by the organisation, and hence lead to a focus on 'doing'. This could be understood within a CMM model (Pearce & Cronen, 1980) to influence the beliefs held by organisations.

Anderson and Goolishian (1992) conceptualise talking itself as leading to new narratives, meanings and realities being developed, and see therapists' roles as facilitating conversations. They describe the process of creating 'conversational space' partly as taking a 'not-knowing' stance, where therapists are curious to hear more from clients. Whilst this may contribute to participants valuing the opportunity to talk, it may also be linked with some frustrations that some participants experienced with wanting therapists to be more directive.

Arkless (2004) found mixed views of talking in systemic consultations for family members and PWIDs. Throughout both Arkless (2004) and the current research, mixed experiences of talking may relate to what was talked about. This links to

the superordinate theme of 'not knowing what to expect; it was something different' and the need to 'warm the context' (Burnham, 2005; see section 4.3.7).

4.3.2 Our relationships improved

The theme of improved relationships appeared to be contributed towards by factors described in subthemes and perhaps vice versa. Due to the type of research carried out however, direct causal relationships cannot be identified. The superordinate theme of 'our relationships improved' was consistent with a theme arising from my service-evaluation (Johnson, 2015) 'strengthening the network' where professionals experienced relationships improving between members of the network. This theme did not arise in Rikberg Smyly, Elsworth, Mann, and Coates (2008), Arkless (2004), or, Petrie (2011). This may be explained by the nature of referrals to systemic consultations in the current research, which may have concerned more difficult relationships, and/or that it felt more relevant and a focus for care staff. Rikberg Smyly et al. (2008) included care staff in their telephone interviews, however, interviews and analyses were not as in-depth as what IPA can offer, and hence, care staff in Rikberg Smyly et al.'s (2008) research may not have raised this.

An important subordinate theme from 'our relationships improved' was 'enabling understanding from another's perspective'. Many participants felt that systemic consultations enabled them to understand perspectives of others. This could reflect participants feeling validated and able to express their views in a calm environment (and therefore be heard by others) and/or techniques used by the lead therapist and reflecting team. Reflections may have highlighted multiple perspectives, amplifying the views of different members of the system, and enabling them to be heard by others (Andersen, 1987; 1990). It may also reflect circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985) eliciting difference between individuals, time points, situations and 'parts of a person', and specifically, 'offering alternative perspective' circular questions (Pote et al., n.d.) may reflect this change requiring thinking from another's

perspective. Arkless (2004) discussed one participant with an ID who felt enabled to understand his mother's perspective.

Subordinate themes of enabling consistency and valuing gains of sharing information also emerged from the current research. These themes appeared specific to this research, suggesting particular relevance for care staff (opposed to PWIDs and their families). The value of sharing information highlighted gaps in important information about the SU shared ordinarily, and perhaps relationship tensions can hinder sharing this information. Systemic consultations may enable reduction in relationship tensions and therefore increasing information sharing between care staff and family. Four participants also valued consistency between everyone who attended systemic consultations "hearing the same thing". Care staff may be more attuned to consistency as they are likely to be encouraged within their organisations (e.g., adhering to care plans).

4.3.3 An outside person enabled us to think outside the box
The subordinate theme 'an outside person enabled us to think outside the box' comprised the value of someone external to the organisation helping participants think from a different perspective. This emerged for four participants. This theme connects with the aim of the reflecting team format (Andersen, 1987; 1990), where difficulties are described and explained differently alongside individuals' views being validated. Andersen (1987; 1990) explained the principle drawing on Bateson's (1972) ideas about "any difference which makes a difference" (p. 381), and discussed that this difference could not be too great or too small. Differences elicited therefore for participants who felt enabled to think 'outside the box' may have been elicited at an appropriate level to make a difference. Another explanation for the emergence of this theme, may be the impact of circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985), eliciting difference.

Rikberg Smyly, Elsworth, Mann, and Coates (2008) also found a similar theme; "broadened perspectives". Rikberg et al. (2008) conceptualised this in context of the reflecting team (Andersen, 1987; 1990). Arkless (2004) found that family members had experienced this as helpful in changing "ways of managing difficulties, stresses and transitions". Anslow (2014) found "differences in metacognitive abilities" in her interviews with PWIDs, where some individuals were unable to think from other perspectives, and others were able to. Additionally, the current research was consistent with Fennessy et al. (2015) who found that external professionals in systemic consultations helped to enable case managers to think differently about cases seeing the 'bigger picture'. This finding within a variety of research where systemic consultations had different purposes in ID services gives weight to a wider systemic approach where participants are enabled to think differently.

4.3.4 Valuing learning and putting it into practice beyond the explicit
The subordinate theme 'Valuing learning and putting it into practice beyond the explicit' occurred in five participants' accounts. Ways of learning were through modelling of therapists' ways of working with the SU, direct advice, and collaboration of attendees working out solutions. This theme was consistent with Rhodes et al. (2014) finding that behaviour support clinicians incorporated techniques and positions of therapists such as facilitating a relationships focus and enabling the system's own resources. This highlights strengths that may not necessarily be a direct aim of systemic consultations, however, important in ID services. Furthermore, in the current research, some participants were able to generalise their learning in working with other SUs. This also arose for one participant within my service evaluation (Johnson, 2015).

A theme of learning was not reported in Arkless (2004), Petrie (2011), Anslow (2014), or Rikberg Smyly, Elsworth, Mann, and Coates (2008). This may be explained by expectations care staff may hold of systemic consultations to learn strategies etcetera, and also by their beliefs about professionals providing this.

This could be understood within the CMM model (Pearce & Cronen, 1980). Emma's comments about lack of training opportunities for care staff, also raises awareness of this.

4.3.5 Not knowing what to expect

The theme of not knowing what to expect was consistent with findings from Anslow (2014), Rikberg Smyly, Elsworth, Mann, and Coates' (2008), and Rhodes et al. (2014), implying similar experiences of uncertainty for PWIDs, care staff, family, and professional colleagues. Interestingly, this theme did not appear within Fennessy et al.'s (2015) research, which may be explained by their population being case managers who may have been more familiar with systemic approaches. Rikberg et al. (2008) found a theme of being worried about the SU's presence, consistent with the current research's subtheme 'making sense of who they are for and who should attend'. However, this concern was specific to professional colleagues, and not care staff in Rikberg Smyly et al.'s (2008) research. The subtheme in my research also appeared to expand beyond the SU, with care staff concerned about the presence of the SU's family members. Furthermore, negative feedback was more noticeable within the accounts of professionals compared to care staff in Rikberg Smyly et al. (2008). These differences may be explained by a potential power difference, with care staff potentially feeling constrained giving feedback due to wishing to access the service in future. 'Feeling unprepared' (Rikberg Smyly et al., 2008) resonated with some participants' experiences within my research, for example, Anne felt that she needed to know a lot about the SU, and therefore felt anxious due to being a relatively new member of staff. 'Confusion' regarding the referral purpose was discussed in Arkless' (2004), consistent with 'uncertainty about the process' in my research. My own service-related research project (Johnson, 2015) also found similar themes of 'differing expectations' and 'uncertainty regarding forum composition' from interviews with two MDT professionals.

4.3.6 How can we understand the discrepancy?

Themes of 'uncertainty about the process' and 'making sense of who they are for and who should attend' within my research could be understood within the CMM model (Pearce & Cronen, 1980). This model (referred to in the introduction; section 1.7.2) theorises that conversations and the construction of meaning are influenced by a number of individuals' contextual levels. More specifically, Reder and Fredman (1996) discussed the interaction between clients and professionals' beliefs about help-seeking. They framed the interaction within the CMM model (Pearce & Cronen, 1980), where both clients and professionals are influenced by a number of contexts regarding how they see the helping relationship. Reder and Fredman (1996) proposed that if the fit between beliefs of clients and professionals about help-seeking are too similar or too discrepant, this is likely to affect the therapeutic relationship, impacting on therapy.

Within my findings, the difference between therapists' and participants' beliefs may have been too different. This is explained within the CMM model (Pearce & Cronen, 2004), and readers are referred to Figure 1 (section 1.7.2) to help hold the different contextual beliefs in mind.. Care staff may have had an understanding of difficulties that they attended systemic consultations for a problem within an individual (the PWID) (influenced by beliefs from their personal/professional lifescript). This understanding may be influenced by societal and cultural beliefs, which relate to an individualistic deficit-based understanding of difficulties within Western cultures where a medical model is dominant. Therefore, care staff's personal and professional beliefs may influence their construction of difficulties such as behaviour that challenges are located within the PWID. This may have contrasted with beliefs of clinicians. Working within systemic models, clinicians may be more likely to hold a relational view of difficulties, underpinned by a social constructionist philosophy (Gergen, 1985). Clinicians' relational understandings of difficulties are likely to have been influenced by their professional training.

Differences between care staff and clinicians' professional beliefs may be in 'vertigo' (incoherent) within the relationship, episode, and interaction in speech acts. The meaning ascribed to the relationship for care staff may be seeking professional expert advice to help the PWID, whereas, clinicians may have held a collaborative non-expert approach focused on enabling change within the system. The 'episode' relates to the systemic consultations, perhaps viewed by care staff based on previous experiences and "rules" of other episodes of speaking to psychologist as a space to gain expert advice. However, for clinicians, systemic consultations may have been seen as a space to explore meaning making and relational patterns. Therefore all these contexts influence the meaning ascribed to the 'speech act'. The 'speech act' focuses on the content of conversations within systemic consultations, where clinicians take a curious stance (Cecchin, 1987), and use techniques such as circular questions (Selvini, Boscolo, Cecchin, & Prata, 1980; Tomm, 1985). However, care staff may have expected more linear questions and advice on how to help the PWID. This 'vertigo' (incoherence) may underpin some of the uncertainty about the process for care staff, who they were there for, and who should attend, and also uncertainty regarding the outcome of systemic consultations. This may also have led to difference in expectations, for example, care staff expecting advice on how to help the PWID and clinicians expecting changes in relationships and patterns of interaction.

'Vertigo' (incoherence) therefore may be explored by the therapist initiating conversations concerning beliefs about location of difficulties and help-seeking (Reder & Fredman, 1996) (i.e., what kind of help care staff are looking for, and what their expectations of the help may be) which in the case of my research findings would be beneficial as early as possible. Discussing the different contextual levels of beliefs may also be helpful.

4.3.7 How can we help in preparing care staff for systemic consultations?
Burnham (2005) draws on Bateson's (1972) ideas that "warm ideas" are more likely to continue than "cold ideas", and applied this to conversations in therapy

where the context needed to be 'warmed'. That is, preparing individuals for conversations that may be held. Burnham (2005) proposed using relational reflexivity, being open with clients and asking about their preferences in advance. Burnham (2005) gave an example in preparing clients for 'praise' from a reflecting team asking clients about their relationship with praise and ways they might communicate this. The context of systemic consultations within the research may not have been 'warmed'. Further, Haydon-Laurelut, Bissmire, and Hall (2009), discussed the importance of 'warming the context' in working with care staff in ID systemic consultations.

Burnham (2005) also described relational reflexivity in 'coordinating resources' between the therapist and clients. He proposed asking clients their preferences of working at thinking, feeling, or doing, levels, and starting from where they would normally act. This may reduce uncertainty of systemic consultations. Within the research, Lucy reported that she was expecting systemic consultations to be discussion-focused, however experienced them as more practical. This could imply more familiarity with a thinking/feeling level for Lucy, rather than a 'doing level'. Whereas, some participants, desired more direction, potentially implying familiarity at a 'doing' level. This was consistent with Rhodes et al. (2014), where behavioural support clinicians also wanted more advice and structure. Due to the number of individuals potentially present in systemic consultations, preferences are likely to vary. Burnham (2005) discussed co-creation of individuals' narratives/expectations, influenced by social constructionism (Gergen, 1985). Furthermore, Andersen's (1987) reflecting team format may aid this, allowing a 'both-and' way of thinking where the reflecting team offer different descriptions and explanations, introducing different ways for individuals within the system to see things, opportunity for "difference which makes a difference" (p. 381) (Bateson, 1972).

Advice giving could be seen as adopting an 'expert' approach, which may be familiar to care staff meeting with professionals, however, previously it has not

been viewed as a systemic technique. Haydon-Laurelut, Bissimere, and Hall (2009) acknowledged the need to adopt an 'expert' approach at times to provide support with care plans for example. It also emerged through the current research that learning through systemic consultation was helpful. Burnham (1992) discussed 'advice giving' reporting its reconstruction by Silver (1991) to fit with a systemic approach. Burnham (1992) explained that by not giving advice, that is advice in itself, and therefore contradictory. He described asking whether advice giving would be the same or different to usual, and hence advice giving may be helpful if it was different. Where it is indicated that advice giving may be wanted by care staff, a combination of warming the context (Burnham, 2005), and asking attendees if this would be similar or different, could be activated.

4.3.8 Making sense of the outcome

There was uncertainty about the outcome of systemic consultations for three participants. Uncertainty of the process and who they were for is likely to have impacted on participants' views of the outcome. For example, Jenny returned to her desire for strategies when discussing the outcome and wasn't sure what they had achieved. Jenny's measure of change was likely to have been based on strategies care staff had, and as she did not feel they had many, she perceived minimal change. It seemed that there was disparity in the purpose and goals of systemic consultations between Jenny and the lead therapist. Burnham's (2005) ideas of relational reflexivity could be useful in collaboratively co-constructing purpose and goals. Furthermore, Burnham (2005) discussed reflexive questions to evaluate experiences of therapy.

Measuring changes in relationships, understandings, and meanings for individuals (second-order changes) appears to be more difficult to achieve than measuring changes in symptoms etc. associated with an individual. The SCORE-15 (Stratton et al., 2014) is a standardised self-report outcome measure of second-order changes (section 1.6.2) for family members. There are currently no

standardised outcome measures for care staff. Being able to measure and evidence change may further help to evaluate systemic approaches in ID services, contributing to the evidence-base, and also could be used clinically with care staff for collaborative goal setting and monitoring of change. Karen discussed the increasing need for her organisation to evidence change; standardised outcome measures could therefore also help organisations justify participation in consultations, as well as helping care staff to recognise benefits. The findings from this research in addition to previous research (e.g., Anslow, 2014; Rikberg Smyly, Elsworth, Mann, & Coates, 2008; Rhodes et al. 2014; Fennessy et al., 2015; Arkless, 2004) could be used, along with future research, to contribute to such measure. Furthermore, the process of reflecting on changes that occurred during interviews, appeared to be helpful in identifying changes.

4.3.9 Emotional impact and ethical dilemmas

A few participants experienced strong emotions during systemic consultations relating to topics discussed and tensions with family members. Strong unexpected emotional experiences raise ethical implications of informed consent of care staff's participation, particularly when care staff may often have expectations of a supporting role. This also evokes ideas around who the 'client' is/are. Rivett and Street (2009) discuss the difficulty where a 'problem-determined system' (Anderson & Goolishian, 1988) can agree as seeing difficulties as located within one person. They describe that the therapist is to deal with this by valuing each perspective and commenting on interactions.

Implications for therapists include carefully considering the dynamics of the 'problem-determined system' (Anderson & Goolishian, 1988) and who systemic consultations are for, and, who is best placed to attend. With systemic approaches, engaging individuals at a personal level, may also challenge the boundaries between personal and professional views of care staff, and what they are happy to be shared with SUs and family members who they are likely to have more professional relationships with. There is a need for an agreement with care

staff beforehand covering boundaries regarding discussion topics, and support they can access following consultations. Although flexibility of who could attend consultations was reported to be helpful by Susie, it may lessen opportunities for care staff to feel contained and supported. Clinicians may want to consider a more closed group to increase attendees' sense of being supported and feeling contained.

Furthermore, Rikberg Smyly (2006) and Rhodes et al. (2014) recommend consideration of who attends from organisations, with Rhodes et al. (2014) specifically recommending managers attend to enhance change.   Other approaches (e.g., Jenkins & Parry, 2006; Rhodes et al., 2011; sections 1.7.3.1-1.7.3.2) which have a greater focus on professionals attending could be explored.

Having become aware of one participant's emotional responses, I checked the support available to her and was reassured of her external support. I also informed my field supervisor linked to the service and we discussed the best way to feed back to therapists. We decided that I would feed back the general findings and clinical implications of this research to all the therapists involved in systemic consultations. Discussions will also follow within the service to take into consideration findings of this research.

4.4 Methodological critique

This section will discuss strengths and limitations of the current research. IPA provides a platform for in-depth analysis and hence the research provides rich accounts of care staff participants' experiences of attending systemic consultations in ID services. Guidelines for ensuring quality and validity of qualitative research were adhered to (Elliot, Fischer, & Rennie, 1999; Yardley, 2015).   The research demonstrated both 'commitment and rigour', and disconfirmation was presented (Yardley, 2015). I kept a reflective journal throughout and have demonstrated reflection from my own personal stance as a Trainee Clinical Psychologist with a special interest in systemic approaches in ID

services, providing transparency to the reader. I kept a 'paper trail' and received credibility checks through my supervisors, and IPA peer group. The systematic literature review (section 1.8.2) provided solid grounding for this research study. The sample was situated as much as possible, however, some details (e.g., participant ages) could not be reported individually for each participant due to maintaining confidentiality. This may affect the research's generalisability.

The research was ethically sound, receiving both ethical and research and development clearance. In addition, ethical issues that arose were discussed with my field supervisor and acted on accordingly.

The research had a small sample size due its in-depth qualitative approach. Due to this, caution should be taken when generalising findings. The sample was homogenous; all participants were members of care staff who had attended systemic consultations through the same ID service. However, there were some differences, including that five participants had additional managerial responsibilities. This was carefully considered within the methodology; by excluding participants with additional managerial responsibilities, it would not represent the care staff who attended systemic consultations. The two care staff without managerial responsibilities may have experienced systemic consultations from a different lens to the five with additional managerial roles. However, interviews were directed through the direct care position, and there did not appear to be considerable differences between experiences. However, it may be that participants with additional managerial roles may have been thinking from a broader perspective about the impact on their staff in addition to themselves. This may have contributed to participants speaking from a collective position, using terms 'we' and 'us', instead of 'I'. Although, this may also be explained by the nature of support work, where care staff work collectively as a team; at some points it may have also represented a need to position oneself within a collective to enhance strength within tense relationships.

Although participants were recruited from a single service, there were four different lead therapists of systemic consultations. Lead therapists were all trained in Clinical Psychology, with three trained to postgraduate certificate or diploma level in systemic practice. The differences in lead therapists, and within the reflecting team, were likely to result in differences between therapist factors such as style, preferred models, etcetera, and is likely to have influenced participants' experiences. Despite this, these differences are reflective of ID services offering systemic consultations (Kaur, Scior, & Wilson, 2009). Also, due to the nature of Clinical Psychology training, Psychologists may have drawn from models outside of systemic approaches. Although recruiting from one service improves sample homogeneity, it also affects generalisability, as systemic consultation may have differences (e.g., whether a SU attends). These factors may have affected care staff's experiences, and also highlight further complexities linking to the theme 'making sense of who [systemic consultations] are for and who should attend'.

I was not involved with any systemic consultations that participants attended. I had worked in the service and had previously met one participant in a different capacity. We acknowledged this and it did not appear to affect the participants' account. My field supervisor worked at the recruitment site which had potential to influence the research, and hence, participants were reminded of confidentiality. I also reflected on the influence of my field supervisor's association with the service and a possible bias towards wanting to find systemic consultations helpful. However, our attendance at the Special Interest Group (section 2.7) helped to increase our awareness of the impact of our different beliefs at different levels in keeping with the CMM model (Pearce & Cronen, 1980).

Participants were recruited within their professional context, and most interviews carried out at participants' places of work. This may have impacted upon participants' understanding of their experiences from a professional

perspective, rather than more personal which IPA endeavours to elicit. Recruitment may have also been influenced by organisational contextual factors, for example, some participants were unable to participate due to staff shortages. This method of recruitment therefore may have missed some important experiences where systemic consultations may have been experienced differently given demands on care staff. In addition, a self-selection bias may have occurred with care staff agreeing to participate if they had particularly strong views about systemic consultations, and therefore omitting participants who may have been more ambivalent.

