Comprehensive Care

Partnerships in Care and Communication

Queensland Mental Health Alcohol and Other Drugs

Resource Guide: Formulation 2020

Comprehensive Care Resource Guide: Formulation

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About this Resource Guide

From 2018 through 2020, various Hospital and Health Service (HHS) and Mental Health Alcohol and Other Drugs (MHAOD) service staff worked with the MHAOD Branch on standardising comprehensive care processes to enable improvement to service delivery and documentation, with a particular focus on *Assessment (including Screening), Formulation (including Diagnosis), Care Planning and Care Review*.

An emphasis on these comprehensive care processes, through standardisation of approaches, can assist individual staff and other service providers in providing care and also supports teams and services in monitoring and improving care. Standardisation will also enable greater involvement of consumers and carers in monitoring their own health and care processes, strengthen communication for safety and facilitate strategic planning and delivery of training and digital health applications to support clinical practice, optimising use of the Consumer Integrated Mental Health and Addictions (CIMHA) application and Mental Health and Addiction Portal (MHAP) capability.

This guide provides recommendations and examples of evidence-based and evidence-informed approaches to **formulation**.

- Background and overarching information (e.g. purpose, target audience, scope, principles of comprehensive care, cultural considerations) is provided here. Please read this prior to reading the specific resource guides.
- A resource guide for care planning is provided here.
- A resource guide for care review is provided here.
- A case example of comprehensive care is provided here.

Formulation

Formulation is a core element in the delivery of high-quality comprehensive care to our consumers. Formulation helps to make sense of evolving information through the consumer journey through the development of hypotheses that can then guide care planning. It has also been noted to generate empathy for the consumer (McGee, 2016).

Formulation: A definition

The term “formulation” describes both the process and its written output.

Formulation is used to promote as full an understanding as is possible of the challenges a person is currently presenting with. It should take a longitudinal perspective, understanding the relationships between their historical and current contexts, causative and maintaining factors, and may include various risk domains. It integrates this with clinical knowledge and evidence informed theory.

Formulation attempts to explain **why** this is happening, **to this person, now**. It takes the data set (history and mental state examination (MSE)) and turns it into a **set of hypotheses**. Therefore, formulation helps staff to understand and explain to others, not just what is happening but why.

In order to create a shared working hypothesis, it should be co-produced with the person (and their carer when appropriate) and incorporate a multidisciplinary approach wherever possible. Identification of the person’s strengths, supports systems, recovery goals and needs are integral to inform and guide future care planning. It should be regularly revisited and revised as a person’s context changes or additional information becomes available.

Approaches to Formulation

A range of approaches to formulation exist, each with slightly different areas of focus, as well as different models for understanding a person's difficulties. Broadly, these approaches can be classified as either theoretical or atheoretical.

Theoretical

- Are based on specific psychological theories.
- Examples include Cognitive Behaviour theory (CBT), Schema theory, Acceptance and Commitment theory, Systems theory, Psychodynamic, humanistic/strengths based theory, cross-cultural theory.
- Some disciplines align particularly to theoretical models.

Atheoretical

- Have a systematic structure but are not based on a specific theory.
- May be useful in assisting staff make links between important aspects of a consumer's presentation.
- Accessible to broader range of conditions.
- The staff may draw on theoretical conceptualisations to add depth.
- The 5Ps is an example of an atheoretical approach.

Principles of Formulation

As outlined in Principles of Comprehensive Care (see Principles of Comprehensive Care within the Resource Guide Introduction Document), principles of formulation include: Comprehensive, Concise, Person Centred, Evolving, and Flexible based on setting.

Development of a Formulation

Formulation occurs at various points in the consumer journey. It has important interactions with Care Review and Care Planning.

Formulation informs and supports Care Planning ensuring care plans are based on the best possible understanding of the consumer's presentation and needs. These are reviewed at Care Reviews, where the team can then further reflect on, contribute to and develop the formulation and care plan.

Information from assessment, formulation, care planning and care review is captured progressively in a Longitudinal Summary.

Consumer perspective

A formulation is a hypothesis or theory. When you are reasonably sure of your formulation, try offering it as an interpretation and invite the person to respond and revise the formulation if they would like to.

Initial Formulation

- Everyone entering a service should have some form of formulation which may be brief and crisis focused on the first assessment, but may expand as more is known and understood about the person, and as they proceed along their recovery journey.

Care Planning

- Formulation informs the care planning process.
- By understanding why this is happening now, more specific and consumer informed plans can be formed.
- Sociocultural considerations should be included in the overall formulation and inform the care plan.

Care Review

- Within Care Review, formulation provides a concise, synthesised way of conveying key aspects of the consumer's presentation and issues to the team which assists in identifying areas of focus for discussion and Care Planning.
- The Care Review process can also facilitate multidisciplinary development or refinement of the formulation.

Review of Formulation

Review of formulation should be triggered by:

- Important new information being presented
- Significant changes in presentation or risk
- When progress is not being made
- When outcome measures are showing a decline
- When the person requests it
- Care Review
- Transfers of care, including exits.

