12. Co-creating 'good practice' frameworks: a 'downstairs' scenario.

Introduction.

My intentions at this stage were to use the 'Patient Journey' concept and to use the two inquiry strategies to elaborate each step, as I perceived them to be. I saw two ways of doing this. One was to use opportunities as they arose through my work with individual cases to develop more explicit understandings from the different individuals and groups involved. The other was to initiate in a timely way some more formal inquiries with colleagues, using the 'Patient Journey' concept to aid us in identifying key steps and deriving accompanying 'good practice' guidelines and standards.

These intentions proved difficult to hold onto within the social topography of the department and the multiple demands generated by the delivery of a day to day service while at the same time accommodating to and managing continuous change. I found myself moving across many different territories in carrying out daily tasks while at the same time trying to work towards a manageable balance between stability and change.

In following the thread of 'complex cases' through the fabric of experience I was able to use both the informal and the formal, the implicit and the explicit in making the most of opportunities to collaborate with colleagues towards a consensus 'understanding' about 'complex cases'. However this did not prove to be the systematic experience I had hoped for, and in terms of a set of 'good practice' guidelines, only partial success was achieved over the eighteen month period I am writing about. Further development took much longer and its description is beyond the scope of this thesis.

However I will make a narrative commentary here that patterns of care around the 'management of complex cases' eventually became embodied in a protocol called the 'Role of the Key Worker' adopted within the department after the period covered in this thesis. This protocol did not prescribe how to work with 'complex cases' but it contained a set of negotiated and agreed steps, roles and responsibilities for 'Key Workers' (those clinicians, like myself, who took responsibility for coordinating and delivering treatment and care of individual clients, their families and related professional systems). Such a protocol signalled the explicit recognition of 'complex cases' and some broad agreements about what was needed to successfully work with them. It is the 'ground work' for this I am covering in this thesis.

In this chapter I am reporting on two domains. Firstly I am charting the initial stages of the development of a set of commonly agreed 'good practice' guidelines with colleagues. Secondly I am charting how I managed the tensions and dilemmas of working across multiple purposes, having to 'let go' at times in order to support growth and change, having to 'hold tight' at others to support stability. I came to realise that the focus of complex cases may have limitations as a focus for researching 'what I do as a psychologist'.

In terms of the Hermeneutic Dialectic Process, I saw the need to gain constructions about working with 'complex cases' from the following groups: the ward nursing team; the day care team; the administrative team; and the senior clinicians, including the two consultants, who made the initial assessments and referred clients into the ward for inpatient or daypatient care. I imagined that the Hermeneutic Dialectic Process would provide a conceptual map for moving between these groups as I carried a set of constructions from within one to the other for consideration and elaboration. It was clear that I would not be able to move from one to the other in a linear and progressive way, but rather in a discontinuous and emergent way, working with all groups simultaneously in the course of any one day. I held the use of the process to be useful at a more 'macro level', more in the sense of a spider building a web over time.

I have chosen to cluster these groups into two according to the metaphor used by the nursing team from time to time. The nursing and day care team, who provide 'hands on' care, are 'downstairs'. The administrative staff and senior clinicians are referred to as 'upstairs', the latter seen by 'downstairs' as

maintaining more distance from clients who are inpatients and daypatients, but as having more power and authority to determine how that care is effected. This chapter is about working with 'downstairs' and I have chosen events which , in Narrative Inquiry terms, hold the 'why' of the research for me.

I will refer to Rosemary's story from time to time to provide a representative client's 'voice' in each of these groups as the patterns around working with her were ones we became very familiar with in working with others and which informed the eventual 'Key Worker' protocol.

Working with the Ward Nursing Team

Developing collaborative relationships in the setting of the ward nursing team required use of more informal opportunities in contrast to what was achieved later with the day care team. I will illustrate with one such occasion in which I observed a new pattern emerging in our work with Rosemary, and how this was 'cheered on' to become a more regular feature of working with 'complex cases'. Firstly I will describe the setting so as to make available the contexts in which this new pattern was observed and 'punctuated' or made sense of.

The setting.