4.5 Self-Reflection

Smith, Flowers, and Larkin (2009) identified that one cannot know all of one's preconceptions prior to research, and hence as analysis develops, further preconceptions can come to light. I kept a reflective journal throughout the research process to write about my preconceptions (advised by Smith et al., 2009) (see examples in Appendix R). Here I will discuss the main topics that arose so that my own stance and experiences are transparent to the reader. I realised that I resonated with a major research finding of making sense of systemic consultations. I too had experienced my own sense-making of systemic consultations which had taken me on a journey from when I was first introduced this way of working as an Assistant Psychologist. I also thought about a similar theme arising in my service-related project of 'differing expectations' and 'uncertainty regarding forum composition' (Johnson, 2015). Being able to reflect on this enabled me to understand what I may have been bringing to the interpretation, and further check this against the data. Whilst this was predominant in my own experiences, I realised through credibility checks with my supervisors, and peer supervision, that this was also something that was predominant for participants.

I related to participants' experiences of making sense of the outcome of systemic consultations. I found myself feeling disappointed upon being presented with

some participants' experiences of doubting the outcome. This led me to think about values within a Western society, filtering to the NHS, where there is a focus on targets and tangible outcomes. This contrasted in some ways with second-order change due to the difficulty in evidencing it. Through this, and the stage of clinical training I was at, I was left questioning views of wider society where mental health difficulties are often seen as located within individuals and the focus on being able to 'fix' a person. The responsibility to 'fix' also appears to often come with a need to 'fix' indefinitely, and therefore perception of failure of services if individuals return for further therapy. Through the research and my reflections, I realised the great opportunities within ID services to evoke wider changes as support networks for PWIDs are perhaps recognised more than some other populations. I wondered whether some of the disappointment I experienced reflected disappointment in participants' views of the outcome as some may have been expecting direct change within the SU, and hence may have been less aware of second-order changes.

I also noticed that I was expecting the reflecting team to be a bigger part of participants' experiences. I may have held preconceptions about the reflecting team being the most different experience and perhaps evoking the most change. I may have been invested in this due to my experiences of being a part of the reflecting team and always having found this (from my perspective) to be helpful. I also realised that some of the empirical research I reviewed had only focused on the reflecting team aspect of systemic models, influencing my preconceptions. It also made sense that at my stage of training, a large part of my experiences in systemic consultations had been as a member of a reflecting team, rather than in a lead therapist role, and hence this lens may have been most present for me.

4.6 Clinical Implications

Findings from the research indicated that systemic consultations could be helpful for care staff in improving relationships with colleagues, SUs, and/or family members. Systemic consultations opened up opportunities to understand from

another's perspective, to think differently, improve communication, consistency, and information sharing, between members of a system. This indicates that the use of systemic approaches within ID services when there are strained relationships can be helpful. Further, the Milan ST principles (Selvini, Boscolo, Cecchin, & Prata, 1980; Cecchin, 1987) and reflecting team format (Andersen, 1987; 1990) appeared useful.

Most participants experienced feeling validated and many experienced systemic consultations as an opportunity to talk. This was understood within the CMM model (Pearce & Cronen, 1980) with organisations potentially being influenced by wider Western cultural beliefs with a focus on 'doing', and therefore care staff appear to have limited opportunities to talk and reflect. This could indicate a role for clinicians within ID services to work at the level of organisations, engaging with managers, to think about the benefits of making space and time for reflective practice in organisations. This could include reflective groups for care staff, provision of regular systemic consultations, and/or review of supervision structures for care staff. This may also include a collaborative and strengths-based approach where care staff can feel valued and validated. Training within organisations could be offered at the level of management to help with thinking more systemically, and therefore to be able to facilitate supervision/reflective spaces/team meetings in a way which elicits views of all care staff and focusses on their resources as well as difficulties. Enabling organisations to understand values in talking, reflecting, and collaborating, which may oppose organisational beliefs about 'doing' may also include being able to provide evidence and psychoeducation about the gains.

Experiences also highlighted valuing of learning opportunities from systemic consultations. Along with a need from some participants for more direction, and psychologists likely to be viewed as experts, it is indicated that advice giving may be helpful to consider in systemic consultations. This may require therapists to reflect on their relationship with advice giving within a systemic approach

(Burnham, 1992), and explore this within consultations using relational reflexivity (Burnham, 2005). Training for care staff could also be considered, including systemic thinking, and more general training in working with PWIDs. Training on the experiences of family members and the impact of reactivation of grief at transition points (as discussed in Vetere, 1993) may also be helpful in enhancing the awareness of the emotional experiences of family members and its impact upon relationships.

Uncertainty about the process of systemic consultations, who they are for, and therefore who should attend, appears to need careful consideration by therapists. Further, there are ethical implications to consider regarding who the client(s) is/are and who is receiving an intervention, given the particularly strong emotions and need for containment that some participants experienced in the research. Attendees at systemic consultations should be given more information prior to set-up. 'Warming the context' and relational reflexivity (Burnham, 2005) could be helpful for therapists and care staff to co-create safe and acceptable exploration regarding setting up the context for systemic consultations. Furthermore, initial exploration at a more individual/separate group level may be helpful in deciding indeed who systemic consultations are for and who should attend them. Therapists could meet initially with care staff alone, to start to 'warm the context', and discuss how difficult conversations may be managed and how the therapist would know if they were feeling uncomfortable and what they should do. An agreement could be made beforehand and include support that care staff can access following consultations if needed.

Clinicians could consider a closed group to increase participants' sense of feeling supported and contained. Other approaches in relation to who attends could also be considered such as a professional/care manager only attending systemic consultations as tertiary supervision (Rhodes et al., 2011; 2014; Fennessy et al., 2015).

Relational reflexivity (Burnham, 2005) may be useful in co-constructing goals and evaluating experiences of the therapy. More consideration of care staff's expectations, levels of beliefs, and pre-session hypothesising may also be useful in preparing for systemic consultations.

4.7 Future research directions

Research in systemic approaches with PWID and their network is still in its infancy. This research was the first to explore care staff's experiences of systemic consultations using IPA (to the author's knowledge), and hence adds valuable information regarding care staff's experiences. Considerably more research is needed in this area, including further qualitative and quantitative research into the experiences and effectiveness of systemic consultations. Future research would also benefit from developing standardised outcome measures to assess second-order change from care staff's perspectives in ID services. It may also be helpful to explore specific factors that enable individuals attending systemic consultations to able to voice their opinions. Future research could include exploration of differences in who attends systemic consultations and the acceptability and perceived helpfulness and unhelpfulness of this. Research may also benefit from investigating factors of systemic consultations (including therapeutic techniques) that lead to changes, and, the similarities and differences of experiences of the same systemic consultations attended by different members of the system.

4.8 Conclusion

This research explored the experiences of care staff who attended systemic consultations in an ID service. IPA was applied and therefore rich data was elicited. Five superordinate themes emerged; 'Not knowing what to expect; it was something different'; 'Our relationships improved'; 'An outside person shone a new light enabling us to think and work differently'; 'Making sense of what we have achieved'; 'They made us feel validated'. These findings were discussed

with reference to existing theoretical and research literature. Clinical implications and future research directions were given. An important clinical implication from this research is the need for careful consideration regarding the set-up of systemic consultations. A need for the context to be 'warmed' (Burnham, 2005), and flexibility in providing advice when indicated (Burnham, 1992), and an agreement to be made with care staff regarding their participation to enable them to feel supported.

"Well begun is half done"
(Aristotle)

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6. Appendices

Appendix A: Table of Lit search articles analysed for appendices

Author(s) & date	Population/ Informant	Design	Methodology	Summary of findings	Strengths	Limitations
Kaur, Scior, & Wilson (2009) Systemic working in learning disability services: a UK wide survey.	14 services (15 participants) (3 declined) clinicians on behalf of the service	Quantitative non-experimental descriptive design	Self-report questionnaire Covering: - degree STs used - type of STs - supervision - resources - training - thoughts re. evaluation.	- 55 clinicians delivered systemic work within 14 services - mean of 46% of referrals - systemic work (range 12-100%) - most common professionals CPs. - 2 systemic therapists. - 7 services – family therapy clinics where 15-100% of work systemic - most common - therapeutic work involving PWID and system - next most common - system without PWID - initial SC to clarify referral - SCs to colleagues/staff teams/organisations - infrequent - 6 services – mostly carried out by individual therapist	- 'first attempt to map work offered as part of NHS LD services in UK' Highlights: - work being done - need to collaborate for evaluation - need to raise profile of STs in ID Recommended: - training - more research & publication	- small sample - many CPs; not other professionals - asked only one perspective - likely to be services missing

	- 6 services - therapy team of 3+ - 2 services – in pairs & 3+ clinicians as part of therapy team. - 57% systemic work 'limited [by number of professionals] who could be involved' - 57% used interpreter/cultural advisor. - range of approaches used including social constructionist, narrative, post-milan, brief solution, and milan - most common - mixture - 1 used one way screen (4 had it) - All had access to video recording but limited number used it. - clinics (57%) - day centre (7%) - staffed home (22%) - PWID's own home (14%). - 17/55 - diploma/masters level post - supervision usually group - supervision – none-		

				fortnightly - All thought 'establishing an evidence base was important' - Barriers to research		
Baum (2006) Evaluating the impact of family therapy for adults with learning disabilities and their families.	Clinicians completed outcome forms for 9 families who had STs. 3 families had planned ending to therapy; 1 DNA after 2nd session; 2 attended one sessions; 2 still receiving ST; 1 just started ST 6 men 4 women with ID – 2 from same family (5 mild LD; 2 mild-moderate; 1 moderate-severe; 1 –	Mixed methods. Non-experimental quantitative & qualitative descriptive design	Descriptive Data collection from outcome forms designed for initial session, end of final session, & satisfaction questionnaires Demographic data also collected	Themes of intervention 5 families – life-cycle transition from childhood to adulthood 3 of fathers – life threatening illnesses 5 – bereavement and loss 5 - 'chronic sorrow' (Wikler et al 1981) 3 - other themes – triangulation and scapegoating 2 – marital difficulties 3 – sibling relationships 2 – fear of violence 3 – parents' feeling of being 'captive' or 'captivated' (Todd & Shearn, 1996) Models of intervention - Milan systemic therapy (Boscolo et al 1987) - Structural family therapy (Minuchin, 1974) Outcomes - 2 – still in therapy - 2 –coming to end of therapy	- represents the start of evaluating STs in ID - reported inter-rater reliability for forms clinicians completed	- Method is not well described - No control group - measures weren't standardised - inter-rater reliability wasn't formally analysed - missing data - outcome forms were completed retrospectively and by clinicians - families' perspectives were missing; there may have been differences between therapists' and families' perspectives

	severe) (Ages 17-44 yrs)			& goals achieved - 2 – therapy completed & goals achieved - 3 – 1-2 sessions only as did not return		
Fennessy et al. (2015) Systemic consultation in intellectual disability case management.	24 case managers working with a 'complex case' ('both child & adult clients within a care home system, foster care, couple or family system')	Mixed methods (Qualitative & Quantitative) compared 2 groups Expt group - 2 sessions over 6 weeks 60-90 mins where presented a case in initial SC to 3-6 members of a RT. *(Sociogram & interventive, circular and relational qus used (Tomm, 1987))* After 90mins, team discuss case while CM in same room listening	**Quantitative** - baseline & 4-6 weeks later Measures: – workflow questionnaire (info on 'people important for case manager providing advice for their work on the case over previous 2 weeks (adapted by Chung, 2008)). - The organisational systems questionnaire (OSQI Billings, Kimball, Shumway & Korinek, 2007) (to measure perceptions or workplace functioning using systemic framework)	**Quantitative** - Research group – decrease in participants' scores on DASS-21 stress subscale & increase in OSQ both approached significance - no changes in comparison group -workflow qu'airre – nodes significantly decreased – CMs consulted less people after SCs (no change in comparison group) - efficiency of info flow increased for research group - No significant differences for comparison group on any measure **Qualitative** 3 themes - 'stuck and stressed' - 'zooming out' - 'becoming an agent of change'	- Ethically sound – did not remove normal supervision - Triangulation of data - Rigorous data analysis - Examples given disconfirming themes - Kept 'paper trail' - First research evaluate SCs for Case Managers in ID	- Participants 'self-selected' into the research group – bias in groups - Didn't report on clinical significance - Omitted family members' views

			(Andersen, 1995). (2nd session – solution-focussed & narrative qus. Actively sought out changes in follow up & amplified changes CM had made. Plus cont.'d to have normal supervision) Control group Usual supervision	- Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) **- Social Network Analysis (SNA)** (Freeman, 2001) (to track changes in case manager's interactions in their cases after SCs. Independent and paired sample t-tests **Qualitative** - at initial SC & follow up - SC audios, transcripts, genograms, field notes. - Grounded Theory analysis			
Rikberg Smyly, Elsworth, Mann, & Coates (2008)	64 participants (5 carers/ service users; 39 care staff; 20	Qualitative	- Interviews (via telephone) - Content analysis	<u>Overall</u> - 86% - positive responses 97% - helpful/useful <u>Only/mainly positive</u>	- Views from different system members - SCs in same service reducing extraneous	- Evaluating only the initial SCs - Few families/ service users

				comments - 86% overall - 100% of carers/service users - 90% of care staff - 75% of professionals	variables (e.g. therapist factors of ability, rapport)	- Interviews not recorded
Working systemically in a learning disability service: what do colleagues and carers think?	professionals)					- Content analysis limits level of detail & may miss linguistic and more conceptual levels
				Mainly negative comments - 25% of professionals.		- Categorising interviews into positive/ negative categories may be reductionist & biased
				Positive feedback themes - helpful/useful (focussed greatly on reflections) - able to voice opinions - enabling 'broadened perspectives' - 'a positive focus', - helping with next steps/giving ideas - 'satisfied with the outcome'.		- 50% mark is set as a cut off for categorising – no rationale
				Negative feedback themes - structure unfamiliar/ uncomfortable - 'unprepared' - worried about presence of a service user - no outcome/not understanding/ remembering		- Telephone interviews - not face-to-face – risks missing something/P not able to speak confidentially
				(Able to voice opinions - more for care staff; 'positive focus' and 'feeling unprepared' - more for professionals and carers/service users)		

Rhodes et al. (2014)
 	
Beyond the impasse? Systemic consultation and understanding complex cases)
	11 clinicians trained in behaviour support 'attending SCs for complex cases'	Qualitative
		
		Semi-structured interviews
		- before SCs
		- after SCs
		- 2 months after SCs *(longitudinal)*
		
		- interviews on clinicians' 'clinical practice and clinical reasoning'
			Interviews and field notes
			
			Thematic analysis with grounded theory tools
				- Clinicians - difficulties in relationships with carers before attended SCs
				- Hoped SCs could help to 'gain some distance' becoming unstuck
				- Clinicians - more focussed on relationships including their role in these
				- Using skills learned through modelling in SCs:
				  - taking facilitative position supporting carers to increase their emphasis on relationships
				  - support the system in helping themselves
				  - reflecting on system's strengths
				- 'barriers to change' including:
				  - difficulties applying different approach if contrary to approach existent in organisations
				  - Less experienced clinicians - 'overwhelmed' due to difference in approach not providing structure
				  - Some wanted advice & more SC sessions.
					Rigorous
					- Analysed observations & interview data
					- Kept audit trail
					- Checked analysis with reflecting team members
					- 'member checking'
					
					Recommendations
					- offering more SC
					- training in systemic approach
					- managers to attend SCs
						- 1/3rd interviews via telephone
						- Unclear whether lead researcher(s) involved in reflecting team
						- Potential power imbalance between the interviewer(s) and participants if interviewer(s) already had relationship with participants especially considering some participants wanted more SCs.

Anslow (2014) Systemic family therapy using the reflecting team: the experiences of adults with learning disabilities.	5 adults with LD 4 female; 1 male 2 participants - 18-24 yrs 2 participants 25-34 yrs 1 participant 35-44 yrs *(all attended systemic family therapy using reflecting team)*	Qualitative	Semi-structured interviews – developed from interview topics used by Lloyd & Dallos (2008) - 'DVD-assisted recall'	5 superordinate themes *(& 12 subthemes)* - therapists' focus on strengths and difficulties' - difference in metacognitive abilities - finding a voice in therapy - frustration with the outcome of therapy - managing an unusual experience	- 'DVD-assisted recall' - interviews shortly after ST session - rigorous & valid	- Some changes may have been missed due to taking longer to develop
Pote, Mazon, Clegg, & King (2011) Vulnerability and protection talk: Systemic therapy process with people with intellectual disability.	4 systemic therapy sessions extracts. These were from ST with: 3 families including PWID. PWID age range 17-54 years; two female and one male; two lived with parents &	Qualitative	Thematic & conversational analysis of extracts where vulnerability and protection talk was identified.	- vulnerability & protection discussed for ¼ of therapy - parents & others - trying to protect PWID from 'disability itself and its consequences; physical harm; peers; siblings; and the world at large; emotional distress caused by discussing delicate or painful issues; unfairness and inequality; and from other undetermined threats, real or imaginary' - parents protecting siblings from PWID & consequences of disability. - Needed to monitor -Reallocation of responsibility for protection across	- Acknowledge their interests & position - Conversational analysis well documented - Triangulation - input from other therapists - Examined for disconfirmation - Looked for alternative explanations for changes in topic/reversals outside of protection lens - Sound rationale re. particular analysis Recommendations - Therapists to	- Thematic analysis process not well described - Extracts supporting conversational analysis hard to follow without specialist knowledge of conversational analysis. - Potential bias analysing data within fixed theme frames - Type of systemic approaches in STs were not described

attended ST with them; one lived in supported accommodation, came with partner & two carers; ID level ranged between severe to mild.			professionals - PWID - protect themselves, parents, wider system from 'distressing talk' & selves from increased independence consequences. – key strategies used by all - most often - topic switch, reversal (positive to negative & vice versa)	normalise protection & enable conversations about protection and acceptability of different types and levels in system - therapists to be self-reflexive re. their own positon in relation to protection	

Appendix B: NRES Ethical Approval Confirmation

NHS
Health Research Authority

NRES Committee Yorkshire & The Humber - South Yorkshire
Unit 001
Jarrow Business Centre
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Tyne and Wear
NE32 3DT

Telephone: 0191 428 3565

9 November 2015

Dr Pieter Nel
Health Research Building
University of Hertfordshire
College Lane Campus, College Lane
Hatfield
AL10 9AB

Dear Dr Nel

Study title:	**Systemic Consultations in Intellectual Disability Services: Experiences of Care Staff**
REC reference:	**15/YH/0425**
IRAS project ID:	**181287**

Thank you for your letter of 26 October 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 opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Ms Gillian Mayer, nrescommittee.yorkandhumber-southyorks@nhs.net.

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.

Additional condition specified by the REC:

The reference to 'Ethnic Background' to be removed from the Reply slip for Research – Care Staff Members – version 1, as this is intrusive and could be construed as discriminatory.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised

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

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

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

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

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

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

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

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 within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity, eg 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 contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Professional Indemnity Insurance]	1	04 August 2015
Interview schedules or topic guides for participants [Interview Schedule v2]	2	13 August 2015
Letter from sponsor [Sponsorship Letter]	1	27 July 2015
Other [Summary CV for Field Supervisor and Local Collaborator (Nina Viljoen) 20.05.15 v1]	1	20 May 2015
Other [Email confirming researcher competence in assessing capacity 29.10.15]	1	29 October 2015
Other [Reply slip for research - care staff v1]	1	09 July 2015
Other [Transcription Contract v1]	1	26 October 2015
Other [Response Letter to REC 26.10.15]	1	26 October 2015
Participant consent form [Participant Consent form for Care Staff v3 26.10.15 showing changes]	3	26 October 2015
Participant consent form [Participant Consent Form for Care Staff v3]	3	26 October 2015
Participant information sheet (PIS) [Participant Information Sheet for Care Staff v3]	3	26 October 2015
Participant information sheet (PIS) [Participant information sheet for care staff v3 26.10.15 showing changes]	3	26 October 2015
Participant information sheet (PIS) [Information Sheet for the Organisation v3 26.10.15]	3	26 October 2015
Participant information sheet (PIS) [Information Sheet for the Organisation v3 26.10.15 showing changes]	3	26 October 2015
REC Application Form [REC_Form_04092015]		04 September 2015
Referee's report or other scientific critique report [Research Proposal Feedback from University 12.03.15]	1	12 March 2015
Research protocol or project proposal [Research Proposal v4 – Clean copy]	4	06 November 2015
Research protocol or project proposal [Research Proposal v4 – Showing Changes]	4	06 November 2015
Summary CV for Chief Investigator (CI) [Pieter Nel Summary CV 15.06.2015]	1	15 June 2015
Summary CV for student [Clair Johnson Summary CV 23.07.15]	1	23 July 2015
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Flowchart for Research Procedure v2]	2	26 October 2015
Summary, synopsis or diagram (flowchart) of protocol in non-technical language [Flowchart for Research Procedure v2 26.10.15 showing changes]	2	26 October 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:

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- 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 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/0425	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

Copy to: Miss Clair Johnson – Trainee Clinical Psychologist, Flat 1 The Old Coach House, Southern Road, Thames OX9 2ED

Professor John Senior – Pro Vice-Chancellor, Research Dept, University of Hertfordshire

Professor Tim Gale - Hertfordshire Partnership University NHS Foundation Trust

Appendix C: University of Hertfordshire Sponsorship in Full Confirmation

Dr Pieter Nel &
Ms Clair Johnson
Department of Psychology and Sports Sciences
School of Life and Medical Sciences

University of Hertfordshire
Hatfield
AL10 9AB
UK

tel +44 (0)1707 284000
fax +44 (0)1707 284115
herts.ac.uk

11 November 2015

Dear Dr Nel and Ms Johnson,

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: Systemic Consultations in ID Services: Experiences of Care Staff
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Pieter Nel
NAME OF INVESTIGATOR (Student): Ms Clair Johnson
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PG/NHS/00406

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also essential that evidence of NHS Trust Management Permissions (formerly known as R&D Approval) is sent as soon as they are received.

