11. Towards 'good practice' guidelines for 'complex cases'.

Introduction

My earlier inquiries into practice with 'complex cases' had revealed a number of patterns which occurred around their management. It was now my objective to become involved in 'complex cases' from the point of first contact because one of the patterns I had discerned was the limited and unsystematic degree of negotiation with the relevant groups and individuals prior to and around the referral to the service. My purpose in involving myself at this point was to both understand more fully what the issues were, and to have a stronger influence in how the 'cases' were managed. I believed that if a much greater degree of collaboration could be introduced from the outset then later problems and pitfalls could be minimised, and continued collaboration would be more possible.

I hoped that this greater understanding would help me in facilitating the more explicit and systematic practice with 'complex cases' across the department that I was seeking. I was at this stage still seeing a focus on complex cases as holding the research questions I was pursuing - understanding how I worked as a psychologist, exploring possibilities for teamwork, and looking to support the immediate 'organisation' towards being more of a community of inquiry which was more self-reflexive and 'alive' to itself. This chapter is about making preparations for a more explicit and systematic inquiry into 'complex cases'.

In addition to exploring ideas from Collaborative Inquiry and the Hermeneutic Dialectic Process, I borrowed a concept called the 'Patient Journey' from clinical audit work in the health sector. I will describe this briefly below. This concept appealed as offering a conceptual map which all staff could share in developing a commonly agreed set of 'good practice' guidelines which would serve to inform quality practice from the moment of first contact through to discharge. I saw this as providing a potential focus for developing the first stage for a Collaborative Inquiry as described in the last chapter, where the initiating actor/researcher and other participants come to agree an aim for inquiry and share the model of an interpenetrating attention.

My involvement in assessing and care-planning with a client called Rosemary provided an opportunity for a 'mini inquiry' in which I could test out these ideas. It is this I will recount in order to describe the issues as I saw them and to describe the process of inquiry which suggested a pattern for a later more prolonged inquiry. Within this mini-inquiry I saw patterns of relationship and constructions of meaning that I was to recognise as recurring over time around other issues among health professionals. I held an assumption from systems theory (e.g. Hoffman, 1981) that patterns of relationship around one problem or issue can be seen as an analogue or isomorph of patterns of relationship which will recur at other times and in other places within the same group. This assumption is more likely to hold if the same people are involved, but can apply if one or more people occupy the same role at different times.

I will begin by describing the 'Patient Journey' concept, then recount Rosemary's beginning to her 'patient journey' through our service. I then reflect on what lessons are learned from this for a more prolonged and wider inquiry to establish 'good practice' guidelines.

The Patient Journey.

This is a concept widely used in managing clinical work in health services and refers to the sequence of events in providing an episode of treatment and/or care to a patient from the point of entry to a service through to discharge. It is one that I had found as offering considerable utility in conceptualising how to deliver services more systematically, and how to structure what can become confusing encounters when thinking about allocation and management of resources. I had developed my own set of understandings over the years, and I will present this here as a 'framework' for thinking about how to structure the delivery of a service with 'complex cases'. The framework is not intended to be prescriptive, programmatical or normative. Rather it is something which I had 'co-evolved' over the years through dialogue with others and with my own experience and which I held loosely in order to

amend it in the light of new experience and new dialogue. Its utility for me lay in providing a language for talking with other health workers at times when we needed to think at the level of 'organisation of services' as opposed to delivery of service with an individual patient. We could then arrive at a consensus agreement about how 'punctuate' our work into chunks which may require different staff with different skills at different stages - for example an initial brief assessment of immediate need could be followed by a more comprehensive assessment of longer term needs, which may be followed by a detoxification, and so on.

What I am briefly describing here is my own set of understandings which I thought I could bring to the task of developing a more explicit and systematic understanding with others about how we worked with 'complex cases' as a group. The patient journey as I conceptualised it requires the identification of the significant steps needed to successfully take a person through an episode of health care. 'Good Practice' guidelines can then be derived for each step by the workers involved which inform how they can implement interventions or processes to achieve optimum quality care. These guidelines are informed by research and the research literature (giving information on 'what works best' for a given problem); by 'bench marking' with other agencies providing similar services (how they have implemented 'what works best' and with what outcomes); and by inquiry within local settings and conditions (what 'works best' for us).

