Care Services Improvement Partnership CSIP

National Institute for Mental Health in England

The British Psychological Society

New Ways of Working for Applied Psychologists in Health and Social Care

Working Psychologically in Teams

DH Department of Health

Summary Report: *New Ways of Working for Applied Psychologists in Health and Social Care – Working Psychologically in Teams* is published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

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ISBN: 978 1 85433 460 2

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ISBN 978-1-85433-460-2

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Incorporated by Royal Charter Registered Charity No 229642

REP63_3/08.2007

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- The BPS Psychosis and Complex Mental Health Faculty
- Attendees at Stakeholder events held in Wolverhampton and Edinburgh.
- The many contributors of examples of positive practice within the document.

Summary and Key Messages

- The aim of this document is to provide an update on our understanding of how teams work and how their effectiveness can be maximised. It was developed as part of the NIMHE New Ways of Working initiative and so has a bias towards mental health services. Nonetheless, it provides positive practice and guidance on effective teamworking for application in a variety of contexts. It aims to have some relevance to any team member wanting to work using psychological principles.
- Psychologists have important roles to play in achieving improved outcomes from teamworking. These include helping to achieve optimal team design and operation, effective individual service planning, peer consultation processes, reflective practice, the effective involvement of users and carers, teaching, training, research, evaluation and development.
- Recent policy and practice developments concerning team working mean that psychologists are required to adopt new ways of working. These are determined by local contexts and include some new and specific challenges. It often requires that psychologists become further integrated into teams.
- The issue of psychologists' integration in teams is a hot one for psychologists and is often determined by local capacity for psychology input. Stakeholders showed an overwhelming preference for the integration of psychologists within teams but only if psychologists retained their unique identity and contribution (e.g. offering an authoritative and constructive counter-balance to the 'medical model').
- Psychologists have a wider role in providing consultancy to organisations on organisational and systems improvement (e.g. leadership and teamwork development) but their competence and confidence to assume these roles cannot be assumed.
- Definition of teams need to be clear and widely understood and differentiated from other descriptions of group working such as networks and communities of interest.
- There is good evidence for positive outcomes from teamworking but benefits will not be achieved without premeditated design of teams based upon research on what promotes effective teamworking.
- Effective teamworking is associated with
  - clear and achievable objectives;
  - differentiated, diverse and clear roles;
  - a need for members to work together to achieve shared objectives;
  - the necessary authority, autonomy and resources to achieve these objectives;
  - a capacity for effective dialogue. This means effective processes for decision making, being able to engage in constructive conflict and if complex decision making is involved the team needs to be small enough (no larger than eight or nine people);
  - expectations of excellence;
  - opportunities to review what the team is trying to achieve, how it is going about it and what needs to change; and
  - clear and effective leadership.
- Dedicated effort is required to improve team working within local whole systems. Tried-and-tested service improvement approaches are available to support this and should be more widely applied.
- Teams exist within complex systems and an understanding of how change and development occurs within such systems is important when aiming to improve outcomes.
- At team level leadership is about creating the conditions that enable the team to do its job; building and maintaining the team as a performing unit; and coaching and supporting the team to success. Leadership capacity is dispersed within complex systems and leadership roles should be determined by context and the demands of the task at hand, not position. It is the quality of the relationship between leader and follower that has most influence on performance-relevant attitudes and behaviour.
- Teams are working with greater reliance on virtual methods of working. Research in this area suggests that the need to consciously design and support teams to be effective is amplified in these contexts with an even greater need to build trust and shared understanding of ways of working among team members.

Key Recommendations

Psychologists should be actively involved in the design, operation and evaluation of teams making use of appropriate research evidence (e.g. with respect to team size, composition, and process). This work should be informed by an understanding of the teams' role in the wider context of the local system of care, an understanding of how change within complex systems occurs, and awareness of forthcoming developments in new roles and work practices (e.g. increased virtual teamworking).

Psychologists should seek to integrate their work within teams in a way that continues to promote their unique contribution to work with service users.

Psychologists should seek to develop their role in contributing to the improved effectiveness of services through process consultancy at systems level, peer consultation and supervision, leadership, and the promotion of effective roles for users and carers. The achievement of effective person-centred planning should be a key marker for the success of this contribution.

Introduction

This document was created as part of the NIMHE New Ways of Working for Applied Psychology initiative. Although this gives it a bias towards mental health it also contains material of relevance to staff working with people across the age range in a variety of health and social care settings. We hope that many disciplines will find it helpful in promoting their own thinking about multidisciplinary teamworking; hence the title: Working Psychologically in Teams. Our understanding of what it is to be 'Psychological' continues to evolve and widen to include issues such as the meaning and values that people attach to behaviours and how power is exercised within complex systems.

The document seeks to provide an update on our understanding of how teams work and how their effectiveness can be maximised, as well as providing positive practice and guidance on effective teamworking in a variety of contexts. Due to this diversity of settings not all sections will be relevant to all readers, particularly in the latter section on 'New Ways of Working'. The diversity and specificity of work settings means that there is little that can be said about new ways of working for psychologists that can be generalised across all team settings. Nonetheless we hope the examples of positive practice convey useful messages.

The major emphasis of this document is on teams working in health and social care at a practitioner level. However psychological models of change are also applicable at an organisational and systems level so it will be valuable to consider the principles of effective teamworking with respect to other teams that psychologists may be involved in; for example, business meetings concerned with professional practice and organisation, and multidisciplinary teams concerned with planning, management, governance, training or research and development.

This document updates aspects of the earlier, more comprehensive BPS (2001a) document, 'Working in Teams'. Some of the topics covered in that document are now addressed through more recent BPS guidance (see Figure 1 below).

Figure 1: BPS Guidance of relevance to Psychologists Working in Teams

- Professional Practice Guidelines from the Division of Clinical Psychology and other key BPS Division and faculties.
- DCP The Core Purpose and Philosophy of the Profession.
- DCP Clinical Psychology and Case Notes: Guidance on Good Practice.
- DCP Guidelines for Clinical Psychology Services.
- DCP Guidelines for the Employment of Assistant Psychologists.
- DCP CPD Guidelines.
- DCP Outcome Assessment in Routine Clinical Practice in Psychosocial Services.
- DCP Policy Guidelines on Supervision in the Practice of Clinical Psychology
- DCP Clinical Practice Guidelines – Psychological interventions for severely chal.lenging behaviours shown by people with learning disabilities.
- Faculty for Children and Young People Practice guidance on consent for clinical psychology working with children and young people.
- BPS Code of Ethics and Conduct.

Creating Effective Teams

Defining teams

The Healthcare Commission (2006) NHS National Staff Survey revealed that 89 per cent of staff responded positively when asked: 'Do you work in a team?' However this shrunk to only 41 per cent when the survey explored whether the team in question fulfilled criteria for a clearly defined team. These findings have been consistent every year since 2003. The definition of a team that was supplied was based upon the work of West (2004). This suggests that teams need to have:

- Shared objectives.
- Members who work closely together to achieve the objectives of the team.
- Members who have different and defined roles within the team.
- As many members as needed to perform the team task but no more. Large teams will have problems with complex decision making.
- Opportunities to review the performance of the team and how it could be improved.
- A team identity, so that others can recognise it as a team.

An important implication of the above finding is that we need to define teams in terms of who needs to work together to achieve a task rather than as a particular service configuration. If the task is to meet the needs of service users then ideally they form the nucleus of the team around which the appropriate interdependent supports are built. Where the task of a team is, for example, to promote recovery and social inclusion, there will be interdependencies between people that cut across agencies and sectors in their task of achieving positive outcomes for a defined group of users (e.g. re links to housing, leisure, employment, etc.).

Increasingly there is a need to consider teams alongside networks. Some definitions of networks include the following:

> *Networks are groups of people who share a common role, occupation or passion and who connect with each other to deal with change. In the practical world of work, networks are a powerful technique for getting where you want to go.*
> Mary Gusella, Former Head, The Leadership Network. http://leadership.gc.ca

> *Successful networking can be seen as a social pursuit with purpose. It happens when groups of people with common interests and passions come together to share and learn from each other. Productive relationships between individual members are a sustaining factor of good networks, which are also a helpful foundation to achieve collective goals. To work well, effective networks usually use a combination of face-to-face and virtual contact.*
> CSIP (2006). Designing networks for collaborative advantage. www.csip.org.uk/partnershipworking

Networks are similar also to the concept of 'Communities of Practice': A group of people informally bound together by shared expertise and passion for a joint enterprise (Wenger & Synder, 2000).

Distinctions between networks and teams are not crisp and in conceptualising both teams and networks it is important to recognise that individuals within them maintain multiple identifications (e.g. as a child psychologist, a team member, a parent). This has led some theorists (e.g. Hosking & Morley, 1991) to move away from construing groups as bounded entities but rather consider that there are 'degrees of groupness' described by cognitive, social, and political[1] processes within and between groups. Degrees of groupness are created by relationships between people that are based upon more or less continuous interactions which including the negotiation of aspects of groupness that allow the group to emerge as a fully fledged team. In comparison with networks, teams are likely to have clearer boundaries within which there is greater interdependence between members to achieve a specific output or outcome. Teams will also usually be formally mandated by higher authorities to achieve those results, and membership is more likely to be denoted through job descriptions offering clearer role definition.

[1] It is notable that this emphasis on process rather than entities means that political processes are seen endemic to organisation, and not something that messes up the rational, managerialist pursuit of shared aims.

Hosking and Morley (1991) advocate caution when talking about groups with 'shared values' as this emphasises a rationalistic, consensual, managerialist perspective that does not place adequate emphasis on conflict and competition. However, greater degrees of groupness will be associated with greater sharing of values as it is likely that the group members will act like a group in relation to a wider range of issues. This is another key characteristic that differentiates networks from teams in that the level of interdependence between team members to achieve agreed outcomes will require shared norms in order to promote effective practice (see, for example, with respect to the later discussion on virtual teamworking).

The following have been identified as success factors derived from research into the effectiveness of partnership working through networks (summarised in CSIP, 2006). They encompass many of the features of effective teamworking described later:

- Organised for participation and inclusion;
- Trust, respect, mutual support and teamwork;
- Positive leadership;
- Culture and infrastructure which support learning and sharing;
- Strategic importance of the work of the network;
- Management support;
- Outcomes focussed;
- Willingness to celebrate success.

Recognising effective teamworking

Teamworking is not a panacea and needs to be applied where advantageous and appropriate to the task in hand – not unthinkingly as a result of custom or fashion. Certainly, the literature on team working suggests that the benefits of team working are not ubiquitous or consistent (Guzzo & Dickson, 1996; Allen & Hecht, 2004). We need to distinguish between work groups that are clearly defined teams (having some the key features above such as clear objectives, and interdependence between team members; West *et al.*, 2006), and those that are only 'nominal'. The latter are groups that are teams in name alone as they do not possess the characteristics described above (referred to by West as 'pseudo' teams). The disparity between people who regard themselves as working in teams and the numbers of those teams that fulfil even a minimal definition of a team as highlighted above (Healthcare Commission, 2006) suggests that there are many people working in health and social care in such 'nominal' teams.

Where the conditions for effective teamworking are in place there is evidence that team working contributes to the improved effectiveness of health care organisations (e.g. Cohen & Bailey, 1997; West & Markiewicz, 2004). However, working in 'nominal teams' may be worse than not working in inter-professional care teams at all. Yan *et al.* (2006) using data from the UK NHS National Staff Survey examined the differential effects of well-structured inter-professional team working, nominal-team working, and not working in a team, on individual well-being, intention to leave and job satisfaction by using multigroup, multilevel analysis on a large sample (over 200,000) of NHS healthcare workers. This evidence suggested that working in well-structured, inter-professional teams was associated with better patient care (including lower patient mortality), more improved ways of providing patient care, work environments in which fewer errors occur, and less stress and more satisfaction among staff. Of more concern from a policy perspective, is the fact that those working in inter-professional situations which they define as team working, but which are not well structured via regular meetings, clear objectives and well-defined roles, are likely to report higher levels of errors, stress and lower levels of innovation and satisfaction than those who do not report working in inter-professional teams. In effect, the illusion of inter-professional team working may be placing patients and staff at risk.

Carter and West (1999) also demonstrated that those who work in nominal teams or do not work in a team, are significantly more likely to report higher levels of psychological distress and lower job satisfaction than those who work in a clearly defined team. Individuals who worked in clearly defined teams were more likely to report greater job satisfaction and less strain than those who worked in nominal-teams and those who work alone.

Aside from the specific outcomes for users and staff described above the following advantages have also been claimed for effective teams.

- Teams can improve the quality care for users (reduced time for users in hospital, better accessibility, enhanced user satisfaction, better acceptance of interventions and improved health outcomes) through the achievement of co-ordinated and collaborative inputs from different disciplines. This can be achieved through improved, better informed and holistic care planning, the development of joint initiatives and thus more effective use of resources.
- Teams can integrate and link information in ways that an individual cannot. For example relevant knowledge on the life of a given client based upon long-term relationships with different team members. Cook *et al.* (2001) concluded that that autonomous teams improved decision making as a result of a more client-led approach and better handling of risk.
- Teams enable organisations to speedily develop and deliver products and services cost effectively, while retaining high quality.
- Teams enable organisations to learn (and retain learning) more effectively since groups of people own knowledge rather than one individual and they can learn from each other.
- Time is saved if activities, formally performed sequentially by individuals, can be performed concurrently by people working in teams.
- Innovation is promoted because of cross-fertilisation of ideas.
- Experience of collegiality, friendship and emotional support from within the team leading to increased staff satisfaction and professional stimulation.
  (Mickan, 2005; Onyett, 2003; Mohrman, Cohen & Mohrman, 1995; Opie, 1997)

Such benefits do not however occur without premeditated design. Mickan and Rodger (2005) found that there are six characteristics that are most able to distinguish effective teams; **purpose** (the vision and values of the organisation), **clear goals** (specific tasks that are consistent with the purpose, clear and motivating), **leadership, communication, cohesion,** and **mutual respect**. Table 1 provides an overview of the model highlighting some of the issue to be explored in considering team development. Vision and values are one manifestation of the team's **ambition** and the expression of a team norm that it will aim for excellence. This is a feature of West's (2004) model predicting team effectiveness and innovation.

Table 1: Framework for Categorising Potential Team Characteristics

Team Environment	Team Structure	Team Processes	Individual Contribution
Organisational context	Purpose	Cohesion	Mutual respect
Team identity	Membership	Social Fabric	Commitment
Mission	Goals	Communication	Flexibility
Hierarchy	Leadership	Managed	Recognition
Resources	Achievement	Problem solving	Maturity
Professionalism	Roles	Feedback	Personal benefits
	Meetings	Participation	
	Time lines	Support for change	
		Decision making	
		Planning	

Carter and West (1999) described a clearly defined and effective team as having **clear, shared objectives, differentiated roles and a need among members to work together to achieve team objectives.** Team members also needed to have members with **the necessary authority, autonomy and resources to achieve these objectives**. Most importantly, the team needs to frequently take **time out to review what it is trying to achieve, how it is going about it and what needs to change**. It then needs to plan and implement change. Indeed, innovation (ideas that are implemented for new and improved services or ways of working) may be the best indicator of effective team functioning.

Diversity is another feature of effective teams. Team working does not mean that all disciplines within teams should become homogenised, although some aspects of their roles will be shared among team members (such as means of communications including record keeping and how core assessments are undertaken). Effective teams require diverse and differentiated roles in order to be effective. For a deep **dialogue** (as formulated by Bohm, 1996) to emerge team members need to be able to suspend

assumptions and judgments, while promoting **active and attentive listening** and **individual and collective reflection** on the thoughts and ideas that emerge (see also Seikkula & Trimble's, 2005 work on *open* dialogue). Rather than focussing on areas of commonality which precludes new solutions emerging, the communications within the team should instead value diversity and thus the fuller universe of solutions which might therefore emerge.

Role clarity is required for diversity to be manifest and for team members to remain effective (Carpenter *et al.*, 2003). This means that psychologists need to be clear about their specific roles within their teams. Role clarity is also important as psychology is a limited resource which needs to be used to maximum effect. The role will emerge differently with different care groups and contexts.

Role clarity tends to correlate with a **positive sense of professional identity**[2] (Onyett, 1997) which to support a strong sense of purpose should also be associated with organisational identification. Team and professional identification need not work against each other, although this has been a particular challenge for psychologists (Onyett *et al.*, 1995; Mistral & Velleman, 1997). This identification will be promoted by objectives that are aligned at a professional, team, organisational and individual practitioner level. Professional distinctiveness can comfortably coexist with collaboration and cooperation in the achievement of a super-ordinate goal, so long as the goal is both salient and meaningful to those involved (Haslam *et al.*, 2003). Indeed Brown *et al.* (2000) found that interdisciplinary working strengthened boundaries between disciplines and professional identification and subsequently observed (Brown & Crawford, 2003) that this very professionalism served a self-regulatory function in absence of management direction.

The formation of effective teams

Based on a meta-analysis of previously developed models, Tuckman (1965) provided an oft-cited model for the development of teams and progression towards teamworking. Its linear progression from Forming ➔ Storming ➔ Norming ➔ Performing assumes that all team members, or at least the majority, join at the same time. More usually team members come and go, the external environment alters and the team may partially regress to an earlier stage of development. The stages of team development may therefore not always be as clear cut or linear as outlined. Indeed, teams may function at a number of different stages simultaneously. Although not all teams conform to this model it has heuristic value, offering a useful description that enables teams to reflect on their development. Farrell *et al.*, (2001) used the model to describe the evolution of informal roles within teams over time. It is shared here as a guiding framework of what to expect at different stages and to promote reflection on where your team might be developmentally.

Forming: This 'testing and dependency' stage is characterised by ambiguity and confusion as individuals become acquainted for the first time, attempt to identify each others' characteristics, and begin to establish their individual identities within the group. Lacking information about each other, members relate on the basis of stereotypes. Intra-team trust is minimal, anxiety very high, and conflict not apparent. Provisional ground rules regarding the purpose and nature of the team are established during this stage.

Storming: During this 'conflict' stage (or period of jockeying for position), personal goals are revealed that challenge the initial consensus achieved during the forming stage. There is likely to be a power struggle between different subgroups that have different perceptions of the nature of the task that the team is engaged in and how this is best achieved. 'Turf' conflicts regarding who does what can emerge, and there may be disagreement regarding how much control one member (often the person with the highest status) should have over others. Initially, such conflict can be denied, ignored or expressed indirectly through passive resistance or backstage complaining.

If conflict is managed appropriately, trust can develop and anxiety can partially diminish (see 'Valuing constructive conflict' below). There is a more realistic consensus regarding the team's mission, the division of labour, roles and procedures. There is a balance to be struck though in that if a team is too inwardly focused, the team can become overly cohesive and distract attention from core issues such as person-centred planning, inter-team relationships and community bridge building

[2] Social identification is a process where self identity merges into social identity and actors strive to create social identities that are positive, distinctive and secure.

Norming: During this 'cohesion' (or 'setting the rules') stage, members review their history and work out both formal and informal norms regarding how they can better collaborate and work together as a team. Hence, there is clarification regarding professional roles, responsibilities, the nature of decision-making and authority. Aided by effective leadership, members also learn to share more than just their work and begin to experience a sense of 'group-belongingness' that facilitates team commitment. They also develop a sense of how together they will manage the inevitable conflicts that occur.

Performing: Once an effective internal team structure and objectives have been established, teams can focus on 'getting the job done'. Interdependence replaces dependence and members experience a greater sense of solidarity. As there is a greater appreciation of each other's strengths and weaknesses, roles are assigned based on skill and expertise. Workload is perceived as fair and equitable. Tension is reduced as members' behaviour is regulated by the shared team culture, so that communication is less likely to be impaired.

Having explored the features of effective teams and how they develop the final part of this section examines some approaches to team development before discussing the particular demands of work in health and social care and new ways of working.

Interventions to improve teamworking

It might seem obvious to suggest that teams need to be designed to be effective. However in practice this is often not what happens. Experience shows that teams are often formed on the basis of the predilections of management teams, the influence of powerful stakeholders, or the indiscriminate redeployment of staff from shrinking services, (e.g. nurses from acute inpatient services). Often the structure of teams and the way they work is the product of the interaction of years of shifting national and local policy, commitment of resources, varying levels of leadership, the impact of partnership working at higher organisational levels and the dynamics of the local labour market. Leaders in service design locally therefore need to be highly proactive, informed and courageous in asserting the need for proper design to meet locally assessed need. This needs to be informed by an analysis of demand and capacity within the local service system, and will be supported by strong working relationships between commissioners and providers.

West and Spendlove, (2005) concluded that in the UK there is a strong need to further improve inter-professional team working, since the weak processes that exist in many UK health care organisations appear potentially detrimental to staff and to patients. In today's dynamic health care organisations characterised by high levels of work demands and rapidly changing structures and cultures, we can enhance performance by the participating stakeholders taking time away together to reflect upon their joint functioning. This enables them to adapt in order to achieve new ways of working that better meet the needs of patients. In demanding, changing, and uncertain environments the different professions must continue to develop norms of supporting one another to create climates of safety, confidence and empowerment. Also inter-professional teams exist within and across organisations and these must provide the appropriate support systems and processes for inter-professional working.