The ward nursing team was led by Anne, the ward manager, and on any one shift comprised herself and three relatively junior nurses. Anne worked 'nine-to-five' during the week, but the nurses worked a shift system to ensure twenty four hour continuity of care. Therefore the membership of this team slowly and continuously changed as the nurses moved around the different shifts. This meant that Anne was the 'anchor' person and provided the interface between the nurses and the remainder of the staff who worked nine-to-five.

Each patient had a 'named nurse' who was responsible for assessing their nursing needs and planning and implementing their nursing care together with them. The nursing care plan was conjointly owned by the nurse and the patient, and the patient had access to the nursing notes and could exercise editorial rights on them. When the named nurse was going off her or his shift, the updated care plan was 'handed over' to the oncoming shift which would pass it on to the next, and so it would rotate back to the shift the named nurse was on for further refinement.

There were three global roles which nurses performed: an *independent* implementation of nursing interventions and processes; the carrying out of *delegated* tasks from doctors such as dispensing medication and observing signs and symptoms to aid their diagnoses and treatments; and an *interdependent* role in which they collaborated with other members of the multidisciplinary team in designing and implementing other treatments or interventions.

During detoxification of patients, the nurses mainly occupied the independent and the delegated roles as the primary focus was to support the patient through the physical and psychological distress arising from withdrawal from drugs or alcohol. This was the most time consuming aspect of their work and often the most demanding. When patients stayed on the ward after their detox was complete, if they required further work in preparation for discharge, then the nurses moved more into their interdependent role. While it was the nurses' job to provide a twenty four hour supportive environment, the responsibility for care planning in this later stage rested more with other team members who were working with the patient. The nursing care plan at this stage was about how to provide an environment in which this later work could successfully take place. The named nurse may take a variety of roles at this stage, according to the purpose of the patient's stay and the requirements of other staff members. One of the key differences between nursing and other disciplines is that a nurse on a ward is required to 'be with' patients continuously and hence they develop different relationships with different nuances and textures than do other disciplines. This requires an ability to both 'get alongside', and at other times set and apply limits about behaviour which may require challenge and even confrontation.

In the earlier days of the department's life, there was less agreement amongst members about how long and for what purposes patients should stay after detox. The priorities tended to be set by the demand on beds and how quickly they could be emptied to allow new patients to be admitted. Patient's tended to stay on if they were waiting for accommodation, if they required further assessment of their physical or

mental state upon becoming drug or alcohol free, or if they were particularly vulnerable because of social or psychological problems which needed addressing immediately. The extended stay tended not to be planned for until admission, and the period after detox tended to be ripe for confusion about 'who was doing what with who'. In this context nurses could find themselves carrying a range of tasks and roles, as much by omission rather than commission on the part of others. This rendered them vulnerable to criticism from other disciplines - for either doing 'too much' or 'too little'. This was my understanding as an 'outsider' but based on close interaction with nurses over the years. I have noticed often that nurses tend to occupy one role more than others, according to personal preferences, skills and experience, and the requirements of the setting in which they work (including other disciplines' understanding of nursing and their requirements of it).

Managing the boundaries.

In developing 'good practice' for 'complex cases' I saw the challenge for myself as supporting the nursing team in creating a twenty four hour environment in which the goals of the initial broad admission care plan could be pursued. This support needed to recognise and affirm the variety of roles the nurses played, needed to allow for individual differences in the nurse's interests and competencies, while at the same time creating a 'space' in which I and other disciplines could work with the client. This required a balancing act between differing world views - ones which arise because of individual differences and ones which arise through different organisational and professional roles.

Practically speaking, this meant that there needed to be a degree of congruence between the nursing care plan as independently done by the nurses, my initial broad care plan about the overall purpose and goals for the admission, the particular work I did as a psychologist with the client, and the views of the client themselves during the admission.

In practice in the early stages, I found myself taking on a role of 'managing the boundaries'. In other words, keeping a noticing eye on 'who did what with whom' and ensuring that as far as possible there was clarity around how individuals participated with each other and that this participation was openly negotiated. One of the boundaries I wanted to respect was the one around the nursing team. Ann led this team and she was responsible for nursing care on the ward. I wanted to support her leadership. On the other hand I also wanted to make sure client's needs were met and I was prepared to advocate for them if need be.