Having established good practice guidelines, standards can be set for each step of the Patient Journey which represent ideal outcomes in a tangible and measurable form. This can enable auditing when problems occur in order to identify factors which require change. It can also inform the concept of 'Risk Management' in health care. If good practice guidelines or standards are departed from in any circumstances, the clinicians involved need to be able to rationalise these departures in terms of either resource limitations, patient characteristics or local conditions. Provided departures are accounted for in this way and appropriate action taken, then risk is deemed to be adequately managed. In this way, the probability of quality care being provided is seen to be reliably improved.

This process is much easier in medical health care which is technological in focus, more easily described in digital and quantitative terms, and neatly bounded in time and place - such as many surgical procedures. However my experience in mental health care, with its interpersonal process rather than technological focus, is that good practice guidelines (how to implement) are much less likely to be informed directly from the research literature (what works with any given problem). Rather, they are more likely to come from quality and audit literature where other workers describe their work (a form of bench marking), from literature with a case study approach, and from local inquiries into 'what works best in this setting'.

I will illustrate with an example from my own prior experience shortly after starting in the department. I employed a research assistant to inquire into clients' experiences in coming from the referring agency to the point of first assessment at a routine outpatient assessment clinic. She and I developed our own tentative understanding of the steps in this part of the patient journey then elaborated on these through inquiry with clients and the clinicians seeing them. From this inquiry into the constructions held by the different participants, we were able to identify changes required to meet both clients' and staff's expectations and needs, including training of staff in particular skills. This previous experience had shown me the utility of the framework for routine initial encounters with more straightforward presenting problems which could be addressed by an individual worker. I saw it as having potential applicability for more complex situations, but also saw that I would need to hold it lightly and offer it up for dialogue and change according to how my inquiries progressed. I knew from past experience that different workers held different constructions about what constituted the 'patient journey'. I was interested in seeing if a more explicitly negotiated set of constructions could be developed from our local practice which included as many 'stakeholders' as possible.

A 'mini-inquiry' into the first steps of the 'Patient Journey'.

I will firstly give some background to Rosemary's story to 'set the scene' and expand the contexts available for making sense of the encounters. I am seeking not to repeat the earlier, more detailed, story form I used as representation of my participation in 'complex cases', but will dwell a little in detail at this point in presenting Rosemary's story. This will enable me to take meaning about the service dilemmas I saw around her referral.

Rosemary's story.

Rosemary was a young woman in her mid twenties who had a professional training, but who had not worked for more than six months at any one time. She had been unemployed since marrying one year ago and was not coping with the demands of a committed and intimate relationship as she perceived them to be. As a result she was in frequent conflict with her husband and lived between their apartment and her parents' home. However, when at home with her parents, conflict would erupt between her and her mother, with the result that Rosemary would become violent towards her mother and then damage property in the house. She would then become suicidal and disappear for one to two days at a time, usually being picked up by the police standing near a bridge or upon a high building.

Admission to her local psychiatric hospital would follow, with her staying for several weeks before discharging herself back home. In hospital, she would become self-mutilating on some occasions. Once back home, the pattern would start again. Most of these incidents happened while Rosemary was drinking heavily.

At the age of sixteen, Rosemary developed the eating disorder called Bulimia Nervosa. Believing she appeared fat and overweight, she would diet severely to keep her body image within limits she perceived as acceptable. Dieting would be punctuated by regular binges on excessive amounts of food, usually triggered by hunger or some form of emotional distress. Feeling intensely guilty and fearful of having put on weight, Rosemary would then empty her stomach by self-induced vomiting. This would then be followed by further dieting and a continuation of the viscous circle.

All of Rosemary's family of origin were diabetic and the management of this condition through dietary control had a strong influence in the organisation of family life. Rosemary often wondered in retrospect whether her feeling excluded from the closeness and the drama the other's experienced because of this was causally connected with her eating disorder.