Second Opinions

- Second opinions should ideally use the existing formulation as a point of reference, and further develop this, or identify points of difference. This process should then be followed by team review of formulation.

Longitudinal Summary

- The Longitudinal Summary contains a section for formulation. Summarised information in the Longitudinal Summary should be synthesised into the formulation.

Documenting the formulation

The formulation may be documented in a variety of places depending on the setting and time point in the patient journey. Specific CIMHA documentation that includes sections to document a formulation include:

- Focused Assessment
- Focused Assessment plus substance use
- Child and Youth Mental Health Assessment
- Comprehensive Assessment
- Longitudinal Summary
- Care Review
- Transfer of Care

CIMHA has the ability to import a previously documented formulation from one of these forms into another, for review and updating with further information.

For example, a formulation created in a Focused Assessment may be imported into a Care Review form to avoid duplication, and to ensure a shared understanding by the multidisciplinary team. The Care Review process may further enhance the formulation from an MDT perspective.

Consumer perspective

A diagnosis says very little about us as individuals, and nothing about the context and impact of our difficulties. Unlike diagnosis, formulation is not about making an expert judgement but about developing a shared understanding of our experiences. It is not based on deficits but draws attention to

Consumer perspective

Formulation is an ongoing process of understanding and so its ongoing development should continue to be made in conjunction with the consumer, including their opinions, goals and understanding over time.

In order to maintain consistency, the formulation, as developed, should be uploaded into the Longitudinal Summary. It is important to ensure that previously documented formulations are reviewed for suitability when imported to more contemporaneous documentation. Where information or our understanding of the consumer's problems have changed, the imported formulation should be updated.

Flowchart of Process and Documentation

Initial Formulation

- Initial assessment, screening, including risk, MSE, Diagnosis. Collateral history obtained.
- Clinician formulates an understanding of what is happening based on the information available in conjunction with the consumer (where possible).
- Formulation is saved in the **relevant assessment document** and must be entered into the **longitudinal summary** for those receiving ongoing care.

Care Planning

- Formulation informs the care plan by focusing on why this is happening rather than just what is happening (symptoms and diagnosis). Identifying areas of initial care delivery focus.
- The **Care Plan** document is shared with relevant others - consumer, carers, family, other care providers.

Care Review

- The MDT discusses the formulation and Care Plan, providing MDT expertise, opinion and theory to further develop the formulation and care plan.
- Involvement of the consumer and family/carers wherever possible.
- The outcome of the care **review**, including the **updated formulation and care plan** are shared with the consumer, their carers, and other healthcare providers.
- The Care Review document is saved and shared as appropriate, and the updated formulation is included in an updated version of the **Longitudinal Summary**.

Review of Formulation

- Change in presentation / setting / lack of progress / consumer need prompts the need to re-think the understanding of what is happening.
- Formulation is reviewed by the clinician with input from consumer, carers, the MDT and other healthcare providers as appropriate.
- **Second opinions, Complex Care Reviews, Ad hoc care reviews** may support this process.
- The **Longitudinal Summary** is updated and the updated formulation is shared with the consumer as appropriate.

Consumer Information

Clinicians developing the formulation collaboratively with the consumer can assist in the development of the therapeutic alliance and in enhancing engagement through greater ownership of the formulation by the consumer. To facilitate this collaboration, consumers may therefore benefit from greater health literacy about the formulation process.

The linked handouts, Formulation guide for consumers and Formulation guide for consumers brief may be further developed by local services and given to consumers and/or carers to support their understanding and engagement in the formulation process. While clinicians may feel it most appropriate to give information verbally, two versions of written information are provided, with different levels of detail. These can be used as appropriate for individual consumers' needs.

The format used to share formulations may vary depending on a range of issues, including staff preference. Sharing of the formulation may occur verbally, or using one of the forms that captures formulation, such as Care Review. It could also be copied and pasted into a word document.

If consumers are given written information that may be confronting, raise strong emotions or be potentially traumatic, the clinician should read it through with them, giving them a chance to reflect and digest it in a supported way, where they feel able to give feedback and check their understanding.

The linked handout *Collaborative Formulation – Tips for Clinicians* provides some support for enhancing a collaborative approach to formulation development and sharing.

Consumer perspective

If a written formulation is developed and given to the person, It should centrally be concerned with the person's own meaning and therefore, wherever possible, the person's own language should be used.

Formulation – from a Lived Experience Perspective

I'd been in the mental health service for 11 years before I had therapy and had attended countless appointments with various mental health professionals. Each appointment with someone new started the same way. I'd be asked what was wrong, how long I'd had my "symptoms" and what treatment I'd been given. I'd be asked questions about my past, my family, my lifestyle and my thoughts.

For years, I had no understanding of what was "wrong" with me. Even after my diagnosis was shared with me, I had no idea why I was doing things that left me feeling ashamed, embarrassed, guilty and out-of-control.