Permission to seek changes as outlined above should be requested from myself before submission to an NRES (NHS) Research Ethics Committee (REC) and notification to the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA), and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

A Charity Exempt from Registration under the
Second Schedule of the Charities Act 1993

Appendix D: Participant Information Sheet

Systemic Consultations in Intellectual Disability Services: Experiences of Care Staff

Participant Information Sheet for Care Staff

Introduction

As a care staff member who supports individuals with a Learning Disability in their own home or a shared group home, who has attended at least one systemic consultation, your views of these consultations are highly valuable. We would like to know about your experiences of attending systemic consultations including what you found helpful and unhelpful about the clinics. Please take time to read through this information so you understand what is involved and therefore can decide whether you would like to take part or not.

The researchers

The study is being carried out by Clair Johnson, Trainee Clinical Psychologist as part of a Doctoral qualification in Clinical Psychology. The study is being supervised by Dr. Pieter Nel, Academic Tutor, Deputy Clinical Psychology Doctorate Director, and Consultant Clinical Psychologist and Nina Viljoen, Chartered Clinical Psychologist.

Why are we doing this research?

We are interested in learning more about your experiences of systemic consultations so that we can understand more about what happens during these and how this impacts on the care staff team and individuals with learning disabilities. We hope that this will help Clinical Psychologists and Systemic Therapists to develop and improve their practice.

What is involved?

If you decide to take part, you will be invited for an in-depth interview about your experiences of systemic consultations. Interviews will take place somewhere quiet and confidential (e.g. at your place of work, home, an NHS building, or another suitable place). The interview will take no longer than 1.5 hours. Interviews will be audio-recorded, transcribed (typed up) and stored securely. Authorised individuals from the University of Hertfordshire, and those supervising the research will listen to audio recordings to ensure reliability. The interview will be about your experiences of systemic consultations, the difficulties that led your staff team to seek support, what and how you think things have or have not changed since the systemic consultations, and what you experienced as helpful and unhelpful during the consultation(s).

1

Participant Information Sheet for Care Staff – version 3

University of Hertfordshire
Doctorate in Clinical Psychology

Do I have to take part?

No. Taking part is voluntary, and your involvement with the study will not affect the service that you, your service, or the person with a learning disability you support, in any way. You can decide to stop taking part at any time. If you do withdraw, we will destroy any identifiable information we have for you, and not collect any more information from you. It may not however be possible to withdraw your data (the information we will obtain through your interview) as this may no longer be identifiable.

What do I have to do?

If you decide to take part in the study, you will be asked to sign a form giving your consent. You will be given a copy of this information sheet and your signed consent form to keep. The researchers will also keep a copy of your signed consent forms.

What are the risks of taking part?

Risks of taking part are usually minimal. The topics we talk about in the interview have a chance of eliciting some distress. The researcher is also a clinician and has skills and experience in talking with people who are distressed. If you become distressed the researcher will stop the interview and will not continue unless you feel able to do so. At the end of your interview there will also be time to 'debrief' and talk about what the interview was like. The researcher may also encourage you to contact the manager of your organisation or your GP for support if you do become distressed.

Is taking part confidential?

All your information (personal details, recordings of your interviews and transcriptions) will be kept in a secure location and will be kept confidential. Interview recordings will be transcribed and transcriptions will be anonymised by removing personal details, such as your real name and home town. Relevant sections of your interview data and the researcher's analysis of this may be looked at by the researcher's supervisors and individuals from regulatory authorities or from the NHS Trust. It is also possible that a non-researcher will be employed to transcribe the recordings, and if so they will be asked to sign a confidentiality agreement.

Information from your interviews would be shared with other professionals or agencies only in exceptional circumstances if you revealed information that indicated that you or someone else might be at risk of harm (e.g. Adult Safeguarding Teams, social services, the police etc.).

The findings of the study will be written up in a report submitted to the University of Hertfordshire as part of a Doctoral qualification in Clinical Psychology and will be kept in the academic library system. The findings may also be published in a research paper in an academic journal, which is likely to include direct quotes from your interviews. These quotes will be anonymised. Finally, a short summary of the findings may also be published

Participant Information Sheet for Care Staff – version 3

University of Hertfordshire
Doctorate in Clinical Psychology

through charitable and/or independent organisations , and/or the NHS so that they can be read by members of the general public. If you decide to take part you should remember that the main report will be available in the academic library system and is likely to be made available on the University of Hertfordshire's online research database. You, your organisation, the person you support and their family would be able to access the report if they wished, and could identify quotes from your interview.

What are the benefits of taking part?

Many people find it helpful to talk about their experiences, and taking the time to reflect on systemic consultations outside of sessions may enhance the effectiveness of the sessions themselves.

We cannot promise that taking part will benefit you, your client and their family and your organisation directly, but we hope that the findings will help us to understand and enhance practice in for networks needing help in the future.

If you wish, Clair can send you a brief summary of the findings once she has completed the study. If you would like this, please tick the box on your consent form.

What if I have questions or concerns?

If you have any questions or concerns about the study please contact Clair by telephone, email or post (contact details below). In the unlikely event that taking part in the study has upset you in any way please contact Clair so that she can give you details of where you can access further help and support.

Who has reviewed this study?

The Research Ethics Committee makes sure that the study is fair and has given consideration to the well-being of participants. This study has been checked by the University of Hertfordshire the NHS Research Ethics Committee and local NHS Research and Development department.

Thank you for taking the time to read this.

If you are interested or have any questions, please contact:

Clair Johnson (Trainee Clinical Psychologist)

Email:
Telephone Number:
Address:

3

Participant Information Sheet for Care Staff – version 3

Appendix E: Information Sheet for the Organisation

Systemic Consultations in Intellectual Disability Services: Experiences of Care Staff

Information Sheet for the Organisation

Introduction
We would like to know about the experiences of care staff members attending systemic consultations, including what they found helpful and unhelpful. The views of care staff members who support individuals with a Learning Disability in their own home or a shared group home, who have attended at least one systemic consultation, are highly valuable. We are currently asking care staff members to participate in this research.

The researchers
The study is being carried out by Clair Johnson, Trainee Clinical Psychologist as part of a Doctoral qualification in Clinical Psychology. The study is being supervised by Dr. Pieter Nel, Academic Tutor, Deputy Clinical Psychology Doctorate Director, and Consultant Clinical Psychologist and Nina Viljoen, Chartered Clinical Psychologist.

Why are we doing this research?
We are interested in learning more about care staff members' experiences of systemic consultations so that we can understand more about what happens during these and how this impacts on the care staff team and individuals with learning disabilities. We hope that this will help Clinical Psychologists and Systemic Therapists to develop and improve their practice.

What is involved?
If your staff member(s) decide(s) to take part, and the service user who the staff member(s) attended consultations in relation to, consents, staff member(s) will be invited for an in-depth interview about their experiences of systemic consultations. Interviews will take place somewhere quiet and confidential (e.g. at their place of work, their home, an NHS building, or another suitable place). Interviews will take no longer than 1.5 hours. Interviews will be about staff members' experiences of systemic consultations, the difficulties that led the staff team to seek support, what and how they think things have or have not changed since the systemic consultations, and what they experienced as helpful and unhelpful during the clinics.

Do(es) my staff member(s) have to take part?
No. Taking part is voluntary, and involvement with the study will not affect the service that staff members, your service, or the person(s) with a learning disability your service supports,

Information Sheet for the Organisation – version 3   1

University of Hertfordshire
Doctorate in Clinical Psychology

in any way. They can decide to stop taking part at any time. If they do withdraw, we will destroy any identifiable information we have for them, and not collect any more information from them. It may not however be possible to withdraw their data (the information we will obtain through their interview) as this may no longer be identifiable.

What do(es) my staff member(s) have to do?

If your staff member(s) decide(s) to take part in the study, they will be asked to sign a form giving their consent. They will be given a copy of the 'pariticipant information sheet' and their signed consent form to keep. The researchers will also keep a copy of their signed consent forms.

What are the risks of taking part?

Risks of taking part are usually minimal. The topics talked about in the interview have a chance of eliciting some distress. The researcher is also a clinician and has skills and experience in talking with people who are distressed. If your staff member(s) become distressed, the researcher will stop the interview and will not continue unless they feel able to do so. At the end of interview there will also be time to 'debrief' and talk about what the interview was like. The researcher may also encourage your staff member to contact the manager of their organisation or their GP for support if they do become distressed.

The only time when information from your interviews would be shared with other professionals involved with the person with a learning disability you support would be in exceptional circumstances if you revealed information that indicated that you or someone else might be at risk of harm.

Is taking part confidential?

All your staff member(s)' information (personal details, recordings of interviews and transcriptions) will be kept in a secure location and will be kept confidential. Interview recordings will be transcribed and transcriptions will be anonymised by removing personal details, such as your staff member(s)' real name, home town, and organisation they work for. Relevant sections of your staff member's interview data and the researcher's analysis of this may be looked at by the researcher's supervisors and individuals from regulatory authorities or from the NHS Trust. It is also possible that a non-researcher will be employed to transcribe the recordings, and if so they will be asked to sign a confidentiality agreement.

Information from interviews would be shared with other professionals only in exceptional circumstances if they revealed information that indicated that they or someone else might be at risk of harm (e.g. Adult Safeguarding Teams, social services, the police etc.).

The findings of the study will be written up in a report submitted to the University of Hertfordshire as part of a Doctoral qualification in Clinical Psychology and will be kept in the

Information Sheet for the Organisation – version 3   2

University of Hertfordshire
Doctorate in Clinical Psychology

academic library system. The findings may also be published in a research paper in an academic journal, which is likely to include direct quotes from your interviews. These quotes will be anonymised. Finally, a short summary of the findings may also be published through charitable and/or independent organisations, and/or the NHS so that they can be read by members of the general public. The main report will be available in the academic library system and is likely to be made available on the University of Hertfordshire's online research database. Your staff member(s), your organisation, the person your staff member(s) support(s) and their family would be able to access the report if they wished, and could identify quotes from your interview.

What are the benefits of taking part?

Many people find it helpful to talk about their experiences, and taking the time to reflect on systemic consultations outside of sessions may enhance the effectiveness of the sessions themselves.

We cannot promise that taking part will benefit your staff member(s), their client and family, and your organisation directly, but we hope that the findings will help us to understand and enhance practice in for networks needing help in the future.

What if I have questions or concerns?

If you have any questions or concerns about the study please contact Clair by telephone, email or post (contact details below). In the unlikely event that taking part in the study has upset your staff member(s) in any way, they would contact Clair so that she can give them details of where they can access further help and support.

Who has reviewed this study?

The Research Ethics Committee makes sure that the study is fair and has given consideration to the well-being of participants. This study has been checked by the University of Hertfordshire, and the NHS Research Ethics Committee and local NHS Research and Development department.

Thank you for taking the time to read this.

If you are interested or have any questions, please contact:

Clair Johnson (Trainee Clinical Psychologist)

Email:
Telephone Number:
Address:

Information Sheet for the Organisation – version 3   3
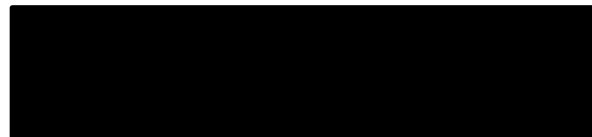
Appendix F: Participant Consent Form

Systemic Consultation Clinics in Intellectual Disability Services:
Experiences of Care Staff

Consent Form for Care Staff

1. I confirm that I have read and understand the Participation Information Sheet dated 26th October 2015 and have had the opportunity to consider the information and ask any questions I had, which were answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time at any time following my interview without giving any reason and without my or my client's medical care or legal rights being affected. I understand that it may not be possible to withdraw my data however. ☐

3. I understand that the topics talked about in the interview may have a chance of eliciting some distress. I understand that I may be encouraged to contact the manager of my organisation or my GP for support if I do become distressed. ☐

4. I understand that my interviews will be audio-taped and transcribed and give permission for this. ☐

5. I understand that relevant sections of my interview data and the researcher's analysis of this may be looked at by the researcher's supervisors and individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐

6. I understand that when a report is written and published about the study, quotes from interviews are likely to be used. I give my permission for publication of quotes and understand that my identifying details will be removed and my confidentiality protected as much as possible. ☐

7. I understand that if the Researcher is worried that someone may be at risk of harm, she will need to disclose this information to the relevant people or agencies (e.g. Adult Safeguarding Teams, social services, the police etc.). ☐

8. I agree to take part in the research interview ☐

9. Please send me a summary of the findings of the research ☐

Name of Participant:
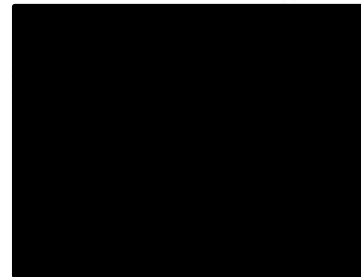
Signature:

Date:

Name of Researcher:

Signature:

Date:

Participant Consent form for Care Staff – version 3

Appendix G: Research and Development Approval

Dr Pieter Nel
Health Research Building
University of Hertfordshire
College Lane Campus, College Lane
Hatfield
AL10 9AB

18th November 2015

Dear Dr Nel,

Permission for research

I am writing to inform you that R&D permission has been granted on behalf of
NHS Foundation Trust, for the following research project, on the basis described in the
application form, protocol and supporting documentation.

Study details:

Study Title	Systemic Consultations in intellectual Disability: Experiences of care staff
Chief Investigator	Dr Pieter Nel
Sponsor name	University of Hertfordshire
█ study number	█/160
IRAS or UKCRN ID number	15/YH/0425

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
█ NHS Foundation Trust	18/11/2015	All sites within this organisation subject to local management approval
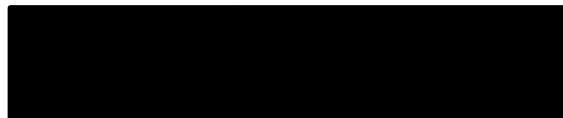
The documents reviewed were:

Document	Version/description	Date
NHS REC form	181287/841389/1/643	03/09/15
NHS R&D form	181287/876098/14/820	13/11/15
NHS SSI form	181287/876102/6/975/287100/335455	13/11/15
Study protocol	Version 4	06/11/15
Correspondence with REC	Letters dated 02/10/15- 12/11/15	Various
Participant information sheet	PIS for Organisation- Version 3	26/10/15
Participant information sheet	PIS for Care staff- Version 3	26/10/15
Participant consent form	Care staff- Version 3	26/10/15
Reply slip for research	Version 2	10/11/15
Interview schedule	Version 2	13/08/15
Summary feedback sheet for MRP proposal	No version given	Feb 2014
Support email from service manager	Andrew Adlem (Lead consultant psychologist)	17/11/15
Transcription confidentiality agreement	Version 1	26/10/15
Confirmation of sponsorship	Professor John Senior	27/07/16
Insurance document	Universirty of Hertfordshire	04/08/15
Flowchart for research procedure	Version 2	26/10/15
Researcher CVs	Pieter Nel, Clair Louise Johnson, Nina Viljoen	Various

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), the Data Protection Act (1998) and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the REC or university ethics committee and which have been authorized by the MHRA (if applicable).

The following local conditions will apply:

1. Sponsorship of Study
The research Sponsor will be the organisation named above; the management and design of the study is not the responsibility of the Trust or Trusts giving permission.

2. Confidentiality
You are required to ensure that all information regarding participants remains **secure** and **strictly confidential** at all times. You must ensure that you understand and comply with requirements of the Data Protection Act (1998) and the NHS Confidentiality Code of Practice. Furthermore, you should be aware that under the Data Protection Act (1998), unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

3. Researcher Authorisation
Only those researchers holding a letter of access or honorary research contract, as appropriate, from ▓▓▓▓▓▓▓▓▓▓ ▓▓▓▓▓ NHS Foundation Trust may have direct contact with the participants of this study or to their patient files, unless they already have a substantive honorary contract with the Trust.

4. Urgent Safety Actions
The research sponsor, the Chief investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. This office should be

notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. This office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

5. Serious Adverse Events

Should an SAE occur during the course of the project, this office must be notified immediately. This is in addition to your legal duty to report such events to the Sponsor.

6. Amendments

All amendments (including changes to the local research team) need to be submitted in accordance with guidelines in IRAS. This office should be informed at the same time as the REC or university ethics committee is notified in order to avoid any unnecessary delays.

7. Indemnity

You must check with the Sponsor that the indemnity arrangements, as confirmed in the Sponsor's Declaration and described in the application forms, are in place before any participants are recruited.

8. Study Progression

You will inform us of any significant developments that occur as the study progresses. You will complete and return any report forms that we send you and provide up to date information on the number of participants recruited when asked.

9. Audit of Study

You may also be subject to a random audit of research which will involve a site visit, a requirement to view study documents and a request to interview researchers.

10. Study Completion

You will notify the Chief Investigator and this office when the study has completed recruiting participants and when the study has finally finished at your site. You will complete and return the final report that we send you and inform us of any publications relating to the study.

11. Presentation of Findings

█████ expects that the findings of this study will be presented to members of the appropriate service line. You should contact the service line research lead upon completion of the study to arrange a suitable venue and time.

Finally, I wish you every success with the study.

With kind regards

███████

Manager, Research and Development Department
████████████████████

Appendix H: Researcher Reply Slip

University of Hertfordshire   10/11/2015
Doctorate in Clinical Psychology

Reply slip for Research: How do care staff members experience Systemic Consultations in Learning Disability Services?

Yes, I am happy for a researcher to contact me about this research.

Name: ……………………………………………………………………
(Block Capitals)
Address:…………………………………………………………………..

………………………………………………………………………………

…………………………………………   Post Code: ……………………

Telephone number: Day: ……………………. Evening: ……………………

e-mail: …………………………………………………………………………

Best time to contact me: ………………………………………………

Age: …………………….

Gender: Male/Female

Date or year started working with people with Learning Disabilities: …………………………

Number of systemic consultations attended: ……………………………………….

Occupation: ………………………………………………

Employing Organisation as a care staff member …………………………………………………

Please return to:

Clair Johnson, C/O Liz Day,
Doctorate in Clinical Psychology
Health Research Building
University of Hertfordshire
College Lane,
Hatfield, Hertfordshire
AL10 9AB

███████████

Reply slip for research – care staff members – version 2

Appendix I: Interview Schedule

University of Hertfordshire
Doctorate in Clinical Psychology

Interview Schedule

(incorporating aspects of The Helpful Aspects of Therapy Form (Llewelyn, 1988) and the Family Interview Schedule by Arkless (2004)

Research Title: Systemic Consultation Clinics in Intellectual Disability Services: Experiences of Care Staff

Participant number:_____

Date completed:_____

Thank you for agreeing to participate in this interview.

Clarify definitions – systemic consultation, team etc. (and compared to other MDT work)

Clarify that I do not know about the work

Clarify confidentiality

Clarify it is their experiences I'm interested in to help improve practice

Before we start, I would like to ask you a few questions to help you to remember the Systemic Consultation(s). It does not matter if you find it hard to remember some details of the meetings as it is your experiences that I am interested in, not an exact memory the consultation(s).

Information Questions
    1. Can you tell me what you remember about the systemic consultation(s)?
    Prompts - When did they begin? Who attended? How they were set up?