Her parents had tried unsuccessfully over the past ten years to get her to engage in various forms of treatment. Rosemary had initially complied but was ambivalent about making change. However, more recently, her ambivalence had begun to swing towards the felt need to change as she increasingly felt out of control and correspondingly more desperate. She had developed a dependence on alcohol. As she told me, it was more acceptable to tell people "I get drunk" than " I throw up most days of the week!" As Rosemary became more desperate she engaged in forms of self-mutilation in an attempt to break the vicious circle she perceived herself to be caught within..

Her parents were also becoming increasingly desperate and were in dispute with the local health authority. Believing that the only effective remedy now was long term in-patient treatment in one of the London specialist hospitals for eating disorders, they had been unsuccessful in obtaining the health authorities permission to fund this. Not accepting this, Rosemary's parents had obtained the support of their local MP and eventually persuaded the health authority to concur.

Alongside the referral to our service, Rosemary's psychiatrist had also made referrals simultaneously to several units specialising in the treatment of eating disorders, and also to a colleague in our own Trust who had a special interest in eating disorders and was internationally renowned. Because of the long waiting lists, the referral to us was for interim help with her drinking problem. The hope expressed in the referral letter was that we could somehow minimise the crises which occurred around her drinking. Rosemary had not engaged well with her local mental health services and it was felt by the referrers that this was in part due to her alcohol misuse, and partly due to the nature of her 'disorder'. She was seen as having a Multi-impulse Personality Disorder. This was a diagnostic label derived over the last decade to describe the above cluster of phenomena, seen as stemming from a personality constellation characterised by impulsivity and difficulty in tolerating emotional arousal. The dysfunction is seen as being located within the individual, and ignores the contexts in which it arises. There is no particular treatment approach suggested by the application of the diagnosis, but it suggests that the individual will not be able to respond readily to treatments of eating disorders which have been shown to be relatively successful with others of a more 'robust' personality.

Link to: http://www.bath.ac.uk/carpp/publications/doc_theses_links/d_quinlan.html

As an aside, the language of diagnoses is not part of my day to day narrative about working as a psychologist. I can speak the language and find it useful on occasions to be able to communicate with those who use it to reflect their dominant framings of mental health. Diagnostic labels have utility for me only at a broadly descriptive level to suggest what phenomena are likely to be experienced by the individual. They operate at a different logical level from the process of therapy and change and do not reliably predict what course of action is required in order to intervene helpfully.

A first inquiry with Rosemary.

I became involved with Rosemary at the point of initial assessment in an outpatient assessment clinic run by a small group of nurses, doctors and myself. We allocated cases between ourselves according to interest and at the same time matching referred problems with relevant skills. Occasionally we conducted assessment sessions in pairs. On this occasion I was joined by Luke, an experienced Clinical Nurse Specialist.

There was no clarity in the referral letter about whether the referrer was transferring total responsibility for the case to us, or only asking us to support treatment while the referrer retained responsibility. What was further unclear was who else was going to be involved, given the multiple simultaneous referrals. Luke and I were a little unsettled by this 'recipe for confusion' but decided to see Rosemary first and to gain her views before seeking further clarification.

Rosemary attended with her father and was seen jointly with him and also on her own. We heard of the problems they faced and their views of the current situation. Father did not see this referral as meeting his view of what was needed and was polite but firm in this view. Rosemary was keen to get help, but on terms which were different from those of the referring psychiatrist and her parents. She had her own views about what the problems were and how she wanted to work on them. There was implicit and explicit conflict between the two, but also evident closeness. However, both she and her father shared the opinion that in-patient treatment was the only acceptable option - they were worn out by crises and felt nothing had worked to date.

At this point I considered a number of dilemmas I saw surrounding this 'case'. I believed I needed to find a way of working with the family in which I could join therapeutically, but at the same time avoid being seen to support one viewpoint about the nature of the problems at the expense of others. I needed to retain a degree of neutrality about this until such time as the therapeutic system-to-be-worked-within had been defined and a consensus reached about the focus of the work to be done. If I could not retain this type of neutrality, then I risked becoming part of the pattern of escalation I had discerned from the family and the referring letter. Furthermore, our department could not provide the degree of intensive nursing support required when individuals were suicidal. Therefore, the referring psychiatrist would have to remain in the picture in the likelihood that the above crisis pattern occurred again and we were unable to prevent it. I did not know how my psychiatrist colleagues in the department would view this as there was a tradition of consultants either managing care or giving opinions, but not a tradition of sharing care through negotiation.