Therapy seemed to start in much the same way as the other appointments. I talked about myself and my jumble of experiences in the same detached and disconnected way I'd talked countless times before.

What made these sessions different was that the clinician wanted to hear about how I had experienced certain events and what sense I'd made of them. She asked me how I felt about things and how I explained things to myself. She gently helped me to start building some order out of my confusion and lack of understanding about certain events by pointing out links between my thoughts, feelings, behaviours and symptoms.

Continued over page

Whenever she proposed an idea about how certain symptoms or behaviours may have developed, she was always curious to know whether I shared the sense she was making of my situation or whether I had a different explanation. It felt like we were detectives, working together to solve a puzzle.

Sometimes things didn't fully make sense or were hard to hear. That was OK though because I felt safe and secure enough to ask questions or to disagree. Trust and relationships were really hard for me so the process of telling my story and having it reflected back to me in a useful and explanatory way was very much part of the healing process.

After four sessions, the clinician I'd been seeing gave me a copy of her formulation which she read to me. I was surprised about how detailed it was; she'd remembered so much of what I'd said. It was so powerful. For the first time in my life, I felt heard and understood. The formulation offered me a new perspective on my difficulties and gave me the strength and courage to recover, supported by someone who I knew could really help me.

Although the formulation made sense and was sensitively written, it was hard to read. It was painful to see my life written out on paper. I had a strong, emotional reaction to one part because it made it real when I didn't want it to be real. That wasn't easy but it meant that I was gradually able to think about it and slowly come to terms with it. The experience helped me learn to deal with some really complex emotions.

Having the formulation on paper was comforting. When I felt low, I'd re-read it and I could hear it being read. It reminded me that someone cared about me and provided me with an alternative, more compassionate understanding of myself to counter to the negative voices in my head. It kept me going so many times.

I still re-read that formulation from time to time. It helps remind me now how far I've come.

Guides for Formulation

This Formulation resource guide contains a number of approaches to formulation. These are not meant to be prescriptive but are aimed at prompting staff to guide them in constructing succinct and synthesised formulations, and in helping improve staff confidence and skills in completing formulations.

They are presented as options that may assist staff in various settings or points of time in a patient journey. A service or area of a service (e.g. subspecialty area) may choose to adopt a particular model so that the teams can be supported through training and supervision to refine their skills in formulation.

Presentation of theoretical approaches to formulation are outside of the scope of this resource, which focuses on two specific examples of atheoretical approaches and a Multidisciplinary formulation.

Outlined are the 5 Ps Formulation and Integrated Formulation which both represent an atheoretical structure for formulation.

Finally, a Multidisciplinary Formulation Approach is described. This approach can be employed in conjunction with either of the above structures proposed, or with an alternative formulation structure (e.g. theoretical), and this approach is particularly useful within a Care Review setting, such as when discussing consumers with complex presentations and needs, where there is more time for the MDT to engage in this collaborative process of formulation. While this process is aligned with a care review process, the focus is

very much on the development of a formulation, including a supportive process to engage staff to refine their skills in formulation.

Formulations aim to understand the individual within their context and journey better, and to identify prioritised areas of focus for **Care Planning**. The Care Planning resource guide provides a useful framework of domains to consider in the Care Planning process.

Examples of completed CIMHA documentation have been provided with a fictional history of a consumer named "Sandra", with examples of approaches to formulation, care planning, care review and longitudinal summary.

The 5Ps Formulation

The 5Ps approach (Weerasekera, 1996) is an atheoretical approach to formulation. Most staff will be familiar with this and may have had experience of using it. It is not discipline specific and is atheoretical, therefore staff can use a variety of explanatory models based on their knowledge and experience. Its relative simplicity allows for use in more acute settings, however it can be used in any setting, and can be built upon as further understanding of the consumer is gained. Staff may draw on theoretical conceptualisations, if desired, to add depth.

The 5Ps highlight an approach that incorporates Presenting, Predisposing, Precipitating, Perpetuating, and Protective factors to a consumer's presentation.

The formulation is developed through a process of reflection on the data collected (e.g. history, mental state examination, collateral, diagnosis, risk screening, and other screening processes/tools).

Collaboration with the consumer in development and a feedback process are ideal where possible.

Following formulation, there should be an identification of the prioritised areas of focus for care – to inform the Care Plan.

The following pages describe two approaches to documenting the formulation using the 5Ps structure, including a narrative and flowchart.

An Alcohol and Other Drugs Service (AODS) specific example is found in "A Case in Point" developed by Insight: Centre for alcohol and other drug training and workforce development.

A Narrative Approach Using the 5Ps Structure:

Presenting Issues	Describe the person first – who are they, demographics, what is their role/ job/ interests/ cultural background. Briefly summarise reason for entering the mental health alcohol and other drug service, referral source and list of current problems, (including psychological, social, cultural, health, legal, accommodation and financial problems), diagnoses (including comorbidities), prominent symptoms, prominent aspects of mental state examination and known risks of all kinds. Include recent/ present suicidal ideation or behaviour. Include any significant negatives.