Experience Questions

General experience of the systemic consultations

1. Can you tell me what brought you to the system consultations?

   Prompts – What was your understanding of the reason(s) for going to the systemic consultations? What was difficult before attending? What led you/others to seek help?

2. Please could you describe what happened in the systemic consultation(s) in your own words?

   Prompts – who attended, how it was set up, what the therapist did, what others did etc.

3. What did you think about the systemic consultation(s)?
   a. At the time?
   b. Looking back?
   Prompts – whether you thought the consultation(s) were useful or not, if you liked them or didn't like them

Interview Schedule – version 2   1

University of Hertfordshire
Doctorate in Clinical Psychology

4. How did you feel when you were in the systemic consultation(s)?

   Prompts – for example, did you feel comfortable or uncomfortable? Did you feel listened to or not?

Experience of helpful/unhelpful aspects of systemic consultations

5. What do you think worked well in the session(s)?

   Prompts – What did you experience as helpful or important to address the difficulties? (By "event" we mean something that happened in the session. For example, it might be something you said or did, or something the lead therapist and/or a therapist listening in, said or did, or something that happened or was said between people)
   Further prompts - What made it helpful/important/what did you get out of it?

6. What do you think didn't work so well during the systemic consultation(s)?

   Prompts – was there anything that you experienced as hindering? For example, it might be something you said or did, or something the lead therapist and/or a therapist listening in, said or did, or something that happened or was said between people.

Change/outcomes

7. Can you tell me about any changes you have noticed as a result of the systemic consultations?

   Prompts – for example changes in the difficulties, interactions between people including the service user and others around them, general atmosphere in the person's home

8. Can you tell me how you think these changes happened?

   Prompts - Can you explain what, if anything, you have noticed that you and/or others are doing differently since the consultation(s)?

9. Did these changes last? Why do you think this was?
   Prompts –For example, this may be something you, or others, said or did, or something you worked towards as a team. This could be something different you and/or others did and/or have carried on doing to keep these changes going.

10. Can you explain what, if anything, you have noticed that you and/or others are doing differently since the systemic consultation(s)?

Other

11. Can you tell me anything else about your experiences of the systemic consultation(s)?

Interview Schedule – version 2   2

Appendix J: Transcript Agreement

University of Hertfordshire

Transcription Agreement

University of Hertfordshire

Doctorate in Clinical Psychology

University of Hertfordshire

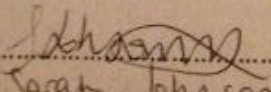Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

CLAIR JOHNSON X ('the discloser')

And

SARAH JOHNSON Transcription service ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:.....................

Name:....Sarah Johnson....

Date:....17/01/16................

Major Research Proposal   Student No:

Transcription Contract – version 1

26/10/2015

Student number: 13088960
Systemic Consultations in Intellectual Disability Services: Experiences of Care Staff   159

- Normal text indicates descriptive comments
- *Italics text indicates linguistic comments*
- <u>Underlined text indicates conceptual comments</u>

Emergent themes		Original Transcript	Exploratory Comments
	1	R- So can you tell me a bit about what you remember	
	2	about the SC's?	
	3	P- Erm, a lot of it obviously was to do with how she was	SCs about how SU was coping with living with other people
making sense of who SCs are for	4	coping with, well 1 XXXX and her issues around living	SCs also about staff understanding SU
	5	with other people (R- Uhuh), erm also to do with staff	*obviously – did P expect me to already have an understanding of*
	6	understanding her.	*what difficulties they went to SCs for help with*
	7	R- Okay.	*'her issues' – it's about the SU and her issues. SU owns the issues.*
making sense of who SCs are for	8	P- Erm, yeah staff understanding what she wants,	wanted help with staff understanding what SU wants. <u>Was this</u>
	9	obviously she's quite verbal (R- Hmmm) so erm, but	<u>hard for staff to understand?</u>
	10	yeah she can change her mind quite a lot so (R- Hmmm)	SU is able to communicate verbally but can change her mind a lot.
making sense of who SCs are for	11	it depends what (R- Uhuh) you know we have	<u>Did they need support in understanding what the SU wants</u>
	12	everything set in place for her you know, routines (R-	<u>because she changes her mind a lot?</u>
	13	Yeah), timetables for you know, certain things within	we have a lot already in place for SU including routines and
	14	the house, and it was just how XXXX was dealing with it	timetables.
	15	(R- Yeah) and everything so.	SU lives with other people – <u>are the timetables and routines to suit</u>
	16	R- Yeah, okay and can you tell me when they began, (P-	<u>the house?</u>
	17	Oh) the consultations?	how SU dealt with routines and timetables for the house she lived
	18	P- I know she had some a few years ago (R- Uhuh) and	in
	19	that was before I started working for AAAA so I don't (R-	*'and everything' –* <u>there is a lot more</u>
	20	Okay), I know a little bit about that (R- Yeah) and I know	*'she' – understands them as the SU's meeting*
person-centred	21	that she's got erm, they made a board for her (R- Uhuh)	SCs started before the P started working with SU
person-centred	22	with erm like how she likes staff's support, so she quite	*'they' – is this the therapist(s)?*
	23	likes like a bit of one-to-one time with staff in the	a board was made for the SU focussed on how she likes support from staff to be
	24	evening (R- Uhuh), you know she likes us to sort of be,	<u>person-centred</u>
	25	as we all are, you know sympathetic when she's upset	SU likes sympathy when upset and doesn't like being told what to do.
	26	(R- Yeah), erm doesn't really like, being told what to do	<u>the P knows about the board and how it started even though it was before she</u>
	27	is probably the wrong thing but(R- Hmmm) there are	<u>started work at the organisation. This may imply its importance throughout her</u>
	28	sometimes where we have to call her in and be like, you	<u>work with the SU</u>
	29	know you live in a house with 5 people, with 4 other	*'is probably the wrong thing' – recognises that her language may not be*
	30	people sorry so you, there has to be a little bit of (R-	*representative/suitable – being told what to do* <u>– perhaps it can feel as though</u>
			<u>sometimes she is telling the SU what to do. This may reflect a dilemma staff may</u>
			<u>have about having to try to help SUs make the best choices but also letting them</u>
			<u>make their own decisions. There may also be competing expectations of staff</u>
			<u>members regarding this (e.g. demands from the service, social services, policies</u>
			<u>etc.).</u>
			P experiences that she has to remind SU that she lives with other people

* At times I have written from my own perspective and at other times, from the participant's perspective. Therefore, my comments can change from use of first to third person

** FM – indicates family member

	31	Hmmm) give and take and just basically around support	P expects give and take from SU as she lives other people.
	32	that she needs from us (R- Okay). You know, more so	the board is about support she needs from staff
	33	like when [family members] have gone away on holiday	P talks from a 'we' position. This may indicate that she feels quite joined up with the
	34	she sort of gets a bit lost (R- Okay) when they're away	staff team. That they work as a team and it may be hard for her to differentiate her
	35	and things like that (R- Hmmm). So I think it was just a	experiences from other staff members as they work so closely as a team. It may also
SCs as a recap	36	bit of a recap to see how she was doing.	indicate consistency needed for the SU as well.
			SU gets lost when [FM]s are on holiday. Perhaps the SU needs more emotional
	37	R- Okay, uhuh, and who attended the consultations?	support during that time? Does the P experience that time as particularly difficult?
making sense of who SCs are for	38	P- Erm, there was myself and [service manager] (R-	SCs as a recap to see how SU is doing.
	39	Hmmm), who's my manager. There was, off the top of	'how she was doing' – these SCs are about how the SU is managing
	40	my head I can't remember 'cause we did a couple and	care staff and service manager attended SCs
SCs as a learning environment	41	(R- Hmmm) we tried to get as many support staff to	
	42	come to the meetings (R- Okay) as possible so that they	do they blur into each other?
	43	could hear it first-hand rather than opposed to us	they tried to get as many support staff as possible to come to the meetings to hear
	44	coming back and doing a handover (R- Uhuh), XXXX was	information first-hand. The P and the service seemed invested in the SCs and
	45	there and her [FM] (R- Yeah), [lead therapist] and a	believed they could help if they were investing a lot of staff time in the SCs.
	46	psychiatrist, I can't remember names (R-Okay). I just	It was important to hear information first-hand rather than it being passed on.
	47	you know, I know [lead therapist] was there so.	perhaps the manager/service felt that staff would take things on board more if they
	48	R- Yeah, okay, and can you tell me a bit about how they	heard it first-hand.
	49	were set up? So what it was like in the room?	the SU's [FM], therapist, and a psychiatrist attended as well. I wonder whether by
			psychiatrist, the P meant psychologist as this would make sense having the extra
			psychologist as a reflecting team. Also P's reference later implies her understanding
			of the term 'psychiatrist' more like a psychologist.
			it was a long time ago. Other psychologist as reflecting person may have been more
			in the background in P's view and therefore not been important to remember name.
relaxed environment	50	P- It was basically totally informal (R- Hmmm). Erm, it	
	51	was literally, [lead therapist] had a chair sort of (pause)	'basically totally informal' – exaggerating informal. Felt relaxed and less pressured?
	52	a bit like we're sitting now, there wasn't like the main	SCs as informal
inclusive	53	chair was there and we were all, it was just basically,	'the main chair' – there wasn't the main chair – lead therapist didn't position
			themselves as the 'main' person? implies equality and non-hierarchical.
relaxed environment	54	totally informal (R- Okay) just seated around (R- Uhuh),	'just basically totally informal' – repeats emphasis on the SCs being informal – feels
	55	you know it, you know [lead therapist] was taking notes	really important
relaxed environment	56	(R- Yeah) and things as were we (R- Okay). So but it was	repeats SCs as informal
relaxed environment	57	totally informal. (R- Yeah) It wasn't set up like you	'just seated around' – we weren't needed to be in any formal positioning. Just also
	58	know, she was at the front of the room and we were all	implies a further emphasis on the informality of the SCs
	59	sitting like you would in school, it wasn't like that at all.	remembers lead therapist taking notes but also remembers it being informal – how
relaxed environment	60	R- Okay, great (P- Coughs), thank you. Erm so just	does P perceive this? Perhaps perceived more as if lead therapist is interested
	61	before we go on to the experience questions (P- Uhuh),	rather than it being a formal thing
			repeats for third time 'totally informal' – this is something that really stood out for P
SCs as a learning environment	62	[Researcher clarifies confidentiality]...	P compares to being taught at school – it is the opposite of this – opposite to a
	63		formal learning environment.
			comparing to school however does imply comparing to a learning environment. SCs
			as a learning environment.

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	72	... Okay, erm so moving	*started to say about SU's perspective and her possibly finding things difficult but*
	73	on to the experience questions (P- Uhuh), erm can you	*then changes her mind in how she will tell me, setting the scene with staff changes.*
	74	tell me what brought you to the SC's?	Perhaps seeing this as the main thing that had let to the service user finding things
	75	P- Erm, basically obviously [service manager] had said to	difficult.
	76	us that you know, [lead therapist], we'd been in contact	*staff changes had led them to SCs. Staff had left and new staff were coming in.* staff
	77	with XXXX (R- Hmmm) and she's finding things, we'd, at	turnaround.
SCs as a learning environment	78	the time we had a lot of staff changes, staff had left (R-	P is experienced in the care profession and has seen turnarounds in staff before.
	79	Okay), you know a lot of new staff coming in. Which	She is understanding of why people may leave.
	80	unfortunately with the care profession you do tend (R-	*'unfortunately' – she views staff turn around as something unfortunate and not*
	81	Hmmm) to, 'cause obviously we do sleep ins and	*desirable.*
	82	everything (R- Hmmm), people just don't like the hours	*wants me to understand about some of the demands on care staff.*
	83	(R- Yeah). So I think it was a bit more of, just going,	anti-social hours that care staff work my lead them to leaving
SCs as a recap	84	more of a recap rather than opposed to necessarily I'd	SCs as a recap and nothing new.
SCs as a learning environment		say anything new. It was going over things that had	a recap was needed because of the changes in staff. For the new staff this
	85	been discussed previously, to get staff in (R- Hmmm), a	information was likely to be new – learning from SCs.
	86	bit of a recap for us all, bit of a recap for XXXX, erm you	*'I'd say' – from P's position there wasn't anything – but maybe she thinks for others*
SCs as a learning environment	87	know and just basically go through things again really.	*there might have been something new.*
SCs as a recap	88		'to get staff in' – does she mean perhaps as an induction for staff?
			SCs as a recap. Recap is repeated a number of times – this is an important way that
SCs as a recap			*the P experienced the SCs – they were a recap*
SCs as a recap			SCs as going through things again – SCs as a recap
			'just basically' – this is what it was – a recap
	89	R- Okay. So what was your understanding of the reason	
	90	of referral, so you talked about staff changes and a	
	91	recap. Would that be it, was there anything else or?	
	92	P- Not as far as I know (R- Yeah), I mean at the time I	*'only a support worker' – does this imply that the P felt less important? Or perhaps*
	93	was only a support worker (R- Okay). So obviously, you	*she is telling me that she wasn't as sure about the reasons for referral to SCs*
Making sense of who SCs are for	94	know (R- Yeah), I was just told right you know this is (R-	*'I was just told' – she was told what was happening.* Was this opposed to being
			asked before perhaps? Who told her? the service manager?
			P seems to have been told an individual understanding of the problem rather than it

		Transcript	Notes
Making sense of who SCs are for	95	Yeah) what's happening with XXXX, you know she wants	being placed in the situation of the staff turn around as she saw it.
	96	to see [lead therapist], going through (R- Hmmm), a bit	P was told that that SU wanted to see lead therapist and was unsettled at the time.
Making sense of who SCs are for	97	unsettled at the time (R-Okay). So I think it was more	Purpose of SCs as building confidence for SU
Making sense of who SCs are for	98	you know to sort of (R- Yeah), a little bit of confidence	'sort of' & 'a little bit of' – not completely convinced of the reason? Perhaps P sees it more as part of the reason?
Outside person is important	99	building for her, because she can every now and again	SU can doubt her own confidence. SCs partly to help SU build confidence.
	100	doubt her own confidence (R- Hmmm). So it's sort of	P understands SU as needing some feedback from someone other than staff that are there with her all the time to help her to build confidence.
	101	you know, and obviously even though we're there for	'obviously' – it is obvious she has staff with her all the time but she needed something more to help with her confidence
	102	her all the time, she does (R- Hmmm) quite like erm,	'as we all would – P sees it as a generic universal thing to need some feedback from
P as normalising SU's experiences	103	(stutters) as we all would, you know just that little bit of	outside one's immediate network/environment to help with building confidence. Normalising.
Outside person is important	104	comeback from someone within, from with outside (R-	'comeback' – P sees SU as having confidence before and this is a dip for SU
SCs as a recap	105	Hmmm) the unit as it were (R- Okay), to go back over	'someone within, from with outside' – P changes words – perhaps she really wants it to be someone from within the home to be able to help SU with her confidence.
	106	(R- Yeah) things so.	'outside' – someone from outside the supported living environment – literally outside and metaphorically outside – someone who can take a more removed unbiased position perhaps
			'unit' – P sees supported accommodation as a unit – a unit referring to different people living in the house? Or is it more that it can feel like a regimented place?
			'go back over things' – SCs as a recap (continued repetition of SCs being a recap)
	107	R- Okay, great. And can you tell me a bit more about the	
	108	staff changes that were happening at the time?	
staff turnaround leading to needing SCs	109	P- At the time, I mean obviously we'd had quite a few	At the time of attending SCs, there were new staff starting and established staff leaving.
	110	new staff coming in (R- Hmmm). Erm, we'd had a few	'they'd **only** been there maybe 2/3 years' – is P trying to downplay the importance of the staff leaving in some ways? Was this perhaps protective for her at the time of
	111	staff that had only, I mean they'd only been there	staff leaving? However she then goes on to say that the staff were 'quite
staff turnaround leading to needing SCs	112	maybe 2/3 years, but obviously (R- Hmmm) they're	established'
	113	quite established staff leaving you know (R- Okay),	The staff that left were quire established – The staff knew what they were doing and how to support the service user. These staff were leaving and being replaced with
	114	things like that so it's just a little bit (R- Yeah), she was	new staff who didn't know the SU.
	115	sort of a but unsettled that all of a sudden, as you know,	The SU was unsettled with the staff changes.
	116	staff get to know her, when they leave (R- Hmmm)	The staff who were leaving had got to know the SU. Does the P see this as in getting
staff turnaround leading to needing SCs	117	you're bringing in new staff who you have to then start	to know how to support the SU or getting to know her in terms of forming a good
	118	from (R- Hmmm) stage 1 again because none of us	relationship with her and supporting her emotional needs? This might be seen by the P as a loss for the SU in many ways – losing that connection with staff as well as
staff turnaround leading to needing SCs	119	knew you know before you work there you don't know	losing staff who know how to support her. This may have also felt a loss for the P
	120	anything about her (R- Yeah), so you know and it's just	and the service as well. A loss of relationships and staff who knew how to support
	121	more so she likes things done in certain ways (R- Okay).	the SU. What does that then leave the P with as a member of staff who remained?
	122	So I think it's more of you know making sure that all	Did things also become more difficult for the P with less people who knew the SU and therefore perhaps more pressure on her to support the SU?
staff turnaround leading to needing SCs	123	staff are aware of, she does like this, this and this (R-	New staff have to start from the first stage as they didn't know the SU.
			'again' – staff starting from stage 1 again – is it again because this keeps

staff turnaround leading to needing SCs	124	Uhuh), but, not that she likes to hear this, there are	*happening? Perhaps it feels like an inconvenience it happening again – constant staff turnover.*
	125	boundaries as well (R- Yeah) (Laughs) (R- Yeah). None of	'none of us knew' – normalising other staff's experiences – can see from their
P as normalising SU's experiences	126	us like (R- Laughs) that.	perspective about not knowing anything about the SU before starting.
			need to pass information on about how the SU likes to be supported
			'this, this and this' – there is a lot that staff need to know about what the SU likes
			new staff need to know what the SU likes and the boundaries as well.
			need to make sure that all staff are aware. Sharing of information. Need for staff to have consistent information.
			'none of us like that' – normalising P's experiences that not liking boundaries apply to everyone regardless of having a Learning Disability or not.
	127	R- Okay, great. And what kind of help were you seeking	
making sense of who SCs are for	128	when you came to the consultations do you think?	did she mean she wanted more help for the SU? Or she wanted more as in better
	129	P- I think it was just a bit more from, from XXXX because	'behaviour' from SU?
	130	she will (pause) she can play staff off against each other	SU will play staff off against each other
	131	(R- Okay). Erm, so it's very, she can go to one member	*'will' – present tense – does P still experience SU as playing staff off against each other?*
enabling consistency in approach	132	of staff and be 'oh, my staff always do that with me'(R-	*moves from 'will' to 'can' – perhaps this means it is happening less now?*
	133	Hmmm), but then more established staff of course she's	*'so it's very...' then stops – perhaps she was going to talk about how she feels about that but something stopped her*
	134	not going to come to them 'cause we know full well	describes how SU plays off staff against each other
	135	that, we'll support her within reason with anything but	SU tries to get new staff to do things with her that she's not supposed to
	136	it is supported living (R- Yeah). We're there to support	SU won't get more established staff to do this as they won't
enabling consistency in approach	137	her not do everything for her (R- Uhuh). So obviously	the playing staff off against each other relates to inconsistency in how staff would respond to SU when they were asked to do certain things with her. so perhaps the
	138	coming to this, literally it was, we were all hearing the	help they were seeking was to enable staff to become more consistent with their responses to the SU rather than just help for the SU herself directly.
	139	same thing (R- Hmmm), we all knew exactly and also	*'more established staff' – staff that had been there longer and knew the SU better*
	140	XXXX had an understanding of you know, she was there	P sees more established staff including herself as knowing what they can and can't
	141	with us, she heard exactly the same (R- Hmmm) as what	do within the supported living remit; to support her and not do everything for her.
enabling consistency in approach	142	we did. And it's more consistency for her (R- Okay), that	Everyone heard the same thing at SCs; new staff, [FM], established staff and SU
enabling consistency in approach	143	we're all working the same, it's not that we're saying we	*the way P speaks about SU being at SCs with them and hearing the same sounds an important part.*
	144	won't do that for her (R- Hmmm) because we're being	*'obviously' 'literally' 'exactly (x2)' – uses these words to describe they were all hearing the same thing – emphasises the consistency in them all hearing it*
enabling consistency in approach	145	you know, horrible. It's that she's able to do things for	Everyone hearing the same thing in the SCs was seen as more consistency for the SU
	146	herself (R- Hmmm), so and obviously by coming to that	All being at SCs together and hearing the same thing enabled consistency.
enabling consistency in approach	147	it was more that, as I say we're all in the same place,	P describes a rationale of why they don't do certain things for her. because they are not being horrible – perhaps she perceives SU as initially seeing it this way?
	148	we're all hearing exactly the same things.	Everyone is in the same place hearing exactly the same things
	149	R- Yeah, okay great. Thank you.	*repeats 'exactly' – emphasises importance of this consistency and the extent of it.*
	150	P- (Coughs).	
	151	R - And can you describe a bit about what happened in	