I will illustrate how we began working towards developing congruence through being more inquiring of each other, and demonstrate the role I played in marking and respecting boundaries by drawing from an incident during Rosemary's first admission

Rosemary's story - roles, boundaries and inquiry.

On Rosemary's first admission she settled into a pattern of spending most of her time on her own, writing, drawing and meditating. At that time there was not an organised programme of activities and she had elected to do little with the newly arrived occupational therapist and physiotherapist. Her named nurse was to provide her with counselling support when she needed to "sound off", when she felt lonely at nights, and with general problem solving about being on the ward and negotiating use of the resources. Rosemary had regular and frequent sessions with me, spent some of her time talking with other patients, and some of her time out of the hospital grounds dealing with practical problems about her day to day life. She was often distressed but did not like others to know it.

The first challenge came when she returned mildly intoxicated from a visit home. This put the nurses in a bind as alcohol consumption during an admission was clearly forbidden and was grounds for discharge. On the other hand they were unsure about whether to exercise this limit as Rosemary had more complex problems and they were aware she was here for us to assess how we could work with her. Ann took me by surprise by approaching me about this before making any decision.

We discussed our respective perspectives. I was willing to advocate for her staying and using it as an opportunity to understand more about the meaning of her alcohol use. But I also wanted to respect that the nurses had responsibility for the whole patient group and knew what the presence of someone

smelling of alcohol and appearing intoxicated could mean for them. I expected Ann to take this view and push for discharge. However, she said she had an instinct not to do this. I inquired into the instinct. Ann felt that Rosemary was ambivalent about being here and by overtly coming onto the ward mildly intoxicated was 'inviting' us to discharge her. If we did so, then we would be the 'baddies' and Rosemary would not have to take direct responsibility for leaving. Furthermore, she recognised Rosemary's capacity for seeing blame in any confrontation and the potential for escalation of self-destructive behaviour which would likely ensue. We discussed this further, and together developed alternative ideas, for example that she might also be testing 'how safe' she was with us. Were we going to tolerate her distress and provide safety without control? And so on. We discussed these ideas in relation to observations we had made of her interactions with others around the ward so far and decided this idea had a contextual appeal. We talked with the named nurse and agreed to let Rosemary stay, but decided that she could only come onto the ward when her breath alcohol reading was nil.

We all inquired the next day with Rosemary into her drinking and on the basis of the discussion together made some small changes to her care plan and re-negotiated the respective roles we would play - to whom Rosemary would go for what sort of problem and support. Rosemary drank again on a further occasion a week later and this time I heard about it after the event. Rosemary had told her nurse directly and offered to spend the afternoon in the grounds of the hospital before coming onto the ward. The nurse had let Rosemary into her room and allowed her to 'sleep it off' provided she did not come out of her room until the nurse agreed. Together Rosemary and the nurse inquired into this drinking incident afterwards and tried to make sense of it in the context of her relationships with men and her confusion in establishing manageable levels of closeness and intimacy with them. This began a relationship in which Rosemary started talking to another woman for the first time about issues of gender and sexuality.

Lessons taken.

This was the start of a pattern in which the nurses both maintained a set of rules (necessary for structure and stability) and at the same time inquired into any challenges to them in the context of the individual patient's life and in the context of the relationships within the ward (necessary for change). I saw this as the beginning of a new inquiring interpersonal strategy and sought to support it where I could. It was also the beginning of the nurses extending their interdependent and independent roles through a more explicit negotiation process which involved the nurses, the client and myself.

I sought to support this newly emerging pattern by:

- Discussing initial admission care plans routinely with Ann and the named nurse.
- Having named nurses attend my initial assessment sessions where possible.
- Attending nurses' hand-overs between shifts when close support was needed.
- Convening regular small 'review' sessions with the named nurse, client and other workers involved.
- Providing ad hoc consultation and supervision as requested.
- Attending the large weekly ward rounds to support the nurses in presenting their work to the whole multidisciplinary team, coaching them before hand and providing re-framings in the meetings when it seemed the consultants were not able to fit the nurses' work into their own frames of reference.
- Sometimes 'getting in the way' by challenging when I perceived that they were letting others 'take charge' of their work, or when they were extending themselves into other disciplines' roles.