Predisposing (or background factors)	These are issues in the consumer's childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health and other difficulties. Includes historical events and biopsychosocial factors that increases the likelihood (or risk) of the consumer developing social, emotional or behavioural difficulties. Consider developmental, family history and relationships, psychological and functional issues, social problems, substance use (patterns of use, associated behaviours), and history of illness and response to treatment/interventions (e.g. age of onset, reasons for diagnoses, suicidal behaviours, aggressive behaviour and forensic history, past complications, past treatments and response, reasons for and length of admissions and significant community-based treatment episodes).
Precipitating factors (or triggers)	These are the factors or key onset events that have brought the consumer's difficulties to the surface and resulted in them accessing treatment. Consider how and why these factors have affected the presentation. Consider biological, psychological and social factors. Consider if specific risks such as loss of status, feeling defeated/ humiliated/ trapped/ burdensome/ provoked in response to events.
Perpetuating (or maintaining) factors	These are the factors in the consumer's life, behaviour, beliefs and psychological state that maintain the presenting issues or cycles of behaviour.
Protective Factors	Captures both individual and systemic strengths that exist alongside the presenting issue. These are the consumer's strengths and resources that offer hope and promote resilience, which may include family support, stable accommodation, school, vocational, employment history, medication compliance, resilience, coping style and problem solving. Include consumer's goals - describe how the patient understands the current situation and presentation, what do they want now and what are their goals to work towards.
Further considerations	Gaps: Outline significant gaps in the history and how these may affect your impression/ plan. Reflect on what need to be the areas of focus for care planning.

Flowchart Approach to Five Ps Structure – Highlighting Factors

Predisposing Factors (Issues in the consumer's childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health and other difficulties.)

- **Psychological Factors:** Conduct, Emotional, Specific learning disabilities, Positive beliefs about drug use, Risk taking and sensation Seeking, Difficult temperament, Low self-esteem, External locus of control.
- **Parent-child factors in early life:** Attachment problems, Inconsistent parental discipline, Lack of Intellectual stimulation, Authoritarian, Permissive or Neglectful parenting.
- **Exposure to family problems in early life:** Parental alcohol and substance harmful use, psychological problems or criminality; Marital discord or violence, family disorganisation.
- **Stresses in Early life:** Bereavements, separations, child abuse, social disadvantage, institutional upbringing, trauma.

Precipitating Factors (Factors or key onset events that have brought the consumer's difficulties to the surface and resulted in them accessing treatment)

- **Biological** – physical health problems, side effects, medication adherence, substance use, acute / chronic pain.
- **Psychosocial** - Acute life stresses, Illness or Injury, child abuse, bullying, births or bereavements, lifecycle transitions, changing school, loss of peer friendships, separation or divorces, parental unemployment, financial difficulties. Availability and curiosity about drugs, peer pressure. Consider meaning of the stressors (e.g. defeat, humiliation, burdensomeness, humiliation).

Presenting Concerns

- Description of the person.
- What is the key issue or problem?
- Why have they presented now?

Perpetuating Factors (Factors in the consumer's life, behavior, beliefs and psychological state that maintain the presenting issues or cycles of behavior.)

- **Biological** – physical health problems, side effects, medication adherence, substance use, acute / chronic pain.
- **Behavioural** – Academic / vocational problems, Involved in justice system, Positive beliefs about substance use, Sensation seeking and risk-taking, Low self-efficacy, Dysfunctional coping strategies
- **Family / Parental factors** - Depressive or negative attribution style, Family history of dysfunctional coping strategies. Parents / family model or reinforce substance use, positive attitudes to drug use /tolerating drug use, Disengaged interaction and neglectful parenting, Father absence, Marital discord.
- **Social Network Factors** - Poor social support network, High family stress, Social disadvantage, High crime rate, Few employment opportunities, Lack of coordination among involved professionals.
- Ongoing availability of substances, member of drug using peer group.

Protective Factors (Both individual and systemic strengths that exist alongside the presenting issue.)

- **Biological factors** -Good physical health
- **Psychological factors** - High IQ, Easy temperament, High self-esteem and self-efficacy, Internal locus of control, Mature defence mechanisms, Functional coping strategies
- **Family / Parental factors,** Family support, secure parent-child attachment, clear family communication and flexible family organization; Family has coped with similar problems before, Secure parent-child attachment, Clear family communication and flexible family organisation, High marital satisfaction, Good parental adjustment , Accurate knowledge about substance use , High parental self-efficacy and self-esteem, Functional coping strategies
- **Social network factors** - Good social support network, Low family stress, Positive educational placement, High socioeconomic status, Good coordination among involved professionals.