Teams are rarely created from scratch. This is where being aware of where the team is in terms of its development, as described above can be invaluable. Team design and operation also needs to be tackled as part of a wider local whole systems approach to development. The role of senior leaders and managers is to clearly define the parameters within which the development work can be undertaken and the outcomes that need to be achieved. The key question is 'How will we know that this investment in team (re)design has been a success?', 'What will we see that is different?' The process of team (re)design itself needs to model good teamwork practice in having clear objectives and appropriate levels of resources agreed (e.g. in time that can be allocated, and support that can be brought in). Where the composition of the team is already clear then team members themselves with their manager can be asked to undertake the work themselves. It is however usually necessary to commission some external support to achieve an assessment of current team functioning and an effective process for design. At the very least senior leaders and managers will need to establish strong feedback mechanisms to the highest levels of governance within the participating organisations to ensure that the (re)design and development process stays on track and informed.

Figure 2: Examples of Resources to Support Team Development

The Effective Teamworking and Leadership Programme. The ETL programme was developed by CSIP and Aston Business School for the Leadership Centre (of the former Modernisation Agency; Onyett & Borrill, 2003). It is a flexible seven-day programme for people within a locality who are interdependent on each other to achieve improved outcomes for a specific group of people. It has been implemented in services for adults and older adults with mental health problems, prison in-reach and prison staff, low secure provision, local implementation teams, primary care and zero-rated trusts through the Clinical Governance Support Team. It particularly focuses on clarifying objectives and values, communication, decision-making and the well-being of participants. An independent evaluation of the programme has highlighted its effectiveness particularly in clarifying aims and objectives and team communication (Rees & Shapiro, 2005). For further information contact: *steve.onyett@nimhesw.nhs.uk*. The new Learning for Improvement Network for Leadership and Teamwork Development will provide a forum for people to share experience and evolve the programme (see www.icn.csip.org.uk/leadership).

The Creating Capable Teams Approach. The CCTA is an 'off the shelf', five-step approach to support the integration of new ways of working and new roles, within existing resources, into the structures and practices of a multidisciplinary team. Following completion of the CCTA the team will have a clearer understanding of the needs of their service users and carers and of the capabilities that exist within the team. They will have had the opportunity to review the team skill mix and consider the introduction of new ways of working and new roles. Completion of the team profile and workforce plan will enable the team to influence and contribute to the organisation's workforce planning process. For further information see www.newwaysofworking.org.uk. Both ETL and CCTA can be applied in concert with each other at local level and in all areas of mental health, across health and social care, for people of all ages and in statutory, voluntary and private sectors.

Clinical Teams Programme. The CTP is a multidisciplinary programme for any practice team working in health or social care. It has been particularly successful with newly formed teams especially where teams have been or are going through a process of integration. It has also been very successful when several teams share a common client pathway. The structure and content of the CTP is based on the evaluations of the Clinical Teams Project which delivered the CTP to 105 health and social care teams across England (the CTP was Funded by the NHS Leadership Centre). The programme brings together evidence from RCN Clinical Leadership Programme and the evidence on effective team working (West, 2004).

Evaluation demonstrated the following benefits:

- Improved service user experience with increased access to the right service in the right place at the right time.
- More proactive and action orientated teams.
- Reconnection with the service user and the purpose of the service.
- Increased openness and critical reflection within the team.
- A group of proactive change agents as a resource for the organisation.

Contact Anne Benson 017810 525 208, *anne.benson@rcn.org.uk*, for more information.

Tools for capacity planning. Any team development process requires good local understanding of local demand and capacity. Tribal, the Sainsbury Centre for Mental Health and Research and Development in Mental Health have produced a briefing document on 'Capacity Planning'[3] which provides a dynamic planning tool for modelling demand and capacity within local service systems based on an iterative process of analysing local data (e.g. on inpatient bed use), agreeing assumptions (e.g. on the functions of parts of the local service system), producing a model and reviewing future activity against the model. A Capacity Management Framework for teams has also been developed by Training and Development for Health (see www.td4h.co.uk).

Byrne, (2006) also provides a very thorough and strongly referenced description of team work issues beyond the scope of the current document.

See also Figure 3 on resources for service improvement more generally.

[3] Download at www.tribalgroup.co.uk/?id=348&ob=2&rid=223

Leaders may need to be courageous in taking a radical approach to team development. The current leadership, objectives and composition of the team may be in question. In these contexts senior leaders and managers may need to maintain close involvement with the (re)design process working with the wider system to collect and share data on current demand, capacity and flow issues. There may be difficult decisions to be made leading to complex change processes that will require the support of local human resources departments. The relationships on which improvement depends are more likely to remain intact where the rationales for change are clear and evidenced.

This whole document is a resource for developing the content of local team development interventions. Whichever approach is used a comprehensive development process will cover:

- Setting realistic and relevant objectives for the team. Creating the right conditions for effective teamworking means ensuring that: (a) the team has a clear task to perform, and one that is best done by a team; and (b) making sure the team has the resources it needs to do its work. Sometimes a key responsibility of the team leader is to procure the necessary budget, accommodation, IT equipment or other tools for the team to do its job effectively. They should be adamant and unapologetic about arguing for the resources the team needs to get its job done.
- Clarifying the client group served in a way that promotes non-discriminatory access to care and support.
- Measurement of performance particularly with respect to outcome.
- Team composition. It is also important for the team's members to be clear about who is and is not in their team – the boundaries of the team. Some teams are composed of core members who work together every day and have others who join the team for much shorter periods of time. In a warm but misguided attempt to ensure inclusion, leaders often include these visitors as team members and try to involve them in the team as much as possible. It is better to designate people clearly as either core team members or peripheral team members. The team is its core members and people are dependent on them for the day-to-day performance of the team's tasks. The peripheral members work with the team from time to time but cannot operate as full team members because they are simply not together with the others enough. Creating inappropriate expectations about the team's boundaries is a recipe for conflict. It is important not to neglect team administrators in this process. They usually have a very central role in team process and decision making and are often the first contact point for service users- a point where emotional impressions of the service are formed very strongly.
- Team size. West *et al.* (2003) found that larger teams have higher levels of innovation. They speculate that this may be because larger teams process more diverse perspectives and, therefore, have the potential to achieve a more comprehensive processing of information and decisions, or that they have the critical mass of people necessary to sustain innovation. Team size however needs to be balanced against the finding that teams need to be small enough to ensure effective decision making over complex issues. West *et al.* (in press) advocates that for this function to be performed successfully teams should not exceed six to eight members. In short we conclude that effective teams have the minimum number of team members required to get the job done. Teams in health and social care are often overly large which means that one key leadership task may be to redesign teams into smaller, more focussed functional units but with strong cross-functional working with other teams.
- Management of the team and of team members. Including arrangements for dual accountability where appropriate.
- Team leadership, including leadership of team development and reporting relationships to host organisations.
- Team process with clients from receipt of referral to episodic case closure, making explicit issues with respect to decision making and the role of users and carers.
- External relationships, e.g. publicising the service, local protocols, open days, liaison roles, etc.
- Type and conduct of meetings.
- Administration including the development and review of policies, use of information systems, record keeping, etc.
- How the team will stay healthy and functioning. Approaches to ongoing reflective practice, team reviews, workload management, training needs assessment and individual and team development, etc.
- Service evaluation, review and reporting structures.

It is important to note that supporting the individual psychologist is itself an intervention to achieve effective teamworking, particularly given the importance of maintaining team diversity. The importance of supervision and peer consultation for psychologists, especially when they are spending most of the working life within multi-disciplinary teams, cannot be overestimated. Practice supervision and peer consultation can be delivered in a range of forms and using a wide variety of theoretical models and approaches. In current settings where change in management and organisational structures is constant, it is particularly important that psychologists receive support and consultation both in terms of their working practice but also in terms of their own personal well-being. For a detailed account of support and supervision in the mental health professions see Scaife (2001) and 'Supporting peer consultation processes and reflective practice' below.

Psychologists in relation to the team

The imperative to clarify core and peripheral roles in teams will be evident from the earlier parts of this document. Psychologists have often been cited in the peripheral category because of their comparatively smaller numbers and perceived specialist expertise. Among all the disciplines that usually make up teams, psychologists have also historically been associated with the greatest ambivalence about teamworking (Mistral & Velleman, 1997); being the most likely to see team membership as conflicting with their professional identification (Onyett, 1997). Over the past decade this picture appears to have changed significantly and within the group producing this document and at stakeholder events there was a strong urge towards greater integration of psychologists into the day-to-day life of teams.

Integration does not mean genericism- everybody within the team blurring roles. We have seen above how diversity of role is important to team functioning. Integration is instead multifaceted with a range of markers. These would include:

- Whether the psychologist undertakes some of the generic work of the team (e.g. conducting initial assessments or answering telephone calls on an open support line).
- Whether the psychologist participates in team processes such as handover meetings, client review meetings, Care Programme Approach (CPA) process and team meetings.
- Whether a formal referral is required to access the input of the psychologist or whether they can be involved through more informal team process or their attendance at team meetings.
- Whether the psychologist is physically located with the team.
- Whether the psychologist is operationally managed from within the team (e.g. with respect to co-ordinating annual leave, expenses, routine appraisal, etc).

These related factors can be configured such that psychologists fall within a middle ground on the separation-integration continuum. For example, they may be operationally line managed within the team but receive peer consultation and professional line management from within the local psychology service. Alternatively, they may partake in all team processes such as meetings, awaydays and social events while not taking a care co-ordinator role choosing instead to support others in this role by contributing more specific psychological expertise.

Some key themes emerged from the range of stakeholders consulted that influence where psychologists locate themselves on the separation-integration continuum. While overall there was a strong urge towards greater integration there was equally no one model that would fit every context.

Our work with stakeholders exploring this issue included users, carers, psychologists and other professionals (including commissioners and senior psychology managers). Though the overwhelming preference was for increased integration there was an important caveat in that this was only *if psychologists retained their unique identity and contribution*. For example users identified psychologists integrated in teams as offering a helpful counter-balance to the 'medical model' (see 'Promoting effective individual service planning' below) because of their perceived status as a valued and autonomous professional discipline. Psychologists needed to protect their identity and use their specialist skills to their full capacity. Relating this to practice; it may be that the psychologist is professionally managed by a senior psychologist, but operationally managed by the team manager with whom day-to-day aspects of their role are negotiated. It may also mean that peer consultation or supervision is provided by other psychologists in order to protect and maintain the specialist skills of the psychologist. Activities such as research and development and continuing professional development may also require specific support from the psychology service.

Key contextual factors included consideration of how much psychological expertise was available locally and thus how it should be most effectively deployed. The demands of psychological input to the team might also vary with the development of the team itself and it might be important to be able to move along the separation-integration continuum according to the needs of the service at different times.

Another important aspect of context is simply how effective the team is. One stakeholder reflected that if a team lacks vision it can hold back the psychologist in achieving their aims. Some dissatisfied team members, 'weighed down with professional luggage' (Gerrish, 1999) and struggling with the threat to their professional identity, may demarcate (or isolate) themselves from team functioning and return to the relative safety of their departmental 'mothership' (Lankshear, 2003; Peck & Norman, 1999). However, such demarcation might merely reflect their self-interest in preserving professional autonomy at all costs (Onyett & Ford, 1996) and their ambivalence about being too closely identified with teams (Peck & Norman, 1999). As reflected in some of our stakeholder commentary such 'opting out' may merely perpetuate ignorance and breed mistrust (Farhall, 2001). The resultant low 'team identification' may also predispose to job dissatisfaction (Onyett, *et al.*, 1997). Stakeholders also highlighted the fact that it is not always up to the psychologist how integrated they are and in some contexts they are specifically excluded.

Taken together there emerged an imperative to weigh up a range of factors when considering the psychologists position on the separation-integration continuum in order to achieve a 'win win' situation where psychologists felt they were able to offer their specific contribution most effectively and teams felt they were able to access the psychologist in a way that was helpful to the work of the team as a whole. Table 2 considers just some of the advantages and disadvantages of the different styles of working to inform local decision making.

Table 2: Considerations on the Separation-Integration Continuum

	Integration	**Separation**
Advantages	Psychology is fundamental to all teams and all mental health issues and so should be fully integrated (an NHS Manager perspective) The psychologist's involvement requires that the team is clear about its role so that they can more effectively contribute. Psychologist may become more involved in initial conversations with clients and generating collaborative construction of what is happening. It enables 'psychological' thinking from first point of contact/ assessment and in the early formulation of the client's situation. More opportunities to influence within the team. Greater understanding of the nature of the work for other professionals. Allows for closer working with other professionals in the team and the two-way exchange of ideas/perspectives. It's safer to work in an integrated team – you are more able to challenge each others' practice from a variety of professional perspectives. It's healthy to have robust debate amongst team members from different professional backgrounds. It may help to establish a more therapeutic milieu within acute services (e.g. Sainsbury Centre for Mental Health, 1998, 2003)	Allows for greater provision of psychological therapy by psychologist using their time solely for this purpose. Some psychologists just want to do therapy and not get bogged down in the rest of the teams functioning. Better value for money because psychologists don't have to spend time in meetings, etc., and are, therefore, more available. Provides more time to undertake structured psychological work using the processes of assessment, formulation, intervention and evaluation. Psychologists may be better placed to provide consultation, supervision, teaching or training to the team with some distance. Too much informal day-to-day contact may make this more difficult. May allow psychologist to have a more independent viewpoint. You can still get different perspectives from others team members. Trainees and assistants are often quite separate anyway. You don't think you can influence much as you're always 'leaving soon', so don't feel yourself to be a member of the team. Therefore, it's difficult to see the advantage of integration in these roles.

	Integration	Separation
	It may encourage more creative ways of working, e.g. joint/multi-disciplinary working, extended assessments. There are advantages to getting involved in care co-ordination – it gives the team psychologist a feel for the machinery of team operation– which may enable them to contribute more thoughtfully to the processes. Being in teams can give psychologists more credibility and thus legitimacy. 'Doing care co-ordination seems to give psychologists more credibility – as if they are prepared to do the 'dirty work'; 'If you go to nurses' handover – you may not be doing much 'psychological' work, but the nurse respect you more for it and listen to you more. You also find out what the difficulties are for nurses'. Psychologists benefit from being influenced by others professions. Psychologists need to be integrated to support other badly treated staff. Better placed to challenge misperceptions of what psychologists actually do.	
Disadvantages	It can be more difficult to hold onto your identity as a psychologist. Providing consultation to the team as a whole can be problematic when they are embedded in the team. Peer support to other individuals in the team can also become contaminated by psychologist being embedded in the team dynamics. Negotiating time/space for specific psychological work (including research and CPD activity) can be difficult if psychologist is seen as a generic member of the team. Specialist skills of the psychologist may not be fully utilised, therefore not providing 'value for money'. May cause difficulties if the psychologist is being paid a higher wage to perform the same role as other members of staff. You risk getting bogged down in the minute detail of the team environment.	As a highly valued profession psychologists can be seen to be modelling lack of commitment to the team. People don't listen to you if you are outside the team. You are easier to dismiss and stereotype. There is less day-to-day inclusion of psychological perspectives in team decision making. There is less opportunity for psychologists to model psychological principles. There is also less opportunity for social learning between psychology and other disciplines. Potentially more misunderstanding of other's roles in the team. Risk of professional and/or personal isolation from the team. Complications arising from multiple/separate management structures for psychologist.

Positive practice example of new roles for psychologists in a new team approach for Child and Adolescent Mental Health Service (CAMHS) Emergency Cover

East Lancashire CAMHS has developed a model of providing 24 hours 7 day a week emergency cover. This is a key service target, which uses a multidisciplinary team, rather than the traditional doctors on-call systems. The change involved a shift from a psychiatric disorder perspective to a psychological understanding of young people presenting in an emergency. The focus has moved from a referral system, to one where advice and support is offered to front line staff in Accident and Emergency departments and paediatric inpatient wards. This project is co-ordinated by the clinical psychologist and considerable change has been made in the overall working of the team. The psychologist's role has included being a senior member of the on call service, replacing what might have been considered the role of the psychiatrist. They have also been leading the evaluation and ongoing development of the service. It has been important that the psychologist has been able to be a flexible key member of the team whilst retaining an overview. The psychological involvement with multidisciplinary team has helped focus the therapeutic orientation of the service.

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Teams in complex contexts

Teams in health and social care are diverse. They include teams of practitioners concerned with co-ordinating and delivering care and treatment to a defined group of service users and their supports (such as relatives and friends), as well as teams concerned with commissioning, leadership, management, service improvement, research and development.

The current policy context means that a variety of different teams have to work harmoniously together at a local level. These are teams concerned with commissioning and providing, the statutory and voluntary sector, primary and specialist care, and health and social care. Even concerning service delivery for a given care group there are different teams concerned with different types of client involvement. For example, in child services the 'Every Child Matters' White Paper (www.everychildmatters.gov.uk) requires multiagency commissioning and services integrated around the needs of the child. Different service ideologies, management structures, and working practices across agencies make this even more challenging than multiprofessional work within a given team. Similarly in adult mental health services primary care, inpatient, early intervention, crisis resolution and assertive outreach teams all need to be able to collaborate effectively.

The move towards team-based organisations in health care has resulted in teamwork receiving considerable attention while the vital question of how these inter-professional teams work together across team boundaries has been comparatively neglected. This inter-team working is crucial to success, particularly where the task is the more effective utilisation of knowledge, skills and experience (Mohamed *et al.*, 2004). Managers heading multidisciplinary teams within and across organisations and between different levels of management need to work together to provide an environment that reduces resistance to change and removes barriers to communication (ibid).

In such continually evolving systems it is helpful to have some shared understanding of the nature of complex systems that is shared among team members and ideally the wider system of which they form a part. There is an emerging zeitgeist that spans both the practice, managerial and inter-organisational levels that pays greater attention to the inherent uncertainty and unpredictability of human systems. This is manifest in interest in complexity theory as an underlying model of change at all levels, the increasing currency of 'mindfulness' in the work of practitioners with service users (e.g. Teasdale *et al.*, 2000) and stressing the damaging effect of certainty on achieving true dialogue (Seikkula & Trimble, 2005 ; Bohm, 1996).

Complexity theory is about looking at how the change that occurs in nature informs our understanding of the systems we work in. Plsek and Greenhalgh (2001) described complex adaptive systems as *'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions change the context for other agents'*. Examples from nature include colonies of bacteria, flocks of birds, termites, and bees. Adaptive systems are continually changing, potentially self-organising, co-evolving with other systems, and unpredictable in detail but with patterns that can be discerned through action and observation (ibid). In some contexts we would call these patterns the 'culture' of the team or organisation.

Durie and Wyatt highlight that proponents of complexity theory (e.g. Rosen, 1996; Morgan, 1997) have stressed the need for a new paradigm that urges those involved in seeking to bring about change in health care settings to adopt principles derived from complexity, rather than from traditional 'command and control' models of management. Their own study applied concepts of complexity theory to a successful example of community engagement and regeneration highlighting the importance of:

- relations between elements of the system and the 'locking' of behaviour that occurs when this is not present;
- the negative impact of this locking on the discovery of new perspectives and the positive impact of new relations on finding new possibilities for action when these behaviours are unlocked;
- a tipping point (or 'point of criticality') where enough people decide that something has to be done; and
- the influence of the history of the system in influencing which path is followed at that tipping point.

Another feature of complex systems is that they are non-linear. In other words small actions can have big affect while large actions can have small affect. Take, for example, work on user-focussed monitoring aimed at improving an acute in-patient environment. It may be comparatively small changes that are sought, such as having a kettle available at night. However, a major change in culture is achieved when different stakeholders come to see this as a shared problem, and then work together, users and staff, to do something about it. Conversely it is not always easy to see how the impacts of large scale actions, (such as NHS reorganisation) improve the lives of individual service users.

Complexity theory has implications for how organisations seek to achieve change at all levels. Plsek's (2002) description of simple, complicated and complex problems (drawing on Zimmerman *et al.*, 1998) illustrates the mismatch between the nature of the problems that we seek to solve and the way we approach them. A *simple* problem is one where there is a reliable known approach that delivers almost identical results every time. For example cooking a meal from a recipe. A *complicated* problem requires much higher levels of co-ordinated knowledge, skills and experience to achieve the required result. An example would be building a space rocket. A clear plan is critical and necessary and the process requires high levels of expertise in many specialised fields that are rigorously co-ordinated. Plsek argues that most problems in health and social care are complex. A *complex* problem is more like raising a child. Formulae have only a limited application, expertise can help but is not sufficient, every child is unique and the outcome remains uncertain despite your very best efforts. This raises the key question, 'Are we spending too much time trying to apply complicated solutions to complex problems?' Plsek is thus posing the possibility that we devote too much energy to analysis, planning and control when the nature of the problem requires an approach that just gets on with it, aims for good enough solutions, and values knowledge acquired through having a go at change and listening to the lived experience of people at the sharp end of the improvement process. Importantly such an approach also builds positive relationships across boundaries. It values methods that promote learning rather than expertise aimed at providing off-the-shelf solutions. In assuming uncertainty, working well with complexity values experimentation and innovation and allows space for learning by doing (e.g. action learning and plan-do-study-act groups). It also requires that people have clear but *minimal* specification of the task that they need to achieve in order to allow space for the exercise of their creativity.

Working well with complexity also values listening to the lived experience of service users. Team development should be shaped by the need for effective staff-user relationships. The reflections above provide a framework for considering the importance of this relationship and all the other connected networks of relationships that are meaningful to users and their supporters. The emphasis on building

relationships and learning from what works has much in common with approaches to systems change such as Appreciative Inquiry (Cooperrider, 1999) and solution focussed approaches (Jackson & McKergow, 2002) that specifically uses approaches that reveal the positive core of organisations and the people that work in them, thereby building positive affect within teams and organisations to create cultural change and sustained improvement (Onyett, 2007). These are processes specifically borrowed from practice-based approaches such as brief solution focussed therapy and other 'strengths-based' approaches which emphasise the practitioners' role in bringing to the fore user's talents, experience and other positive qualities as resources for improvement (de Shazer, 1985; Onyett, 2003; Ryan & Morgan, 2004). Their core principles should therefore be familiar to many applied psychologists.