In all of these interactions, I would link with Ann at some point to keep her 'in the picture'. There were occasions in which Ann would try and formalise some of these arrangements into regular time slots with regular membership, but these never succeeded. It seemed that in this setting, with changing membership and with the priority being to respond to patient needs moment to moment, inquiries worked best 'on the spot' when required in a less formalised way.

The key process I saw evolving within this group as being significant to 'good practice' with 'complex cases' was that of negotiation about roles and style of involvement. There was a wide range of skills and experience among the nursing team and this was the start of a more negotiated involvement between nurses, clients and key workers according to age, sex, interest, skill level and client preference.

Working with the Day Care Team.

Within this setting I also played a role of 'keeping an eye on boundaries'. The process I will describe is one of continuous experimentation and evolution to find a form of providing a day care programme of activities and interventions which provided a 'fit' between the requirements of the clients, the staff and the overall pattern of service delivery within the department. It was within this setting that I also kept a 'noticing eye' for the possibilities of developing a cooperative inquiry group. I will firstly describe the setting and then how we inquired together to develop some further steps along the 'patient journey' for complex cases, together with some agreed processes for managing them. The workers in the day care team could structure their time with patients differently than the nurses, so a more formalised inquiry became possible. However, that had a surprising ending for me.

The setting.

At this point in the department's history, a more structured day care service was developed. This was provided by an occupational therapist, a physiotherapist, a part-time nurse with counselling experience, and supported and coordinated by Ann the ward manager. I will give a brief history of the development of this day care team as a backdrop to understanding the work we did together.

As a department, we had attempted several such programmes from the outset but had failed for many reasons. Among them was our inability to involve clients successfully in a routine timetable of fixed activities. When I joined the department at the outset, there had been an occupational therapist who provided a programme of leisure, occupational, educational and interpersonal skills training. She was not employed by us and was managed from within another department.

This programme was pronounced unsuccessful by all. Some clients saw it as being irrelevant to their needs and refused to attend, others saw it as relevant in parts but attended all only under pressure from the nurses. The nurses resented the conflict they encountered in trying to convince clients to attend, and felt excluded from contributing themselves because of their shift system. The occupational therapist resented the nurses not doing more toward the programme and felt they did not provide sufficient encouragement to clients to attend. Her being managed from outside our department precluded the flexibility that was required.

When she left there was wariness all round about asking again for occupational therapy time in our department. Within the Core Group, we developed ideas about what was needed to succeed in the future. We wanted a range of interventions which would be applicable to the broadest group of clients to help them cope successfully with life stresses without relying on drugs and alcohol. We considered how we might organise these so that they meshed in successfully with other treatments and activities.

Most of the interventions we decided upon were psychological in nature, and could be grouped under the categories of problem-solving skills, stress management and interpersonal skills training. These would need to be supplemented with leisure and recreational activities, and some physical therapies such as massage and exercise. In our discussions in the Core Group we had identified that the key requirement was to have these available as 'packages', to be used flexibly according to the needs of the client group at any one time. Past experience had shown that clients attended for different reasons and for different motivations. A fixed daily programme met the requirements of staff for stability and

predictability, but not the requirements of those clients who saw little relevance in it and refused to attend. We needed to be clear among ourselves about what choices we were providing, so that in turn we could be clear with clients, and so prevent on-going conflict during their stay about differing expectations. I jokingly called this the "Cafeteria approach", where we provided a menu from which clients could choose, with our guidance.

We were eventually able to obtain funding to employ our own occupational therapist and physiotherapist, to be managed from within the department. This structural arrangement made us feel more confident we could develop an appropriate day care programme this time around.

Inquiring together about day care.

Following the failure of the early programme, some day care groups and activities had been provided by several of the nurses from the ward, supported by me through consultation and supervision. There had been experimentation with the form, the content and the timing of these activities, so some baseline knowledge existed about how to implement the 'Cafeteria approach'.