	152 the SC's in your own words?	*'obviously'* - is this used because it was expected that they all go in and all get introduced
Making sense of who SCs are for	153 P- Erm, obviously all go in, all get introduced (R-	SU was asked why they were at SCs. <u>What did P think about this? Was she asked</u>
Person-centred	154 Hmmm) erm, I think XXXX was asked why we were here	<u>why they were there also? Or is it that she remembers the SU being asked why she</u>
	155 (R- Uhuh).Yeah it was, obviously it was all centred	<u>was there because of thinking the SCs were mainly focussed only on SU?</u>
	156 around XXXX, it's all person-centred (R- Yeah). So erm	<u>centred around SU.</u> <u>Person-centred.</u>
Person-centred	157 XXXX was very going over, as I say she's got a board (R-	Person-centred.
SCs as a recap	158 Hmmm), that's like things she likes, things she doesn't	*'very going over'* – SCs as a recap
SCs as a recap	159 like, what she'd like staff's support with. So she was sort	<u>SCs using SU's board to 'go over' things.</u>
Person-centred	160 of going through that and then basically just to see if	<u>Person-centred board</u>
Person-centred	161 there was anything that needed to change from XXXX's	The board has things the SU likes, doesn't like and what the SU would like support with from staff
Person centred	162 point of view (R- Uhuh). Erm and then obviously from	<u>The board was used as a reference point to base the SC discussions. It is something</u>
	163 staff point of view we were also asked you know, if	<u>concrete that can be used as the focus.</u>
Person-Centred	164 some things weren't working or, and also if things	*'she's got a board'* –present tense – still has this board. It is the SU's. She owns it.
SCs as a review of SU's support	165 weren't working was there any way that we could alter	*'basically'* – simply/matter of fact
Person-centred	166 it slightly for it to work (R- Uhuh, uhuh). You know from	<u>lead therapist was going through the board to see if SU needed anything to change.</u>
Enabling SU's voice	167 going back to the original meetings that XXXX had	<u>The 'board' as a person-centred live plan incorporating SU's interests and support</u>
Person-Centred	168 another, I don't know when they were (R- Oh okay)	<u>enabling SU's voice</u>
Enabling SU's voice	169 because they were before (R-Yeah) I started so (R-	P experienced it as the SU asked first. Person-centred. SU's meeting.
	170 Hmmm). But yeah so.	Staff were then asked if some things weren't working – *'we'* were asked – *P felt joined up with other staff?*
		staff were asked if they could alter things slightly that weren't working
Person-centred		<u>SCs as reviewing SU's support and changing things that weren't working</u>
SCs as a review of SU's support		<u>This review was based on the board/plan devised in previous SCs before P started</u>
Person-centred		<u>working there.</u>
Inclusive.		Staff and SU were asked. Inclusive. Person-centred.
Person-centred.		
	171 R- Okay, erm and then what happened when you	
	172 discussed about what was, what wasn't working and	
	173 what you could do?	*Starts to say they came up with things that SU was happy with but then says tried. I*
	174 P- Basically sort of came, tried to come up with things	*wonder if it was difficult to come up with these things? And whether there had to be negotiation?*
Increasing flexibility of	175 that XXXX was happy with (R- Hmmm) that the ways we	<u>There were ways they could work around most things?</u>
approach/openness to trying	176 could work around most things, so if it wasn't working	Discussed doing something a different way if it wasn't working
something different	177 doing this we'll go 'oh okay hold on we could try doing it	*Speaks about it quite calmly – I wonder whether she felt quite calm in SCS?*
Increasing flexibility of	178 this way' (R- Okay). Erm, you know (pause) as	*'try'* – try doing it another way – <u>it's not fixed, it's fluid, not set in stone, open to new</u>
approach/openness to trying	179 everybody that we support, they all have staff that they	<u>ideas and trying new things.</u>
something different	180 would prefer to do (R- Uhuh), I don't know whether it	*'we'* – speaking from a position of talking from all staff's perspective rather than just
Staff as unified	181 be a one-to-one day with (R- Hmmm) or an activity. Erm	*her own perspective. Links to working as a team? Not feeling individual? Enabling*
P as normalising SU's experiences	182 and just trying to work it that because all staff knew	*consistency?*
		<u>compares to other SU's she (they) support(s) – this normalises this SU's experiences.</u>
Enabling consistency in approach		<u>All SUs the P supports have staff they prefer to do things with.</u>
		Working towards all staff knowing how to support SU so anyone could do an

enabling sharing of information Enabling consistency in approach	183 184 185 186 187 188 189 190 191 192 193	how XXXX liked her things done (R- Uhuh), any of us could do it. Obviously as a rota we can't guarantee that someone's going to be there every XXXXXX (R- Yeah) you know off on A/L and things. Obviously [FM] had XXXXXXXXXXXXX as well (R- Uhuh) erm, obviously she sees it from being the [FM] and (R- Yeah) also that, and she gets away with it, XXXX can be quite erm, she changes her mind quite a lot (R- Hmmm). You know we're, she's exactly the same as all of us but you know I think it was putting it into context as well that [FM] was
enabling understanding from another's perspective	194 195	there as well, so that [FM] knew that where XXXX might go and say 'oh, they're not doing this with me' (R- Right), [FM] had that opportunity, in front of XXXX, that
P as normalising SU's experiences	196 197 198	we were saying 'well hold on a minute, we did do this with you, (R- Uhuh) but you didn't want to do it for that amount of time or' (R- Hmmm). (Coughs) I think it was
enabling understanding from another's perspective enabling understanding from another's perspective enabling understanding from another's perspective Making sense of who SCs are for	199 200 201 202 203 204 205 206	more building up, I mean we have a pretty good relationship with the [FM]s as a whole (R- Uhuh) but it's sort of going in when, and when we have family meetings but this included XXXX 'cause it was about her (R- Okay). You know (R- Hmmm) so I think that was the main thing that she felt that she was included in every part of her care (R- Hmmm). You know we're not sort of [FM] and staff are talking about it or (R- Hmmm). Do
Person-centred. Inclusive. Enabling SU's voice. Making sense of who SCs are for Person-centred. Inclusive. Enabling SU's voice. Enabling SU's voice.	207 208 209 210 211 212	you know what I mean? (R- Hmmm) And it was basically centred round XXXX, XXXX was in the middle and it was up to her to put out those things that she wanted this done or that done, and we work with her as much (R- Yeah) as we can (R- Yeah) to get you know as and what she wanted (R- Okay). So.
Enabling SU's voice.		

activity/one-to-one day with SU.

SCs - sharing information & enabling consistency so staff can support in same way There seems to be inconsistency with having a staff rota as they do not seem to have set days. How does P experience this inconsistency? Does this add to difficulties? P seems to experience it as working around that so all staff learning so anyone could support her in her activities. I wonder whether this overlooks relationship factors and attachment somewhat. It seems to be that support is offered within the limits of the rotas – external systems which may not be as amenable to change?

'we can't guarantee' – there's no promises – it can't happen. this may feel uncertain for the service user. this seems okay for the P though and like they have worked around this.

'Obviously' – repeats this – obviously in relation to rota and in relation to [FM]'s input – this feels obvious to the P.

[FM] had quite a bit of input.

'obviously' – repeated again in terms of [FM] seeing it from being the [FM] … Who gets away with it? [FM]? Or SU with [FM]? In context it seems to mean that the SU gets away with it with [FM].

SU changes her mind a lot – what impact does this have on the support they provide and the relationships with [FM]s?

SU as the same as all of us but... Seeing the SU as human but...? But needs support?

SCs as enabling things to be put into context.

SU and staff both able to give their perspectives in front of [FM].

P saw SCs as opportunity for SU's [FM] to see both sides of the story (SU's and staff's)

It almost feels that [FM] is the judge here – it feels that the P feels the need to defend herself and her actions (as well as other staff).

P may have felt that it was perhaps a good opportunity for the SU's [FM] to hear the perspective of staff instead of perhaps just hearing the SU's.

'building up' – building up of frustrations?

Staff have a pretty good relationship with SU's [FM]s

SCs as a meeting with family that included the SU

P compares to other meetings – family meetings she has had and highlights the difference of SCs as they included the SU. Person-centred. Inclusive. Enabling of SU's voice?

SCs as about the SU. SCs understood as about the SU but I wonder about how other meetings are understood like the family meetings – are they about the family or the SU or both?

The main thing was that the SU felt included in every part of her care. Inclusive. Person-centred. Enabling SU's voice.

'the main thing' – it was really important that the SU felt fully included in her care.

SCs aren't a conversation between staff and [FM]. The SU is included.

centred around the SU. person-centred.

SU in the middle. this could mean in the middle of her care or in the middle of disagreements between staff and [FM]?

it was the SU's decision to bring up things that she wanted

Enabling SU's voice Person-Centred.	213 214	R- Great thank you. And what did you think about the SC's?
	215	P- I think they're a really good idea (R- Hmmm). I really
Outside person is important	216	do. Erm because I think you've got a totally
Outside person is important	217	independent person (R- Uhuh), seeing it from
Outside person is important	218	everybody's point of view, whereas I think sometimes
Outside person is important	219	when you're in the middle of something, obviously you
Outside person is important	220	know what's going on but (R- Hmmm) someone else
	221	coming in going 'well hold on you've been doing it like
Outside person is important	222	this, that's good but why don't you try this option' (R-
	223	Uhuh) you'd be like 'ahhh okay' there maybe something
Increasing flexibility of approach/openness to trying something different	224	we might have not thought about doing it that way (R-
	225	Hmmm). Erm obviously with XXXX, it's, it does work to a
	226	point (R- Uhuh). Erm, but then as I say she will (pause),
Increasing flexibility of approach/openness to trying something different	227	every now and again she'll be 'no we're not doing it this
	228	way, we're not doing it that way', she wants to, she's
Increasing flexibility of approach/openness to trying something different	229	(pause), she likes sh-, it's habit. She likes to do things in
	230	certain ways, so to change it throws her routine
Enabling SU's voice	231	completely (R- Uhuh). So (coughs) with her you have to
	232	take it very slowly and do it step by s-, you can't just go
	233	from A to C (R- Hmmm), with her it's very you know,
	234	and explain everything to her. But I mean it's good in
SCs as a learning environment	235	the fact of obviously we had the board but if there is
SCs as a learning environment	236	you know XXXX saying 'oh la la la, you know this, this,
	237	this' we're like 'hold on we're going to get the board out
Person-centred	238	and we're going to sit and we're going to go through it'
	239	and then she's sort of like 'ahhh okay', goes back to 'oh
	240	yeah we did discuss it that way, okay then' (R- Okay).
something concrete to refer to	241	You know so (R- Yeah), I think it's good in that respect
something concrete to refer to	242	that as well with like the board that we made that
	243	you've always got a reference to go back to (R- Uhuh,
	244	uhuh). So, you know I do, I think they're a pretty good
Outside person is important		

P saw herself and other staff as supporting SU to get what she wanted.
'work *with* her' – P sees herself and other staff as working with the SU not for her.
SCs are a really good idea. 'Really' and repeats 'really' – emphasising that SCs were a good 'idea'.
'good idea' – what does she mean by idea? It feels more conceptual like a good thing to think about doing rather than the actual doing/meetings themselves. Is it something she feels is more theoretically good than it was in practice?
SCs as having an independent person.
'totally independent person' – felt that the lead therapist was completely independent and non-biased
the lead therapist was able to see things from everyone's point of view. Non-biased. Lead therapist as aligned to each person the same amount.
P compares this independence to being in the 'middle of something' – being in it perhaps you can't see what's happening clearly.
appreciating someone else's perspective. Someone independent.
Sees the lead therapist as making positive comments about what is tried and also suggesting another option to try. This sounds like it may have been validating for P. P appeared really receptive to the lead therapist's ideas. Open to trying something new.
P thinks that she (and other staff) may not have thought about doing it another way.
'try' 'maybe' 'might' – all feels like tentative language – nothing is set in stone – things can be tried but don't have to be stuck with. They can always be revised and revisited. Like the board is.
Trying something different works to a point with the SU. There are times where it doesn't work.
SU will occasionally say that they are not doing it a certain way. The language the P uses to describe the SU's views at these points feels quite strong. As if the SU is putting her foot down and taking control.
the P uses the SU's language to explain to me what she says.
SU likes routine
Change disrupts the SU's routine completely
'completely' – feels as if it has very strong effects
Need to take change slowly with the SU.
Need to explain everything to the SU. Can't go from A to C.
P seems to know the SU really well.
The 'board' (something concrete) was good to help explain the changes to the SU. SU is receptive to going through things using the board (something concrete). Perhaps it helps her to hold things in mind more?
The board is good in helping remind the SU of the discussions they had.
'the board' – references this a lot – it was really important to have something concrete
The board is a reference – something to go back to
Present tense – still use the board – something concrete – implies lasting changes.
SCs as a good idea
The outside person is important. Referring to a person from outside of supported living environment.

	245	idea, because as I say you've got that outside person (R-	The lead therapist still knows the SU to some extent.
	246	Hmmm). But obviously they know her (R- Uhuh) it's not	'not just a random person' – letting me know its not just anyone from outside – its someone that the SU still knows and is skilled.
Outside person is important	247	just random outside person (R- Yeah). Erm but as I say I	someone from outside that isn't as close to SU is helpful
Outside person is important	248	think it does help when you've got someone outside	compares the outside person to people who are particularly close or involved with the SU like staff and family
Outside person is important	249	that isn't as close to XXXX (R- Hmmm) as staff, family (R-	The lead therapist being from outside is able to see things from a different
	250	Uhuh) that look at it from a little bit of a different	perspective and input that view.
Outside person is important	251	perspective and put it in that view that we're like 'oh,	'a little bit of a different perspective' – so the P sees the therapist as offering a perspective that isn't too different. Perhaps this links to theory 'difference that
	252	yeah okay' and it gets XXXX thinking as well and it's like	makes the difference'.
Increasing flexibility of approach/openness to trying something different	253	'oh yeah we could try' (R- Uhuh). So I think that's, it	gets SU thinking as well
	254	probably is a good idea (R- Hmmm) rather than just	all appear willing to try something different
			'rather than just staff going on at her' – having a different person suggest something new/different was more helpful than staff repeating suggestions. Did the P think
	255	staff going on at her. (R- Okay (laughs)) Yeah.	that the SU felt criticised by staff?
Outside person is important,	256	R- Erm and you said, so you talked about the outside	'rather than just staff….' – does this imply that the P thinks that it is not enough for
	257	person, independent person (P- Uhuh), was that, did	staff to be suggesting things to the SU? That she needs something more, someone
	258	you s-, see that as [lead therapist] or the other person	external to help her to try something new/different?
	259	that was there?	
outside person is important	260	P- Probably as [lead therapist] (R- Hmmm, hmmm). And	the outside independent person was the lead therapist not reflecting team member. lead therapist seen as most important in the SCs
	261	that's not, it's not in a bad way at all (R- Hmmm) it's just	'that's not, it's not in a bad way at all' – the P may also think it was helpful to have a
	262	obviously she was the one that you know, she knows	reflecting team member at the SCs as well, but found the lead therapist the most helpful
outside person is important	263	XXXX (R- Yeah), she know you know, us as a service (R-	the lead therapist as the one the P knows
	264	Uhuh) and everything so obviously you know she has	it is helpful to have someone who knows you and the SU.
	265	got the little bit of background on okay, this is how the	it was helpful for the lead therapist to know the service
	266	service works (R- Uhuh). We can't just throw it in and	lead therapist knowing the service can help her to have background information regarding how the service works.
outside person is important	267	totally disrupt everybody else (R- Hmmm) in the service	lead therapist was aware through her knowledge of the service of the other SU's needs as well as the SU the service were seeking help in relation to. The P may have
	268	because obviously we have other people to support	felt that the lead therapist knowing this was helpful in terms of the interventions
	269	other than her (R- Yeah). So it was good in that respect	they suggested and these not being impractical.
outside person is important	270	that she knew enough about how we worked but (R-	'we can't just throw it in' – suggests that the lead therapist is thoughtful and considered in her suggestions and this was appreciated.
	271	Okay) wasn't there on the day to day (R- Yes). Yeah.	I (P) have to be mindful of the other SUs we support, thinking about their needs to.
	272	R- Yeah, okay. Great. Wh- what do you think it, about	if the lead therapist knew the service, then perhaps she also knew the other
outside person is important	273	that is helpful? So what is it about having that	services.
	274	independent person that's not there day to day there	Lead therapist knew enough about how we (P and other staff) worked. It was a good balance between knowing the service user and the service enough and being
Outside person is important	275	helpful?	able to take a removed/outsider position.
			importance of having a removed/outsider position.
Outside person is important	276	P- Because they do see things from a different point of	helpful to have an independent person because they see things from a different
	277	view (R- Okay). Whereas, as I said just now when you're	point of view.
			'they' – P may be referring to lead therapist and reflecting team member here.

Outside person is important	278	(pause), if you're in the middle of something all the time	Someone independent can come up with a different idea than someone who is continuously in the middle of something.
	279	(R- Hmmm), you will obviously you'll sit there and you'll	I (P) will try and think about how to try things differently but an independent person can think up something really different that I'm not able to think of because I'm in the middle of it.
	280	be 'right okay, yeah we could try it that way, that way',	
	281	but then they come up with a totally different idea and	'obviously' – I (P) will try
Outside person is important	282	you're like 'oh, okay (R- Okay) didn't think about that'	'totally different idea' – something the P hadn't thought about and would be useful to try
	283	(R- Yeah) it's, it's that thing of having to step out of it (R-	a need to 'step out' to 'step back in'. P feels that you need to be more removed from a situation in order to go back to that situation. The independent person is able to step out more easily as they are already 'out'. Perhaps the SCs themselves helped the P to 'step out'? The removed position of the therapist(s) helped the P to 'step out' to 'step back in'. stepping back in with new knowledge about the situation and other things to try?
Outside person is important	284	Uhuh) to step back in it (R- Yes, yeah). Whereas, when	
	285	you've got it 24/7 you wouldn't necessarily, there could	'24/7' – sees herself supporting the SU 24/7 or sees the staff team as doing this.
	286	be some things, don't get me wrong they don't you	a need for someone to help that is not supporting the SU 24/7
Outside person is important	287	know it's not we support them wrong or we don't give	I (P) support the SU (and other SU's) to the best of my ability and make sure they have enough support. However this doesn't feel as much as someone else can offer from an outside perspective
Outside person is important	288	them enough support (R- Hmmm). But sometimes just	
Outside person is important	289	over certain angles of how to work with people (R-	the independent person helps to look at things from different perspectives.
	290	Uhuh, uhuh), you know where we do something, and	'they put a whole different light on it' – being independent in the SCs can put a different light on it. They (therapists) can help me to see something differently.
Outside person is important	291	we've got you know (R- Yeah) sometimes they put a	'light' – perhaps the light is not only representing something different, but something more positive and more optimistic.
	292	whole different light on it and also from XXXX's	
	293	perspective, I think she sees it as someone else has	P understands the SU as being more receptive to ideas from therapists as they are not staff.
Outside person is important	294	come up with the idea, it's not staff (R- Okay). So	'she'd be **more willing** to listen' – the P may see the SU as reluctant to listen to new ideas/suggestions generally, and when they are proposed by therapists the SU is more willing.
Outside person is important	295	sometimes, depending what mood she's in, she'd be	
	296	more willing (R- Yeah) to listen to the outside person	staff are there all the time and therefore their suggestions may be frustrating for the SU.
Outside person is important	297	rather than opposed to staff that are there all the time	'depending what mood she's in' – SU's mood changes and with this so does her willingness to listen to 'the outside person'.
	298	(R- Yeah) driving her mad (R- Okay) (laughs).	I know the SU listens to outside people more than staff and I accept that and don't take it personally.
	299	R- (Laughs) And how did you experience that?	
Outside person is important	300	P- What with [lead therapist]?	P explains that she experiences being sworn at from the SU and other SUs and doesn't take it personally.
	301	R- Erm, so what you said about XXXX listening to	P is now in a role where she is inducting new staff and giving them advice and therefore advises them not to take things personally.
	302	somebody that's an outsider rather than staff?	The P seems to have accepted this and appears calm when talking about it.
It wasn't all down to the SCs - Learning from experience	303	P- To be honest, that's XXXX (R- Yeah). You know I	'working in this job' – it is a job – putting personal-professional boundaries into place. This is a job and I'm not going to take things personally. P may see it this way in order to cope with some of the unkind things SUs may say to her.
	304	wouldn't, I wouldn't take offence (R- Hmmm) you know	
It wasn't all down to the SCs - Learning from experience	305	working in this, this job you know not just with XXXX but	refers to other SUs – this is common to other SUs as well and is part of the job
	306	with other people we support. You learn, I mean I've	'you learn' – knowing this comes with experience.
It wasn't all down to the SCs -	307	obviously done inductions with new starters (R- Uhuh)	'as an individual' – the choice of language implies a really human/personal