Promoting effective individual service planning

Effective team functioning achieves nothing if it does not achieve more effective person-centred individual service planning. Indeed given the importance of interdependence among team members it is helpful to conceptualise users and their supports as being at the centre of the team, working alongside an identified care co-ordinator who then facilitates contact with other personnel who will deliver the bespoke interventions needed. Indeed this is the model used for example, with older adults with long term conditions through the community matron role[4].

The policy context has perhaps never been more supportive of an emphasis on person-centred individual service planning. For example, the draft Commissioning Framework for Health and Well-Being (DH, 2007b, p.25) states that 'Individual needs assessment means working with a person to identify their care and treatment requirements and then, where appropriate, co-producing a care or treatment plan or assisting the person in directing their own care and support'[5]. The Ten Essential Shared Capabilities underpinning the work of the entire mental health workforce focus on 'providing service user centred care … primarily from the perspective of service users' (Hope, 2004). This is also the stated aspiration of the Care Programme Approach in adult mental health.

So why when there is so much apparent alignment of stakeholders towards person centred care does the reported experience of users and carers so rarely indicate that such an approach is in evidence? For example, the Commission for Healthcare Audit and Inspection (2005) survey of 26,555 mental health service users found that less than half of those responding felt that they definitely had enough say in decisions about their care and treatment.

In a team context this bears upon the need to make conscious the underlying ideologies and models of care in play, formulate the current situation as a working hypothesis that generates action and maximise the involvement of users and carers in the process throughout. This will also be influenced by how decisions are made, the exercise of power and authority within the team and its capacity for reflective practice. These issues are explored in more detail below.

The need to clarify the underlying assumptions in use

As Kurt Lewin (1951) observed, *'There is nothing so practical as a good theory'* (p.169). Team practice will be guided by a variety of theories about how users' difficulties come about and thus the best way to intervene. These theories and the assumptions in play that underlie them form the prevailing 'ideology of care' that shapes the work of the team and influences the achievement of a person-centred approach to individual service planning. Underlying assumptions have implications for what counts as legitimate information within the team and how power is exercised among the various stakeholders involved. For example, the values assigned to certainty, predictability, positivism and the centrality of relationships described above when discussing complexity will also get played out in how team members interact with service users and the people that support them when issues are described and acted upon. These theoretical assumptions that underpin practice are too rarely articulated. Woodbridge and Fulford, (2004) provide a useful workbook for exploring values-based practice in mental health care.

Applied psychologists have often been associated with the role of providing a counterweight in team decision making process to the dominance of a 'medical model' approach. Indeed this emerged in our stakeholder consultations as a valued role for psychologists that they needed to hold onto when becoming more integrated into teams (see above). By a 'medical model' we mean an approach whereby

[4] See the National Service Framework for Long Term Conditions available to download at www.dh.gov.uk.

[5] Further guidance on 'person-centred and integrated care planning' is to be published later in 2007.

(a) a constellation of signs (demonstrable physical changes) and symptoms (what people say about their experience) are summarised into a diagnosis which then becomes the focus of intervention, and
(b) biological causes of the current situation are privileged in the explanation of the persons' difficulties and hence the decision-making process with the result that physical interventions (such as medication) are prioritised when it comes to considering action.

Of course, in some contexts (e.g. health psychology, or neuropsychology) it may be entirely appropriate to prioritise biogenic factors and indeed even within mental health services the physical health needs of individuals are often comparatively neglected as a source of social and psychological difficulties or problems in their own right (DH, 2006a).

Within mental health services particularly, the 'medical model' has been the focus of sustained critique over the years, most notably by key figures such as Laing and Szasz from the 1960s, but also more recent authors such as Bentall, (2003), Boyle, (1990) and Johnstone and Dallos, (2006). A key tenet of their critique is that psychiatric diagnosis has none of the qualities of a viable scientific construct in being neither reliable nor valid. Also problematic is the observation that diagnosis is often based on social rather than medical judgements about the acceptability of various ways of thinking, feeling and behaving. These commentators also argue that there is no firm evidence for a primary causal role of 'biochemical abnormalities' or genetic factors in the aetiology of mental distress. They propose an alternative framework wherein mental distress is primarily construed as an understandable response to psychosocial factors, and not a biologically-based disease process. A current example of this perspective is the BPS report 'Recent advances in understanding mental illness and psychotic experiences' (BPS, 2001b) which attempted to shift prevailing attitudes to work with people diagnosed with psychosis by arguing for greater use of evidence-based psychological therapies that focus on the particularly phenomena associated with distress (such as hearing voices, or 'delusional' beliefs) as an alternative to traditional diagnosis-focussed approaches (Harvey *et al.*, 2004).

Latterly 'vulnerability-stress' or 'diathesis-stress' or 'biopsychosocial' approaches to understanding mental distress (e.g. Zubin & Spring, 1977; Engel, 1977; Neuchterlein & Dawson, 1984) have emerged that aim to integrate a range of causal factors into a single model. These assume that service users are born with a certain 'vulnerability' to, say, psychotic symptoms, which is then triggered by stressful life events. This has allowed for the development of new approaches such as cognitive behaviour therapy for psychosis, which run alongside the more traditional medical model. One of the best known examples is the field of family work with people with a diagnosis of schizophrenia which attempts through education and problem-solving to reduce risk of relapse (see BPS, 2001b).

However, there is some unease with 'biopsychosocial' models. While it is undeniable that there are biological correlates to every aspect of human experience, this commonsense view can serve as a smokescreen for a model which posits these as primary causal factors – an assumption unwarranted by the evidence. As a result life events can be divested of their personal meaning and reduced to the status of 'triggers' of an underlying 'illness', which then becomes the focus of treatment. When non-biological factors are treated in this way the biopsychosocial model can in practice become the 'bio-bio-bio model' (Read, 2005). This commentator further notes that: 'Psychologists. … tend to be rather thoughtful and kindly folk. Most prefer not to engage in wars of any kind. So it is understandable that so many have accepted the biopsychosocial model … (But) this is not an integration of models, it is a colonisation of the psychological and social by the biological.' From a nursing perspective Barker and Buchanan-Barker (1999) also observed that 'Although Engel's (1977) original biopsychosocial model has at last found its way into the parlance of contemporary psychiatry, often this is used merely to grease the wheels of the traditional psychiatric process'. As service users have said: 'It was not these (psychosocial) factors which *led* to their problem; these *were* the problem.' (cited in Rogers *et al.*, 1993).

Columbo *et al.*, (2003) described the unarticulated and unresolved tensions in different models of working. They studied 100 multidisciplinary professionals within mental health teams. Psychiatrists, community mental health nurses and social workers were interviewed regarding their approaches to a vignette of a person whose behaviour suggested psychotic symptoms. Although social and psychological models of psychosis were present in teams, a major theme across all staff groups suggested that non-

medical viewpoints were often ignored in the care-planning process. The study also drew attention to the 'ideological vacuum' that exists between medical and social/psychological models of mental health difficulties, with different staff groups reporting different and often contradictory models of working.

Columbo *et al.* (2003), suggest that attempts should be made to air and resolve such differences. This is problematic in practice. Lang (1982) highlighted the paucity of theory and intellectual substance to be found in the content of interactions among practitioners. This ethnographic study demonstrated how avoidance of substantive discussion served to mask ideological conflicts and structural inequalities within the team. Borrill *et al.* (2000) similarly noted how impoverished team communication could be in many settings. Johnstone (1993) listed some of the numerous ways in which challenges to biomedical assumptions are rejected in day-to-day practice. These included ignoring or discounting non-medical input; attributing all improvements to medical intervention; disqualifying the counter-evidence; and so on. This can be a major source of frustration for psychologists working in teams (Gelsthorpe, 1999).

Boyle (2001) exhorts applied psychologists to provide a more open challenge to dominant discourses, stating: 'We work in service systems largely based on a theoretical model which is more or less completely incompatible with ours. Heaven knows, we have bent over backwards to disguise this fact, to fit in, not to give offence. We have extensively adopted the language of medicine, calling our clients' problems symptoms, illnesses and disorders … we have eagerly adopted models such as the biopsychosocial model or the stress-vulnerability model which make it easy for genes and biology to remain privileged'. On the basis of her personal experience of team decision making one author of this report with experience as a carer reflected that this avoidance of offence makes the assumption that there are not other like-minded individuals present and so draws other informed team members into a position where everyone is colluding to protect others from discomfort. She comments, 'I think this attitude is condescending and has the potential for stifling and superficial relationships' (see 'Valuing constructive conflict' below).

A 'recovery' focussed approach may offer an alternative ideology of care that has strong support and currency among many mental health service users, and is supported by policy imperatives (NIMHE, 2005). The term 'recovery' does not have the same currency within other care groups but the underlying values are often recognisable. It refers to a collaborative, client-focussed approach characterised by the user exercising maximum choice and control over the process of care. Furthermore, what is meant by 'recovery' is not solely a quantitative reduction in signs and symptoms of a disorder. Instead, the emphasis is placed on the minimisation of the disruptive impact of mental health difficulties on a person's ability to lead a fulfilling and meaningful life (Anthony, 1993). In that way it can be best construed as recovery of valued and meaningful 'roles' rather than recovery in the traditional medical sense of 'getting better' from an illness. The approach aims to view service users holistically, as complete people who have the capacity to cope effectively with their difficulties and to function in a way that allows the development of self-esteem and self-efficacy. The role of the multidisciplinary team is to identify and help to maximise a person's potential, identifying realistic life goals with service users and facilitating their achievement (Darton, 2005). For example, recovery for a person suffering from psychotic experiences would be based upon the degree to which they are able to achieve their own goals in terms of social, emotional and occupational functioning (e.g. regarding their ability to return to work, or to look after their children, or to cope better with day-to-day stress) and may be totally independent of whether or not they continue to hear voices. As such, the role of the mental health team becomes much more diverse than traditional approaches which focus on compliance with medication and specific symptom reduction.

Aspects of a recovery-focussed system of care include:

- Being based on people rather than services;
- Emphasising strengths rather than deficits or dysfunction;
- Being respectful of the user's own construction of their distress rather than working to indoctrinate them into a specific way of understanding;
- Monitoring and working towards valued outcomes;
- Educating people who provide services and the public to combat stigma and create more supportive environments (as indeed is required by disabiilty anti-discrimination legislation);
- Fostering collaboration as an alternative to coercion;
- Promoting autonomy, choice and decreasing reliance on staff;

- Approaches that span a range of contexts including specialist services and ordinary facilities used by the general public, hospital and community-based services; secure, acute and non-acute levels of care; active treatment and rehabilitative interventions; self-help and peer-run services and supports.

The Tidal Model (Barker & Buchanan-Barker, 2006) is an articulation of a recovery-based approach that has the advantage of having currency among nurses. In common with other approaches, such as a solutions-focussed approaches (e.g. de Shazer, 1985) it places less emphasis on historical factors and focuses more on the user's personal narrative; the specific individual and group processes within Tidal seek to enable people to reclaim their story, and explore different ways that they might respond to life situations, which are embedded within their narrative (ibid). Since its inception in Newcastle in the late 1990s, it has become the focus of almost 100 projects worldwide, which contribute to the continuing development of a genuinely cross-cultural model of mental health recovery. In England over 50 projects in acute, forensic and rehabilitation care, across statutory, voluntary and private settings are led by nurses, but rely on effective interdisciplinary teamwork (see www.tidal-model.co.uk and www.clan-unity.co.uk).

Wellness Recovery Action Planning is another very popular recovery based approach that has increasing currency with a range of team disciplines including psychiatrists (see www.mentalhealthrecovery.com or www.copelandcenter.com). Developed in the US by Mary Ellen Copeland it has had application in adult mental health, with children, people with dual diagnosis and with military personnel.

This question of ideologies of care was an area that generated considerable debate in the writing of this document and was an area where some felt that applied psychologists should use their training, status and knowledge of evidence to advance a principled alternative approach to diagnosis, particularly in situations where biogenic factors are afforded an unwarranted central role. This issue of how ideologies and models of care are realised as working formulations is turned to next.

Achieving an effective working formulation to guide team interventions

Formulation is defined as one of the key skills of a psychologist (DCP, 2001), and a growing number of books on the topic testify to its continuing importance (Johnstone and Dallos 2006; Tarrier 2006; Morrison 2003.) Formulations are detailed descriptions of why this person came to have this problem at this time; they draw on a range of psychological models, and one of their main purposes is to indicate the appropriate interventions. Unlike a diagnosis, an individual formulation is unique to a given individual and continuously open to revision in light of experience. As with a functional analytical approach used with a variety of care groups (Owens & Ashcroft, 1982) an effective formulation will take a systemic view that includes highlighting the circularity binding connected events where, for example, the consequences of problematic behaviours, emotions or thoughts are contributing to the conditions that created the events in the first place.

Once again it is important not to deny the importance of biological events in formulating current difficulties and how people will respond to different interventions. For example, as we will see later, applied psychologists working with people with severe and long term mental health problems are feeling that they need to have a stronger grasp of the effects of psychotropic medication. One of the authors of this report with a caring role reported personal experience of the severity of iatrogenic conditions (side effects and adverse reactions) as influenced by individual inability to genetically metabolise psychotropic drugs efficiently. To properly address this issue formulations would need to be informed by routine genotyping in mental health services; a blood test available in ordinary acute medical care that is used to establish that specific medicines will be therapeutic and safe.

However, even where biological events are contributing factors Kinderman (submitted) has argued that formulations should focus on the hypothesised disruption to mediating psychological processes or mechanisms. He argued that all interventions are more likely to be effective if they are designed on the basis of their likely beneficial impact on underlying psychological mechanisms. For example, serotonergic processes associated with depression are believed to be associated with mental disorder because of their effects on psychological processes associated with self-esteem, beliefs in self-efficacy, motivation and expectations of reward. Kinderman extends a similar argument to social factors: 'social deprivation and poverty can indeed lead to problems such as depression – but through the effects on psychological processes related to the disillusionment, hopelessness, and learned helplessness which

constitute a realisation that one's actions have no effect or purpose' (p.8). However there is a danger here that applied psychologists will get caught in a form of psychological reductionism that deflects attention from the very evident social factors underlying distress that need to be addressed directly. Indeed this ability to address a range of factors simultaneously is one of the key advantages of a multidisciplinary team process.

Despite the fact that sound formulation will contribute to the role clarity that underpins effective teamworking, surprisingly little has been written about the contribution formulation can make to team work (Christofides, in press). Dallos *et al.* (2006) have outlined some of the dilemmas raised by formulating outside of one-to-one contexts to include wider systems such as teams and services. Taking formulation into a wider setting can be a powerful way of shifting cultures towards more psychosocial perspectives. It can be a very effective use of a psychologist's limited time, and is much appreciated by staff whose training does not equip them with these skills. It is perhaps especially useful with complex clients with long-term psychiatric histories, where transference and counter-transference issues are likely to be played out in relation to the whole team (as with people often labelled as having a 'personality disorder'.)

However, formulation is not an unproblematic solution to the issue of competing models of care; the debate arises within this topic too. Formulations in mental health settings are often seen not as a replacement for, but an addition to, the standard biomedical understandings (Weerasekera, 1996; Eells, 1997). Some have argued strongly that formulation should be seen as a radical alternative to psychiatric diagnosis (Pilgrim, 2000; Johnstone, 2006) or the effectiveness of interventions will be compromised.

Another key role for applied psychologists in achieving a formulation is the use of research-informed approaches to assessment and the evaluation of outcomes for service users. As formulation is ongoing such approaches have an important role to play in informing its evolution. Approaches might include standardised psychometric instruments, time sampled observation, approaches to self-monitoring and diary keeping.

A key feature of any model is its 'heuristic' value- in other words the extent to which it serves to resolve problems and can be recognised as underpinning a useful working hypothesis by service users in a way that promotes their commitment to action. In many ways this criteria of having heuristic value is probably more important than whether the formulation is 'true' in a demonstrably scientific way (Owens & Ashcroft, 1982).

Individual service planning encompasses exploring underlying assumptions of causality, formulating issues in a useful way and then taking action. It is this latter aspect that it explored below with respect to communication and how decisions are made.

Communication and decision-making

The Aston group (e.g. Borrill *et al.*, 2000) highlighted that effective communication requires:

- **Interaction:** team members need to meet so as to co-ordinate activities, develop shared understanding (based on examined assumptions as described above), share knowledge skills and experience, learn to work together and feel safe with each other.
- **Information sharing:** to ensure effective co-ordination and use of team resources as they work together to achieve the team's objectives.
- **Influence over decision making:** to fully realise the benefits of multi-disciplinary team working, and to ensure that the team makes informed, considered decisions. Processes need to be in place to ensure that all team members can contribute their particular knowledge and expertise in the decision making process in the most effective way.
- **Participative safety:** for team members to be able to contribute fully to decision making it is important that they feel that there is a climate of interpersonal safety; that they can express their views free from the possibility of attack or ridicule. Participative safety is achieved when team members feel free to participate and share ideas, even if those ideas are a little 'half-baked'. It allows constructive controversy in pursuit of excellence.

Communication in teams needs to be centred on the user themselves and those people that they chose to involve (e.g. family, friends and/or other significant others). Communication for decision-making is a process where people come together with a clear understanding of the outcomes to be achieved, equally

equipped with information about the current situation and what is available to improve the situation. This requires that users come invested with enough authority in the process to ensure that they can take a full and active role. This in turn demands that they have access to the right information and where necessary the support of an advocate who can support them in making their views and preference known. It also requires flexibility about how their views are fed into the process. Some may chose to communicate their views on a one-to-one basis with their care co-ordinators or other key workers while others, recognising the power and authority of others in the team, may wish to engage with a larger group of the people involved.

There are other preconditions for effective communication. Firstly, there should be a recognised need to communicate. It should be seen as necessary to get the job done. Secondly, team members must have shared social reality about what they are doing, and a shared language with which to describe this reality. Building this shared reality should start with the experience of the user, and use language that promotes their inclusion. Thirdly, team members should be able to take the perspective of others into account in relation to both their emotional and cognitive position. Often this is a characteristic of maturing teams with stable membership. In these circumstances the team is better able to recognise the source of communication difficulties when they arise. Finally, there needs to be a recognisable and agreed process for communication and decision-making. It is important that decision-making is visible, inclusive and coherent, and that it is afforded time and substance. Borrill *et al.* (2000) found that interaction frequency, frequency of meetings, attempts at integration within teams, and communication in meetings played very important parts in distinguishing between health care teams. They reported that, 'It was striking how poorly managed were many of the meetings we observed.'

Power needs to be exercised within teams or there will be no action. This means that particular stakeholders need to lay claim to authority and exercise it. For example, applied psychologists are well placed to use research-based theory to inform the application of therapeutic interventions (e.g. cognitive behaviour therapy for psychotic phenomenology (BPS, 2001b); and how to work within complex systems (both at the family level, and in terms of how that system interacts with the wider community and service system)). Service users and carers also need to claim and apply their authority as 'experts by experience' of coping with difficult circumstances over protracted periods. This is rarely easy (see, for example, Clarke, 2006).

Addressing how power is exercised in teams requires high levels of courage, candour and safety to ensure strong participation. Achieving this is one of the key tasks of leadership discussed later. Often this requires challenging highly valued notions such as 'Democratic' or 'Non-hierarchical teams'. In practice, it seems that when team members refer to their team in these ways they are really referring to a participatory style of decision-making (West and Farr, 1989). Hierarchy only becomes problematic when associated with domination by top-down information flow, highly formalised rules, narrowly defined jobs, and norms that require obedience to official policy. Hierarchy may in fact be associated with clear accountability relationships and responsibilities. Making conscious the benign (e.g. on the basis of expertise and experience) and malign (e.g. on the basis of social inequalities) exercise of power in teams is likely to be easier where there is role clarity.

Addressing such concerns requires skilled reflection on the process of working as a whole team, particularly with respect to the clarification of shared objectives, roles, and interdependencies on each other. This is further covered below under 'Supporting peer consultation processes and reflective practice'.

Risk and choice

One key organisational cultural issue that influences decision making is the way in which risk is addressed within and between agencies. Good communications and teamwork are important factors in effective inter-agency working and concerns about risk management can test such joint working to the limit. There can be differences of terminology and approaches to risk assessment between agencies, which hinder a common approach to managing risk. Where possible, inter-agency agreements should include agreed definitions and shared approaches that are understood at team level.

New guidance is available from the Department of Health on best practice in supported decision making (DH, 2007a). It stresses that while we should never expose people to an unreasonable level of risk it is also important to recognise that making a choice always involves some level of risk. Trying to remove risk altogether can obstruct the quality of life benefits for the person. People have a basic right to live as they choose. The need is therefore to help people understand their responsibilities and the implications of their choices, including any risks.

The guidance suggests that for teams to work effectively with respect to risk management they need:

- Clear lines of accountability;
- Clear roles and responsibilities;
- A single management structure;
- Co-location (if possible);
- Good quality supervision and support including professional development;
- Agreed policies and procedures for delivering the service which everyone uses including regarding responses in crisis;
- Agreed documentation for the common assessment process, care planning, risk assessment/monitoring and review/recording;
- IT systems which support practice;
- Information sharing policies with other agencies;
- Agreed process for resolving complex funding issues;
- Processes for managing complex cases;
- Processes for conflict resolution.