The arrival of the occupational therapist and the physiotherapist signalled the need for change in roles within the nursing team. It was assumed by the Core Group that Ann would take responsibility for negotiating with those involved and I did not anticipate that I would need to be a part of this. However, this was not to be so. Ann requested me to meet with herself, the occupational therapist and the physiotherapist as she was having difficulty negotiating the changes.

On meeting with the three I felt a tension in the room and I observed that they were very tentative with each other, nobody stating openly what the agenda of the meeting was nor taking the initiative. I wondered what was restraining them. Was it that the two newcomers had had little experience in this field and were tentative about taking the initiative? Was it that Anne was ambivalent about the changes? Or was it that she did not have a vision herself of how the day programme could work and could therefore not provide a framework within which the two newcomers could orient themselves and begin contributing? Was it in this way that they together lacked a wider context or frame which they shared which would support inquiry and collaboration? I decided the latter assumption would be the most productive to pursue.

I inquired whether the purpose of the meeting was to discuss how the occupational therapist and the physiotherapist could take over responsibility for providing the day care programme with support from the nurses. There was a noticeable lowering of tension. The occupational therapist and the physiotherapist nodded as if that was exactly the case, and Ann sat back in her chair with a look of relief on her face. I offered to give a brief historical outline from my perspective on how the department came to this point and what the expectations were for the day programme, thinking that this might provide an initial frame for further dialogue and negotiation. This offer was accepted and I told them the story of the 'cafeteria approach' to day care. The dialogue flowed from that point. Following this meeting I retreated to a more distant stance, assuming they were now 'on the move' but nonetheless ready to move in 'close' again if needed.

As the occupational therapist and the physiotherapist developed a 'menu' of activities and experimented with how to engage clients, they became clearer about what they could offer and more confident about negotiating with other colleagues. In my role as case manager of 'complex cases' I involved them routinely in mini-inquiries around individual cases.

As their confidence grew in their roles, the day care team began expanding their range of interventions and developed special interests such as pain management and acupuncture. As with the nursing team, I wished to support this development by keeping a 'watching eye'. I wanted to ensure that activities were grounded in sound psychological principles and practice while at the same time the individuals felt that they 'owned' the programme and made full use of their competencies. My intentions were to do this gently and through collaborative dialogue. In this way, our interactions with each other around case work were infused with this intent. But I also made it clear I was available for supervision, consultation and support in other ways.

As this pattern of work became more consolidated, I received clear feedback that they liked the role I played. Specifically, they liked the care plans I drew up, they liked the 'mini-inquiries' with clients, and they liked my "sensible suggestions" and availability when needed. They appreciated being able to develop their own roles and style of practice. This seemed to be a similar pattern to the one which had evolved in my work within the nursing team.

To my surprise one day the day care team suggested we all meet together weekly to review clients collectively and 'trouble shoot' the programme. I responded enthusiastically as this seemed to be a move to another level, of inquiring together collectively rather than in dyads or triads. It offered a more systematic development of a consensus understanding about day care to clients, some of whom were representative of 'complex cases' such as Rosemary.

We started by discussing individual clients and ensuring that there was clarity about their care plans and coordination between all those involved in delivering care. In so doing, we began to notice patterns in the nature of problems which arose. The major source seemed to stem from other clinicians in the wider department referring clients to the ward for day care but supplying insufficient information, making inappropriate requests, or failing to be available when needed for longer-term planning. Or alternatively, clients were being referred to the ward by outside referrers, such as other hospitals, but not having a named worker assigned within the department from the outset who could take overall responsibility for care-planning and follow-up help after discharge. We realised that this was 'true' for all cases irrespective of degree of difficulty or complexity. To this point, I had bracketed off my interest in developing 'good practice guidelines for complex cases'. Now there was no need as we were discussing basic principles central to good practice with all cases in terms of providing day care activities.