The Integrated Formulation

The Integrated formulation builds on the familiarity of the '5Ps', with the aim of specifically integrating that

structure with a number of other important aspects of formulation including:

- A more strengths-based approach
- Integration of the consumers' goals into the formulation
- A pause to reflect on the data gathered (static and dynamic factors) during risk screening and documented in the Risk Screen form. In addition to the central consideration of static and dynamic factors, reflections should also include consideration of the meaning of the events for the consumer, for example for suicide - humiliation, social defeat, entrapment, thwarted belongingness, or burdensomeness; and for violence the loss of status, or feeling provoked or humiliated.
- Embedding an overt consideration of Diagnosis (or Provisional Diagnosis), with a prompt for a 'pause point' (reflection) to specifically challenge cognitive bias. This prompts consideration of a range of differential diagnoses (Mental Illness, Substance Use, Personality Disorder, Physical Illness, Cognitive Impairment).
- Integration of a 'Risk Formulation' (the Prevention Oriented Risk Formulation (Pisani, Murrie and Silverman, 2016) into this broader formulation. Furthermore, multiple domains of risk (e.g. Suicide, violence, vulnerability) are integrated into the one formulation.

  Many MHAOD services across Queensland have adopted the Prevention Oriented Risk Formulation ('Risk Formulation') as part of a suicide prevention pathway, that moves away from a categorical approach to risk (high, medium, low) to conceptualising risk in relative terms, depending on clinical context **(risk status**), and also relative to the consumer's own baseline level (**risk state**). It focuses on the development of an individualised care plan that takes into consideration these relative risks and possible future changes in this risk in response to events (**foreseeable changes**) and what mitigations can be put into place within **available resources** (internal and social strengths). Specific training in the 'Prevention Oriented Risk Formulation' for suicide risk, is provided in the following courses through the Queensland Centre for Mental Health Learning (QC2 Engage, Assess, Respond to, and Support Suicidal People (EARS), QC28 Youth: EARS (Y:EARS) – eLearning component Module 4, and QC30 Violence Risk Assessment and Management – eLearning component Chapter 3).

  A major driver of the Integrated Formulation was to provide a practical approach to give staff clearer guidance on integrating this frequently used 'Risk Formulation' within the broader formulation.

How to use this Guide

1. Reflect on the data you have collected – the history, MSE and collateral. Document your data in the consumer assessment/ medical review/ care review as usual. Try to keep the history simple – the data only, keep reflection on it for the formulation (avoid duplication).
2. Try to make sense of the data by thinking about why this has happened to this person at this time.
3. Use the 'Integrated Formulation diagram' to guide you through the formulation. Work your way down the left-hand side of the guide. There are prompting questions in each section to guide you to reflect on the data you have.
4. Consider the 'prompts to reflect' to ensure that you reflect upon – diagnosis, risks, gaps, and counter-transference.
5. Enter your risk assessment in the standalone Risk Screen form. Reflect on the information in the

Risk Screen before embarking on the Risk Formulation section.

6. Document your formulation in the relevant form (assessment/ care review/ longitudinal summary).
7. Add your formulation to the longitudinal summary for the consumer (if relevant).
8. Try to collaborate with the consumer where possible to both create and then share the formulation.
9. Integrated formulation table – is provided with and without prompts if you prefer to complete your formulation in a table and then paste into your clinical document.
10. Once the formulation is completed, reflect on the areas of focus for care planning for the consumer. Take into consideration the consumer's goals as part of this consideration.

Notes:

1. The greyed out 'Reflection' sections do not require documentation.

2. In terms of assessment of violence, the above process represents Tier 1 of the Violence Risk Assessment and Management (VRAM) framework. Consideration will need to be given as to whether a more comprehensive assessment of violence risk is undertaken in line with the three-tier framework.

An example formulation is attached (see A case example: "Sandra") as an example of the type of output you might produce. The detail and length of formulation will depend on the setting you work in, your experience, your discipline, existing preferences for model of formulation and time limitations (e.g. those in an acute setting may have less time to form a detailed formulation).

Integrated Formulation Table with Prompts

Person Describe the person first – who are they, what is their role/ job/ interests/ cultural background
Presentation Describe the clinical presentation including: Demographics, reason for entering the mental health alcohol and other drugs service, referral source and list of current problems, diagnoses (including comorbidities), prominent symptoms, prominent aspects of mental state examination and known risks of all kinds. Include recent/ present suicide ideation or behaviour.
"This has occurred in the context of…" **Precipitating Factors -** Describe the recent triggers or events that have exacerbated the problem, how and why these factors have affected the presentation e.g. **Biological** - Mental Illness, Substance Use, Physical Illnesses, Medication adherence. **Psychological -** Coping mechanisms, losses, loss of status, response to events – feeling defeated/ humiliated/ trapped/ burdensome/ provoked. **Social / Cultural aspects-** Housing, employment, finances, access to healthcare, isolation, relationships, culture, availability / curiosity about drugs.
"This is on the background of…" **Predisposing factors and Patterns of Symptoms and behaviour over time-** Describe how and why the consumer's lifetime experiences have contributed to the development of the current problems e.g. **Developmental Factors -** Problems during birth/ development/ attachment/ childhood/ trauma history. **Family History and Relationships –** Family history (genetics)/ family relationships/ family response to illness or problems; parental substance use.