Who decides what?

Practice autonomy, the practitioner's freedom to decide their own behaviour with regard to their work with individuals, is a strong signifier of professional status. Practice autonomy is often claimed even when practitioners lack confidence in their abilities. As Cherniss (1995) observed of professionals in their first year of practice:

> *'The new professionals valued autonomy in part because it was linked to achieving a sense of competence. When others imposed restrictions on the new professionals, it not only limited their autonomy – it also called into question their ability. Competent professionals are supposed to enjoy a high degree of autonomy. So a lack of autonomy made the novices feel less competent'* (p.23).

As we shall see below, achieving a qualified autonomy for practitioners is not only important for their own sake of efficacy; it is also required for smooth running of the team. Practitioners need to be able to make a defined range of decisions for themselves, or else the team would spend all its time managing itself and never doing any work with users. From the point of view of staff, autonomy is also important in terms of managing their own working lives. For example, Cooper *et al.* (1989) reported that the highest levels of satisfaction reported among general practitioners were associated with the amount of responsibility given, the freedom to choose working methods and the amount of variety in the job. But there needs to be checks and balances.

Morrall (1997) examined practice autonomy among team-based community mental health nurses over two years, and found their practice to be arbitrary and unregulated. They were able to regulate the size of their caseload by choosing not to visit practices where referrals might be picked up and discharging people rapidly that they deemed to be inappropriate. There was no systematic approach to assessment and there was very minimal discussion of practice with either team colleagues or supervisors. Patmore and Weaver (1991) were strong opponents to the exercise of professional autonomy within CMHTs and advocated strong operational management to restrain it. Achieving an appropriate balance between professional discretion and operational management is a critical tension within leadership and management roles and requires clarity about how decisions are to be made and by whom.

Four types of decision-making can be delineated (after Øvretveit, 1993). The concept of care co-ordination below has most currency within adult mental health services but there will normally be a similar role within teams for other care groups with respect to one team member taking special responsibility for co-ordinating inputs concerning a given client and acting as the first point of contact for care co-ordinating decisions.

1. **Decisions about work with an individual user within the user-staff member relationship.** This will include arrangements made with the team member and the user for how they will manage their work together, such as when they will meet and where. It also includes profession-specific decisions that do not need wider consultation such as which profession-specific assessment to use (e.g. for assessing activities of daily living skills, or vocational preferences), or which medication. By definition the profession concerned would need to exercise these decisions without fear of being impeded by the team, otherwise they would find themselves unable to discharge their professional responsibilities. It nonetheless remains positive practice to be constantly ready to seek advice and support from the team that will inform and improve decision-making.

2. **Care co-ordination decisions concerning an individual user.** These decisions will be delegated to a care co-ordinator in partnership with the user themselves and others involved. It is this group of people that constitute the team for the purposes of meeting the needs of the client. It is therefore in this domain that most team communication needs to take place. Care co-ordination decisions include for example who should be working together and how, what the objectives of different inputs to care are, whether a new or different approach should be used, and whether other resources can be brought to bear to improve the situation. These decisions should be very visible and subject to regular review by the team as a whole. The team should feel able to challenge decisions and suggest alternatives. Indeed the team as a whole and the user themselves are a resource for thinking creatively about alternatives. In only rare cases will there be a prescribed team policy that will tell the practitioner everything they need to know.

3. **Policy or management** decisions about how the team serves all users, and how care co-ordination will be undertaken within the team. In order to promote sound policy and effective implementation it will be important that all team members are involved in such decisions.

4. **Planning** decisions, for example, about the team's objectives, the assessed needs of the client group or substantial changes in operational policy. These decisions will extend to involve people outside of the team but clearly should include team members in order to ensure the decisions are informed by practical experience and to ensure appropriate ownership of new ideas and effective implementation.

With respect to team policy on the third category of decision making above there is the further important issue of the sort of work that psychologists are allocated within teams. There is an expectation, from both within the profession and from other professionals that psychologists will work with those users whose needs are more complex[6]. The reasoning behind such expectations and definitions of what constitutes complexity are rarely made explicit. The factors that appear to be used by staff to gauge levels of complexity vary with the client groups concerned and will often include co-morbidity (multiple mental and/or physical health problems), long term problems with many failed attempts at improvement, significant risk issues including impacts on carers, difficulties in establishing a therapeutic relationship, and the need for the co-ordinated involvement of a range of agencies. Complexity is therefore a concept that goes beyond merely the presenting problems. It involves the perceptions of users, carers, staff, the relationship between them, and the service context both past and present. There are formal measures of complexity (e.g., the Pearce Case Complexity Scale; Pearce, 1996) which attempt to encompass such factors. Such measures can inform teams' debates about what constitutes complexity within the team. This should be recorded as part of the team's operational policy, and accompanied by details of the ways in which differing levels of complexity affect the decisions and actions that the team takes.

With greater levels of complexity, it is likely that there will be a need for a team to have a wider range of skills to draw upon, and smaller caseloads (e.g. to be able to provide more intensive interventions, and to have more time for liaison with other professionals; assertive outreach team in adult mental health provide an example of such teams). Referrals involving greater complexity where a profession-specific set of knowledge and skills is required are best allocated to qualified members of staff rather than students

[6] Note that 'complex' is being used here in a way that differs from the specific construction of 'complexity' described in the context of 'complexity theory' described earlier. See the New Ways of Working in Mental Health Working Party on Complexity (2007) Interim progress report.

or trainees within a given profession. Where knowledge and skills are required that are shared across staff, referrals should be allocated to the team member with the greatest level of knowledge, skill and experience in that particular area. This requires high levels of awareness within the team of the resources of knowledge, skills and experience that it has at its disposal. This awareness needs to encompass not just specific training in therapeutic approaches but also the non-discipline specific qualities of the team members such as their cultural background and life experience. It should also, of course, be informed by the knowledge, skills and experience of the users themselves and the people that support them.

Valuing constructive conflict

Rogers and Pilgrim (1996) describe the role relationships between disciplines as the outcome of successful bids for legitimacy on the part of particular disciplines rather than rationally determined roles that are self-evident from the knowledge and skills that a particular discipline brings. It is therefore not surprising that role relationships should provide a rich vein of conflict within teams (Galvin & McCarthy, 1994) as people defend their positions and perspectives.

There are 'perhaps few other sectors where relationships are as contested and professional identities so closely guarded as in mental health' (Henderson, 2001). There are many reasons why 'a multidisciplinary team without differences is a contradiction in terms' (Øvretveit, 1995). As highlighted by Lankshear (2003), like all health care teams, mental health teams are a site for contest and negotiation due to a variety of factors including differences in world view (Øvretveit, 1995), professional allegiances (Peck & Norman, 1999), and pay and status (Norman & Peck, 1999). Where inadequately defined, dual accountability (or matrix management) arrangements also offer tremendous latitude for conflict (Galvin & McCarthy, 1994) as well as role clarity when they are well delineated.

Avoidance of conflict can be destructive. Possibly out of a fear of jeopardising a favoured intra-team position or in reaction to what they perceive as illegitimate claims to power (e.g. by Consultant Psychiatrists equating medical responsibility with 'ultimate clinical responsibility'), many team members may minimise or deny the existence of intra-team differences (Øvretveit, 1995). They may attempt to conceal power relations by advocating 'democratic' or 'non-hierarchical' teamwork (Norman & Peck, 1999). However, such concealment predisposes to avoidance of substantive discussion about power relations that only serves to mask intra-team inequalities and potential ideological conflicts (see above; Lang, 1982). Hence, these 'unspeakables' remain 'unspoken' (Byrne *et al.*, 2006) and remain 'all the more oppressive by being implicit and difficult to challenge' (Onyett *et al.*, 1997). Lang (1982) offered an example of how lack of conflict can reveal an attempt to create and maintain the illusion of egalitarianism within teams: *'Staff meetings and case disposition meetings, which could have served as the basis for more sustained and substantive interaction, were remarkably, even compulsively, devoid of substantive discussions which might bring forth indications of the workers' very different intellectual, social and professional levels. There was little in-depth discussion of cases, virtually no conflict over diagnoses or treatment recommendations, and rarely any discussion of issues drawn from the larger fields of psychiatry or mental health. In this instance the avoidance of substantive discussions and conflict can be viewed as a mechanism by which the reality of stratification was suppressed and prevented from interfering with the goal of equality'* (p.164). Watts and Bennett (1983) also underlined the positive aspect of disagreements over work with users stating that *'one of the problems that can afflict an over-cohesive team is a kind of "Groupthink" in which the team ceases to pay attention to information that conflicts with its general assumptions, and strong social pressures are brought to bear on any members who challenge these assumptions'* (pp.317–318).

Intra-team conflict can, therefore, remain hidden and sometimes unconscious (Heginbotham, 1999). Taking conflict off the team discussion agenda makes it more likely to occur and even more destructive when it finally does break out (Øvretveit, 1995). Without the expression of difference within teams there is a danger that meetings diminish the intellectual contribution of everyone present (Lang, 1982). It may also mean that the user's own representation of their situation is not taken fully into account as part of the decision-making process (Opie, 1997).

Well-functioning teams are not characterised by an absence of conflict (Senge, 1990). Interdisciplinary 'creative tension' can enrich team functioning and predispose to greater innovation and more effective interpersonal relations (Tjosvold, 1997). However, if not managed appropriately it can lead to lower team effectiveness, reduced well-being and increased turnover (Spector & Jex, 1998). This often happens when

'task' conflict escalates into 'relationship' conflict – in other words things get personal. Intra-team 'task' conflict typically pertains to divergence of opinion relating to some aspect of teamworking (e.g. roles and responsibilities, clinical judgements, caseload sizes). Where it escalates into 'relationship' conflict (De Dreu & Van Vianen, 2001) it involves negative emotions and threatens one's personal identity and feelings of self-worth (Pelled, 1995). Whereas task conflict may motivate team members to look for optimal judgements and decisions, relationship conflict can hinder social behaviour, damage team climate and predispose the team to failure.

A commitment to engagement in 'constructive controversy' (i.e. the open-minded discussion of opposing stances) can build mutual respect, facilitate resolution of differences and prevent conflict from escalating unnecessarily (Tjosvold, 1997). West and Farr (1989) noted that successful organisations manage rather than suppress or avoid conflict, and that responsibility for managing conflict should be seen as part of everybody's job rather than located with particular managers acting as referees or arbiters. Resolving conflict is clearly easier where there are well defined responsibilities and lines of accountability within the team, and where there is a shared understanding and agreement of who decides what and how.

To promote effective discussion of difference while promoting a sense of containment it is important to create space for discussion of difference. It can also be helpful to have a series of 'backstops' agreed as part of operational policy between team and other line managers for conflict resolution. One approach that was found to be effective was to use the team manager, a team support group and a management steering group as a mechanism for conflict resolution (Onyett, 1998). There was agreement that the manager would first approach the conflicting team members and encourage them to make use of the support group. Where this was refused, inappropriate or ineffective the manager had the authority to liaise with the appropriate line managers to attempt resolution. Where this failed there was the possibility of then using the team's steering group, on which key external managers and agencies were represented. Having clear mechanisms laid out in this way had the effect that there was only one occasion where issues had to be taken outside the team's support group. This also appeared advantageous in promoting a sense of team identification and autonomy. Such measures should complement the more conflict-preventative measures such as building and maintaining intra-team trust that may reduce the likelihood of task conflict developing into relationship conflict (Simons & Peterson, 2000).

Supporting peer consultation processes and reflective practice

Traditionally, reflective practice has several meanings: personal use of self and impact of self in and on therapeutic or team relationships; learning by doing or practice based learning, developing a procedural knowledge gained through experience; and locating practice in wider socio-cultural and economic contexts. At its core it is about creating opportunities for reflecting on the team process, and work with individuals, groups and families. It is part of creating what Roberts (1998) refers to as 'the consultant in the system'; a third party that alters the shape of the system from a two-person, user-worker bi-polar system to a triangular user-worker-consultant system. In the psychoanalytically informed approach of Roberts (1998) this triangular system forms a reflective space within which it becomes possible for projections to be acknowledged, owned and processed. It creates the possibility for us to observe ourselves in interaction with others and to see the situation from alternative perspectives. It also helps counter a tendency towards frenetic activity and doing (e.g. another change in medication) rather than reflecting and staying with the user to better understand and respond to their experience. Schön (1983) saw reflective practice as addressing the gap between scientific theory and the moment by moment decisions that characterise skilled practice. He argued that reflective practice is needed for dealing with the unexpected and unique situations that arise in practice settings, or for those that give rise to value, role or professional conflicts.

The 'consultant in the system' can be achieved both through individual peer consultation or supervision from a respected source. It can also be achieved as a group process involving all members of the team together. Both approaches require that space is defended and respected (for example by turning off mobile phones or pagers). Promoting reflective practice through team processes requires highly developed facilitation skills. For each user being reviewed someone will need to ensure that the discussion is divergent and inclusive enough for participants to truly understand the situation and generate new ideas. Teams must not become committed prematurely to ideas, which may be false, incomplete or too

readily suggested by custom and practice. However at some point the discussion will need to shift from being divergent to convergent, narrowing down on some key actions to be taken forward.

Psychologists can support reflective practice in team contexts both through offering peer consultation (or supervision) as required in individual and team contexts but also as modelling being able to use and apply the consultation and reflections from other peers in the team.

Team-based peer consultation processes may be of particular value to teams working in an in-patient or residential setting or which adopt a whole team approach to working with service users, such as assertive outreach teams. Peer consultation may take place through routine case review meetings, individually arranged appointments with other members of the team or through bringing disciplines together specifically to reflect on team process. Often it can be problematic for psychologists as integrated members of a given team to act as the facilitator of this process. Some organisations get psychologists to provide this role with teams that they do not belong to within the same organisation.

Individual peer consultation and supervision processes can be offered by psychologists to individuals both within and outside the team, though in the former case it will be important that it does not conflict with the more open and transparent decision making processes of the team as a whole, or become perceived as a covert form of influence. Beinhart (2004) has reviewed the features that promote effective relationships for peer consultation and supervision. At the core is mutual trust and respect. It is important to establish rapport and role clarity, exploring hopes and expectations and setting clear boundaries both in terms of structure and what can be brought for discussion. An effective consultant/supervisor will maintain interest, curiosity and commitment. As with consultation delivered as a group process, turning up late and not maintaining the structural boundaries that might be expected risks damaging relationships. It is also important not to ignore the power relationship inherent in the relationship and recognise that what is needed will be very specific to the needs and development of the individual (or team) concerned. The BPS has developed Supervisor Training and Recognition learning outcomes for supervisor accreditation which describe the competencies required of supervisors. They also are likely to be of relevance to peer consultation processes offered at team level which may be an increasingly important role for applied psychologists.

Positive practice example: Supporting peer consultation process and reflective practice.

In Wandsworth, Bluebell Ward has been running a reflective practice group facilitated by clinical psychologists for over a year. At each meeting, one inpatient's history and current concerns are presented. The group then develops a family tree and a formulation. This helps the group reflect on the developmental, social, psychological, physical and behavioural aspects of an individual's experience, in order to make better informed decisions about their care. The group is held on a weekly basis and provides an additional opportunity for the inpatient team and the community mental health teams that are linked to the ward to care plan together. The meeting is attended by all the multidisciplinary staff involved in the care of inpatients on the ward. Senior staff such as the ward manager, consultant psychiatrists, CMHT manager and the head of arts psychotherapies regularly attend. An evaluation of the group showed that overall inpatient and CMHT staff found the group useful, helping them to gain a better, more holistic understanding of the inpatients and giving them useful ideas to use on the ward.

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Positive practice example: An innovative approach to consultation.

East Sussex Mental Health Services have been using a model to work with individual, adult users of mental health services that draws on theories more commonly used with families, for example systemic and social constructionist perspectives. These ideas have been translated such that two practitioners see each client. One practitioner takes an 'interviewer' role and the other the 'reflector'. The interviewer begins the conversation during which they explore the client's situation, their current difficulties and also any ways of coping that they find helpful. At least once during the session, and with the client's permission, the interviewer and reflector have a conversation in front of the client during which they tentatively explore any ideas and thoughts they might have about the client's situation and what they think might be helpful. Practitioners from a range of different professional backgrounds, including psychology, are involved in offering these sessions.

These ideas were developed by clinical psychologists locally (see Jones *et al.*, 1997), to work with clients who had been involved with CMHTs over a long period of time with the aim of reviewing the input the service was offering, or to explore times when input to a client felt 'stuck'. The model has more recently been used for new referrals into the CMHT, to assess whether psychological input might be useful to clients involved with the CMHT and to offer a brief therapy service within Primary Care (Moss, 2002).

In a recent audit of this new way of working staff members reported that they found it beneficial; their comments included finding:

- the reflecting conversation powerful;
- that it offers a more comprehensive and collaborative assessment;
- there are opportunities to learn from other disciplines; and
- it is supportive when working with high risk and complex clients.

An audit of clients undertaken within the primary care setting has also shown this approach to be empowering for many service users, having a positive and empowering impact on their self-narrative and enabling them to make changes within their lives.

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Positive practice example: Defending space to offer a consultation service to staff working in inpatient wards for older people.

The broad aims of the service are: to provide a direct, accessible and responsive consultation service to all staff working on older adult inpatient wards; to enhance collaborative working; to promote psychological services and resources; to promote psychologically informed practice within person-centred principles. A qualified and an assistant psychologist visit three older people inpatient wards for an hour per week at agreed times to be available to staff. Results of a recent evaluation of the service suggest a broad range of professions are using the service. The heaviest users of the service are nurses. Reasons for seeking consultation predominantly focussed on accessing psychological knowledge/advice/support for client related issues such as psychological input into individualised care planning, requests for training (e.g. understanding mental illness, undertaking psychological and neuropsychological assessment), or input with families and carers. However, the service was also frequently sought for personal issues related to staff stress and coping. In all, the service is viewed as a valuable and effective way of raising the accessibility and responsiveness of psychologists and psychology into inpatient settings.

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Promoting effective participation of service users and their relatives/carers

User and carer participation in the design and delivery of UK health services was central to the NHS Plan (DH, 2000) and is recommended in the NICE guidelines (see www.nice.org.uk). Harnessing the unique experiences of users and carers to inform practice is key to local service improvement, providing an evidence-base from which commissioners and practitioners can identify and address the issues of most importance.

The range of potential roles includes:

- **Involvement in own care planning and delivery**
  - Collaborative care planning
  - Informed choice
  - Advance directives
  - Self-help
  - Use of direct payment, individual budgets, and other mechanisms for personalised care.

- **Involvement in practice development**
  - Providing feedback through complaints, satisfaction questionnaires, audit, outcome scales etc.
  - Representation at team community meetings, staff away days or development meetings
  - Designing service information literature, user-friendly documentation
  - Providing staff training

- **Involvement in service development, leadership and management**
  - User-led service monitoring
  - User-led research design and implementation
  - Representation on partnership forums, management, governance and commissioning boards, e.g. as non-executive directors
  - Selecting staff
  - Contributing to staff appraisal

- **Direct practice involvement within services**
  - Employment to existing posts
  - Employment in user or care participation development posts
  - Providing advocacy, befriending services.
  - Facilitating or co-facilitating support activities, e.g. support groups, befriending
  - Facilitating or co-facilitating therapeutic activities, e.g. hearing voices groups

- **Involvement through other organisations**
  - Advocacy and link workers
  - User/carer led organisations in the third sector
  - Involvement in Local Involvement Networks and other processes for the commissioning and governance of service provision.

The involvement of users and their relatives or carers has often been seen as synonymous. However, the needs of service users and carers, their views and contributions, will very often differ considerably. Even the term 'carer' can feel disparaging to some service users as it defines their relationship to their relative uni-dimensionally (see Perkins & Repper, 1998). It is well acknowledged that the needs of carers should assume a high priority in treatment and care planning. Carers have a unique perspective to offer, in particular when service users are less able to convey their difficulties. Carers through their long standing knowledge of their loved one play a vital role of advocacy in communicating with professionals.

There are a number of ways in which the psychologically-minded practitioner can promote the role of service users and their carers. Some of these are covered elsewhere in this document with respect to encouraging proper formulation of the current situation and promoting person-centred planning. It is essential for the psychologist to be working to these goals in collaboration with other team members, service users and carers, team managers and management.

Some key functions that psychologist can support include the following:

Supporting users and carers in finding a voice
Lack of funding and user participation being a low service-level priority were reported to be the major barriers to achieving and maintaining effective service user involvement in teams (Sarsam & Kinderman, in preparation). Addressing attitudes of front-line staff was considered essential. Applied psychologists have a role in making the case and creating the right conditions for effective user and carer participation.

Service user and carer involvement provides clear advantages for health and social care systems (Beeforth *et al.*, 1994). Sarsam and Kinderman's study found that these advantages varied from notable increases in engagement and motivation of current service users when ex-service users were visibly employed in services, to changes in staff and management attitudes and value systems towards a greater understanding of service users as 'whole people' and a reduction in 'us and them' attitudes. For service users and carers becoming involved in the design, monitoring or delivery of services allowed the development of a meaningful role and identity outside their difficulties. It allowed the formation of relationships, both social and occupational, facilitated social inclusion, and (when adequate payment was provided) helped address the financial difficulties experienced by many service users. In aspiring towards person-centred services, providing such opportunities for service users sends a clear message regarding the real possibility of recovery and the achievement of meaningful life goals.