As we paid attention to this pattern and discussed it further, we began deriving a list of activities and events which were seen as critical to a successful transition through the day care programme. Up to this point I had participated as another clinician with a direct involvement with some of the clients, and as a member of the Core Group concerned with supporting this group in owning and delivering a quality service. I was reluctant to impose any structures which did not 'fit' with this purpose. However, at this point I saw the concept of patient journey as being highly germane to what we were doing. It also had relevance within the broader 'Quality Assurance' remit we had been given by central government. It seemed timely to introduce it here. I also had rising hopes of this being a setting in which I could introduce a 'research' frame and invite the group members to form an inquiry group and explicitly explore some of the research strategies in our work together - but this seemed still slightly premature and I decided to leave this for a little while. First things first.

For the next two months we meet weekly and gathered data from our day to day work and brought it to the group to reflect on and to use in developing our own 'map' of the patient journey through an episode of day care. By this time, Rosemary had had several admissions and we had all worked with her to varying extents. We used her and several other clients to refer to and explore the implications of a patient journey approach. I had asked Rosemary to evaluate her admissions in terms of the goals she had set for herself, to what extent she had reached them, to what extent she had found the process of care helpful, and what could be changed to improve things. I contributed these data to the discussions.

Once we had developed a tentative map with which we all agreed, we went through several cycles of taking this map out to other members of the department, interviewing them about it and incorporating the feedback into a more embellished form. We used the idea of the audit cycle to inform this process as it was one which was closely linked to the concept of the patient journey. We called this 'map' a protocol, containing the significant steps along the patient journey, with standards and guidelines for each. Central to this was the idea that one person needed to retain responsibility for accompanying the client through this journey and this protocol outlined what those responsibilities were. This role we called 'Key Worker'. At a later date it was to be adopted across the department and extended into new services with which several of the senior staff, including myself, became involved.

Unexpectedly, this process had mapped the views of a wider range of colleagues than I had anticipated in my earlier thinking about 'good practice' guidelines. The community team and the senior clinical nurses from 'upstairs' had been included in this process. The two consultants had not as they were not seen as occupying the key worker role at this time. Although the process was aimed at making the jobs

of the day care and nursing teams easier, it also began raising the issues for other staff who referred in to the ward. I saw this as being a useful focus for further inquiry with senior colleagues.

By this stage my hopes were rising that this group could easily become a Cooperative Inquiry group within which we could extend our work to inquire in more depth around 'complex cases'.

Then the group members took me by surprise yet again. They told me that they had decided to use our meeting time with the ward nursing team instead. They perceived them as needing support in dealing with problems they were facing and the only possible meeting time coincided with ours. They offered to negotiate an alternative meeting time but we could not find a mutually suitable one. I then suggested that we should discontinue - after all, we had almost completed our objective and I could finish off the protocol myself with the information available. There was no protest at this.

Lessons taken.

• Personal/Professional.

I had mixed feelings. Partly I was a little insulted that they had done this unilaterally. On the other hand, their decision signalled a transition in their relationship with the ward nurses. As they worked alongside each other everyday, it was important that they began sharing more closely the responsibility for managing the ward environment. The day care team joining with the nursing team was a more natural 'sub-system' than their continued meeting with me. I felt pleased at this development. I had a wider set of responsibilities which required me to move across different groups and my place was not as a permanent member of this sub-system.

My view was that if issues arose in the future which required a regular involvement from me for a while, then we would re-negotiate how to achieve that when and if it arose - it would emerge naturally. It was time to 'let go'. What we had created together was solidly grounded in our own experience and incorporated the views of other members of the wider department. On reflection, we had developed a much more detailed 'map' about 'good practice' than had existed previously, which indicated the steps on the journey with some guidelines on how to negotiate them. Others ought to be able to follow this map, with some initial guidance. I could offer such guidance to colleagues outside the nursing and day care team, and at the same time invite collaboration in further embellishing the map. Even though others' views had been actively sought and incorporated into the 'map', it would be only by using it in practice and 'walking' the paths themselves that colleagues would become active participants in negotiating this 'territory'.

• Inquirer/Researcher.

In terms of Collaborative Inquiry I saw us as having got to 'first base' in agreeing a focus for working together, beginning to make explicit our purposes and strategies, and relating these to outcomes. However, we did not get to second base in terms of explicitly agreeing to inquire together in terms of using the model of interacting qualities of experience and agreeing to collect on-line data about our own experience. The model remained useful to me in guiding my own actions and awareness, but not in sharing with others as a model to guide inquiry.