Psychological and functional issues - Development of coping style, interpersonal problems, social skills deficits; functional/ cognitive problems and their impact on illness and health seeking behaviour; drivers for substance use/ impulsivity/ self-harm; positive beliefs about substance use.

Social Problems - Housing, employment, finances, access to healthcare.

Substance use – Patterns of use, associated behaviours.

History of illness and response to treatment/ interventions – Age of onset, reasons for diagnoses, suicidal behaviours, aggressive behaviour and forensic history, past complications, past treatments and response, reasons for and length of admissions and significant community-based treatment episodes.

"Some of the issues perpetuating the current issues/ illness include . . ."

Perpetuating factors - Describe the potential contributors that maintain the problem or may worsen the problem if not addressed, such as insight, personality style/vulnerabilities, co-occurring conditions and substance use, employment status, lack of social supports, substance using peer group; family attitudes, beliefs and behaviour with respect to substance use.

"The Strengths of the consumer include . . . "

Strengths and Protective Factors – Describe the Internal resources and external supports that can be drawn upon to improve their illness outcomes e.g.

family support, stable accommodation, school, vocational, employment history, medication compliance, resilience, coping style and problem solving.

"The main issues and drivers identified by the consumer are . . ."

"The goals of the consumer include . . . "

Describe how the patient understands the current situation and presentation, what do they want now and what are their goals to work towards.

"**There are some gaps in the current information which will be important to follow-up on . . ."**

Outline significant gaps in the history and how these may affect your impression/ plan.

Reflection: Consider Risk Screen form and Reflective Questions.

Consider enduring and dynamic factors and reflective questions. (Document on Risk Screen form)

Reflection: Consider Diagnosis – document in appropriate section on form for Diagnosis.

Consider all diagnoses– mental illness, substance use, personality disorder, physical illness, cognitive impairment.

Consider possible differential diagnoses.

Risk Status- Consider risk compared to others in the current treatment setting and the treatment setting being considered. Also consider risk relative to the general population.

Provide examples and explain why you have come to these conclusions (this will be influenced by more enduring factors, as well as some dynamic factors).

Include Suicide, Violence, Vulnerability, Disengagement / AWA, Child Safety.

NB. The risk state may be higher than the population in the treatment setting being considered if there are adequate available resources and foreseeable changes can be mitigated.

Risk State – Risk relative to self at baseline or selected time period.

Give examples / rationale; Include Suicide, Violence, Vulnerability, Disengagement / AWA, Child Safety.

Available Resources – Internal and social strengths to support safety and treatment planning.
Foreseeable Changes – Changes that could quickly increase (or decrease) risk state.
Reflection: Given the above, consider the Areas of Focus for Care Planning.

Integrated Formulation Table without Prompts

Person
Presentation
Precipitating: "This has occurred in the context of…"
Predisposing: "This is on the background of…"
Perpetuating: "Some of the issues perpetuating the current issues/ illness include . . ."
"The Strengths of the consumer include . . . "
"The main issues and drivers identified by the consumer are . . ." **"The goals of the consumer include . . . "**
"There are some gaps in the current information which will be important to follow-up on . . ."
Reflection: Consider Risk Screen form and Reflective Questions. Consider Enduring and dynamic factors and reflective questions. (Document on Risk Screen form)

Reflection: Consider Diagnosis – document in appropriate section on form for Diagnosis. Consider all diagnoses– mental illness, substance use, personality disorder, physical illness, cognitive impairment. Consider possible differential diagnoses.
Risk Status- Consider risk compared to others in the current treatment setting and the treatment setting being considered. Also consider risk relative to the general population.
Risk State – Risk relative to self at baseline or selected time period.
Available Resources – Internal and social strengths to support safety and treatment planning.
Foreseeable Changes – Changes that could quickly increase (or decrease) risk state.
Reflection: Given the above, consider the Areas of Focus for Care Planning.

Integrated Formulation Guide

Person and Presentation

Describe the clinical presentation including:

demographics, reason for entering the mental health service, referral source and list of current problems, diagnoses (including comorbidities), prominent symptoms, prominent aspects of mental and physical state and known risks of all kinds. Include recent/ current suicide ideation/ behaviour.

"This has occurred in the context of…"

Precipitating Factors - Describe the recent triggers or events that have exacerbated the problem, how and why these factors have affected the presentation.

Biological - e.g. Mental Illness, Substance Use, Physical Illnesses and Medication adherence.

Psychological- e.g. Coping mechanisms, losses, feeling defeated, humiliated, trapped, provoked, burdensome

Social- Housing, employment, finances, access to healthcare, isolation, relationships, loss of status

"This is on the background of…"

Predisposing factors and Patterns of Symptoms and behaviour over time- Describe how and why the consumer's lifetime experiences have contributed to the development of the problems.

Developmental Factors - Problems during birth/ development/ attachment/ childhood/ trauma.

Family History and Relationships – Genetics/ family history and relationships/ family response to illness/ problems.