The involvement of service users and carers is also beneficial to health and social care more generally because of the expertise that they bring through their experience. Service user workers in teams can understand, empathise and communicate to health professionals the complexity of current service users' difficulties from a unique perspective. They can provide a voice and much needed advocacy. Very many service users who express an interest in becoming involved at service provision level hold a psychosocial perspective on such mental health difficulties. Therefore, the prominent involvement of service users in teams, particularly through training and staff induction, helps to advocate to team workers the importance of addressing these issues as a priority, directly aiding psychosocially awareness.

Maintaining some policy awareness on national development to support user and carer participation will also be important. Many of the systemic processes for allowing service user and carer involvement in individual treatment plans should already be in place, for example through the effective implementation of the Care Programme Approach which should result in care plans that are agreed with users and their supports. Policy rhetoric can often be a useful lever for change. See, for example, the new Commissioning Framework for Health and Well Being (DH, 2007b, p.25) references to the need for co-production of care plans and support to people in directing their own care and support.

Raising awareness of the possible
Visible service user involvement has a clear implication for current users of a service. It provides a model of recovery. Service users are presented with evidence that people with difficulties can assume valued roles which are respected and have status and value.

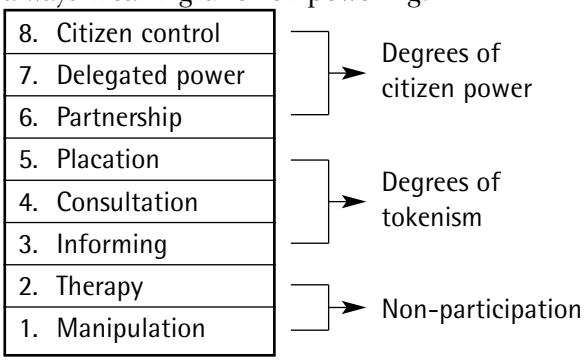
It is important for advocates of user and carer participation to maintain awareness of the many advantages cited here and elsewhere and also a sense of the possible in terms of exemplary examples of positive practice. One example with respect to team process is the Open Dialogue approach pioneered in Finland wherein all decisions about care are made in the presence of users and their wider networks even at a stage where the individual is experiencing severe psychotic phenomena (Seikkula & Trimble, 2005).

In the UK care plans are often limited by workload and service constraints (Sarsam & Kinderman, in preparation). As such, staff's ability to fulfil the needs of service users and carers utilising a truly collaborative, joint-working approach can be compromised to the extent that a 'tick-box' approach to care planning may result with little true collaborative involvement. The applied psychologist has a role in helping the team and the organisation remain alert to such degeneration and maintaining awareness of the value of investing time in proper process. This means demystifying recovery-focussed working practices and helping maintain a sense of the possible through a thorough understanding of what can be achieved. Low expectations among staff and indeed users themselves can constrain ambition, (e.g. with respect to social inclusion; Social Exclusion Unit, 2004) and so maintaining awareness of the available evidence and concrete examples of positive practice will be critical. This serves

to acknowledge and address cynicism and disempowerment among service users, carers and staff.

Supporting individuals in their roles

Ensuring role clarity with clear job descriptions and reporting and accountability relationship is essential. The range of roles which people are able to undertake, alongside the increasing call for greater involvement from government bodies and watchdogs, means that service user may become overwhelmed with involvement requests, risking overwork and high stress levels. Clear roles with clearly defined terms of reference and outcomes are also important in guarding against tokenistic involvement in services, and in providing appropriate or inadequate support. The following 'Ladder of citizen participation' (Arnstein, 1969) provides a useful way of schematising how users can be involved in ways that are not always meaningful or empowering.



Psychologists may be well-placed to provide mentorship, consultancy and supervision for service user and carer workers and can also utilise their understanding of systemic processes within teams to understand, monitor and nurture staff attitudes and working practices. The provision of a simple safe space for reflection is another particularly important role (see Hossack & Brookfield, 2007) and it is important that service users and carer roles have the same access to defended time for reflection as any other team member. Service users and carers can also feel isolated in their participation and development roles and peer support and user networking may also be helpful (Branfield & Beresford, 2006).

Another key element of helping users find a voice is to advocate that support to service users and carers, their payment, training and preparation is in line with existing positive practice[7].

Making good use of information

People need to be aware of how they may take a more active role in decisions about their own care and treatment. Such informed choice is central to a collaborative psychological way of working, but its' fundamental importance may often be overlooked in busy health and social care settings.

Information is also needed on how service users and carers can become more involved at all levels, from involvement in their own care through to involvement in wider service development. It might be as simple as ensuring that people know how to complain.

Training

A particularly important area of training might be in how service users and carers can feel confident in relating to professionals and communicating within teams (see Clarke, 2006). This may include public speaking (Sayce, 2000), and understanding the context of services, teams, and outside agencies. As well as this, the provision of training regarding supervision, support and managing personal boundaries will be particularly important in safeguarding the wellbeing of people who have experienced services first-hand when working in practitioner roles. Equally important is training for team members on the advantages of working with service users and carers and how they may feel confident in relating to service users and carers as colleagues. There are some exemplary examples of training to support service users and carers in these roles, such as the service user and carer leadership programme at Surrey University. This programme is designed and driven by users and carers and is accredited at level 3 in the knowledge and skills framework (contact Lu Duhrig on L.Duhig@bath.ac.uk for more details).

[7] See the forthcoming guidance from www.csip.org.uk following the HASCAS 'Making a Real Difference' report.

User-led training and education has also been seen as key to promoting participation (Branfield and Beresford, 2006) and applied psychologists may have important roles as co-trainers, evaluators or in helping to build training capacity.

Positive practice example: Development of Self-Help Hearing Voices Groups.

In East Sussex the role of psychologists in teams includes working alongside experts by experience to develop self-help groups along hearing voices network lines.

Multi-disciplinary co-working of psychologists, other professionals and users as equals with different areas of expertise enabled them to develop self-help groups in an area where previously there were few. An evaluation of outcomes demonstrated effectiveness including increased self-esteem, decreased voice hearing, people feeling better able to cope and increased social inclusion. Staff, volunteers and group members reported the experience to have been positive.

Some of what makes this work well include:

- Psychologists engaging in groundwork with managers, teams and concerning resources.
- Psychologists co-facilitating groups in the early stages of development and at later times of transition.
- Employment of a project worker with personal experience of hearing voices.
- Allowing time for the groups and individual members to gain confidence and feel ready to progress to self-help (after approx 12 to 18 months).
- Breaking down facilitator and leadership roles into tasks, e.g. buying refreshments, sending out letters, chairing/facilitating groups.
- Training, e.g. about voices, assertiveness.
- Regular supervision by the psychologist.
- Development of a team of facilitators that includes self-help facilitators, psychologists and others involved with the groups.
- Clear contracts, status and lines of accountability for self-help facilitators. Within Sussex they have worked as Trust volunteers but alternatives could include linking with relevant voluntary sector organisations.
- Reasonable adjustments, e.g. quiet office space to minimise distractions other than voices.

For more information contact Sara Meddings on 01323 446059 or sara.meddings@sussexpartnership.nhs.uk or see www.sussexvoice.org.uk

Positive practice example: Ex-service-users working therapeutically in Merseycare Outpatient Sex Offenders Service.

For several years, the psychological services outpatient sex offender treatment programme has employed ex-service users on contract to work alongside clinical psychologists. Having undergone the treatment service themselves, they have been provided with Level 1 counselling training by Merseycare NHS Trust. Their roles include co-facilitating group therapy sessions, acting as advocates for current service users during clinical interviews, providing training for police and social services, sitting on recruitment panels, and making themselves available for questions and support.

Psychologists working within the service are directly responsible for supervising, briefing and debriefing ex-service user staff in their roles on the treatment programme. These programmes are also designed in response to the insights and suggestions provided by service-user workers.

The ex-service-user's role in the treatment programme is of crucial importance. Their presence provides a model of success for current users of the service, who consistently identify these individuals as one of the main agents for their change in attitude. Their presence allows a bridging of the 'us and them' gap between professionals and service users, which is particularly pertinent in forensic services. For the service-user-workers themselves, they describe how their role in the team is important in their continuing recovery, facilitating the development of a sense of identity, usefulness, confidence and empowerment, allowing them to define themselves as something other than 'ex-sex offenders'.

For further information contact: Alex Hossack, Head of Psychological Services Directorate, Mersey Forensic Services, 0151 709 7010.

Positive practice example: Service users involved in their care at Pathways Psychiatric Intensive Care Unit, North East London Mental Health Trust.

The client group at Pathways Psychiatric Intensive Care Unit consists solely of those detained under the Mental Health Act – a population at significant risk of disempowerment and stigmatisation. The ethos at Pathways is first and foremost to promote empowerment and this is reflected in the integrated way in which service users are involved in their own care.

In the Community Meeting, jointly run by a weekly-elected service user and a staff member, service user concerns can be discussed and problem-solved with the team. An elected service user also attends the weekly multidisciplinary team meeting, where voicing their opinions on team decision making is encouraged. Service users are also able to make use of the team's ex-service-user advocate who is able to represent and support them at ward rounds.

A major role of psychology on Pathways is to encourage service users to acknowledge their rights to feel valued both as individuals and service 'consumers' with valuable advice and insights into 'what works' in promoting recovery for those with severe mental health difficulties. Important links have been set up by psychology with the voluntary sector for employment both as service-user development-workers and in other, non-mental-health fields, ensuring the continuation of a positive, empowering, recovery-focussed experience of inpatient mental health services.

For further information: Marc Kingsley. Clinical Psychologist. Pathways PICU. Tel: 020 8215 6640.

User and carer participation concerns the exercise of power. For all practitioners issues of responsibility and accountability are key and this is the issue turned to next.

Responsibility and accountability

The terms 'responsibility' and 'accountability' are often used inter-changeably. Here 'responsibility' is defined as a set of tasks or functions that an employer, professional body, court of law or some other recognised body can legitimately demand of a practitioner. Accountability describes the relationship between that practitioner and others with respect to those responsibilities. In other words, accountability describes the mechanism by which failure to exercise responsibility may produce sanctions such as warnings, disciplining, suspension, criminal prosecution, or deregistration from professional status.

Practitioner responsibilities

Professional practitioners within teams are accountable for different responsibilities to different authorities.

Employee responsibilities are defined by a contract of employment, which usually includes a job description describing responsibilities in detail. These objectives should be discussed, developed and clarified with the individual's line manager informally and formally as part of the performance appraisal process. It is important that the employee appreciates the link between their work objectives, that of the team and the organisation.

Professional responsibilities are defined by a duty of care to users, professional codes of conduct, and in some cases state registration requirements. For staff in training or recently qualified this includes formal accountability to a professional line manager in a practice supervisory role.

Legal responsibility forms part of professional responsibility and describes an obligation to recognise and observe the limits of your training and competence and satisfy yourself that anyone else to whom you refer is also appropriately qualified and competent.

Certain members of the team will also have additional legal responsibilities. For example, under a revised mental health act, senior team members assuming a 'Responsible clinician' role will have particular responsibilities. These will be enshrined within a Code of Practice but are likely to include ensuring that users know their rights, helping them access the tribunal process, and monitoring whether they remain eligible for supervised community treatment.

Problems with responsibility and accountability arise when:

- employers demand that a practitioner assumes responsibilities that they are not qualified or competent to exercise;
- practitioners themselves assume such responsibilities, e.g. seeking to control the work of others where they have no formal accountability for their work;
- lines of accountability conflict, creating confusing sources of feedback and support for practitioners- this is particularly likely where the responsibilities that pertain to the different lines of accountability are not properly differentiated;
- allocated responsibilities cannot be executed because of lack of resources (e.g. capacity to fulfil all responsibilities within reasonable work-time boundaries);
- Allocated responsibilities conflict with the practitioners own personal values and the values embodied in their role as a professional practitioner;
- Responsibilities and accountability is simply poorly defined.

As we have seen above, practitioners are accountable to employers, their professional bodies and society as a whole through the legal system. However, they are also accountable to people that use their service. They may find themselves in conflict between what they perceive as expected of them from powerful authorities around them and what they perceive to be in the best interests of the users of their service. As Barker and Baldwin (1991) observed *'Each worker has a responsibility to determine where his or her ultimate responsibility rests. Within these constraints, many workers will decide that they are, ultimately, responsible to themselves, and will operate according to a personal ethical code'* (p.195).

The responsibilities of employing authorities

It is important for practitioners to be aware that employing authorities also have a direct duty of care towards users, visitors and their own employees. They need to ensure that those they employ are suitably qualified, competent and supported to carry out their roles. Employers also have a duty to ensure a safe system of care for both users and employees. They must provide proper facilities and equipment and ensure that staff are able to exercise their professional responsibilities (BPS, 2001a). They are also responsible for the development and monitoring of realistic operational policies.

Employers also carry liability for the acts of their employees when acting in the normal course of their employment. However, this does not protect the individual practitioner from personal litigation. They remain personally responsible for their own acts, even though claims are usually made against the employer.

Tasks that shape practitioner behaviour

In order to be clear about what needs to be achieved when establishing frameworks for responsibility and accountability, Onyett and Ford (1996) advocated that the following three tasks that shape the practice of team members be borne in mind. It is important to stress that this is just one take on the issue- rather than definitive guidance. It is designed to challenge our thinking about the language we use and what it means in practice.

1. **Practice supervision** operates in the context of a formal accountability relationship between a line manager and a more junior staff member who has yet to achieve the status of an independent practitioner accountable for their own decision-making on casework. The word 'supervision' is often used too loosely in a context where clarity is critical. It is commonly used to describe a relationship that is more akin to peer consultation (see below) or mentoring. In social services the term 'supervision' is used more precisely and in accordance with the dictionary definition, which stresses 'inspection' and 'control' (Chambers 20th Century, 1983). There the term 'supervision' describes an accountability relationship that requires the supervisee to act in accordance with direction given by their supervisor. By this definition, supervision of decision-making and actions can only operate

within a relationship where the supervisor has the training required to adopt this role. It is not possible for a supervisor to supervise work for which they are not trained, as there is therefore no way in which they could be held accountable for that work (BPS, 2001a). Practice supervision most commonly occurs where a professional is supervising the actions of a more junior or aspiring member of their own profession who has yet to achieve independent practitioner status, for example someone in professional training. This narrower definition should not detract from the central importance of that process that is commonly referred to as 'supervision'. However, it is a misnomer and this important process is more accurately described as 'mentoring' or 'peer consultation' where it spans disciplines.

Each independent practitioner is personally accountable for the exercise of their professional responsibilities, once they have completed training and any post-qualification supervision period. The requirement of practice supervision is often used as the rationale for retaining primary accountability through professional line management structures. In fact, once practitioners have achieved independent practitioner status they are accountable to their professional bodies and the courts for the exercise of their professional responsibilities (and the legal responsibilities that these subsume). They should nonetheless have an effective relationship with a manager who will support, advise and if necessary constrain them to act in accordance with their acknowledged standards of their profession. That manager will themselves have a responsibility to do everything in their power to ensure that the people they manage act appropriately. This function should be distinct from support concerning personal or professional development, although the same person might fulfil the role. Practitioners should be able to seek support with their practice from whoever they judge to be most suitable.

Different professions and disciplines have different procedures concerning when and if practitioners can be said to be independent in the sense of being accountable for their own practice decision making.

2. **Peer consultation** is support and advice given within and across disciplines. It is this activity that is often too casually referred to as 'supervision'. Lack of formal accountability through 'supervision' (as defined above) does not render the support and advice given in case review meetings or through individual peer consultation unimportant. *This peer consultation (both from within profession and from others) is perhaps the core rationale for operating in a team.* Individual peer consultation with a respected practitioner should be required of all practitioners, regardless of whether they require formal practice supervision (as defined above) or not. Aside from the importance of continuously developing the capabilities of practitioners, it may also be required to help practitioners recognise where they may be exceeding their competence. Those that fund teams need to ensure that time and resources for peer consultation, and practice supervision for those that need it, are available and secure.

3. **Operational management** occurs where a manager has devolved responsibility for management tasks and can supervise the compliance of any discipline within the operational policy. Increasingly this form of accountability is exercised at team level through team manager roles.

   It is important that practitioners are aware of the distinction between professional and legal responsibilities, as described above, and their responsibilities as employees of the managing authority. In order to promote effective teamworking it is often advantageous for the management of their responsibilities as employees to be through a team manager to the employing authority. Should a management intervention be necessary then this would be the job of the team manager, seeking advice from others, including senior members of the relevant employee's own profession, as appropriate. The argument that only someone from within the same profession can exercise line management on behalf of the employer is no longer tenable, particularly since the introduction of clinical governance (Department of Health, 1998a). As team managers are often at the interface of issues concerning operational and professional responsibilities it is clear that they will require considerable skill and understanding of the demands of professional practice if they are to be credible to the people they manage.

Medical accountability

The role of some doctors in asserting accountability for the work of others in teams has been as a historical source of conflict within teams. In fact the General Medical Council guidance (2005; cited in 'New Ways of Working for Psychiatrists' see www.newwaysofworking.org.uk) on this topic is a model of clarity. It could apply to any discipline within the team and is entirely in line with the guidance given above. It states… *'doctors should establish clearly with their employing or contracting body both the scope and the responsibilities of their role. This includes clarifying: lines of accountability for the care provided to individual patients; any leadership roles and/or line management responsibilities that they hold for colleagues or staff; and responsibilities for the quality and standards of care provided by the teams of which they are a member … Doctors are not accountable to the GMC for the decisions and actions of other clinicians … many psychiatrists work in systems that are not based on referral of patients to a specific consultant. Instead, the multi-disciplinary teams of which they are a member may provide health and social care services to a substantial number of patients. Referrals are made directly to such teams and decisions about allocation to an appropriate professional are made according to the teams' policies. In these teams, the responsibility for the care of the patients is distributed among the clinical members of the team. Consultants retain oversight of a group of patients who are allocated to their care and are responsible for providing advice and support to the team. They are not accountable for the actions of other clinicians in the team.'*

The leadership of teams

There are a variety of competency frameworks for describing leadership for particular groups of practitioners many of which have been translated into tools for 360 degree feedback and development (e.g. the NHS Leadership Qualities Framework, see www.nhsleadershipqualities.nhs.uk; Alimo-Metcalfe, 1998). However, recent reviews of leadership behaviour emphasise: (a) its context-bound nature with respect to the task at hand; (b) the finding that it is the quality of the relationship between leader and follower that matters most to performance-relevant attitudes and behaviour; (c) that it is the relationship with your immediate line manager that has most impact on how you feel about your work rather than the behaviours of people at the top of the organisation (Alimo-Metcalfe & Alban-Metcalfe, 2000); and (d) that leadership capacity is often dispersed within complex systems (e.g. Bolden, 2004; Millward & Bryan, 2005).

As the 'New ways of working for psychiatrists' report states (p.46 – see www.newwaysofworking.org.uk): *'Clearly no discipline can claim to have exclusive competences for [team leadership] as a consequence of their professional training. Individuals from all professional backgrounds need to be developed and selected with care to fulfil these crucial team management/leadership roles'*. In this context applied psychologists need to highlight the skills that they can bring to the leadership role. For example, The New Ways of Working for Applied Psychologists Leadership document (2007) states that *'Psychologists, by virtue of their training, competencies and experience, can lead and manage teams, and take 'clinical responsibility' while supervising more junior staff'*. However, we also need to avoid replacing one hegemony with another and recognize that given the wide range of knowledge, skills and experience among disciplines within the team an open, transparent and equitable approach is needed to determine leadership roles that are not overly influenced by the social value attached to particular disciplines. It is however important that leadership is clear and that there is an absence of conflict about leadership as leadership clarity is associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation (West *et al.*, 2003).

Hosking and Morley, (1991) provide a description of leadership as *'a process in which leaders collaborate with others to generate commitments based on a shared sense of social order'* (p.159); *'a more or less skilful process of organising, achieved through negotiation, to achieve acceptable influence over the description and handling of issues within and between groups'* (p.240). It therefore has a *creative* dimension that helps people make sense of their social worlds, and a *political* dimension concerned with valuing possible lines of action in different ways.

A good example of the context-bound quality of leadership is Mannion *et al.*'s, (2003) study of culture and the performance of health care organisations. This showed that low performing organisations (in terms of 'star ratings') needed to focus on strengthening systems of accountability which in turn required strong directive leadership while not becoming seen as remote or disconnected from day-to-day concerns. In other contexts different aspects of leadership and management should be ascendant although the personal leadership skills to ensure a culture of improvement should endure. Scott *et al.*

(2003) cited leadership as a key factor in achieving culture change, not just in using transactional skills to influence behaviour but also transformational skills to shape the interpretation and meaning attached to those behaviours.

This contextualised formulation of leadership as a process of dispersed influence makes leadership and team work processes inextricable. As Senge *et al.* (1999) observed leadership is about *'The capacity of a human community to shape its future, and specifically to sustain the significant processes of change required to do so'* (p.16). In that staff can exercise discretion about whether they give their minimum or maximum effort to achieving improvement and high performance, leadership is about creating environments in which staff motivation, morale and commitment flourish. In exploring how team leaders get members to 'go the extra mile'. Haslam and Platow (2001) found that it had little to do with the personality or charisma of individual leaders but rather *'in the higher order relationships between leaders and followers … an emergent social identity in which leaders and followers are creatively united'*. In this model, the success of leadership hinges on an ability to turn 'me' and 'you' into 'us' and to define a social project that gives that sense of 'us-ness' *meaning* and *purpose*' (emphasis added).