I was also a little anxious about the degree to which we could meet the needs of Rosemary and her family as our department had not yet had much collective experience in managing this type of problem. Yet in developing our departmental philosophy we had agreed to take a broad view of what constituted addictive behaviour. In the core group we had decided that we would work with any individual who engaged in repeated cycles of self-harming behaviour, particularly if drug or alcohol misuse was involved. Rosemary fitted this description so she presented us with not only a challenge but an opportunity to develop effective ways of working with her.

A further factor to take into account was that I knew my two psychiatrist colleagues, William and Stewart, did not believe hospitalisation was required in order to treat eating disorders. Once in psychiatric hospitals, the boundaries about who was responsible for the individual's intake of food, and the health consequences of that, created double binds around issues of 'control' for both patient and staff. There was an increasing view among mental health professionals that hospitalisation was only warranted when the patient was physiologically in emergency, and then admission to a general medical service was needed. I would have to negotiate through this potential polarity as well.

And finally, I felt as though the different agencies and individuals who had become involved formed a potentially critical audience who would watch with interest what we did. Would I meet expectations? Would we as a department be seen to be doing a good enough job?

Against all that, was Rosemary's demeanour in the session. She was very tense and wary, yet also had clear ideas about what she was looking for in terms of help. She struck me as being very present in the session and as seeking to find a safe place in which to explore change at her own pace. In seeing her alone and asking her views about 'what needed to happen for things to change', she told us with some feeling "I am sick and tired of focusing on all the negative aspects of myself. I would like to develop the good parts, the talents I know I have." This could be construed as signalling her continued ambivalence, avoiding directly facing the 'giving up' of her alcohol and eating problems. But it could also be construed as 'taking charge' of her own experience and as such, needed to be supported as a more viable form of agency in the face of chaos. Furthermore, I thought she was offering us a frame for working with her which neatly bypassed many of the dilemmas about focusing on alcohol versus eating disorder, and about potential polarities around 'who was in control' which were strong sub-texts in the 'stories so far'.

During a break in our session Luke and I discussed these issues. Luke thought she was "shopping around" and not serious about engaging with us. He thought we should let her visit all the other agencies before deciding, despite the sense of impending further crises. That part of me which was anxious allowed Luke's view to have weight. Perhaps he was right, and that approach would save a good deal of work negotiating through the maze of different views and agendas. But I could not let go of my other impressions of Rosemary struggling for survival and wishing to exercise agency in the type of help she received. I also knew that if we went with Luke's suggestion, there would inevitably be further crises as there would be no relationship or potential relationship which would 'hold' the family in some frame of hope. To some extent, she could be seen as "shopping around" with the help of her father - but why not? Surely clients should exercise choice! It was our job to create the conditions in which she might choose to work with us.

With both frames jostling for ascendancy, I suggested we tell the two that we would like to help, but with two provisos. Firstly, we would not wish to treat her alcohol problem separately from her eating disorder and related difficulties as they were part of an indivisible whole. This would address both Rosemary and her father's concerns, but this framing also needed to be tested for acceptability with others in the professional network. Secondly, in order to know if we could help by providing inpatient care we would need to discuss the case further with our own colleagues. Luke deferred and we presented this to Rosemary and her Father who agreed with this proposal and to a further meeting.

An inquiry with the professional network.

My task was to get a clearer map of the different viewpoints held by those professionals who were going to be significant in developing an initial care plan. From there I could begin negotiating a common frame in which we could begin working with Rosemary and her family, one which honoured the dominant constructions of all involved about the nature of the presenting problems and the help needed, while at the same time providing possibilities for further negotiation and change.