Learning from experience	308	with staff and everything and I'm just like you can get	connection with the SU. She hasn't used 'as a staff member'.
	309	sworn at, you can get called every name under (R-	*uses 'you' a lot – 'you as an individual have to' 'you learn' 'you just can't take it*
It wasn't all down to the SCs - Learning from experience	310	Hmmm) you just don't take it personally (R- Uhuh,	*personally – feels as if P is talking from an experienced position where she is giving*
	311	uhuh). You know, you as an individual have to, have to	*others advice which fits with her new managerial responsibilities which was different at the times of SCs.*
It wasn't all down to the SCs - Learning from experience	312	find the slot where you fit into in their life (R- Hmmm),	it's important for staff to find the slot where they fit into the SU's life.
	313	so it could be that I could go today and XXXX wouldn't	P experiences that the SU can do something for one person but another.
	314	be doing something for someone but I could walk in and	*Refers to SU doing something for herself and not another person first – does this imply that the SU does do more when she is supported by the P? Is this connected*
	315	be 'okay, then XXXX, okay why don't we try it this way'	*with the P's experience and knowledge she has gained from working with SU as an 'established staff member'?.*
	316	(R- Hmmm). 'Okay then' and she'll do it for me could be	Repeats 'its's the slot that you fit into in their life' – <u>this is an important way that the P understands her work with the SU (and other SUs).</u>
	317	she wouldn't do it for me she'd do it for somebody else,	<u>repetition of find/finding (3 x between 312-318). Finding - you have to search for</u>
It wasn't all down to the SCs - Learning from experience	318	you know, it's finding, it's finding the slot that you fit	<u>it. It doesn't come easily or straight away. It's active not passive.</u>
	319	into in their life as well (R- Uhuh) and also how you say	<u>it's how you say things with the SU. P sees that you need to say things in a certain way in order for the SU to listen/take up your suggestions?</u>
	320	things. But as I say going back to the board (R- Okay), is	<u>P refers to the 'board' – something concrete again (there is repetition of the board being brought up by the P many times and therefore it seems an important part of</u>
	321	a pretty good thing 'cause we sit there and be like 'oh	<u>the P's experiences of the SCs).</u>
something concrete to refer to	322	with the meetings (R- Yeah), we did suggest doing this'	'The board' – something concrete can be referred to after the SCs
	323	and it's, whenever it need be it can be changed (R-	*'meetings' – SCs understood as meetings.*
something concrete to refer to	324	Uhuh). You know so that if, I don't know she decides	<u>'The board' – something concrete – as a memory aid for the SU.</u>
	325	she needed more support with something (R- Hmmm)	'the board' did the P perhaps also experience this as a tool for the staff to use with
something concrete to refer to	326	that's fine, we'll sit there, we'll have a little juggle	<u>the SU to add authority and consistency?</u>
	327	around of it (R- Hmmm). It's like a working progress,	the board (ways of supporting SU) can be changed
enabling consistency in approach Increasing flexibility of approach/openness to trying something different Enabling SU's voice	328	rather than opposed to, we've had the meetings, this is	The P the board as something that isn't set in stone and can be adapted to the SU's <u>changing needs.</u>
	329	what we've said and it's set in stone.	P will help SU to amend the board (her support) if the SU decides she needs more support with something.
Person-centred Increasing flexibility of approach/openness to trying something different Enabling SU's voice			<u>referring to 'the board' as an entity. The board represents the SU's support.</u> the board is a work in progress, not set in stone. <u>Flexibility of support.</u> <u>compares 'the board' to SU's support plans and others' lives emphasising that things change.</u> 'she decides she needed more support with something' - <u>the board seems to enable the SU's voice.</u>
			consistency but still having some flexibility the support/board works if all staff are consistent in the way they work with the SU.
enabling consistency in approach	330	It's not (R- Yeah), it's the same as her support plans,	*'another one' – referring to the SCs as when she refers to the board it is about updating/changing not doing another one.*
	331	same as mine and your lives (R- Hmmm). We don't do	P thinks that there should be another SC.
	332	everything the same from day to day (R- Uhuh, uhuh)	<u>P feels that it would be helpful to have another SC due to their new staff</u>
SCs should continue	333	but it's consistency-wise that I think is, that as long as all	P thinks that the SCs should continue – having a on-off meeting every now and again <u>P sees SCs as meetings</u> P feels that one-off SCs would be helpful for new staff

SCs as a learning environment SCs as a recap	334 335 336 337 338	staff work the same with her (R- Uhuh), then it works (R- Yeah). I think you know, I think sometimes I do think yeah we should do another one because we've got a lot more new start-, new staff (R- Uhuh). Erm, but yeah I do think every now and again I do think they should be,
Outside person is important	339 340 341	just have a little you know a one-off meeting (R- Hmmm, okay, uhuh). So you know obviously for new staff and also as we all do, we all do get a little bit
SCs as a recap SCs as a recap	342 343	complacent (R- Hmmm) and but you know, that's life, that's what we do as (R- Yeah), that's human nature and
SCs should continue SCs as a review of SU's support SCs should continue SCs should continue SCs as a recap	344 345 346 347	so and the same with obviously the people we support (R- Hmmm). You know sometimes they like, not major change but things change in their lives that we have to accommodate, so.
	348	R- Okay, so having a one-off might be helpful?
	349	P- Yeah.
	350	R- Yeah.
SCs as a review of SU's support SCs should continue	351 352 353 354	P- You know I'm not saying it has to be every 6 months (R- Hmmm), it could even be once a year (R- Hmmm). Obviously in the meantime if something major happens then we might have to go back and say 'look, you know
SCs should continue SCs as a recap	355 356 357	can we sort of arrange' (R- Yeah). But you know I do think every now and again just as a recap and just to find out how things are working (R- Hmmm, hmmm)

Right column notes:

Also thinks they would be helpful for all staff as they (including P) can become complacent. *Speaks about complacency quite casually. Perhaps this has a different meaning to the P as it has for me. Perhaps her meaning of complacency is about out of practice/getting into bad habits?*
P normalises staff getting complacent.
Is the P meaning that an outside person is helpful to look in and see what the staff are doing and how and pick up on things that they could do differently and/or things that may have slipped?
SCs really useful as a recap and recalibrating good practice?
Does the P mean that SUs can also become complacent? Or that they can forget things and need a recap too.
We accommodate changes in SUs' lives.
SCs would be helpful to continue as one-off meetings as SUs' lives do change and hence their support needs to be reviewed. SCs as a useful way of reviewing SUs' support
SCs as one-offs might be helpful – every 6 months – 1 year
P would like for SCs to continually happen on a less frequent basis. P may find these helpful to review and recap the support that the SU has from staff.
What is it about the SCs that the support can be reviewed/discussed in a way that is seen perhaps as more helpful than other review meetings? The P has spoken about having an 'outside' person and having something concrete – the board – which might be the really helpful aspects.

P recognises that things change.
P would like for SCs to be arranged in the event of major things happening.
'obviously in the meantime' – P would seek support anyway
'you know' – P uses the phrase 'you know' a lot throughout the transcript so far – wants me to understand.
SCs every now and again as a recap and review would be helpful. The P would like these regular SCs. Does it feel reassuring as they are receiving input from Psychologists who the P sees as knowledgeable?
356 – *'just as a recap and just to...'* – repetition of *'just'* – is the P emphasising that it makes sense for SCs to happen more frequently to recap and review? Or perhaps the *just* is about getting reassurance – it isn't new ideas/help the P wants, it is a review of what is currently happening and a recap of previously suggested ideas.
357 – *'how things are working'* – it seems important for the P to see that things are *'working'* – what does the P mean by working? Is this perhaps that relationships between the SU and staff are good, or the SU's anxiety is lower, or staff are experiencing less hostility from the SU?
P spoke a lot more in the meetings
Although P experiences the SU as speaking ('quite sort of verbal'), the SCs appeared to enable the SU to be speak honestly. Why was this? Perhaps the relaxed/informal environment, or the space dedicated to talking about the SU's support? Or the lead therapist being aligned to everyone – being unbiased?

	358 you know she sort of seems more open, she's spoke a	
	359 lot more (R- Okay, uhuh) in the meetings and she was	
	360 quite sort of verbal, which she is normally (R- Uhuh),	*361 – 'pause' – the P seemed to need to think about how she would say this – perhaps she was realising the difference then in the interview, or perhaps she needed to find words to say it in a positive way.* How did the P experience the SU's honesty?
Enabling SU's voice	361 but you know she is very erm (pause), she was very	
Enabling SU's voice	362 honest in what she said (R- Hmmm) and was quite	The pause in the P's speech may indicate either that the P was pleased that the SU could be honest or that it felt difficult when she was honest.
	363 happy to talk about it as she was after (R- Okay). I think	SU was happy to talk about SCs after them. P may have experienced this as a good
	364 it makes her feel a little bit better (R- Hmmm) it's like	thing as they are able to continue those open conversations and continue the
Enabling SU's voice	365 she sort of can go and vent all her issues (R- Uhuh) and	consistency of the suggestions with the SCs.
	366 then we come back and it's like 'okay' (R- Okay) you	P experienced SCs as making SU to feel a little bit better as she can vent and then have reassurance from staff when she is home.
	367 know (R- Hmmm) (coughs).	*'a little bit better' – does P see SCs as having a small effect on the P's mood?* However this seems to be added to because it may be that P sees the reassurance they offer the SU at home after the SCs as also helping the SU to feel better.
		SCs as a space for the SU to vent
	368 R- Okay. And I wondered if you could tell me a bit more	
	369 about the board? Erm, so is this something you did	
	370 within the sessions or?	
Enabling consistency in approach	371 P- At the initial meetings (R- Hmmm) before I started	'The board' was made at initial meetings prior to this period of the SCs.
Enabling SU's voice	372 that's when the board was made (R- Okay, uhuh). Erm,	The board existed prior to the P starting to work with the organisation and hence
Enabling SU's voice	373 and then obviously [lead therapist] brought up as, does	the SU. The board's existence has been greater in length P's own existence in the organisation. The P might think that because the board has been in existence for a
something concrete to refer to	374 XXXX still have the board, erm and it was like yeah so	long period of times then it works with the SU.
	375 we sort of went through (R- Hmmm) what was on it,	*373 – 'obviously [lead therapist brought up...' – it is obvious that the lead therapist would bring up the board as this is core to the support the staff are offering SU.*
SCs as a review of SU's support	376 you know erm and obviously you know if there'd been	discussed what was on SU's board in SCs
something concrete to refer to	377 certain things in her life that had changed then we	discussed if things had changed so could adapt the board. SCs as a review of SU's
	378 could take them off, we would add different things (R-	support. using something concrete to refer to in the SCs and outside of them.
person-centred	379 Okay). It was mainly about how, how she likes to be	*'went through'*
	380 supported (R- Uhuh). What she likes support with, who	the board was mainly focussed on how the SU likes to be supported. What SU likes support with and who is important to her.
Enabling SU's voice	381 are important to her (R- Hmmm), she likes being	SU wants to involved with all decisions in her life. Has the board enabled this to
Enabling SU's voice	382 included in all decisions to be made with her life she's	happen? Enabling the SU's voice to be heard and enabling her more input into decisions.
	383 more than able (R- Hmmm) to understand all that erm	P understands that SU is able to make decisions
	384 you know and, and just things like that really (R- Uhuh),	*384 – 'and just things like that really' - it covered more than how SU liked to be supported. 'just' - does that indicate perhaps this is something that has become well*
	385 you know issues she'll have, we didn't name people but	*known to the P so feels easy to explain?*
	386 erm you know if she has an issue with another one of	*'you know' – wants me to understand (you know is also repeated)*
	387 her housemates, don't get really confrontational, (R-	The board also covered along with the discussions in the SCs about issues SU has with housemate(s).
Enabling coping mechanisms for the SU	388 Okay) so it was like, she was sort of like 'okay' she'll step	*'don' get really confrontational…. She'll step back, take a breath…'.* The board also had strategies that the SU could use in difficult situations for her.
Enabling coping mechanisms for		

Codes	Line	Transcript	Notes
the SU	389	back, take a breath (R- Uhuh). Whereas before she'd	SU learned to take a step back, go to staff, when she had a difficulty with a housemate, rather than being confrontational.
Enabling coping mechanisms for the SU	390	have gone charging in, now she won't (R- Uhuh) she'll	compares how SU used to react in situation to how she would now. A change in her being able to respond more calmly.
Enabling coping mechanisms for the SU	391	sort of step back, come to staff. Rather than make an	'before she'd have gone charging in' – P experienced the SU as being very reactive,
Enabling coping mechanisms for the SU	392	atmosphere within the house (R- Hmmm), she'll come	showing her anger and frustration and being confrontational when dealing with a situation with a housemate prior to SCs.
Enabling coping mechanisms for the SU	393	to staff and say 'look you know, I've got a problem la la	repetition of SU taking a step back – emphasising that she found that the SU was
Enabling coping mechanisms for the SU	394	la la'. So staff will sort it rather than opposed to XXXX	able to take a step back and that this was helpful.
Enabling coping mechanisms for the SU	395	and whoever she's having a row with (R- Okay) end up	Compares to perhaps how the P viewed the SU prior to SCs. SU used to 'make an atmosphere'.
			Now SU is able to go to staff to explain the problem so staff can sort it. Perhaps P's experiences have improved since the SCs in terms of now there isn't an atmosphere in the house where she works?
	396	World War 3 and then (R- Hmmm) you know not a nice	396 – 'World War 3' – the arguments between the SU and her housemate were intense. Do others also become involved? Do people take sides?
	397	atmosphere for all the other people that live in the	397 – repeats about the atmosphere not being nice and expands this by saying for other SUs.
	398	house, so (R- Hmmm). But no with that I think that	398-399 – repetition of 'that works'– emphasising that the coping strategy of the SU
	399	works, that works with her really well.	going to talk to staff instead of being confrontational was really helpful/worked well
Enabling coping mechanisms for the SU	400	R- Okay, so it's, so that's an example that's on the board	
	401	so (P- Yes) she can (P – Coughs) maybe look at the	SU able to look at the board to see what to do
Person-centred/something concrete to refer to.	402	board if she's had a row and then see what to do, is	SU will ask staff to go through the board with her. P experiences SU as taking initiative to ask staff to go through it with her. P may see herself and other staff as
	403	that?	providing a recap with the SU through using the board.
	404	P- Yeah she can do, yeah she can do (R- Okay) by all	SU seeks support from staff if she can't remember and/or understand something on the board.
something concrete to refer to	405	means (R- Hmmm) or she'll sit there and every now and	The way the board is spoken about is quite descriptive. What are the P's experiences
	406	again she'll ask members of staff to go through it with	of being able to use the board with the SU?
	407	her (R- Okay). If there's something on the board that	Staff can adapt the board so SU can understand. Person-centred.
Increasing flexibility of approach/openness to trying	408	she doesn't quite, or she can't remember (R- Yeah)	Flexibility of the board
something different	409	exactly what it means. So we can either change the	
	410	wording (R- Uhuh, uhuh) you know to make it 'right	
	411	okay XXXX it says here you're' I don't know, for	
something concrete to refer to	412	arguments sake you've got to cross at the crossing not	'you've got to' – prescriptive - does the SU need this clear instruction?
	413	just randomly in the middle of the road (R- Okay). And	
Increasing flexibility of approach/openness to trying	414	then so it's like if that's not worded how she'd like we	
something different	415	can change the wording (R- Hmmm), you know and it's	going through the board as a recap.
Person-Centred	416	just a little bit of recap because as I say she doesn't look	The board is available when the SU wants to look at it and adapt things
Collaborative			The board is in SU's room. SU owns the board. It is hers as it details her support.
Enabling SU's voice	417	at it every day (R- Yeah). Erm I think she's, I think it's in	Person-centred.
Increasing flexibility of approach/openness to trying	418	her cupboard in her room, but she will every now and	'We'll' – it sounds like the P is referring to herself and the SU. Sounds joined up – collaborative – enabling SU's voice and person-centred.

something different	419	again pull it out (R- Okay), we'll have a look through it,	The board is flexible, as is the support.
something concrete to refer to	420	we'll change things round (R- Hmmm), she'll decide that	
	421	something else is a priority (R- Uhuh), as opposed to	The SU may decide a different priority. The P is well tuned into things changing for the SU.
	422	what was 6 months ago, so.	The board as something concrete being really useful to recap and review the SU's support.
Person-centred.	423	R- Okay. So, so what other things are on the board?	People important to the SU are on the board.
Person-centred.	424	P- Erm, things on the board are, erm all about the	How SU likes staff support is on the board.
Person-centred.	425	people who are important to her (R- Okay), erm so like	SU has different options she can choose when she has one-to-one support.
	426	family (R- Uhuh) and things. Erm, how she likes staff to	
	427	support her with things (R- Hmmm), so like on a one-to-	
	428	one day she'll, one week she'll go shopping as in food	'just down the town' – is it referred to as 'just' because it is not focussed on a
Enabling coping mechanisms for the SU	429	shopping for herself, the next week it could be just	chore/activity the SU has to do, and therefore may be seen as less important to P?
	430	down the town. Erm, things like doing her room with	Other things on the board include other activities and how the SU would like to speak to staff.
	431	her (R- Uhuh), how she'd like to speak to staff, normally	SU speaks to staff in the evenings about her concerns.
	432	in the evening, erm how she'd like to have a little chat	
	433	with staff if there's anything worrying her (R- Okay).	Everyday issues are on the board.
	434	Things that you know, things like that every day, every	'everyday issues' – does the P see this as things that come up frequently for the SU in terms of things that concern her or are difficult for her to deal with?
	435	day issues (R- Okay) that you know (R- Hmmm, hmmm).	'you know' – repeated – does the P want me to understand or assume I already have some understanding about what the board is?
something concrete to refer to	436	So it could be whether she doesn't get on with a	P lists things she sees as everyday issues that might come up for the SU.
	437	housemate, whether you know (R- Okay) family	The board helps the SU with everyday issues.
	438	members are ill, whether she you know needs a	The board includes support around relational issues, decisions, and emotional support.
	439	XXXXXXX appointment (R- Hmmm), and you know	
	440	whether she'd like us to support her to the XXXXX	
Enabling SU's voice	441	appointment (R- Hmmm) or whether she'd like to go on	
	442	her own. Erm whether she'd like family members to be	P understands the SU as having a choice and helps to enable this.
Person-Centred	443	told that she has a XXXXX appointment, 'cause	
Person-Centred	444	obviously that's her choice as well (R- Hmmm).	P acknowledges that the SU can want different things at different times/make different decisions at different times.
Enabling SU's voice	445	Sometimes she'll say 'yeah, can we ring my [FM] and	P appears very person-centred in her support with the SU. The board may help with this in terms of it covering many different issues which SU can receive support with.
	446	let her know I've got an appointment' but other times	Does the extent of the many issues that are covered on the board help staff to
Person-centred.	447	it's like 'no, (R- Okay) I don't want [FM] to know' (R-	become more person-centred about more aspects of the SU's life? And perhaps
Enabling SU's voice	448	Yeah). So lots of differ-, basically just everything to do	help them to think through more decisions with the SU?
Enabling SU's voice		with her (R- Hmmm) day to day life you know, from	'So lots of differ-, basically just everything to do with her' – P goes to say lots of
Increasing flexibility of	449	emotions to how to work best with XXXX (R- Okay)	different things and perhaps realises the extent of the things that are on the board
approach/openness to trying	450	really, so.	and changes her language to 'basically just everything to do with her'. Implies a
something different	451		really person-centred way of working. The SU is involved in all aspects of her care.
something concrete to refer to			She is also continually involved as she initiates recapping and reviewing of her