Similarly Alimo-Metcalfe and Alban-Metcalfe (2002) described leadership as being about: *'engaging others as partners in developing and achieving the shared vision and enabling staff to lead. It is about creating a fertile, supportive environment for creative thinking, for challenging assumptions about how a service or business should be delivered. And it is about much closer sensitivity to the needs of a range of internal and external stakeholders, inside and outside the organisation. It is about connectedness'*. The qualities needed to deliver this correspond closely with some of the features of effective teamworking described in the literature. Table 3 (from Onyett, 2004) summarises these drawing on the work of Alimo-Metcalfe on leadership and West and colleagues on team working.

Relating leadership specifically to team contexts, West & Markiewicz (2004) refer to three key tasks:
1. creating the conditions that enable the team to do its job;
2. building and maintaining the team as a performing unit; and
3. coaching and supporting the team to success.

Most of the issues under the first task have been covered above when discussing the features of effective teams. However it is worth stressing again the importance of the inter-team context. For most effective knowledge management (and in line with the principles of complexity theory described above) *'Leadership needs to stay away from meddling and forcing mechanisms, while at the same time foster the learning environment to motivate to experiment'* (Mohamed *et al.*, 2004, pp.128–129). Leadership to support effective inter-term contexts also requires a strong connection to leadership at the level of locality services so that teams can be encouraged to identify with the whole service system that users are navigating rather than merely their one corner of it. This higher identification may also serve to avoid the common stereotyping and rivalry between teams that often characterises local services, particularly where the team can see how its own work contributes to the wider work of the locality service as a whole.

With respect to the second task we have seen above how in order to build and maintain the team as a performing unit the leader must ensure that the team is composed of members with the necessary skills and abilities. As described above the team must also be sufficiently diverse. A team of people who are simply clones of the leader will be neither effective nor innovative.

The leader must develop team processes that help the team to perform effectively by nurturing good decision making, problem solving, conflict management and the development of new and improved ways of working together. Good team working doesn't occur naturally. It takes practice. Following one world cup, promoters formed a team from the very best players of all the sides to tour Europe to play exhibition matches. They lost every game they played. They were excellent individually but had not learned to work as a team. The leader's job is to encourage the team to practise teamwork so they do learn to work as a team.

The third task of the team leader is to coach and support the team to success. It means intervening to help the team do its work successfully by giving direction and support. The team leader has to learn to

Table 3: Factors promoting effective team working in relationship to leadership qualities.

Factors promoting effective team working in the UK public sector	Effective leadership qualities in the UK public sector
Clear, shared objectives with feedback on performance	A clear vision, developed by engaging various internal and external stakeholders. Invests the time to gather information from a wide range of sources. Inspiring communicator of the vision of the organisation/service to a wide network of internal and external stakeholders; gains their confidence and support of various groups through political astuteness- being sensitivity to their needs. Clarifies objectives and boundaries; team-orientated to problem-solving and decision-making, and to identifying values. Ability to draw people together with a shared vision
Participation – team member interaction, communication of information, influence over decision-making	Trusts staff to take decisions/initiatives on important matters; delegates effectively. Genuine concern for others' well-being, their development and their contribution. Accessible, approachable and flexible. Charismatic in staying in close contact with others and encouraging their participation.
Focus on quality – critical evaluation of performance, constructive controversy, commitment to improving quality	Committed to working and engaging constructively with internal and external stakeholders. Committed to making service performance improvements with a determination to achieve positive outcomes for users. Encourages challenges to the status quo. Supports a developmental culture – taking risks and modelling expression of dissatisfaction. Supportive when mistakes are made but holds people to account where required; encourages critical feedback of him/herself and the service provided. Analyses and thinks creatively with a wide range of complex issues. Transparency. That aspect of integrity concerned with honesty and consistency. Placing the good of the organisation above personal gain.
Support for innovation – social support and practical support (time, resources, effort, co-operation)	Leads change through others – engages and facilitates others to work collaboratively to achieve real change Being prepared to take action now Being able and prepared to adopt a number of ways to gain support and influence diverse parties with the aim of securing health improvements

be sensitive to the mood of the team and to how well members are interacting and communicating with each other. The leader must pay attention to these processes and intervene to encourage more meetings between particular members, encourage more exchange of information, or shape a supportive approach to suggestions made by team members. The leader's task, alongside professional line managers where appropriate, also includes helping team members develop their skills and abilities. This means taking time to review what it is they want to achieve, what skills each needs to develop, and creating learning opportunities for them (see above under 'Interventions to improve teamworking'). These opportunities could include formal training, visits to other organisations, or learning on the job.

Psychologists as consultants to their own organisations

The New Ways of Working initiative has highlighted a need for process consultancy to organisations. Much organisational development theorising draws upon psychological models of change that derived from therapeutic theories of change (e.g. psychodynamic approaches such as those developed at the Tavistock Clinic; Obholzer, 2005; Foster & Roberts, 1998) or solutions-focussed approaches (see Jackson & McKergow, 2002). Our stakeholder consultations sought views on whether applied psychologists therefore represented a resource for consultation to their own organisations. There appeared to be strong demand for this from operational managers, and clearly strong economic arguments could be made given the costs of external consultancies. Overall, however, there was a prevailing view that although psychologists *should* be a resource for this sort of work, we could not assume that they *are*. They may have neither the capability nor the local credibility. With the exception of occupational psychology there is nothing required within applied psychology training that gives applied psychologists a unique role and others locally might have more specifically relevant training. Some stakeholders did not want to see psychologists prioritising this role because of the overall lack of capacity for psychological input at the clinical level. Others took the opposite view feeling that seeing clients one-to-one is not necessarily the best way to improve the psychological-mindedness of services. Some senior psychology managers were keen to promote this as part of their service portfolio, suggesting the applied psychologists had more to offer than they realised and that simply getting involved in organisational consultancy quickly builds confidence and credibility. The role of applied psychologists in these roles is clearly therefore to be negotiated locally in light of the nature of demand and the particular skill profile of the local service, including the capacity of local psychologists to undertake this kind of work. The following positive practice examples give some sense of the possible, with Table 4 concluding this section describing some of the resources that are available for staff who want to improve their local service.

Positive practice example of role of psychologists in teams involved in the reorganisation of care for children and families affected by a cleft of the lip and/or palate.

The teamworking described here includes representation on the Dept of Health's Cleft Care Implementation Group. The work of this group underpinned the 1998 Health Services Circular which recommended a radical reorganisation of cleft care in the UK, and a clear focus on all patients being treated by multidisciplinary teams with large patient loads. Subsequently psychologists have participated in teams setting appropriate standards of care, developing protocols for audit and research and in appointing suitably qualified staff. Currently psychologists work as key members of each cleft care team. In addition to clinical intervention, their roles include screening, audit and research in addition to team building and the management of change as the new teams come into being.

For further information: Maggie.Bellew@leedsth.nhs.uk

Positive practice example: Using psychological theory and research on decision making to inform the interpretation of a consultation exercise.

The Area Psychology Professional Committee for Ayrshire and Arran prepared a 'Background Briefing on Cognitive Psychology Research Findings regarding Heuristics and Decision Making' to inform the NHS Board regarding research from cognitive psychology that is relevant in understanding the processes that may have informed the comments made by staff and the public during a review of services consultation on emergency and unscheduled care. This briefing covered issues such as the impact of heuristics and intuitive feelings (e.g. dread) on reasoning and how these influence, for example, public evaluations of risk in contrast to expert evaluations (e.g. based on analysis of hazard derived from information such as mortality statistics).

The Board members confirmed that they found the document very helpful in considering public reaction to the proposals and the way it gave more depth and perspective to some of the comments received.

For more information contact: Professor Craig A. White, NHS Ayrshire and Arran, Pavilion 7, Ayrshire Central Hospital, Kilwinning Road, Irvine, KA12 8SS. Tel: 01294 323552. E-mail: Craig.White@aapct.scot.nhs.uk

Positive practice example of how psychologists can contribute to service improvement through research and consultancy.

In a major review of burns services in the UK, The National Burns Care Review Team (NBCR) reported in 2002 (www.nationalburncaregroup.nhs.uk) that psychological support for burns care in the UK was lacking, and also noted that appropriate evidence to guide recommendations for this psychological support was also insufficient. In response, a working group comprising stakeholders from the NBCR, patient groups, and representatives from several health care professions, was set up to gather data and formulate recommendations. Psychologists played a number of key roles in this group. Clinical psychologists advised on clinical need and appropriate interventions, using examples of good practice based on practice experience. Health psychologists designed protocols for the collection of data, collected, analysed and reported on the data. The psychologists played a key role in the formulation of recommendations for improving burn care to more closely meet the needs of patients. This work is playing a crucial part in the final report currently being formulated by the NBCR.

For further information contact: Nicky Rumsey, nichola.rumsey@uwe.ac.uk

Table 4: Resources for service improvement.

For resources relating specifically to team development see the "Interventions to improve teamworking" section above.

Your local Care Service Improvement Partnership development centre (see www.csip.org.uk) is a good first place to look for advice, support and information regarding service improvement work.

One of the best sources for information on service improvement techniques is the excellent 'Improvement Leaders Guides'. These have recently been updated and are available to download or order from:
http://www.wise.nhs.uk/cmsWISE/Tools+and+Techniques/ILG/ILG.htm

It is important to think about the sustainability of your improvement work right from the outset.
See the NHS Institute for Innovation and Improvement NHS Sustainability Model and Guide at:
http://www.institute.nhs.uk/ServiceTransformation/Using+the+NHS+Sustainability+Model+and+Guide.htm

See also the information on the '10 High Impact Changes' and the service improvement directory on the Care Services Improvement Partnership website.

http://www.csip.org.uk/resources/directory-of-service-improvement.html

For those seeking a more academic review of service improvement in health care settings, 'Organisational Development in Healthcare' (Peck, 2005) is a useful resource.

Teaching and training

Teaching and training has long been part of the applied psychologist's role. Their role with respect to teaching and training with respect to teamworking bears all the caveats regarding their role regarding process consultancy or opportunities for whole team consultation described above. However, the following positive practice examples again provide some example of what can be achieved.

Positive practice example: Post qualification training on teamworking in acute environments.

South West London and St. George's Mental Health Trust have developed an accredited post qualification module in collaboration with Kingston University in Enhancing Multidisciplinary Work in Acute Environments. The module is offered at Level 2 and 3 as part of a diploma or Bachelor of Science in Health Care Practice. The course was developed and delivered by the full range of disciplines as well as service user and carer representatives. The module aims to:

- Promote, enable and empower the recovery of the service user in an acute environment.
- Meet and understand the complex needs of people with acute mental illness.
- Understand and work with different roles within the Multidisciplinary Team.

Teaching content includes:

- Therapeutic alliance, interaction and engagement skills.
- Planning and preparing for admission and discharge.
- Working in and with multidisciplinary teams.
- How to plan, organise and structure the work of the day.
- Record Keeping.
- Risk Assessment.

Practitioners in their evaluation of the course found the module very helpful in their day-to-day clinical work. Sharing views and ideas with fellow colleagues and staff running the course was identified as one of the best aspects of the module. From the evaluation received all the practitioners would recommend the module to colleagues.

For more information please: Harjinder Sehmi, Senior Lecturer in Mental Health Nursing, School of Nursing Faculty of Health & Social Care Sciences, Kingston University & St. George's University of London. E-mail: hsehmi@hscs.sgul.ac.uk

Positive practice example: Training on challenging behaviour and stressful interactions.

A two-day workshop was run by two clinical psychologists for 46 staff of Woodhaven, the Inpatient Psychiatric Hospital for the New Forest. The overall aim of the training was to strengthen staff team-work using evidence-based psychological principles in a way that treats clients with dignity and empowers them, while minimising risk. The training introduced staff to evidence-based psychological approaches, facilitated discussion on how to develop care plans for challenging behaviour using these approaches and incorporated time for reflection on the strengths and diversity within the team. The two-day format with two weeks between each day meant that the teams were able to apply their new care plans to the 'real world' of the ward and then bring their experiences for further reflection and discussion on the second day. Evaluation of the training was undertaken by means of a staff questionnaire as well as monitoring the effectiveness of the care plans developed. The questionnaire responses revealed that the staff valued the workshop highly with an average of 90 per cent of responses across both days agreeing that the workshop was relevant, well organised and useful. Open-ended responses included comments such as 'I though the day was very helpful in terms of giving staff time out of clinical areas to reflect on difficult issues. It encouraged teams to be more positive'. Evaluation of the effectiveness of the care plans revealed that a reduction in the frequency and intensity of challenging behaviours had been achieved in some cases. As a direct result of the training, staff have requested further input from psychological therapies to help develop care plans by organising regular multi-disciplinary care planning meetings.

For more information contact: Isabel Clarke, Consultant Clinical Psychologist, AMH Woodhaven, Loperwood, Calmore, Totton SO40 2TA. Tel: 02380 874467. E-mail: Isabel.Clarke@hantspt-sw.nhs.uk

Research and service evaluation

Applied psychologists have the competencies to carry out audit, service evaluation and research in a broad range of applied settings – often in the context of team working. There are a number of tools to support this work such as the Productivity Measurement and Enhancement System (ProMES; Pritchard, 1990); a system of facilitation enabling team members to measure outputs from their teams. It establishes measures that the team wants to use to measure their performance. This data can be collected by the team, regularly reviewed and acted upon to improve performance. The approach requires external training support on how to deliver this method[8].

Within adult mental health Rees *et al.* (2001) have developed the Community Mental Health Team Effectiveness Questionnaire which can used in research studies of the environment and effectiveness of teams and by those seeking to evaluate performance change over time. The Aston Team Performance Inventory is a widely used in research and service evaluation for a broader range of teams (contact info@astonod.com or visit www.astonod.com). Other examples of the role of applied psychologists with respect to research and evaluation in team contexts are given below.

Positive practice example of service users and psychologists working as research partners in service evaluation for improvement.

The Chichester Assertive Outreach Team was struggling to assess its effectiveness. Their clinical psychologist had researched and instigated the use of standardised measures to assess and measure changes in quality of life and engagement, but they were not meaningfully connected with by many colleagues and clients. Unsure of how to progress, he consulted service user colleagues at the Capital Project Trust, a user organisation influential in training, research and service development domains within West Sussex. A collaborative project resulted, with the clinical psychologist and four Capital members leading a qualitative evaluation of the views of clients, carers and team members.

The evaluation encountered many barriers (e.g. the indemnification of user interviewers and recruitment of participants), the overcoming of which required us to have energy, creativity, clarity of vision and a sense of pragmatism. Views were elicited, analysed and then fed back to participants. A stakeholder group was then given a remit to turn themes into actions to enhance the effectiveness of the Chichester Assertive Outreach Team.

Lessons learnt at a process level included:

- the ability of psychologists and service users to work effectively as equal partners who learn from each other;
- attempting to pioneer and dismantle, rather than bypass barriers is hard work;
- service users have an energy and clarity of vision that may be lacking in professionals who are often bogged-down by bureaucracy and defensive practice;
- Principles versus tactics – aim high, but don't lose sight of the overall goal as compromises have to be struck.

This and other lessons have been shared nationally through presentations and papers (see Hayward *et al.*, 2004; 2005).

For further information contact: M.Hayward@surrey.ac.uk

[8] Details available from Angela Carter, a.carter@sheffield.ac.uk

Implications for psychologists of new ways of working in teams

Developments in practice, policy and the expectations of a range of stakeholders means that new possibilities are envisaged for the roles of psychologists. This section highlights some of the new ways of working pertaining to applied psychologists in specific contexts, provided by psychologists working in those contexts. Roles described above, such as research, training and supporting reflective practice can be taken as read and so do not require reiteration in this section even though they continue to play an important part of the role of applied psychologists.

How psychologists undertake these new roles will be shaped by their local capacity, the resources available locally and the ways in which their mandate is negotiated. Clearly, as informed by the discussion above, these roles need to be clearly delineated, negotiated and based upon a clear understanding of the role of psychologists and their added value to the team.

Concern is often expressed about long waiting lists and pressure to see a given volume of clients which means that exercising these new ways of working can become a challenge. This is not unique to psychology and systematic approaches to team development (such as the Creating Capable Teams Approach described earlier) and proper capacity management provide a team-wide approach to looking at how team capacity is best linked to demand.

Primary care

Recent years has seen policy imperatives to shift resources 'upstream' using a 'stepped care' approach so that client involvement with services is only that which is necessary to achieve the desired outcomes. This has meant greater involvement for applied psychology in primary care services and teams working to support and enhance the capacity of the primary health care team. Increasingly distinctions between 'primary' and 'secondary' services become less helpful as complex interventions are provided in general practice or the even more 'primary' setting of the client's own home. Psychologists have a role in widening access to a wider choice of psychological therapies, including provision of supervision and consultation to team members and others involved in providing psychosocial interventions. Group work and service development in primary care also serve to increase access to psychological therapies (e.g. book prescription, advice clinics, and large-scale psycho-educative groups).

Positive practice example: Child psychology in primary care.

An example of effective integration of clinical child psychology within a primary care team was originally developed in response to a request by a GP fundholding practice and is now provided via a service level agreement. The practice is spread across three sites and four NHS Trusts on the Oxfordshire-Buckinghamshire border.

The initial 'Emotional Needs Project' was led by a senior partner and practice manager, and advised by the clinical psychologist. It explored the prevalence of mental health needs of primary school-age children living within the practice boundaries. The prevalence rate was 19 per cent, which is consistent with other non inner-city populations. Whole practice training sessions took place on the identification and management of emotional and behavioural problems in children. The practice manager led focus groups with parents and the local community to assess needs. As well as research advice, training and consultation a direct referral service is provided by psychology. This is enhanced by good communication and regular attendance at GP practice and Health Visitor meetings. An audit of 100 referrals showed high attendance rates (87 per cent), good outcomes and overall referrer satisfaction.

Some of the reasons that this works well include:

- The role of the psychologist is adapted to primary care work – shorter sessions, no waiting list, flexibility of referral criteria and ways of working.
- The service was initiated and developed through assessing user and service needs.
- Psychological needs of children in primary care are clearly recognised, discussed and if appropriate, referred.
- The primary care team owns the service and provides reception, administrative support, dedicated clinical space and facilities.
- The psychologist is integrated within the primary care team which allows for mutual respect and easy access for team members, children, young people and families.

For further information contact Helen Beinart on helen.beinart@harris-manchester.oxford.ac.uk

Positive practice example: Developing primary care graduate mental health workers as a way to improve access to psychological therapy.

Gloucestershire Primary Mental Heath Service has been running for six years. Staffing includes triage nurses, graduate mental health workers (GMHWs), occupational therapist and clinical psychologist (0.5 WTE) covering 34 GP surgeries. The aims of the service include: primary health care team development, mental health assessment and improving access to psychological therapy. Following NICE Guidelines, treatment choice is cognitive behaviour therapy (CBT) at steps 1, 2 and 3 of a stepped care model. At step 1 we offer CBT Books on prescription, information, education and training to primary health care staff. At Step 2 we offer telephone guided self help for anxiety and depression and stress management courses in local colleges. For moderately severe presentations, at Step 3 we have trained 12 GMHWs in core CBT skills. The Oxford Cognitive Therapy Centre was commissioned to deliver the course and evaluate trainee competence. Evaluation methods included tape recordings of work rated on cognitive therapy scale and case report. CBT Master Classes are now scheduled for specific disorder management.

The impact of the course on improving access to psychological therapies has been tremendous. Each GMHW has an average case load of 16 patients for an average of 12 sessions, thereby greatly increasing the potential of patients having access to CBT. Clinical effectiveness is good as measured by CORE and patient satisfaction high. Their enthusiasm of GMHWs and their ambition to develop themselves and adherence to protocol makes them a fabulous group of staff who offer a pragmatic solution to the thorny issue of improving access to psychological therapy.

The role of the clinical psychologist has been to train, supervise and provide protocol and operational policy guidance to the work of the GMHWs. The greatest challenge has been the perception of the GMHWs, not by primary care but secondary mental health colleagues. They are not readily recognised as skilled practitioners, with proven competency in CBT, making an enormously valuable contribution across stepped care by improving access and reducing referrals to secondary care. Given appropriate and sufficient training, good quality supervision and a career pathway that encourages retention, we have a workforce to embrace, not to fear or dismiss. As clinical psychologists, we could do worse than invest our expertise, time and effort into the development of this new workforce.

For further details contact: Alison Sedgwick Taylor, Consultant Clinical Psychologist in Primary Care. E-mail: Alison.Sedgwick-Taylor@glos.nhs.uk

Positive practice example: An approach incorporating issues of how power and choice is exercised in a multi-disciplinary primary care setting – the Wadebridge Memory Bank Group.

This is a group of people diagnosed with dementia who meet weekly at a GP practise in Wadebridge, Cornwall. The philosophy behind it was that: (1) psychologists should focus on specific difficulties, and not diagnostic categories; (2) that dementia is a very loose diagnosis, used when no more specific cause can be found (Bender, 2003), which covers a very wide range of different difficulties; and (3) therefore, as a corollary, members of a group of people so diagnosed may have skills and experiences to offer each other. The group format encourages this resource sharing.

Therapeutic groups had previously only been run on a time-limited basis, often for research studies, but the psychologist and his colleagues in the North Cornwall Older People's Mental Health Team, recognised that, when people have a chronic condition, such a group must be ongoing if the members are to rely on it for support, and to see it as their group that they can develop. The group has been meeting for over three years with very high attendance rates.