I first needed to gain the viewpoint of medical and nursing colleagues to see what the possibilities were before contacting the referring team members. I decided to gain William's viewpoint first as the consultant who would take medical responsibility for Rosemary as an in-patient. I knew ahead of time that he was interested in working with these sort of problems. I also knew from previous conversations that he liked people to come to him with solutions as well as problems, and equally I knew he could abruptly dismiss solutions which fell outside his view of what was needed. The dilemma for him was likely to be how we could rationalise in-patient care when the tradition he had tried to establish as Clinical Director had been towards only brief admissions. As I have mentioned, I predicted he would be particularly dubious about admitting someone with an eating disorder.

In conversation with William these indeed proved to be the issues he was concerned about. After discussion I suggested that we could offer to admit Rosemary for a detoxification from alcohol, then have her stay on for a three week period where, free of alcohol, she together with us could gain a clearer picture of her needs. William agreed with this.

This intervention would offer an initial way through the dilemmas of the referrer, ourselves and Rosemary and her family who were not yet committed to a particular service. It might also create the conditions for further change as it seemed that no-one had worked with Rosemary while she was alcohol free for a sustained length of time. I also saw it as being able to incorporate Rosemary's framing of being able to focus on her strengths and talents, and it would enable her to exercise an informed choice about which agency she committed herself to working with. But I did not include this latter observation at this stage in my conversation with William.

We also discussed what the implications would be if during an admission Rosemary became either suicidal or engaged in self-harm to the extent that she needed close supervision. William decided that the referring psychiatrist would need to take Rosemary back into her local psychiatric ward, although he expressed unease at the difficulties he foresaw in getting a clear agreement with the referring psychiatrist about consultant responsibility. He was keen that we be able to provide for her needs within the department.

The next person I needed to see was Ann, the Nurse Manager of the ward, and talk through the implications for the nursing team of working with Rosemary in this context. Ann was worried about Rosemary's self harm and her eating disorder and the degree to which the nursing team could provide support to her in managing these. Conventional inpatient treatment for eating disorders required very tight contractual agreements about how much the individual needed to eat in return for earning privileges. There was much debate about the long-term effectiveness of this approach, but what remained was a generally held framing that working with clients who had eating disorders somehow involved struggles over issues of control, leaving many wary about the degree of conflict thus engendered and how this could be managed while at the same time keeping a rapport with the individual.

Our ward had a lower patient to nurse ratio than would be needed if such close supervision and support were required. I introduced the agreement with William that the extended admission should be for assessment only and that perhaps we should not attempt to urge Rosemary to make changes, merely to help us understand more clearly what the problems were. Under these circumstances the choice remained with her about how she ate. We could certainly support any changes if she so wished, but only if she felt ready. Ann agreed that under those circumstances the nurses could certainly work with her as an inpatient. I made it clear that I would work closely with Rosemary and the nurses in developing this care plan. We agreed that the services of the occupational therapist and the physiotherapist would be needed to provide a range of activities during the day time which would meet with Rosemary's goals, to allow for an assessment of her needs while alcohol free, and to support her in staying alcohol free during her stay.

I met with these two next. They were new in the department and were unsure about their roles and how they could be seen to be effective with this client group. However they were very experienced in their own fields and contributed ideas about what they could offer. I offered conjectures about what I thought Rosemary's needs would be when she stopped drinking and we mapped the possibilities for providing structure and support. Both agreed to meet with myself and Rosemary after admission to negotiate a day time programme with her.

With a map of how we as a department could proceed I was now able to talk with the referrer and other team members from Rosemary's local service to gain a clearer view of how they were seeing the situation. The overriding view from them was that Rosemary had failed to engage in any treatment they had attempted to provide in the past and had only attended sporadically. The team psychologist had offered individual therapy but had only seen her on two occasions. In the group programmes they had offered, Rosemary was seen as actively involved in supporting others but not involved in talking about her own problems. The referring psychiatrist preferred that Rosemary be treated locally, but in the circumstances felt she had no option but to refer to the London services. She was sceptical that Rosemary would engage in any such treatment, because of her 'underlying personality disorder'. She was feeling exasperated and hopeless about the continuing cycle of crises. In particular, she was both worried about and feeling pressured by Rosemary's husband and parents as they were becoming increasingly stressed and looking to her for solutions which she felt she could not provide. Although she had considered detaining Rosemary for her own protection under the Mental Health Act, there were insufficient grounds.