something concrete to refer to Person-centred Enabling coping mechanisms for the SU			support documented on the board (something concrete). 'day to day life you know, from emotions to how to work best with [SU]' – it's really encompassing and centred on the whole of the SU's support. It is also a tool for the staff regarding how to work best with the SU. It also helps the SU with her emotions. Is this what to do when she experiences certain emotions/coping strategies? Or perhaps more understanding her emotions?
	452 453 454	R- Oh great. Hmmm okay. And I wondered kind of looking back at the SC's (P- Hmmm), what, what you think about them now?	
SCs would be helpful for all SUs SCs would be helpful for all SUs SCs would be helpful for all SUs Inclusive	455 456 457 458 459 460 461 462 463 464	P- As I say I do think they're a really good idea (R- Hmmm, hmmm), and I think they should be, I think they should be across the board (R- Okay). I think everybody that we support (R- Yeah) should have the opportunity to do it (R- Uhuh). Because I think it's more of a you know we have one-to-one meetings with them, erm we have family meetings, we have XXXXX meetings you know so we can speak to them individually (R- Hmmm), erm with everybody they live with you know as a family meeting and everything. But I do think it's quite a good	SCs as a really good idea. SCs should be in place for everyone the P (along with other staff) support(s). SCs are really useful. SCs are seen as something that can be helpful to all SUs. SCs as an opportunity. Only some people have the opportunity to have SCs however they would be beneficial for everyone. SCs are beneficial because they are inclusive. P speaks about other meetings she has in her service like meetings with the family, XXXXX, individual meetings. These give the opportunity to speak to SUs in different formats.
Outside person is important Outside person is important Outside person is important Outside person is important Enabling SU's voice Outside person is important	465 466 467 468 469 470 471 472 473 474 ...	idea (R- Hmmm) because people tend to, if you've got someone else there, as I call an 'outsider' (R- Hmmm) that sounds probably the wrong wording, erm I do think a lot more things come out (R- Okay, hmmm). They sort of feel a bit more open to talk to someone (R- Hmmm) you know, whereas course they'll try and get away with things that they think you know (R- Hmmm), okay we'll get this person to cook our dinner for us when (R- Laughs) they don't need that but course (R- Yeah) staff know that, but that other person doesn't (R- Hmmm).	SCs a good idea because of an 'outsider' An outsider enables more to be shared. P feels that 'an outsider' is the wrong wording. However implies something important about someone coming in from the outside that hasn't been involved in the day-to-day activities etc. 'They sort of feel a bit more open to talk to someone' – 'they' refers to the P's experience of the SU. The P saw that the SU spoke to an 'outsider' more and felt able to be more open with this person. I wonder whether the P experienced something similar or different? Did the P feel more able to talk to an 'outsider' or more able to speak because the meetings were being facilitated by someone external to the service? 'an outsider' – perhaps P meant someone external to their supported accommodation service and someone who is able to take an unbiased position? 'you know' – repeats this several times again – wanting me to understand or thinks I already have some understanding of what she is referring to. P experiences the SU as trying to get other staff to do things for her whereas they are supposed to enable the SU to do these things for herself, for example, cooking. 474 – 'but that other person doesn't' – who is the other person? The SU? The [FM]? The new staff?

Appendix L: Emergent themes from Emma's interview as they arose

Bold = first occurrence of emergent theme

making sense of who SCs are for
making sense of who SCs are for
making sense of who SCs are for
person-centred
person-centred
SCs as a recap
making sense of who SCs are for
SCs as a learning environment
relaxed environment
inclusive
relaxed environment
relaxed environment
relaxed environment
relaxed environment
SCs as a learning environment
SCs as a learning environment
SCs a recap
SCs as a learning environment
SCs as a learning environment
SCs as a recap
SCs as a recap
SCs as a recap
Making sense of who SCs are for
Making sense of who SCs are for
Making sense of who SCs are for
Making sense of who SCs are for
Outside person is important
P as normalising SU's experiences
Outside person is important
SCs as a recap
staff turnaround leading to needing SCs
staff turnaround leading to needing SCs
staff turnaround leading to needing SCs
staff turnaround leading to needing SCs
staff turnaround leading to needing SCs
staff turnaround leading to needing SCs
P as normalising SU's experiences
making sense of who SCs are for
enabling consistency in approach
enabling consistency in approach
enabling consistency in approach

enabling consistency in approach
enabling consistency in approach
enabling consistency in approach
Making sense of who SCs are for
Person-centred
Person-centred
SCs as a recap
SCs as a recap
Person-centred
Person-centred
Person centred
Person-Centred
SCs as a review of SU's support
Person-centred
Enabling SU's voice
Person-Centred
Enabling SU's voice
Person-centred
SCs as a review of SU's support
Person-centred
Inclusive.
Person-centred.
Increasing flexibility of approach/openness to trying
something different
Increasing flexibility of approach/openness to trying
something different
Staff as unified
P as normalising SU's experiences
Enabling consistency in approach
enabling sharing of information
Enabling consistency in approach
enabling understanding from another's perspective
P as normalising SU's experiences
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
Making sense of who SCs are for
Person-centred. Inclusive. Enabling SU's voice.
Making sense of who SCs are for
Person-centred. Inclusive. Enabling SU's voice.
Enabling SU's voice.

Enabling SU's voice.
Enabling SU's voice
Person-Centred.
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Increasing flexibility of approach/openness to trying
something different
Increasing flexibility of approach/openness to trying
something different
Increasing flexibility of approach/openness to trying
something different
Enabling SU's voice
SCs as a learning environment
SCs as a learning environment
Person-centred
something concrete to refer to
something concrete to refer to
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Increasing flexibility of approach/openness to trying
something different
Outside person is important,
outside person is important
outside person is important
outside person is important
outside person is important
outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important

Outside person is important
Outside person is important
Outside person is important
Outside person is important
Outside person is important
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
something concrete to refer to
something concrete to refer to
something concrete to refer to
enabling consistency in approach
Increasing flexibility of approach/openness to trying something different
Enabling SU's voice
Person-centred
Increasing flexibility of approach/openness to trying something different
Enabling SU's voice
enabling consistency in approach
SCs should continue
SCs as a learning environment
SCs as a recap
Outside person is important
SCs as a recap
SCs as a recap
SCs should continue
SCs as a review of SU's support
SCs should continue
SCs should continue
SCs as a recap
SCs as a review of SU's support
SCs should continue
SCs should continue
SCs as a recap
Enabling SU's voice
Enabling SU's voice
Enabling SU's voice
Enabling consistency in approach
Enabling SU's voice

Enabling SU's voice
something concrete to refer to
SCs as a review of SU's support
something concrete to refer to
person-centred
Enabling SU's voice
Enabling SU's voice
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
Person-centred/something concrete to refer to.
something concrete to refer to
Increasing flexibility of approach/openness to trying something different
something concrete to refer to
Increasing flexibility of approach/openness to trying something different
Person-Centred
Collaborative
Enabling SU's voice
Increasing flexibility of approach/openness to trying something different
something concrete to refer to
Person-centred.
Person-centred.
Person-centred.
Enabling coping mechanisms for the SU
something concrete to refer to
Enabling SU's voice
Person-Centred
Person-Centred
Enabling SU's voice
Person-centred.
Enabling SU's voice
Enabling SU's voice
Increasing flexibility of approach/openness to trying something different
something concrete to refer to
something concrete to refer to

Person-centred
Enabling coping mechanisms for the SU
SCs would be helpful for all SUs
SCs would be helpful for all SUs
SCs would be helpful for all SUs
Inclusive
Outside person is important
Outside person is important
Outside person is important
Outside person is important
Enabling SU's voice
Outside person is important
family involvement as helpful
family involvement as helpful
family involvement as helpful
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
Enabling consistency in approach
inclusive
Enabling consistency in approach
Staff as unified
Outside person is important
enabling understanding from another's perspective
Enabling SU's voice
Outside person is important
Outside person is important
Staff as unified
Outside person is important
Outside person is important
from a battle to working together
enabling consistency in approach
staff as unified
P as normalising SU's experiences
relaxed environment

neutral environment
relaxed environment
enabling understanding from another's perspective
enabling understanding from another's perspective
enabling understanding from another's perspective
Collaborative
Enabling SU's voice
Inclusive
Staff as unified
SCs would be helpful for all SUs
relaxed environment
inclusive
Person-centred
SCs as a review SU's support
bigger picture/the whole
relaxed environment
staff as unified
relaxed environment
bigger picture/the whole
Person-Centred
relaxed environment
relaxed environment
relaxed environment
relaxed environment
relaxed environment
person-centred
relaxed environment
didn't know completely what to expect
didn't know completely what to expect
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
from a battle to working together
staff as unified
from a battle to working together
from a battle to working together
from a battle to working together
concerned about entering into conflict
enabling SU's voice
enabling SU's voice
concerned about entering into conflict

concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
concerned about entering into conflict
relaxed environment
relaxed environment
inclusive
enabling understanding from another's perspective
relaxed environment
inclusive
enabling understanding from another's perspective
Person-Centred
Enabling SU's voice
relaxed environment
staff as unified
staff as unified
staff as unified
staff as unified
staff as unified
staff as unified
SCs as a learning environment
SCs as a learning environment
Increasing Flexibility in Approach/Openness to
trying something different
improved relationships
Increasing Flexibility in Approach/Openness to trying
something different
Increasing Flexibility in Approach/Openness to trying
something different
enabling sharing of information
Increasing Flexibility in Approach/Openness to trying
something different
outside person is important
outside person is important
enabling sharing of information
Increasing Flexibility in Approach/Openness to trying
something different
outside person is important
outside person is important
Enabling understanding from another's perspective
Increasing Flexibility in Approach/Openness to trying
something different

Enabling understanding from another's perspective
validating
validating
validating
making sense of who SCs are for
making sense of who SCs are for
enabling SU's voice
enabling consistency in approach
person-centred
something concrete to refer to
enabling consistency in approach
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
It wasn't all down to the SCs - Learning from experience
enabling consistency in approach
staff as unified
enabling sharing of information
enabling sharing of information
enabling sharing of information
enabling sharing of information
enabling understanding from another's perspective
enabling SU's voice
Person-Centred
SCs as a learning environment
improved relationships
Enabling SU's voice
Enabling SU's voice
Enabling coping mechanisms for the SU
staff as unified
enabling SU's voice
enabling consistency in approach
person-centred
enabling coping mechanisms for the SU
SCs should continue
SCs as a review of SU's support
SCs should continue
Person-centred
SCs as a recap
SCs as a recap
SCs should continue
SCs as a recap
SCs as a review of SU's support
outside person is important
SCs as a recap

Enabling SU's voice
SCs to continue/SCs as a recap
SCs as a review of SU's support
SCs as a learning environment
inclusive
enabling a support network for staff
enabling a support network for staff
SCs as a learning environment
SCs as a recap
SCs as a learning environment
Enabling understanding from another's perspective
Enabling coping mechanisms for the SU
SCs should continue/SCs as a recap
Enabling coping mechanisms for the SU
P a normalising SU's experiences
Enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
enabling coping mechanisms for the SU
enabling coping mechanisms for the SU
SU calmer but still has bad days
some interventions are straightforward
Outside person is important
Outside person is important
Outside person is important
staff as unified
increasing flexibility of approach/openness to trying
something different
collaborative
improved relationships
staff as unified
SU calmer but still has bad days
SU calmer but still has bad days/improved relationships
enabling coping mechanisms for the SU
Enabling coping mechanisms for the SU
staff as unified
staff as unified
enabling coping mechanisms for the SU
enabling coping mechanisms for the SU
improved relationships
improved relationships
person-centred
Enabling SU's voice
improved relationships
enabling SU's voice

improved relationships
enabling SU's voice
collaborative
Increasing flexibility of approach/openness to trying
something different
person-centred
enabling understanding from another's perspective
Enabling SU's voice
SU now able to reason
enabling understanding from another's perspective
SU now able to reason
enabling understanding from another's perspective
improved relationships
improved relationships
SU now able to reason
person-centred
SCs as a learning environment
SCs as a learning environment
staff as unified
inclusive
SCs as a learning environment
staff as unified
SCs as a learning environment
 SCs as a learning environment
making sense of who SCs are for
collaborative
SCs as a learning environment
SCs as a learning environment
SCs as a learning environment
SCs as a learning environment
improved relationships
improved relationships
staff as unified
Increasing flexibility of approach/openness to trying
something different
enabling sharing of information
Increasing flexibility of approach/openness to trying
something different
making sense of who SCs are for
inclusive
enabling sharing of information
enabling sharing of information
enabling consistency in approach
enabling consistency in approach

P as normalising SU's experiences
person-centred
P as normalising SU's experiences
SCs as a learning environment
staff as unified
SCs as a learning environment
something concrete to refer to
SCs as a learning environment
something concrete to refer to
something concrete to refer to
something concrete to refer to
collaborative
something concrete to refer to
something concrete to refer to
staff as unified
Outside person is important
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
enabling a support network for staff
staff as unified
increasing flexibility in approach/openness to trying
something different
increasing flexibility in approach/openness to trying
something different
enabling understanding from another's perspective
increasing flexibility in approach/openness to trying
something different
SCs as a learning environment
SCs as a learning environment
increasing flexibility in approach/openness to trying
something different
Increasing Flexibility in Approach/Openness to trying
something different
Outside person is important
outside person is important
SCs as a learning environment
SCs as a learning environment
SCs as a learning environment
SCs as a learning environment

SCs would be helpful for all SUs
enabling understanding from another's perspective
improved relationships
improved relationships
improved relationships
enabling understanding from another's perspective
enabling understanding from another's perspective
from a battle to working together
from a battle to working together
SU calmer but still has bad days
SU calmer but still has bad days
SCs as a learning environment
SCs as a learning environment
SCs as a learning environment
SU calmer but still has bad days
enabling understanding from another's perspective
P as normalising SU's experiences
SU calmer but still has bad days
P as normalising SU's experiences
It wasn't all down to the SCs - Learning from experience
SCs as a learning environment
SCs as a learning environment
enabling coping mechanisms for the SU
something concrete to refer to
SCs as a learning environment
staff as unified
collaborative
SCs as a learning environment
staff as unified
SU calmer but still has bad days
SCs should continue
SCs as a recap
SCs should continue/SCs as a recap
Enabling SU's voice
SCs should continue
SCs as a review of SU's support
SCs as a review of SU's support
SCs should continue
SCs should continue/SCs as a recap/SCs as a review of SU's support
making sense of who SCs are for/**we all benefitted**
SCs as a recap
SCs as a recap
P as normalising SU's experiences

SCs should continue
SCs as a recap
outside person is important
SCs as a learning environment
Increasing Flexibility in Approach/Openness to trying something different
SCs as a learning environment
collaborative
SCs should continue/SCs as a recap
SCs as a recap
SU calmer but still has bad days
SU calmer but still has bad days
Making sense of who SCs are for
SCs as a recap
SCs as a review of SU's support
SCs as a review of SU's support
Increasing Flexibility in Approach/Openness to trying something different
SCs as a review of SU's support
P as normalising SU's experiences
SU calmer but still has bad days
improved relationships
SU calmer but still has bad days
Enabling coping mechanisms for the SU
SU calmer but still has bad days
improved relationships
SCs as a learning environment
staff as unified
Increasing flexibility of approach/openness to trying something different
Increasing flexibility of approach/openness to trying something different
Increasing flexibility of approach/openness to trying something different
SCs as a learning environment
improved relationships
SCs as a learning environment
enabling consistency in approach
enabling understanding from another's perspective
enabling consistency in approach
enabling understanding from another's perspective
enabling consistency in approach
Increasing Flexibility in Approach/Openness to trying something different

Increasing Flexibility in Approach/Openness to trying something different
enabling consistency in approach
enabling consistency in approach
enabling consistency in approach
some interventions are straightforward
enabling consistency in approach
SCs as a learning environment/SU calmer but still has bad days
enabling understanding from another's perspective
Enabling coping mechanisms for the SU
Increasing Flexibility in Approach/Openness to trying something different
Increasing Flexibility in Approach/Openness to trying something different
Increasing flexibility of approach/openness to trying something different
outside person is important
enabling a different way of seeing something
staff as unified
enabling consistency in approach
enabling a support network for staff
improved relationships
enabling understanding from another's perspective
improved relationships
improved relationships
from a battle to working together
from a battle to working together
improved relationships
enabling sharing of information
enabling coping mechanisms for the SU
 SCs would be helpful for all SUs
SCs as a recap/SCs as a review of SU's support/SCs should continue
Outside person is important
Enabling a support network for staff
SCs as a learning environment
making sense of who SCs are for/we all benefitted
improved relationships
enabling SU's voice
SCs would be helpful for all SUs

Appendix M: List of all emergent themes from Emma's interview

Bigger picture/the whole
Collaborative
Concerned about entering into conflict
Didn't know completely what to expect
Enabling a support network for staff
Enabling consistency in approach
Enabling coping mechanisms for the SU
Enabling sharing of information
Enabling SU's voice
Enabling understanding from another's perspective
Family involvement as helpful
From a battle to working together
Improved relationships
Inclusive
Increasing Flexibility in Approach/Openness to trying something different
It wasn't all down to the Systemic Consultations (SCs) - Learning from experience
Making sense of who SCs are for
Making sense of who SUs are for/we all benefitted
Neutral environment
Outside person is important
Participant (P) as normalising SU's experiences
Person-centred
Relaxed environment
SCs as a learning environment
SCs as a recap
SCs as a review SU's support
SCs should continue
SCs would be helpful for all SUs
Some interventions are straightforward
Something concrete to refer to
Staff as unified
Staff turnaround leading to needing SCs
Service User (SU)calmer but still has bad days
SU now able to reason
Validating

Appendix N: Clustering of emergent themes for Emma – stage of single case analysis

Making sense of who they were for	Valuing improved relationships	An outside person shone a new light	Enabling a comfortable environment
making sense of who SCs are for	Improved relationships	Outside person is important	relaxed environment
making sense of who SCs are for/we all benefitted	Concerned about entering into conflict	Enabling understanding from another's perspective	neutral environment
Enabling coping mechanisms for the SU	Staff as unified	Increasing flexibility of approach/openness to trying something different	Validating
SU calmer but still has bad days	from a battle to working together		person-centred
SU now able to reason	family involvement as helpful		Enabling SU's voice
SCs as a learning environment			*('collaborative' removed as it is covered in improving relationships themes with subtheme battling to collaborating)*
staff turnaround leading to needing SCs	Enabling sharing of information		
Something concrete to refer to	Enabling consistency in approach		
Some interventions are straightforward (*removed as not enough evidence for final theme*)	enabling a support network for staff		*('inclusive' taken out as included in person-centred, collaborating, and learning from SCs themes/sub-themes)*
SCs as a recap			
It wasn't all down to the SCs - Learning from experience			
SCs should continue			
SCs as a review of SU's support bigger picture/the whole			
SCs would be helpful for all SUs			

*Two emergent themes were removed ('P as normalising SU's experiences' (not enough evidence to relate this to an experience of systemic consultations) and 'Didn't know completely what to expect' (not enough evidence throughout to make this a theme for single case analysis).