There are two main factors in its success:
(1) The commitment of a small number of professionals working together who can see the benefits and the time saved of creating an on-going group. These staff prioritised and publicised it and created a setting in which members have agency and can feel the support they are giving each other. The group has been extensively written up in peer reviewed journals (e.g. Bender & Constance, 2005) which appears to have helped to defend it in the face of resource constraints.
(2) Within the group, probably the key factor is member power; members only leave their group when they decide to do so. At least some of their confidence relates to the fact that it is made quite clear to them that the leaders do not have the power to make that decision. Other, power-giving features of the group are: at the first meeting each term, members decide on what topics they wish to have speakers on; members have presented to planning groups; members were asked what name they wanted for the group, came back with possible names and the group voted on it. Also members agreed that a group photograph, using their real names, could be used in an article that is to be published this spring, so that anonymity would not hide their achievement, or suggest shame.

The group meets for three terms – a phrase used to suggest structure and lack of crisis – of approximately 14 weeks, in an very socially valued and prestigious primary care setting. The group is led by an occupational therapist and a community mental health nurse with sessional input from the psychologist whose main role is to provide supervision and support. He also attends the final session, where the group feeds back its evaluation of the term. The term ends with a meal out, to which members can invite relatives.

For more information contact the team's occupational therapist, Gilly Constance on 01208 25359. E-mail: Gilly.Constance@cpt.cornwall.nhs.uk

Physical health care

Applied health psychologists have a key role to play in care teams which have a focus on the management of long term conditions, particularly those with an emphasis on the promotion of optimal self-care and independent living. In the context of team working, psychologists have the competencies to assume responsibility for the design, implementation and evaluation of interventions for clients in the following areas:

- adopting effective self management techniques;
- implementing planned lifestyle changes;
- improving adherence to treatment regimes;
- improving the ability of clients to cope with the demands of their condition.

Positive practice example: a health psychologist working in a multidisciplinary team.

The team includes nurses, counsellors, health psychologists in training and health promotion specialists. The team is located within Camden PCT Directorate of Public Health. The team has a focus on smoking cessation and other public health initiatives. This work is focussed on achieving national targets relating to increasing life expectancy and reducing health inequalities, particularly those targets relating to smoking in manual groups and in pregnancy. The consultant health psychologist is a senior manager within the Directorate and leads the Tobacco Control and Cessation team, taking the lead on evaluating performance and using this to inform the strategic direction of the service, the psychologist also leads the organisation, delivery and evaluation of interventions. The work of the service includes direct provision of specialist stop smoking services aimed at those who do not access mainstream services and those with complex health needs. In addition the service develops the capacity of other organisations to provide stop smoking interventions through provision of training, guiding interventions and performance management. The health psychologist also acts as a professional lead to the health psychologists in training; including guiding research, consultancy and teaching activities within the service. This work is carried out in partnership with the City University Dpsych Programme Director.

The Consultant health psychologist is on the management group of and provides the clinical leadership for the 'health trainers' employed within the PCT. These posts were proposed in the Department of Health (2006b) Social Care White Paper and are people from the local community who are trained and employed to engage local people in their health care and provide support, signposting and/or behaviour change interventions as required. This work contributes to the aforementioned targets as well as those relating to obesity and physical activity. The Centre for Outcomes, Research and Effectiveness at University College London is currently evaluating the programme and the health psychologist works in collaboration with them to direct the ongoing support and supervision that the health trainers require to provide effective interventions.

With specific competency in developing, providing and evaluation teaching and training, the health psychologist also provides specialist input into the development of new public health training for staff in local organisations, beginning the process of enabling the 'fully engaged' scenario, as outlined in the White Paper, to become a reality. The e-mail contact for this is sasha.cain@camdenpct.nhs.uk.

Psychologists are contributing to current national public health initiatives such as the introduction of Health Trainers described in the example above. Health psychologists are acting as consultants and as members of the national team (comprising representatives from the Department of Health, Spearhead and early adopter PCTs and the armed forces) tasked with rolling out the new role of Health Trainer to the majority of PCTs in the UK. Their input is focused on assessing the evidence for behaviour change interventions, designing the intervention underpinning the Health Trainer role and advising on its implementation. They are also playing a key role in the evaluation of this role.

Community development and social inclusion

It is now widely recognised that recipients of health and social care are often excluded from a wide variety of opportunities in society, including paid employment and volunteering, housing, lifelong learning, financial services, access to civil rights, and social participation (see Social Exclusion Unit, 2004). The new white paper 'Our health, our care, our say' (Department of Health, 2006b), and the Disability Discrimination Act 2005 will place further requirements on organisations and the people that work within them to systematically assess and work to reduce the negative impacts of social inequalities.

Contributors to this document made the point that teasing out the teamworking issues with respect to social inclusion was problematic in that all psychological practice should be concerned to promote inclusion as a human right. In the same way as we would not be defending racist practice, avoiding social exclusion as a discriminatory practice was advocated as a core value for psychological practice rather than a specific aspect of service provision. For example, taking a person-centred approach to assessment and care planning that seriously addresses the full range of significant life domains that are important to the individual will usually serve to promote inclusion in the process. However, in some areas there is specific capacity dedicated to promoting social inclusion which psychologists can work to support. The following positive practice example describes how psychologists can support this capacity while assuming a range of other roles such as helping to design systems for assessment, planning and evaluation.

Positive practice example: Psychologists working in support of socially inclusive practice.

In Bromley, psychologists provide formal consultation to social inclusion project staff on how to manage when their relationship with the service user is challenged because of a mental health issue, a service or staff related issue or an interagency issue. We offer this support to day service staff, Support, Time and Recovery workers and employment and education specialists via group meetings on a monthly basis. We also offer an informal consultation process prior to formal referral because these same inclusion workers are also some of the first to rediscover long term service users 'hidden' or previously undisclosed mental health problems which often re-emerge during the inclusion process.

In addition, psychologists co-run (with social inclusion workers and/or service user consultants) recovery groups or offer supervision for recovery group facilitators. Psychology contributes to the development of other inclusive practices such as person-centred planning and community bridge building. We also help in the development and evaluation of self/assessment and planning tools, and outcome measures. We take part in the audit of social outcomes and have a small hand in mental health awareness training for local community organisations. We are available for consultation but this rarely happens directly as we usually work through others by supporting the relationships they are developing beyond the mental health service boundary. The head of the community and social inclusion specialty also leads on the local interagency activity on community engagement/development, improving joint working, service development and evaluation.

For further information contact: Dr. Fabian Davis, Consultant Psychologist (Community & Social Inclusion), Lead for Social Inclusion, Bromley Mental Health Services. E-mail: Fabian.Davis@oxleas.nhs.uk

The Committee for the Training of Clinical Psychology accreditation criteria already requires that it produces practitioners that have *'The skills, knowledge and values to work effectively with systems relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.'* However, expectations from key stakeholders, such as users and carers, and the requirements of the policy environment mean that a richer description of the skills required is needed.

Work is in progress to develop the 10 Essential Shared Capabilities (Hope, 2004) with respect to social inclusion. It is recommended that that psychologists seek to develop these capabilities in themselves and the people they work alongside.

Positive practice example: a multi-agency, holistic service, jointly provided and managed by Health and Children's Services.

The Integrated Service for Looked After Children (ISL) works in partnership with all relevant agencies and services to ensure that Looked After Children gain maximum benefits from educational opportunities, positive health and well-being, community and leisure opportunities and positive and stable social care environments. It consists of two education support teams. These provide flexible, rapid response support for Looked After Children to prevent exclusion and/or to raise achievement. A further team provides carer support and promotes inter-agency working through holistic and collaborative interventions. The aim is to maximise placement stability through the provision of advice and guidance to carers and the network.

Clinical psychologists work as part of the carer support team, providing psychological advice, support and training for the carers and other professionals; and psychological assessment and a limited amount of therapeutic work provided direct to the children and young people. In addition clinical psychologists provide clinical leadership and psychological advice across the three teams and within the ISL management team.

ISL, therefore, brings together psychologists, social workers, teachers and other health and education professionals to provide three integrated teams. These teams impact on the well-being of looked after children through additional support to carers, children and schools. This includes:

- Increased advice and support via consultation and training for carers about the mental health and emotional well-being of the young people from health professionals and specialist social workers.
- Increased support for education via proactive monitoring, intensive support, mentoring, transitional support and training from specialist teachers, nursery workers and children's support workers.
- Increased opportunities to access community and leisure opportunities in the statutory and voluntary sectors.
- Increased training for all professionals about the health and emotional needs of looked after children.

Evaluation of projects developed and evaluated within ISL include:

- The initial carer support project, including independent evaluation of views of service users (Burgess & Smith, 2002): *'Having had experience of life before the Project it's hard to believe how we managed...'* (Residential Manager); *'The child's behaviour is much better ... leaps and bounds. The child knows everything is firmer'* (Foster Carer).
- The group work for foster carers. (Golding & Picken, 2004): *'I feel calmer and feel less helpless knowing that I can try lots of different ways to help us both. I feel that I understand her feelings better and try not to take things personally'* (Foster Carer); *'Interesting ... full of ideas to go home and try out'* (Foster carer).
- The consultation service (Golding, 2002; 2004): *'I felt totally refreshed and positive after the meeting – the report gave me another boost. Coincidental or not things have much improved – I feel relaxed and in control'* (Foster Carer); *'The fact that people listened and acknowledged the problems – this dramatically reduced my feelings of isolation and also the feelings of frustration that I had been experiencing'* (Foster carer).

For further information contact: Kim Golding, ISL, The Pines, Bilford Road, Worcester, WR3 8PU. E-mail: kgolding@worcestershire.gov.uk. See also: Golding, 2003; Golding *et al.*, 2006.

Work with people diagnosed with psychosis and other complex mental health needs

The first National Service Framework was for adult mental health (Department of Health, 1999). That and the subsequent NHS Plan (Department of Health, 2000) with its Mental Health Policy Implementation Guide (Department of Health, 2001) brought about new ways of working through: assertive outreach, early intervention and crisis resolution and home treatment teams. There has been no clear guidance on how the roles of psychologists in these settings should be defined, therefore, psychologists nationally have been learning the most effective ways of working through day-to-day practice and networking. The Psychosis and Complex Mental Health Faculty has published separate briefing papers on working in assertive outreach (Cupitt *et al.*, 2006) early intervention in psychosis (Leadley *et al.*, 2006) and crisis resolution home treatment teams (Hurcom *et al.*, forthcoming). Rather than replicate this work, the following summarises some of the new ways of working that psychologists in these novel teams have in common, alongside changes in practice associated with inpatient settings and CMHTs (where they focus on people with psychosis and complex mental health needs):

- Informal referral systems wherein filling in referral forms are not required- merely a conversation with the team psychologist, normally instigated by the client's care coordinator or self-referral. The inception of psychology involvement is marked by discussion at team meeting and recorded in notes.
- Shared case notes and the attendant transparency with clients about this– it would be an exception to have separate psychology notes.
- Out of hours working, e.g. to see families and undertake group work.
- Supervising or mentoring users, carers or professionally non-affiliated staff in their roles as practitioners, e.g. as 'Voices' groups facilitators.
- Training alongside users and carers in their role as experts by experience e.g. on social inclusion, recovery, working with auditory hallucinations, etc.
- Managing professional boundary issues when working with users in other roles, e.g. training with a user in an expert by experience role, meeting an ex-client at a service development meeting.
- More self-disclosure than in traditional psychotherapeutic relationships (see Perkins & Dilks, 1992)
- Seeing people in ordinary settings (e.g. their own homes, cafes, etc.) rather than in a mental health facility
- Doing more tasks not traditionally seen as the role of applied psychology – both as a means to engagement and as a team role; e.g. help with daily living (household tasks, help with self-care such as washing hair, etc.), help with travel (driving clients to get to sessions, accompanying someone on public transport, etc.), delivering medication, participating in leisure groups (pool, outings, etc.), and supporting access to community services (e.g. libraries).
- Care co-ordination when capacity allows (see 'Psychologists in relation to the team' above).
- Developing education materials, including leaflets and websites.
- Use of new technologies, e.g. texting, e-mail and e-chat forums.
- Emphasis on team consultation and reflective practice.
- Working alongside like-minded colleagues as 'culture carriers' and advocates for psychosocial, whole person, strengths, social inclusion and recovery perspectives.
- Making philosophies and models of care explicit within service systems.
- Helping services to develop clarity of purpose and models of care.
- Assertive engagement with clients.
- Advising, supporting and delivering interventions using novel formats and locations, for example recovery groups, hearing voices groups, social groups, separately gendered groups, and relatives/carers' groups.
- Working with social and environmental contexts, e.g. to support promote social inclusion in work, education and leisure activities.
- Building in support structures to maintain one's own psychological knowledge, skills and perspective when you are the only psychologist working in the team.
- Working with clients whom traditionally psychology has seen as inappropriate referrals, e.g. people with psychosis, personality disorder, chaotic lives, not 'psychologically- minded' or hitherto deemed unsuitable for psychological therapy.
- Working with clients who are acutely distressed or in crisis, and across the course of difficulties, from the acute phase of mental distress through to stabilisation and recovery.
- Promoting culturally sensitive services including concerning youth (e.g. in early intervention services), ethnicity, gender, sexual orientation, disability and religion.

- A stronger role in differential diagnosis, e.g. Asperger's from psychosis in an early intervention context.
- Early detection and prevention, e.g. younger adults who are at very high risk of conversion to psychotic states ('at risk mental states') as early intervention can delay or stop conversion to a psychotic state.
- Work with people in the prodromal phases of a relapse to achieve relapse prevention.
- Developing a working knowledge of medication and impacts on psychological states such as the ability to process information as well as potential side effect difficulties triggering further symptom experience or exacerbation.
- Teaching and training of other staff including in primary care and other agencies.

While not all of these development will be new to the services in question they represent trends in development and it appears that there are growing similarities in the work of psychologists in teams which work with people with psychosis and complex mental health needs. The learning from work in these more specialised teams has wider application. For example, the development of assertive outreach teams has promoted the development of more assertive and creative engagement and working in less traditional settings; early intervention teams have highlighted the value of intervening early and to recognise the importance of texting, age-appropriate environments and materials; Crisis resolution and home treatment teams have highlighted new ways of working with people in crisis and the importance of teams working effectively together (e.g. with CMHTs) as a coordinated local whole system.

Again, the New Ways of Working which have been most developed in the context of new kinds of teams working with people with psychosis, are not confined to psychologists working with this client group. Much can be gained from inter-specialty learning. For example, people with dementia and other cognitive difficulties can be helped to remember appointments and strategies through texting; and services are intervening earlier and learning from the ideologies of the hearing voices networks to promote self-help and self-esteem.

Positive practice example: Increasing access to psychological therapy in psychosis within a CMHT.

In South London the CMHT has moved from a position of having no psychological input for people with severe and complex mental health problems to meeting trust NICE guideline targets for offering individual CBT for psychosis in a CMHT where 75 per cent of clients have been given a schizophrenia spectrum diagnosis. This was achieved using time from a psychology post but also through peer consultancy to team colleagues. The process began with the team's wish to have psychology input and a re-allocation of funds to create a post. However, there was no clear understanding within the CMHT at the outset about what psychology might offer to this client group. Discussing care co-ordinators' caseloads in depth started a collaborative process of identifying clients who might benefit from a psychological approach. Priority was given to those people the care co-ordinators identified as of most concern and session by session informal feedback helped elucidate the process of psychological assessment, formulation and intervention.

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Positive practice example: Assertive outreach into inpatient care with high levels of user participation and planning.

Psychologists in the Assertive Outreach Team in East Surrey are working to promote and encourage recovery based approaches both amongst service users and colleagues. In order to do this they have set up inpatient groups that are covering topics such as 'self-esteem', 'relaxation' and 'medication'. The role of psychology has included working closely with the ward manager and the nursing staff to ensure the groups have the support of staff, as previous attempts at this kind of work had not been successful. Service users were involved in planning what was included in the sessions. Psychologists provided resource materials and supervision to the nurses running the group. Psychologists have conducted two evaluations, the second involving interviews with all staff and service users who have been involved. Following on from the success of this initiative we are now running a recovery group co-facilitated by trainee clinical psychologists and service users. The recovery group has also had the agenda set by service users and involved inviting in someone from an employment service who gave information about job applications and interviews. This group has been very popular with the service users and led to further training of the inpatient staff. The experience of seeing service users working alongside psychologists has been particularly inspiring for a wide variety of people.

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Inpatient care

Clinical psychologists working in acute inpatient mental health wards generally deliver a service in two distinct ways. Some remain primarily community-based psychologists, usually working for a CMHT more than half-time, and generally spend around a tenth of their time working with their sector's inpatients. This leaves little time for ward staff training and development and contributing to the wards' group programme, but it ensures that local service users have access to psychology whether they are inpatient or not. It further allows for service users to continue therapy across service areas. Inpatients can begin a therapy that can be completed after discharge, and community-based service users can continue therapy sessions if admitted. This service delivery model can be co-ordinated by a lead psychologist for acute inpatient care; or each CMHT psychologist can hold responsibility for providing input into their sector ward. The principle challenge for team-working within this role is one's membership within two teams, generally with a stronger identification with the CMHT.

The other prevalent model of service delivery involves a small team of psychologists, or an individual psychologist, dedicated to working across acute wards at a designated site or sites. This team's remit involves providing a psychology service to inpatients, offering only a restricted number of post-discharge sessions to bring therapy to an end. This model is more frequently employed where CMHT psychologists are not practically able to provide input to wards, often because their posts are half-time or less. The advantage of this model is that psychologists are better placed to influence the ward milieu through peer consultation and support and to contribute to broader service development initiatives. Its disadvantage is usually a break in continuity of care as responsibility for psychological care provision is transferred between teams. A similar centralised service model provides assessment and formulation for inpatients, with a less emphasis on follow-up therapy provision. This model has the advantage of working with a greater number of inpatients, thereby potentially shifting the culture of the wards towards enhanced psychological thinking. Its disadvantage is however that inpatients do not receive therapy while they are in hospital. In both of these more centralised psychological services, integration in teams can depend on the degree to which the work offered by psychologists is congruent with the aims of the ward-based team.

The most prevalent models of service provision, therefore, emphasise direct patient contact and employ psychologists primarily as practitioners. An alternative training/consultation model, dedicated to the optimal development of psychological therapy skills of ward-based staff at an organisational level, uses clinical psychologists to develop a more broadly biopsychosocial approach to service delivery. Access to

expert peer consultation from the psychologist will increase the availability of psychological therapies, as staff with relevant training (e.g. Thorn) will be enabled to practice, and staff with an interest in developing these skills will be able to gain the supervised experience to facilitate entry to advanced training. Some services choose to use a psychology/psychotherapy resource in setting up reflective practice/case review meetings led by a psychological therapist, both to address the impact of acute distress on care-givers as well as to conceptualise the individual's difficulties in a psychological context and to plan care accordingly.

Models which emphasise staff skill development and enhanced psychological thinking may be optimal when insufficient financial or human resources are available to create one of the more comprehensive services described above. They may well achieve a more psychologically-oriented inpatient service than models which emphasise direct patient contact though only where the psychologists remain credible to other staff, particularly nurses, the ward manager and the senior medical staff. Psychologists are more likely to be seen to be working with, rather than within, ward teams, and more effort may be required to achieve the desired inclusion in team-working. Where resources permit the provision of both individual therapy and staff development work, the two can reinforce each other, as the psychologist's ability to engage with clients with intractable problems increases their credibility with the team

A challenge for psychologists working with inpatients is the goal of treatment, which is not necessarily the optimal resolution of psychological distress within that particular setting. The goal of admission is often merely the reduction of distress necessary to facilitate a transfer to a less restrictive setting. Bed management often acts as another barrier to engagement in psychological therapies on the ward. Problems arise with frequent transfers to other wards that may be offsite or people leave for home at short notice because of bed shortages.

Both the aims of admission and frequent absences and transfers can make it difficult for ward-based psychologists and other team members to provide evidence-based interventions in the time frame recommended by the National Institute for Health and Clinical Excellence (www.nice.org.uk). Recommendations include, for example, a six month or longer course of CBT for people with a diagnoses of schizophrenia or bipolar disorder. However, engagement in a therapeutic approach should not be deferred. Hospitalisation might provide one of the best opportunities to enhance psychological thinking and raise awareness of the potential of psychological treatment. Once again the imperative of effective transfer and continuity of care to other parts of the service system is of critical importance, with an emphasis on receiving therapy from a service using a particular approach, rather than from one particular individual.

Probably the biggest challenge of working on inpatient wards is the nursing shift system where the whole staff team rarely meets together. This hinders opportunities for whole team training or consultation or involving the whole staff team in any service improvement initiative. On occasions, the movement of staff through shifts and across wards means that a 'team' exists in name alone. Leadership can also on occasions be ambiguous. In some settings, the consultant psychiatrist takes the role of team leader, in others, this role is firmly held by a ward manager, while it remains unclear in some services who leads the team.

A further challenge awaits the psychologist in working, often on one's own, with a team holding compulsory power over many of their patients and following a more traditional medical model (as defined earlier) than one might perhaps find in community-based services. Working in services built around compulsory treatment can make it difficult for psychologists to work in a truly collaborative way with their clients. However, this is a challenge that may soon be shared with psychologists working in community settings with people with severe mental distress.