Despite this, I could not get any sense that the consultant psychiatrist was wanting to 'let go' the case and ask another service to 'case manage'. This was a mixed message of despair, of looking to others for solutions, but also of not wanting to 'let go control'. She was happy to accept our offer, but behaved as if she was still case manager and would continue to pursue the referrals to other agencies and make decisions about longer term plans. We agreed that I would keep her informed about progress. I decided that as I could not get clarity about 'who was the responsible consultant' then I could at least put boundaries around my work. I could claim the role of 'key worker' in our department and if the consultant roles became an issue then it was up to William and the referrer to clarify this. In the meantime I was wanting to keep my relationship with the referrer as collaborative as possible, and could easily work within a frame of 'case support' instead of 'case management' where the relationship between the two services was concerned.

At this point I recalled a recent conversation with a male consultant who viewed a referral to another inpatient service as a sign of personal failure. He felt he could provide any treatments a patient needed, and if referral was required it was only because the nurses on his ward were not able to manage. These were the only grounds on which he would countenance a referral. I wondered if Rosemary's referring consultant was operating under the same set of beliefs. I was later to learn that she did, but would also 'flip' to the other pole by asking for other wards to take her patients then not accept them back. In this way she engendered much covert criticism from her male consultant colleagues. It seemed they were unable to negotiate with each other about supporting each other's casework.

Reflections on 'mini-inquiry'.

• Personal learning.

At this point I considered what I had learned and what had been achieved. I had inquired of individuals and representatives of groups who had been immediately involved, and who either needed to remain involved because of statutory roles or because they could contribute to finding solutions. There were conflicting constructions (both implicit and explicit) among the professionals about who would remain overall 'case manager'. There were conflicting constructions (both implicit and explicit) amongst all involved as to the nature of the problem/s and how they should be addressed. But there was agreement among professionals on the offer of admission, and on the terms of the admission.

I could also see potential for agreement between the relevant department members and Rosemary and her family on the immediate focus for the work to be done - a detox and assessment of need for further help. I knew that Rosemary and family wanted in-patient care, but I needed to negotiate the terms of this with her within the frames we had discussed amongst ourselves within the department.

Following such a negotiation, Rosemary accepted the terms of the admission and stayed for four weeks as planned. She pursued her goals of focusing on the 'positives' but paradoxically in so doing also allowed us to see more of the problems she was facing and began to trust us to work with her on them. I urged her to accept the assessment appointments with the other specialist services when they were offered so that she could make the best possible choice for herself. This she did. As it turned out this was the beginning of a two year engagement with us which I will return to from time to time to illustrate and inform further inquiry in subsequent chapters.

From these encounters I saw a tension between the 'implicit' and the 'explicit'. The challenge was to know how far to go in making the implicit explicit. Too much surfacing of the implicit, and too soon, risked heightened difference and hence probable conflict and/or loss of face in already difficult and potentially dangerous conditions. Too little risked there being insufficient richness of data from which to construct similarity and agreement necessary for continued collaboration. The metaphor of 'balance' occurred to me in which I needed to pay attention to whether either was happening at the expense of the other.

• The Patient Journey.

In relation to the patient journey, my reflections at the time were that several issues had been suggested by this mini-inquiry as needing further consideration. There seemed to be a number of stages which

may constitute important first steps in the patient journey of 'complex cases', around which guidelines for 'good practice' would need to be developed. My tentative findings so far about these were:

- The needs of both the referring person/team and the client/family must be inquired into and clarified as far as is possible and as is necessary in order to know whether or not we can 'do business together'.

- Whether the referrer or ourselves becomes 'case manager' was an issue needing clarification. This may be difficult to gain complete clarity on, especially if the referral is initially from one consultant to another. Perhaps a way forward is to think of ourselves as either 'case managing' (taking whole responsibility) or 'case supporting' (contracting to do a bounded area of work while referrer retains case management).