The Hermeneutic Dialectic Process remained useful as a macro-map to keep me alive to the importance of weaving together constructions about 'complex cases' from the different groups. However, I was beginning to feel that the focus on 'complex cases' was not going to serve as a means of holding all the research strands I was carrying. I realised from the dissolution of the group meetings that I was unlikely to obtain the kind of explicit co-researcher/co-subject relationships I was seeking. This was remaining a personal journey. I could see that the development of a set of consensus understandings about complex cases was going to be a discontinuous process and that I was not going to suspend personal learning and inquiry into my practice in the meantime. Similarly I was not going to suspend my clinical work in the meantime - I was going to carry on and be prepared to pick up the strands in a timely way when they surfaced again. I was more curious about the patterns of relationship which had emerged 'downstairs'.

Reflections on 'downstairs' inquiry.

In reflecting on the patterns which had emerged in working 'downstairs', I was drawn back to Marshall's (1984) conception of agency and communion as providing an explanatory and descriptive 'fit'. Her conceptions of action from within the two domains constructs the agentic as 'doing' by internal, personal objectives, engaging in idealisation and trying to change the environment to match its own preconceived images. By contrast, communion is directed from its open contact with and appreciation of the environment, and action is mainly context-motivated. Prior acceptance of the world-as-it-is results in action which is in tune with the surrounding context, but is not conceptually premeditated. Therefore action based in the communion may be highly appropriate as a result, but it also risks being too thoroughly shaped and determined by the environment.

The agentic mode is based on the principle of independence, whereas communion is part of a wider context of interacting influences. I saw myself as moving between these two modes. In relation to boundaries around the ward I tilted toward the agentic in terms of supporting sufficient independence of the surrounding environment to allow communion-based action to flourish within. I did this in relation to referrers' framing of the problems and solutions (as in Rosemary's case), and in relation to the two consultants in ward rounds who similarly adopted views of problems and solutions which were independent of any inquiry into the views of clients and 'downstairs' workers. My role had been to maintain boundaries by reframing problems to the degree that sufficient interdependence could be maintained which supported the various actors in doing their work from a position of personal authenticity. In that role I could be assertive and 'hold my ground', although not in a fully agentic sense of making attributions about causality and outcome which were context-independent.

Within the 'downstairs' team, I tilted more towards communion. To this extent I was willing to go with what emerged and depart from pre-conceived notions of 'how things should be'. However, I did have certain pre-conceived notions from which I was not going to depart easily but they tended to be more process variables (such as boundaries, negotiated roles and so forth) rather than outcome variables. I was able to let go the unfinished 'good practice' guidelines (a hoped for outcome) because I afforded the processes which occurred around their production a higher value than the finished tangible product itself. There have been times since then when I have wondered about this, thinking that the finished product would have been useful, and liking to have tangible outcomes which give rise to personal satisfaction. However, more recently the 'wheel turned full circle' and there was a revived interest from both 'upstairs' and 'downstairs' in finishing these. In this context of interest from others, it became more easy to complete.

Marshall's conception of the role agency plays in relation to communion captured the spirit of what I had been trying to achieve, namely: protection for communion's vulnerability in hostile or new environments; creating structures within which communion can operate; supporting communion by giving it direction; affording a systematic understanding of alternatives within which communion can locate itself; and helping translate communion into direct effects through judicial instrumental action. Within this understanding, I became more accepting of the way my inquiry was heading, letting go of the idea of a formal inquiry group.

Activity within the tradition of agency, by its very nature, is easier to describe than activity from within the communion which is more context-dependent and muted. In the next chapter I tell of how I worked with 'upstairs' staff and discovered personal limitations of trying to operate from within this model alone without an explicit awareness of power issues in relationships. It is perhaps no accident that 'upstairs' we were all men, with the exception of Jan and the administrative staff. I found I needed to move away from the focus on complex cases in seeking to develop a more mutually inquiring relationship with William.