The following New Ways of Working proposals are suggested with these challenges in mind:

- All acute inpatients should have some form of access to psychological therapies and interventions provided by a qualified practitioner who may or may not be a clinical psychologist (but who would ordinarily be either supervised or receive peer consultation from a clinical psychologist).
- Inpatients should be given the choice whether or not to meet and work with the psychologist, whether they are voluntary or under section.
- Being overt about the implications of compulsory admission for patients is likely to promote more successful collaborative work with them.
- Psychologists need to work proactively with the ward-based team on proceeding toward discharge, avoiding scenarios where discharge is delayed due to lack of psychology service provision outside of hospital.
- Psychology involvement with multidisciplinary care planning and reflective practice can help to focus the therapeutic purpose of the admission, manage challenging behaviours according to the best-evidence based practice and reduce staff burnout by allowing for expression of and reflection on staff reactions to high stress work.
- Psychologists should be closely involved in the adaptation of care planning procedures to ensure that psychological and psychosocial needs are given as much emphasis during an inpatient stay as other clinical priorities.
- More research is needed on how to adapt practice and establish an evidence base for therapy delivered in acute ward conditions characterised by short periods of time for intervention and a high level of acute distress. For example, the 'Woodhaven model' (Durrant *et al.*, forthcoming) was developed to provide a combination of simple formulation and skills based treatment. It gives prominence to the arousal component of the emotional reaction. The intervention is based on the premise that most psychopathology can be understood as a phobic reaction to aversive emotion (Clarke, 1999). An evaluation (ibid) is showing promising early results and is ongoing. The evaluation measures concentrated on measuring confidence and locus of control as the central aim of the therapy is to enable people to find their role in managing their own mental process.
- Psychologists should be working with the multidisciplinary team and management to enhance the therapeutic milieu (in the areas of ward structure, patient involvement, physical and psychological containment, culture of support and validation of the individual).

Positive practice example: Running Reflective Practice Groups on an Inpatient Unit.

As psychology input time to inpatient units is often limited, a potential effective use of the psychologist's time when on the unit is to offer reflective practice groups to the staff teams. Two psychologists at an acute adult mental health inpatient unit in the New Forest run regular, weekly Reflective Practice Groups for all ward based staff. A recent evaluation project has attempted to assess the effectiveness of these groups by asking staff to complete a self-report measure on their perceptions of the impact of the groups on their professional and personal development. The results of this study indicate that all those who completed the questionnaires (about 30 per cent of attendees) reported a significant benefit in terms of both their professional and personal lives. Perceived benefit did not vary with staff experience measured in terms of length of service. Open-ended comments suggested that these benefits related to reduced stress (e.g. 'I feel it helps nurses to avoid getting the negative effects of stress') and encouraged discussion as well as open mindedness (e.g. 'We learn from both positive and negative experiences'). Other comments suggested that the groups improved the working relationships with clients: 'I regard reflective practice as an essential part of enhancing our abilities to build the best possible therapeutic relationships with out clients.'

The study, therefore, suggests that Reflective Practice Groups are valued by the staff and have a perceived beneficial impact. In order to assess this further the study needs to be expanded to capture a wider representative sample of those who attend.

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Positive practice example of psychology leadership of a Leaving Hospital Group.

At the Highgate Mental Health Centre in Islington, all inpatient wards have access to a weekly Leaving Hospital group. This group forms part of a wider community re-integration strategy, which endeavours to build bridges to sustainable community living for inpatients returning home. The Leaving Hospital group follows a recovery and social inclusion model; it is an open group based on the wards themselves with a regularly rotating membership. Participants are invited to discuss the obstacles they face in achieving a discharge from hospital as well as their plans, and concerns, about post-discharge life. The group focuses on one or two central concerns and provides mutual support with empathy and practical suggestions, including the provision of information about local resources. Topics have ranged from anxiety and avoidance, negotiating leave within ward round, developing social support networks and meaningful work related experience and preventing relapse and re-admission. Wherever possible, the facilitators raise awareness of psychology's evidence base and provide on-the-spot, brief solution-focussed interventions. At the close of each group, members are asked to make a pledge of something they will do in the coming week to advance their recovery.

The group is staffed by one clinical psychologist and up to two members of the ward-based team, who rotate every six weeks. The ward staff member receives *in vivo* training in group facilitation as well as post-group consultation and guidance on individual care planning in relation to what is revealed in the group. Service users have commented that the group provides a valuable opportunity to think realistically ahead and to begin to take back responsibility and control in their lives. Staff co-facilitators have remarked on the usefulness of receiving a psychological perspective on their patients' presenting problems. With a limited amount of psychology input to the wards, the Leaving Hospital groups offers a chance for service users to opt-in to regular contact with psychologists and to work collaboratively with peers and staff on something very meaningful to them. It further helps the inpatient service by introducing one small but significant method to address the challenge of community re-integration with individuals who are among the most socially excluded in our communities.

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Please see also positive practice examples under 'Teaching and training' and 'Supporting peer consultation processes and reflective practice'.

Further issues with respect to crisis resolution and home treatment teams (CRHTs)

Guidelines for how to structure a CRHT team are provided in Mental Health Policy Implementation Guidelines (Department of Health, 2001). The document includes a recommendation for psychologists to be included in team structure, but as CRHT teams are a fairly new development, there is no clear guidance on how the role should be defined. Therefore, psychologists nationally have been learning the most effective ways of working in CRHT teams through day-to-day practice. More recently they have been pooling their resources and experiences through the CRHT psychologist network. This section shares reflections and learning from the network so far.

CRHT teams work with clients in the acute stages of their distress, often as an alternative to hospitalisation. Typically, CRHT teams have a predominant medical model focus in terms of the understanding of client difficulties and treatment approaches. The work is often stressful, pressured and reactive in nature, providing few opportunities for reflective practice and formulation-based approaches. In this setting it is therefore particularly important that in addition to providing psychological assessment and intervention, the psychologist encourages a whole-person approach to CRHT working, with an emphasis on social inclusion (Social Exclusion Unit, 2004; National Social Inclusion Programme) and recovery (NIMHE, 2005).

In CRHT working, the psychologist will have increased exposure to the first contacts with clients; often at a time they are acutely distressed. This may increase awareness and understanding of the impact of acute phases of distress on the client and their family/carers. It also gives an insight into the pressures on health care professionals in these situations. With good inter-team working they have the opportunity to see the full course of difficulties, from the acute phase of mental distress through to stabilisation and recovery.

Positive practice example: The development of Family Work for Psychosis in a CRHT team

The NICE guidelines for schizophrenia recommend family work as part of the treatment approach in the early post-acute period of a psychotic episode. CRHT staff are well-placed to deliver such an intervention, due to the use of home visits and frequent involvement with the family and carers of clients during this time.

It is not possible to deliver a full programme to each family, due to the time limited nature of CRHT work. Therefore. in the Swindon CRHT team the lead psychologist for psycho-social awareness training, the CRHT psychologist and a CRHT team mental health worker developed a tailored training package to aid the CRHT team staff to deliver a brief version of family work for psychosis. This enables the CRHT team family workers to provide support and education to families and carers in a structured format, as well as to support families in the acquisition of specific skills such as problem-solving. It also raises awareness of further support available for families of people diagnosed with psychosis, including how and when to refer for a full course of family work. This will be supported by monthly consultation from the CRHT psychologist as a forum to develop skills in family work, whilst encouraging the use of reflective practice and consultation.

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In the CRHT psychologist network, it has been evident that each psychologist has a slightly different way of working, which is influenced by the needs of the team, the style of the psychologist, and service, manager and commissioner level agreements. However, common skills are evident in all ways of working. These include the psychologist's training and skills in assessment and use of formulation to aid understanding of the client's difficulties from a variety of psychological models and literature and the importance of evaluation and measuring effectiveness, both in terms of individual client outcomes and at a service delivery level (see Table 4). The psychologist is also challenged to think creatively about the most effective way to deliver a psychological intervention, taking into account the resources of the client and team, and the time-limited nature of CRHT working. This may lead to adapting therapeutic approaches such that they can be delivered in a brief time period, or such that acquired skills can be applied by other members of the CRHT. It also challenges the psychologist to adapt the therapeutic intervention to the current resources and abilities of the client, which may be reduced in the context of their current distress or difficulty.

Positive practice example of CRHT service evaluation.

The CRHT psychologist was involved in the development of a service evaluation/client satisfaction project relating to a three-year-old crisis team which had recently become a CRHT team. Multi-disciplinary working occurred between the psychologist and senior nursing and social work staff in order to construct a semi-structured interview format, which was informed by the team's operational policy and DOH/NIMHE documents. A student social worker and assistant psychologist undertook the interviewing and collation of interview data under the supervision of the qualified psychologist. The psychologist played a central role in clarifying the purpose and methodology of the evaluation and in constructing coherent and operationally relevant evaluation criteria. Strategically, the psychologist helped the team to think about how, where and when the results of this project should be disseminated in order to promote further service development.

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Further issues with respect to early intervention teams

Early Intervention Teams are designed to treat people aged between 14 and 35 with a first presentation of psychosis or during the first three years from the onset of psychosis.

As with CRHTs there is significant latitude in the specific undertakings that a clinical psychologist might be expected to contribute and strong emphasis in such teams towards a medical model. Psychologists therefore have a role in helping to develop education and materials such as websites (e.g. www.gripinitiative.org.uk), leaflets and other educational materials aimed at raising awareness and understanding of psychosis. Given the focus on symptoms it will be important for psychologists to contribute their expertise on assessment of young people across the child and young adult spectrum. Psychologists have a role to play in differentiating for example autism/Asperger's from other developmental difficulties before establishing any definitive diagnoses of psychosis.

Psychologists have been at the forefront of early detection efforts to identify older children and younger adults who are at very high risk of conversion to psychotic states. Such 'at risk mental states' (ARMS) are important to detect early as research has shown that interventions such as targeted cognitive therapy can stop or delay conversion from ARMS to a full blown psychotic state. The psychologists' role in being able to offer training regarding early detection is a resource for increasing the effectiveness of the team as a whole.

Early and sustained engagement is vital following the assessment of a first episode of psychosis. Psychologists should be able to contribute to the design of youth appropriate and youth sensitive services and should be able to work pragmatically and flexibly in an assertive outreach fashion. They should also be able to fit in to a shared team caseload way of working as opposed to a parallel caseload. Of course, there may be occasions when specific tailored individual psychological intervention is necessary but this should always be viewed within the context of the wider team.

It may be particularly important for psychologists in early intervention to have at least a working knowledge of medication as this clearly impacts on psychological states such as the ability to process information as well as potential side effect difficulties triggering further symptom experience or exacerbation.

There may be differing views as to whether psychologists ought to act as care co-ordinators but from a pragmatic and flexible viewpoint psychologists do act in this role in a small number of cases and where there are perhaps more complex issues. This could include linking in for example with helping to provide pathways to recovery involving valued education and occupation.

Psychologists would have a major role to play in teaching and training of other staff members in the early intervention team. There is also an important role in the training up of workers in other statutory and non-statutory services in order to facilitate effective referrals. This would also be the case for training up workers in primary care settings e.g. within GP surgeries and also primary care mental health teams.

Implications of virtual teamworking

Virtual teamworking is where technology allows team members to work separated by time and distance through email, teleworking, teleconferencing, video conferencing and the creation of digital workspaces. The trend appears to be towards practitioners spending increasing amounts of time working through computer or video interfaces and communicating via e-mail. Rather than just reflecting a social trend some teams specifically choose to adopt virtual teamworking as a result of the need to organise work over large geographical, often rural patches. A tendency towards larger health provider partnership trusts and the use of digital technology to support community engagement and other forms of stakeholder involvement is likely to further increase the use of these methods.

In general it seems that those processes that are important in achieving effective teamworking become even more important when working virtually. As Cascio and Shurygailo (2003) observe, '*Virtual team environments magnify the differences between good and bad projects, organisations, teams and leaders'* (p.375). Connor and Phillimore (2003) also note that the key features of effective virtual team working are as teamworking generally and stress: (a) that roles must be clearly understood; and (b) that team members discuss and agree how they will work in the virtual workplace resulting in established norms of behaviour to which everyone is committed. With respect to these norms, they particularly stress the importance of aligning mission and goals, goal setting, roles clarification, codes of conduct and decision making. Codes of conduct might include expectations around the handling of e-mail and virtual meetings as described below. Holton (2001) similarly stressed the need for virtual teams to *'ensure that adequate time is devoted to strategies and systems for generative conversations as well as creating shared meaning and a commitment to a culture of collaboration'*.

Describing clearly the tasks to be undertaken and the interdependence between members to achieve the tasks is particularly important. Responsibility for communication and progress reporting needs to be highly specified, and where tasks span teams there needs to be formal processes in place to ensure regular updates and clear accountability for task completion. Where team members have to work together on complex tasks requiring exchange of ideas and information the volume of email traffic that can be generated is enormous. There is therefore merit in having preset times for verbal interaction at meetings even if these contacts rely on tele- or video-conferencing. Team leaders need to establish norms early in team development, and maintain appropriate levels of control on the process and progress of work. One important discipline is to ensure that every communication moves the issue one step forward. For example, a message such as 'Got your message, call me' is effectively useless without further specification of how and when this might best happen.

Clarifying roles is as important as in any type of teamwork. Effective development of forums around particular aspects of provision or interest allows the emergence of leaders within these groups who can assume greater responsibility for coordinating with the whole. Cascio and Shurygailo (2003) describe this as an 'initiating structure' style of leadership that gets teams focussed on what needs to be accomplished. In order to avoid 'document attachment frenzy' (for example, when working with regularly updated documents) it is also helpful for a team member assume a librarian role, building an archive of documents relating to the teams work on a website or shared drive.

Where an incremental collaborative approach to a project is desirable the use of weblogs (or 'blogs') have advantages over e-mail in that the thread of work done by a range of participants is easy to follow. Relying on the search facilities of email software leaves one liable to errors and failure to capture the whole story, particularly where issues evolve but people fail to update the subject line so that some stakeholders become inattentive because they do not realise that things have moved on. Using weblogs usually means that the material (being on a website) is more secure. CSIP continues to experiment with new ways of creating collaborative digital spaces.

Connor and Phillimore (2003) stressed the importance of the architecture of the virtual space within which the teams work is collated and accessed. Teams need to design the categories within their virtual workspace so their work, their discussions and the questions they are pursuing can be accessed by everyone. It is where people see all of the same information, debates and issues all at the same time. How people access information will be critical; as the authors stated, '*Our experience with change over the past six years leads us to conclude that speed and scale of the agenda facing most staff in the health care environment, necessitates that you update and learn on a* ***just in time*** *basis, ensuring safe practice and client satisfaction'* (p.84; emphasis added). For this reason pushing information towards people is unproductive. They need to be able to pull it down easily when needed. Connor and Phillimore construe this as providing the crucial learning that is normally acquired through informal interactions; the 'water cooler discussions' that occur when teams work together face-to-face. They also however stress the need for a balance between a strict work-objective focus and members' needs for social interaction and affiliation. They therefore also established a 'gin bin' (based on one team members predilection for that particular spirit) wherein members could contribute jokes and photographs.

The downside of the whole team seeing the whole picture all the time is the potential to be overwhelmed by information. This risk was highlighted by Connor and Phillimore's (2003) pilots of virtual teamworking using a digital workspace. They advocated virtual teamworking on the basis of a range of benefits in terms of saved time and efficiency but counselled that teams should proceed cautiously, particularly if they are not confident with technology. With this overload comes an even greater imperative to prioritise work tasks, which is another area where established team norms and guidance can be highly beneficial.

In establishing teams, time for face-to-face team building when individuals meet in person and get to know each other personally may be even more important in virtual teams than in teams wherein trust and understanding can develop more incrementally. Trust is a consistent theme in research on virtual teamworking as it is in teamworking generally. It is trust, which provides the collaborative dynamic of a learning organization (Handy, 1995). Holton (2001) describes trust as developing through, 'frequent and meaningful interaction, where individuals learn to feel comfortable and open in sharing their individual insights and concerns, where ideas and assumptions can be challenged without fear or risk of repercussion and where diversity of opinion is valued over commonality or compliance'.

An empirical study of trust among 29 virtual teams (cited by Cascio & Shurygailo, 2003) found that teams with higher levels of trust: (1) began their email interactions with some off-task social messages introducing themselves and offering some personal background; (2) were very clear about roles; and (3) displayed positive attitudes such has enthusiasm, eagerness and an intense action-orientated approach. These higher trust teams were more productive.

E-mail communication can be a liability in maintaining trust as it allows the reader to infer the affective tone from text alone. Some users are proficient in the arcane language of emoticons[9] but one cannot assume the e-mail recipient will be and thus the tone is always likely to be inferred from very debased information. When you are concerned to make sure the right emotional tone is established (e.g. when apologising or conveying bad news) voice mail should be considered even if you are still communicating with a machine.

The implications of an e-mail interaction that is perceived as negative can be significant as it is also not so easy to resolve it through sensitive emotional interaction. Furthermore, the threshold for what constitutes a negative interaction may be lower. For example, Crampton (2002) found that e-mail silence was variously interpreted as *'I agree. I strongly disagree. I am indifferent. I am out of town. I am having technical problems. I don't know how to address this sensitive issue. I am busy with other things. I did not notice your question. I did not realise that you wanted a response'* (p.362). Silence can be interpreted as disrespect for the sender or their issue in that it may be inferred that neither are important enough to respond to in a timely manner. In most cases and in a context of high volume of traffic this is likely to be an unintentional message but there may be knock-on effects in terms of self-worth, commitment and trust.

[9] See, for example, www.computeruser.com/resources/dictionary/emoticons.html

The inference that silence means consent can be particularly risky. Given the ease with which human and technical errors and problems can contribute to non-response it may be important to establish a discipline wherein expectations concerning responses to e-mails are established, that teams agree ways of highlighting important matters (e.g. using colour), and that the need for response to indicate support for action is made explicit.

Higher levels of organisation around the conduct of virtual meetings will also be needed. It is important that everyone is aware who is in the meeting and their role, and that events such as people leaving or entering, are communicated. Encouraging the use of protocols whereby people identify themselves when they speak may also be necessary.

Enabling equitable access to virtual team working processes is key, particularly when involving people from outside of statutory organisations who might enjoy (even) less access to up-to-date hardware and software (e.g. users and carers and staff working in the voluntary and community sector). Virtual meetings need to be planned way ahead in order to ensure that all stakeholders have access to the same information. In addition to the usual information requirements there is a need to consider: (a) broadband access, (not everyone may be able to be online and take a call at the same time); (b) connection speeds and how long it will take people to download documents, (c) access to printers, modems and network connections; and (d) specific software or equipment required to view or edit documents. Such awareness of the context in which people undertake virtual teamworking is crucial to the building of what Crampton (2002) referred to as 'Mutual knowledge'. This is not only the body of knowledge held by the team, but also the *levels of awareness that others hold this knowledge also.* This mutual knowledge forms the basis of successful communication and co-ordinated activity. Working from different bases means that participants in projects may have different information. When this is not known it can create false assumptions and a rich source of misunderstanding, poor communication and mistrust. Crampton observed that virtual team members were vulnerable to such uneven distribution of information along with failures to communicate and remember information about the context in which participants worked. She found that problems in developing mutual knowledge led to more attributional (and thus personal) rather than situation attributions, impairment of the team's capacity to learn, and failure to meet each others expectations. Perceptions of dependability and reliability are particularly salient to virtual team members and problems in these aspects create lingering damage to trust.

A much neglected aspect of leadership is the need to provide affirmation, recognition and praise. Cascio and Shurygailo (2003) reported that this is even more important for remote workers. Other implications for more remote workers include feelings of exclusion or inequitable access to guidance and support when necessary. Leaders being contactable by pager can help this access issue but once again building an effective team through shared trust and understanding remains paramount.

Increasingly we may encounter localities where there are multiple managers managing several teams, which will themselves need to collaborate on diverse projects. It is important that these managers themselves meet to share and understand the processes that they will use for virtual teamworking in order that confusion and misunderstanding can be minimised and that team members can expect positive practice to be apparent throughout the system.

A final key aspect of virtual teamworking that needs to be considered is its potential to erode work-home life boundaries. Holton (2001) found that the greatest frustration and challenge facing the virtual team she studied arose from limited time. Even when time can be used very flexibly team members in her study identified the challenges of limited availability for communication, and considered reflection. She concluded: *'The same technologies that enable us to work together irrespective of geography and time zones also enable our work to "invade" our personal lives and space. Unless carefully managed, the boundaries between office and home, work and family, duties and pleasure can quickly disappear. For each of us, this can represent a different context. What one may find integrating another will find intrusive. The important personal challenge here is finding the balance that suits one's individual needs'* (p.45).

Continuing the dialogue together

The recommendations of this report advocate that applied psychologists become more actively involved in team practice, team design and evaluation and work at the level of the complex systems of which teams form a part. This is a challenging agenda spanning many levels and ways of working. This report has highlighted some sources of support but there is likely to be a continuing need for networking, support, training and continuous professional development in pursuit of these ends. The BPS itself has its Management Faculty within the Division of Clinical Psychology and all the expertise of the Division of Occupational Psychology to draw upon. Further groupings may emerge among people with a particular interest in team development and consulting to organisations.

The New Ways of Working website is also a rich source of information of relevance to the continuing demands of teamwork improvement (see www.newwaysofworking.org.uk). CSIP Networks have recently established a Learning for Improvement Network on Leadership and Teamwork Development which aims to bring practitioners from a variety of fields together to share resources, experience and expertise in this area (see www.icn.csip.org.uk/leadership). We look forward to seeing you there.

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