- Considerable negotiation is needed across the individuals involved. It seems that one person needs to retain responsibility for this in order to successfully 'orchestrate' the process. This person needs to have sufficient authority and expertise to obtain the consent of the individuals to participate. Part of the expertise lies in knowing what resources are available (and what the pattern of that availability is) within the service, and in being able to negotiate an initial broad 'match' between needs and resources.

- This same individual needs to be the person who also coordinates an initial 'care plan' around a broad focus with which all involved agree, and all of whom contribute to its drafting.

There was a strong degree of resonance between these tentative findings and what I had observed in earlier work with 'complex cases' after the point of admission. My tentative map about the process of working with 'complex cases' had been elaborated and it was bounded now by experiences from the point of entry to the point of discharge. I needed to ground these in further inquiry and to see how much these tentative findings would fit with or be elaborated by others' constructions about the process of care and treatment. There was a further boundary to be explored and that was the one at discharge. If in fact we were to offer 'case support' as an intervention, then the process of 'handing back' to the 'case manager' with a viable care plan, with which all involved could continue working, would also require careful negotiation and planning which involved all parties. There was much more to be done yet.

- The inquiry process.

This process had been driven by my own sense of what 'good practice' was, being informed by some of the experiences and practice frameworks I have described in this thesis so far. At the time, my reflections about the relationship between practice frameworks and the strategies of Collaborative Inquiry and the Hermeneutic Dialectic process were as follows:

- The two inquiry strategies seemed to intersect to some extent. Despite the implicit and explicit incongruities across the domains of purposes/strategies/actions/effects between different parts of the system around 'complex cases', it had been possible to obtain sufficient collaboration around an individual case to arrange a successful admission. There were indications that some individuals in the department may share sufficiently overlapping perceptions of the issue involved in dealing with this type of case to warrant further collaborative inquiry. But Torbert's (1981) requirements for the first stage still remained to be tested - namely, whether the participating parties can come to share the aim of collaborative inquiry and the model of interacting qualities of experience.

- As for the Hermeneutic Dialectic Process, it seemed too early to say. It occurred to me during the mini-inquiry at various stage that it was helpful to have a name for the circular process of gathering different constructions, and in naming it in this way I became more conscious of including constructions of previous

'respondents' into any one conversation. There seemed many differences however. I was purposeful in who I selected; there were differences in power between the 'respondents' (which I was seeking to minimise by putting all on the same level with respect to their involvement in the dilemmas and their possible dissolution); and I did not formally analyse each developing construction after talking to each individual. Although I sought to honour each set of constructions (in so far as I was aware of them) in my analysis, I afforded them different weight according to my purpose which was to rapidly find 'just sufficient enough' agreement to be able to take the first step. In this way there seemed to be an intersection here with collaborative inquiry's experiments-in-practice which is a more discontinuous and emergent process. It occurred to me that perhaps there would need to be many laps around the circle or traverses up the spirals of the Hermeneutic Dialectic Process.

At this point I felt I had now 'sampled' the experiences of working across the whole of the patient journey for 'complex cases' through an episode of inpatient care. I had developed my own understanding of the significant steps and what the issues were at each of them for the client, for myself, and for the various other professionals who would be involved. I now felt I had a tentative 'map' which could guide me towards a systematic and collaborative development of a set of 'good practice' guidelines.

I considered that in terms of a gender analysis, much of what I had done had been in the traditions of agency providing structure in the face of chaos and uncertainty, and in providing a protective space in which communion could occur to mitigate and soften the struggles for control over the definition of realities and ownership of body and identity. I saw myself as seeking communion potentially at work and exercising agency to facilitate its further expression. This was useful to enhance the sense of balance I was looking for in moving between the implicit and the explicit.

To date I had only a global and intuitive sense of how I moved between the two traditions. I will reflect further on this at the end of the next chapter in which I tell of further inquiries with different staff groups towards developing an explicit set of good practice guidelines. In these I learn about the tension between differing purposes - on the one hand developing a body of knowledge through systematic and explicit means; and on the other hand following events in a 'naturalistic' sense in order to foster a wider sense of development towards interdependence, autonomy and self-validation in working relationships. Maintaining my balance across this tension required moving in some unexpected directions.