Psychological and functional issues - Development of coping style, interpersonal problems, social skills defects; functional/ cognitive problems and their impact on illness and health seeking behaviour; underlying drivers for substance use/ impulsivity/ self-harm.

Social Problems and substance use - Housing, employment, finances, access to healthcare, Substance use pattern, associated behaviours.

Perpetuating factors

Strengths and Protective Factors

Describe the internal resources and external supports that can be drawn upon to improve their illness outcomes such as family support, stable accommodation, school, employment history, medication adherence, resilience, coping style, problem solving.

Main issues/ drivers/ goals identified by consumer

Describe how the patient understands the current situation, what they want now and their goals to work toward.

Gaps

Outline any significant gaps and how these may affect your impression/ plan.

Risk Screen form
Complete form while considering reflective questions.

Consider all areas of risk.

Consider diagnoses and differential diagnoses

Include co-morbidities –Mental Illness, Substance Use, Personality, Physical, Cognitive Impairment.

Complete appropriate section of form.

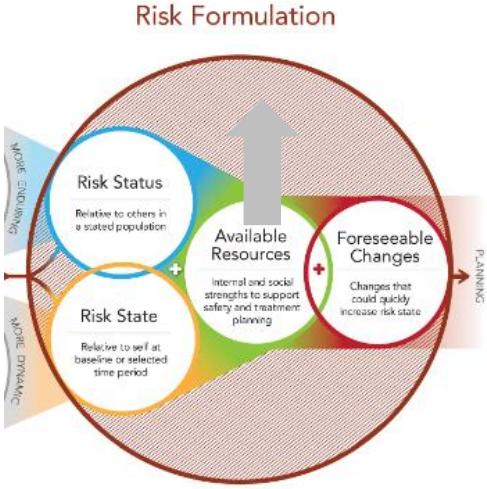

Image from Pisani et al (2016).

Pause to think

- What information is missing that might change my impression?
- How do I feel about this person and could this be influencing my impression?
- In addition to review of Risk Screen for suicide, violence, vulnerability and treatment non-adherence, reflections should also include consideration of the meaning of the events for the consumer, for example for suicide - humiliation, social defeat, entrapment, thwarted belongingness, or burdensomeness; and for violence the loss of status, or feeling provoked or humiliated.

The Multidisciplinary Formulation

The MDT Formulation Process guides teams on how to come together to generate a formulation informed by the various members of the team. This has been found to be very helpful in situations including complex

care reviews, rehabilitation or extended care settings or complex presentations that may require extensive multidisciplinary involvement. It has also been found to be a supportive process in which to build confidence and skills in formulation amongst the MDT.

The focus of the Multidisciplinary Formulation is the **process**, rather than mandating any particular structure to the output, however a service could certainly use this process in conjunction with their choice of a standardised way of documenting formulation such as the 5Ps or Integrated Formulation.

The Multidisciplinary Formulation process seeks to engage all members of the multidisciplinary team to contribute their unique perspectives and understanding of the issues. By achieving this, the "sum will be greater than the parts", and a rich understanding of the issues will be developed, and then this explicitly leads to care planning, which respects the contributions of all members of the team and assigns roles and responsibilities for the relevant staff.

Principles include safe and respectful, recovery oriented, strengths-based, evidence-based, flexible, curious and reflective, person centred and holistic, inclusive and collaborative.

Given the time taken for this approach, it will be most suitable for situations such as Complex Care Reviews or Extended Treatment and Rehabilitation settings. When used it can greatly add value to the engagement and cohesion of the team, ensuring all members feel heard and are able to actively contribute to a shared understanding of the issues and plan going forward. This can then assist in clear and consistent communication with consumers, carers and other teams. Opportunities to engage with the consumer and carers in the development of the formulation can then add further to this process.

The documentation of the output of this process should be included in the relevant formulation sections of the CIMHA forms, such as Care Review, and then included into the Longitudinal Summary.

The actions and interventions generated should be incorporated into the consumers' Care Plan.

Facilitating the Process

Essential roles include:

Facilitator: Facilitates the actions as described in the Agenda which follows and keeps the meeting on track with time and procedure and guide the reflective process. They ensure participation by all MDT members; validate the unique contributions of each participant and support the group to reflect on new ideas with openness and without fear of judgement of right or wrong.

Presenting Clinician: Completes actions as per Preparation Checklist and Agenda including preparation of summary, copy of documentation, presentation, upload summary into CIMHA following meeting and engage follow up actions.

Scribe: Documents the discussion and organizes/clusters information into key themes or grouping of ideas – represented visually for all members to see. Develops a written summary of the discussion and agreed actions for the presenting clinician to upload onto CIMHA including:

- Summary of information shared
- A set of collaboratively generated hypothesis statements
- A list of intervention ideas and opportunities
- An action plan including plans for feedback and review (incorporated into the Care Plan).

MDT Members: Each discipline to consider the case presentation through their own formulation and theoretical lens and contribute ideas on presenting issues, factors contributing to, maintaining and explaining the presenting issues. Members should engage fully in all aspects of the Agenda.