Appendix O: Final names for themes Emma's single case analysis

1. **Making sense of who they were for**
   a. Working out whether they were for the SU, us, or everyone
   b. Admiring and supporting the SU develop coping mechanisms
   c. Putting learning into practice
   d. Desiring the process across the board for recapping and reviewing SU's support

2. **Valuing improved relationships**
   a. From Battling to collaborating
   b. Valuing gains from sharing of information
   c. Enabling consistency was important
   d. Gaining a support network

3. **An outside person shone a new light**
   a. An outside person was important in introducing a different perspective
   b. Enabling understanding from another's perspective
   c. Becoming open to trying something different

4. **Enabling a comfortable environment**
   a. They were totally informal
   b. Nothing was too small
   c. Enabling SU's voice

Appendix P: Subordinate themes and corresponding quotes/extracts

Subordinate theme	Page: Line	Quotes
Making sense of who they were for		
Working out whether they were for the SU, us, or everyone	1: 1-6	R- So can you tell me a bit about what you remember about the SC's? P- Erm, a lot of it obviously was to do with how she was coping with, well 1 XXXX and her issues around living with other people (R- Uhuh), erm also to do with staff understanding her.
	3-4: 94-100	I was just told right you know this is (R- Yeah) what's happening with XXXX, you know she wants to see [lead therapist], going through (R- Hmmm), a bit unsettled at the time (R-Okay). So I think it was more you know to sort of (R- Yeah), a little bit of confidence building for her, because she can every now and again doubt her own confidence
	5: 127-130	R- Okay, great. And what kind of help were you seeking when you came to the consultations do you think? P- I think it was just a bit more from, from XXXX because she will (pause) she can play staff off against each other.
	46: 1429-1435	But with this, this is the fact of you're getting input as well (R- Yeah) for us and for the person we support (R- Yeah). You know it's helping them and helping us in turn, enabling us to work with them better and enabling them to get their opinions across to us
Admiring and supporting the SU develop coping mechanisms	13-14: 385-399	you know issues she'll have, we didn't name people but erm you know if she has an issue with another one of her housemates, don't get really confrontational, (R- Okay) so it was like, she was sort of like 'okay' she'll step back, take a breath (R- Uhuh). Whereas before she'd have gone charging in, now she won't (R- Uhuh) she'll sort of step back, come to staff. Rather than make an atmosphere within the house (R- Hmmm), she'll come to staff and say 'look you know, I've got a problem la la la la'. So staff will sort it rather than opposed to XXXX and whoever she's having a row with (R- Okay) end up World War 3 and then (R- Hmmm) you know not a nice atmosphere for all the other people that live in the house, so (R- Hmmm). But no with that I think that works, that works with her really well.
	26: 768-773	So which obviously is a benefit to her as well (R- Hmmm) 'cause she, she's learnt those techniques of the calming down, go in her room, breathe for 10 minutes (R- Hmmm), come out, speak to staff again or come to staff and say 'look you know I'm having a row with so and so that I live with'
	29: 875-886	Whereas before she would just carry on and on and on and you're just like 'right XXXX I can't' (R-Okay), but so you know I mean most of it is, has been around how she deals with when she gets anxious and upset and (R- Hmmm) angry (R- Hmmm, hmmm). She's in herself learnt how to deal with that, that she will get the support that she needs (R- Uhuh) trying to understand that if she's shouting at us we can't help her (R- Okay) 'cause she gets so '(mumbles)'(R- Yeah), we don't al- (R- Yeah), you know the calming down mechanism she can go from there to there now (R- Hmmm) in about 2 seconds (R- Hmmm), whereas before it could take ages
Putting learning into practice	11-12: 335-345	I think you know, I think sometimes I do think yeah we should do another one because we've got a lot more new start-, new staff (R- Uhuh). Erm, but yeah I do think every now and again I do think they should be, just have a little you know a one-off meeting (R- Hmmm, okay, uhuh). So you know obviously for new staff and also as we all do, we all do get a little bit complacent...
	32-33: 987-994	But I do you know obviously having the tools that we were given for that (R- Uhuh), erm you know we still use the board with her as well (R- Yeah), you know and it's, it's a brilliant thing that possibly we could then carry that on with other people (R- Hmmm), because I can think of (R- Okay) everybody we support (R- Yeah), we could make one for (R- Okay). So that's always a bonus.
	35-36: 1081-1089	...but then in turn that's then wor-, it's worked with other people we support (R- Uhuh) not just XXXX (R- Yeah), because we've taken that thing and gone ' ahhh okay, right this person this, this and this (R- Hmmm), we're having a nightmare with this. Okay let's try this with them' (R- Okay) so it's

		had a knock on effect then with other people we support (R- Hmmm). Which is why I said if everyone could have one of these meetings it would be brilliant (R- Yeah) (coughs).
	37: 1124-1129	So then it's like 'right okay shall we have a meeting with you and that member of staff?' if she says yes that's brilliant we'll sit there and be 'right this room, there is no shouting, there is no screaming. You have your say, you have your say, don't be shouting (R- Hmmm) over each other (R- Hmmm) or we're not going to'
Desiring the process across the board for recapping and reviewing SU's support	11-12: 335-347	I think you know, I think sometimes I do think yeah we should do another one because we've got a lot more new start-, new staff (R- Uhuh). Erm, but yeah I do think every now and again I do think they should be, just have a little you know a one-off meeting (R- Hmmm, okay, uhuh). So you know obviously for new staff and also as we all do, we all do get a little bit complacent (R- Hmmm) and but you know, that's life, that's what we do as (R- Yeah), that's human nature and so and the same with obviously the people we support(R- Hmmm). You know sometimes they like, not major change but things change in their lives that we have to accommodate, so.
	46: 1427-1436	obviously we do as I say we do the whole life reviews but there's no, if some them have a social worker they're there. But with this, this is the fact of you're getting input as well (R- Yeah) for us and for the person we support (R- Yeah). You know it's helping them and helping us in turn, enabling us to work with them better and enabling them to get their opinions across to us (R-Yeah). So I do think it should be a thing that everybody should have.
	19: 553-557	So but yeah so I do think they do work (R- Yeah) and I would recommend any of the people we support (R- Okay, hmmm). I would say it should be one of those things that you know, every- (R- Okay), all of them should have.
	46: 1423-1426	Yeah (R- Yeah) but no as I say I mean obviously I think if everyb-, if anybody, if everybody that we support could have one (R- Hmmm, hmmm), even if it's a one off
Valuing improved relationships		
From Battling to collaborating	23: 675-678	it was all very open (R- Hmmm) and everything so you just sort of bounce ideas off of people (R- Okay) and I think it's made us work better as a staff team.
	31: 931-932	So that's always a bonus there's less confrontation (R- Hmmm) as well.
	32: 960-965	P- Erm, (pause) as I say I mean as the staff team we work a lot, we're a lot more open with each other (R- Hmmm, okay), erm you know obviously if something goes wrong you know they will come to management and tell us and everything. But I just think you know we're open more to suggestion
	36: 1096-1110	She will go back to [family member] and say staff have refused to do something (R- Hmmm), [family member] will be on the phone to us 'you won't let XXXX do this' or 'you said she', it's like right hold on a minute, XXXX hasn't given you the full story (R- Okay, hmmm). So now she knows that [family member] will listen to her (R- Uhuh) but [family member] will also call staff (R- Okay). So it's that rather than it being XXXX and staff at you know (mumbles), XXXX will going to [family member], [family member] being back on the phone to staff shouting at them (R- Hmmm), it's not now (R- Okay). It's, it's cut down on the amount of animosity (R- Right), that [family member] will come to us and be 'right I've just had XXXX on the phone, she's said la la la la la' (R- Yeah) and it's like right hold on a minute no 'yes that did happen but so did this'
	45: 1379-1396	the relationship with the [family member] (R- Okay), with well [family members] (R-Yeah, okay). You know that they've obviously changed a lot which has taken a lot off of us 'cause when she'll go home and be 'oh staff have done this' you just know when she's coming home the [family member]'s going to come in and go mad (R- Hmmm) it's like 'ahhh'. But now she won't she'll come in, so I think the relationship is more, we talk more (R- Okay, hmmm). You know so she's not literally straight away

		coming down on us like a ton of bricks (R- Hmmm) for how she hasn't got the whole story (R- Yeah), you know and she's also, whereas before she would question what we did (R- Okay), you know it would be very, but she'd do it in front of XXXX (R- Hmmm). So then it was like we had the battle of XXXX playing one off against the other (R- Okay), now that's not (R- Hmmm) we're actually probably working as a team
Valuing gains from sharing of information	25: 741-753	You're knowing things that she possibly hasn't said before, you know I mean erm, I don't know, I can't I'm just trying to think of 1 of the things on there (pause), apparently she used to go XXXXX (R- Okay), I didn't know that (R- Hmmm). But it's things that have come out of this meeting (R- Uhuh) that it's like 'oh okay' (R- Hmmm). You know I don't think any of us as a staff team knew (R- Okay) apparently she hadn't done it for about 10 years (R- Uhuh), but it's then the possibility of okay, maybe that's something we could find staff members that are willing to go swimming with you (R- Hmmm), something else you can do
	32: 966-978	it's that issue of if she's not, if a member of staff is having an issue with working (R- Hmmm), they just can't work with her you know she, she's very stroppy with them she's not receptive to what they're saying (R- Uhuh), at least then we've got other members of the team that are like 'right okay here we go, why don't you try this with her' (R- Okay), 'why don't you try' so I think it's helped as in that we can then pass on knowledge (R- Okay) to other members of staff and as I say because we've got quite a few members of staff (R- Hmmm), new members of staff, it's, she'll try, she'll push her luck (R- Uhuh) with new members of staff
	45: 1405-1406	P- No as I say obviously share-, sharing suggestions and ideas (R- Yeah) and everything erm,
Enabling consistency was important	5: 131-148	Erm, so it's very, she can go to one member of staff and be 'oh, my staff always do that with me'(R- Hmmm), but then more established staff of course she's not going to come to them 'cause we know full well that, we'll support her within reason with anything but it is supported living (R- Yeah). We're there to support her not do everything for her (R- Uhuh). So obviously coming to this, literally it was, we were all hearing the same thing (R- Hmmm), we all knew exactly and also XXXX had an understanding of you know, she was there with us, she heard exactly the same (R- Hmmm) as what we did. And it's more consistency for her (R- Okay), that we're all working the same, it's not that we're saying we won't do that for her (R- Hmmm) because we're being you know, horrible. It's that she's able to do things for herself (R- Hmmm), so and obviously by coming to that it was more that, as I say we're all in the same place, we're all hearing exactly the same things.
	32: 980-984	but it's the consistency (R- Okay). You know (R- Hmmm) which everybody thrives on routine (R- Hmmm), we all do, doesn't matter who you are (R- Hmmm), but XXXX knows that everybody is going to work with her the same which is what she wants
	43: 1331-1340	So it's literally, you know new staff come in, you'll go through you know they'll read support plans (R- Hmmm) and everything (R- Hmmm) and you're like right okay you know they'll ask you what it's like (R- Hmmm) working with and it's like 'okay right, the best way to work with this person, if she starts shouting and screaming you just ask her nicely is she can go and calm down for 5 (R- Hmmm) minutes' (R- Yeah). So it's literally, it might as well be written in big letters in the support plan
Gaining a support network	28: 824-828	and also you get to meet people that aren't just within our service (R- Yeah). You know put a name to the face and (R- Yeah) you know and also it's that opportunity that if new staff are finding something hard that we've not
	34: 1028-1050	I don't know I think it as well some of it is obviously having the support of somebody else (R-Okay), that you know, that you're not, alright as a staff team obviously they have me and [service manager] as management erm but it's that outside (R- Hmmm), outsiders you know the whole social services and everything you know that they're on our side (R- Okay), not that there's sides us against XXXX it's not that at all (R- Yeah), but you've got that extra help if you need it (R- Okay). You know that you can go to

		someone, alright we don't see [lead therapist] all the time but we can drop her an email and be 'look you know (R- Yeah), having real problems with this, you know that you know could you come in, could we arrange a meeting?' (R- Yeah), as well so it's just a little, it's a little bit like a, it's the whole support network (R- Hmmm). You know, XXXX needs it and as staff so do we (R-Yeah), you know we don't know everything, we don't get everything right all the time (R- Hmmm) but you can go to someone for that little bit of extra advice (R- Okay) and just be 'right okay you know we've tried this, this, this, this and this, do you have any other suggestions (R- Yeah) of what we can do?', which obviously is a bonus (R- Hmmm) 'cause we all need that
Increasing flexibility in thinking		
An outside person shone a new light	7-8: 215-224	P- I think they're a really good idea (R- Hmmm). I really do. Erm because I think you've got a totally independent person (R- Uhuh), seeing it from everybody's point of view, whereas I think sometimes when you're in the middle of something, obviously you know what's going on but (R- Hmmm) someone else coming in going 'well hold on you've been doing it like this, that's good but why don't you try this option' (R- Uhuh) you'd be like 'ahhh okay' there maybe something we might have not thought about doing it that way
	8-9: 244-255	So, you know I do, I think they're a pretty good idea, because as I say you've got that outside person (R- Hmmm). But obviously they know her (R- Uhuh) it's not just random outside person (R- Yeah). Erm but as I say I think it does help when you've got someone outside that isn't as close to XXXX (R- Hmmm) as staff, family (R- Uhuh) that look at it from a little bit of a different perspective and put it in that view that we're like 'oh, yeah okay' and it gets XXXX thinking as well and it's like 'oh yeah we could try' (R- Uhuh). So I think that's, it probably is a good idea (R- Hmmm) rather than just staff going on at her.
	9-10: 276-297	P- Because they do see things from a different point of view (R- Okay). Whereas, as I said just now when you're (pause), if you're in the middle of something all the time (R- Hmmm), you will be 'right okay, yeah we could try it that way, that way', but then they come up with a totally different idea and you're like 'oh, okay (R- Okay) didn't think about that' (R- Yeah) it's, it's that thing of having to step out of it (R- Uhuh) to step back in it (R- Yes, yeah). Whereas, when you've got it 24/7 you wouldn't necessarily, there could be some things, don't get me wrong they don't you know it's not we support them wrong or we don't give them enough support (R- Hmmm). But sometimes just over certain angles of how to work with people (R- Uhuh, uhuh), you know where we do something, and we've got you know (R- Yeah) sometimes they put a whole different light on it and also from XXXX's perspective, I think she sees it as someone else has come up with the idea, it's not staff (R- Okay). So sometimes, depending what mood she's in, she'd be more willing (R- Yeah) to listen to the outside person rather than opposed to staff that are there all the time
Enabling understanding from another's perspective	17: 487-493	But to put her on the spot in that resp-, she's like, XXXX will sit back and listen to it from staff's point of view as well(R- Uhuh), so it's an understanding that this is the reason why we don't do this (R- Hmmm), this is the reason why we have to do this (R- Hmmm). So she sort of takes it in, digests it then comes back to us and says 'oh okay, (R- Okay) yeah'.
	17-18: 506-511	XXXX was like 'no. I want it done this way' and [lead therapist] would be 'well hold on a minute, you've got to remember there's 4 other people that live in the house. (R- uhuh) You can't always have, what about if we try to do it this way?' and she's like 'oh, okay'
	19: 547-553	So I think from XXXX's point of view that's what helped as well, you know but she realised that we were there to support her (R- Hmmm). We weren't going to say 'XXXX does this, this, this and this wrong' (R- Hmmm), it was a thing of 'okay, we have rows about this but we'll try and work (R- Hmmm) with you to get that right'
Becoming open to trying something different	6: 176-178	so if it wasn't working doing this we'll go 'oh okay hold on we could try doing it this way'
	8: 220-224	someone else coming in going 'well hold on you've been doing it like this, that's good but why don't you try this option' (R- Uhuh) you'd be like 'ahhh okay' there maybe something we might have not thought about doing it that way
	9: 250-253	look at it from a little bit of a different perspective and put it in that view that we're like 'oh, yeah okay' and it gets XXXX thinking as well and it's like

		'oh yeah we could try'
	29: 864-866	she's a lot more open to change (R- Okay) not major change, we can't as I say can't change anything major but she's open to different options
Enabling a comfortable environment		
They were totally informal	2: 50-57	It was basically totally informal (R- Hmmm). Erm, it was literally, [lead therapist] had a chair sort of (pause) a bit like we're sitting now, there wasn't like the main chair was there and we were all, it was just basically, totally informal (R- Okay) just seated around (R- Uhuh), you know it, you know [lead therapist] was taking notes (R- Yeah) and things as were we (R- Okay). So but it was totally informal.
	19: 542-546	You know, but with these meetings because it was so informal (R- Okay) and it was very you know, staff were there, it was relaxed, there was no confrontation (R- Hmmm). It was in a total neutral environment as well (R- Okay), it wasn't in XXXX's home, wasn't in our office
	22: 650-656	But she wasn't, she actually (R- Hmmm) you know was quite, I think because it was sat down, very calm, we all had a (R- Yeah) chance to say, if [family member] didn't agree with something we would then come back and be 'well okay (R- Hmmm), the reason we do this is because this, this, this and this' or and 'also this is what XXXX wants'
Nothing was too small	24: 714-718	You know erm but yeah no I, I seriously do think they're a good idea in the fact you can sit there, you can talk about every aspect and it's all you know none of it is stupid, none of it, there's no (R- Hmmm) that whole thing it's not a stupid question.
Enabling SU's voice	6: 155-159	Yeah it was, obviously it was all centred around XXXX, it's all person-centred (R- Yeah). So erm XXXX was very going over, as I say she's got a board (R- Hmmm), that's like things she likes, things she doesn't like, what she'd like staff's support with.
	7: 201-212	it's sort of going in when, and when we have family meetings but this included XXXX 'cause it was about her (R- Okay). You know (R- Hmmm) so I think that was the main thing that she felt that she was included in every part of her care (R- Hmmm). You know we're not sort of [family member] and staff are talking about it or (R- Hmmm). Do you know what I mean? (R- Hmmm) And it was basically centred round XXXX, XXXX was in the middle and it was up to her to put out those things that she wanted this done or that done, and we work with her as much (R- Yeah) as we can (R- Yeah) to get you know as and what she wanted
	22-23: 656-659	So which is the main benefit of this (R- Yeah) for what they want, it's not what we want or what families want it's what the person we support (R- Uhuh) wants
	12-13: 358-366	you know she sort of seems more open, she's spoke a lot more (R- Okay, uhuh) in the meetings and she was quite sort of verbal, which she is normally (R- Uhuh), but you know she is very erm (pause), she was very honest in what she said (R- Hmmm) and was quite happy to talk about it as she was after (R- Okay). I think it makes her feel a little bit better (R- Hmmm) it's like she sort of can go and vent all her issues (R- Uhuh) and then we come back and it's like 'okay'

Appendix Q: Master table of themes for the group

Superordinate Themes	Subordinate Themes	Anne	Andrew	Lucy	Emma	Susie	Karen	Jenny
Not knowing what to expect; it was something different	Uncertainty about the process	✔	✔	✔	✔	✔	✔	✔
	Making sense of who they are for and who should attend	✔	✔	✔	✔	X	✔	✔
Our relationships improved	From difficult relationships to more open communication and working together	✔	✔	✔	✔	X	✔	X
	Enabling understanding from another's perspective	X	✔	✔	✔	✔	✔	X
	Valuing gains from sharing of information	✔	✔	✔	✔	X	✔	✔
	Enabling consistency was important	X	✔	✔	✔	X	✔	X
An outside person shone a new light enabling us to think and work differently	An outside person enabled us to think outside the box	X	✔	✔	✔	X	X	✔
	Valuing learning and putting it into practice beyond the explicit	✔	X	✔	✔	X	✔	✔
Making sense of what we have achieved	Making sense of the outcome: Uncertainty Vs it helped us all	✔	✔	✔	✔	X	✔	✔
	Some factors out of our control got in the way	✔	✔	X	X	X	X	✔
They made us feel validated	Feeling validated	✔	✔	✔	✔	✔	✔	X
	Appreciating the SU's voice being enabled	X	X	✔	✔	✔	✔	X
	An opportunity to talk	X	✔	✔	X	✔	✔	✔

Appendix R: Reflective Journal Extracts

This appendix contains shorts extracts from my reflective journal that I kept during the research.

Reflections following interview with P3

… The participant was reflective wondering whether he would have preferred actions and goals because of his personality. He seemed to appreciate different ways of doing things but also be able to express his own view which was really helpful.

Something that struck me was how attentive the lead therapist was in his consultations – even noticing when someone nodded their head. It seemed the inclusivity of everyone in the meeting was really helpful for the participant.

The participant was very professional in his manner and I do wonder if that had some effect on what he felt able to share in the interview or not. I asked about his experience of the interview after and he felt it was good, it flowed. The only thing he was nervous about was the audio recorder at first and then he later forgot it was there. I wonder whether I should explain this a bit more in future interviews…

Reflections whilst analysing P4's transcript

…What is coming up in the P4's experiences is a dilemma (p28-29) of whether the SU should attend SCs or not. I wonder if this is also reflected in my own dilemma of whether SUs should give consent for their care staff to participate in the research or not. This question seems to also come up within different contexts of clinical work like whether SUs should be invited to meetings, SCs, or whether the service can work with the network if the SU does not want help from services etc…

Reflections whilst analysing P6's transcript

…The P talks about coping with the emotional impact of the SCs as not understood and seen as unimportant. This makes me think of wider societal values of 'doing'- getting things done and the continued focus on this rather than stepping back and assessing your emotional state and reflecting on things. This feels unfair. In my position as Psychologist, we are more tuned into the impact of emotional experiences and have a really good support network and supervision. This is different to support staff who may deal with emotionally upset day to day but have a lot less time to process this. Perhaps that is why some staff partly feel that the space for the SCs are helpful as it does provide that time and space to think things through – reflect and process things with others who may share similar experiences…