Multidisciplinary Formulation Agenda

Preparation Checklist

- Identify case for presentation e.g. new consumer; complex case; clinical case that would benefit from MDT input; a case clinician is feeling 'stuck' with etc.
- Who should be invited to participate?
- Presenting clinician - complete and document initial assessment and case summary (e.g. Focused Assessments, Substance Use Assessment, Psychosocial Assessment, Risk Screen, Longitudinal Summary, recent Care Review).
- Circulate any relevant information in advance.
- Identify Facilitator and Scribe.
- What resources will be needed?

Session Agenda

Welcome and Introductions:

- Who is present, from which team, what service and role

Overview of Process:

- Facilitator to clarify with the presenting clinician what specific area of input they would like from the team (i.e. what would you like the team to focus on/reflect upon?)
- Overview of agenda
- Safety set up – what are the group rules and expectations? Re-visit principles.

Case Presentation:

- Presenting clinician to provide a summary of the initial assessment findings and longitudinal history
- Presenting clinician to present their initial case formulation
- Facilitator: MDT to ask the presenting clinician any clarifying questions about the information presented.

Ideas Generation:

- Each discipline to consider the case presentation through their own formulation and theoretical lens and contribute ideas on the presenting issues, factors contributing to, maintaining and explaining the presenting issues
- Identification of strengths helping the consumer and family.

Hypothesis Generation:

- Each discipline to contribute their best guesses about what is going on
- Hypotheses can be grouped into themes.

Prioritisation:

- Which are the most important hypotheses to address?
- What would the consumer / family consider the most important?
- What would create the most change? What would be the easiest to change?

Intervention Planning:

- Match recommendations or intervention ideas to each of the hypotheses
- Identify goals, actions and roles and responsibilities - Identify which positions within the team are best placed to offer required interventions.

Closing:

- Facilitator summarises the MDT discussion, recommendations and agreed actions to close meeting.

Follow Up Checklist

- Has the session been documented and uploaded to CIMHA?
- Are there any post session contributions to incorporate from people unable to attend the formulation session?
- How are we going to proceed with implementation of actions?
- How will we share information, monitor and review outcomes?

Embedding the Formulation Approach within your Service

While both the process and content of formulation are essential to understanding a consumer's presentation, and the provision of appropriate, effective and individualised care, there are a number of challenges to the successful **completion** and **incorporation** of the formulation as routine practice across services. These challenges include time, skills, knowledge, attitudes and beliefs of clinicians and supervisors, availability of clinical information, availability of training and supervision, knowledge, skills and attitudes towards engaging with consumers in a collaborative formulation process, limited health literacy on the topic of formulation and lack of clarity around documentation and processes.

Local consultation, together with reference to literature (McGee, 2016), highlight a number of strategies that services can employ to embed formulation, including formulation-based care planning.

Establish clear expectations, standards, policies and procedures

- Include clear local processes regarding the consistent use of formulation in Care Reviews, Complex Care Reviews, Second Opinions, and at points of transfer across the service.
- Consider adoption of a particular approach to formulation in a service or area of a service, so that training and supervision may be targeted.

Take the long view

- Building skills and practices will take time.
- Supervisors and clinical leaders in the service can take frequent opportunities to reinforce expectations.
- Consider a stepped approach to increasing the use of formulation across the service.

Get system-wide buy in

- The merit of formulation is not usually contested, however there are many challenges to consistent completion. A shared understanding and commitment to an approach across a service, together with training and publications to support this will foster its progress.
- Identify opportunities to demonstrate that spending time will save time (e.g. better understanding of consumers' narratives, reductions in readmission rates).

Set up ongoing structures for training and coaching

- Recognise that skills develop over time, rather than being achieved through a one-off introductory session.
- Ensure training demystifies formulation so that all staff see it as a core skill.
- Consider the needs of the Peer Workforce and training for these staff.
- Embed in the Orientation of new staff and ongoing practice, training and supervision.
- Find opportunities to have clinical discussions that move on from recitation of clinical data to synthesised understanding of the consumer.
- Take every opportunity to highlight efforts to use formulation and provide positive feedback.

Create systems that optimize the continuity of the working formulation and the coordination of treatment

- Process of Formulation, Care Review, Care Planning, Complex Care Reviews and Second opinions should reinforce the ongoing development of the formulation, rather than starting from scratch. This should also be reinforced during internal transitions of care, and transitions into and out of the service.

References and Suggested Readings

1. Armitage, E. (2019). A Case In Point: A Queensland guide to alcohol and other drug clinical documentation and case formulation., Insight.

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Appendices

Appendix 1: Formulation Working Group

The development of this resource guide was led by Dr Kathryn Turner (Gold Coast HHS) with the following working group members:

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We also acknowledge the input by multiple teams across MH and AOD services in the state who undertook trials of the range of formulation approaches and provided valuable feedback which has informed the development of this resource.

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