Chapter 4

Cross-professional working and development

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Introduction

Changes in service organisation in health and social care (HSC) have led to increased requirements for team working between different HSC professionals and, often simultaneously, to a blurring and overlapping of traditional professional role boundaries. The public inquiries into the deaths of children undergoing cardiac surgery at the Bristol Royal Infirmary (Department of Health, 2001) and the death of Victoria Climbie (Department of Health, 2003) have demonstrated that these cross-professional teams do not always work optimally, leading to a lack of continuity of,(Service Delivery Organization (SDO), 2001) or even serious errors, in care. It is therefore essential that practitioners involved in practice development have an understanding of the dimensions and challenges to cross professional team working.

A clear articulation of some of the principles underpinning cross-professional team working is important for practitioners as these principles provide practical tools to enable team members and managers to reflect, articulate, identify dilemmas and improve practice. It can assist with predictions and plans for working with and between health and social care colleagues. If practitioners are not conscious of the theoretical underpinnings of their actions, it could be argued that this brings their professional accountability into question. Such awareness is particularly important when practitioners face times of change (as practitioners do in the current HSC system Eraut, 2003). This chapter presents some tools with which practitioners may use and apply to articulate their cross professional practice.

Defining cross professional working

A first step in this direction is to develop an understanding of the variation in the type of teams that exist and the terminology used to describe how different professional groups come together when working within them. Although clear distinctions are drawn between terms, these are still used interchangeably and with some confusion (Thylefors et al., 2005; Hall and Weaver, 2001; Miller et al, 2001)

Uni professional team working

Uni professional team working occurs within teams comprising of only one professional group. Challenges and structures that apply to all forms of team and collaborative working discussed elsewhere in this book will apply. The team tasks do not involve collaboration across professional boundaries.

Cross professional team working

Thylefors et al. (2005) recommend the generic use of the term ‘cross professional’ to encompass

all teams in which several professional groups are represented. These include teams that exhibit either multi or inter professional working. These two forms of cross professional working can be distinguished by the specialization of the role of each professional, the interdependence of the task they perform, the coordination that is required to achieve this task, the specialization of the task involved and the interdependence of the roles within the team (Thylefors et al.2005): In Multi-professional teams a range of professionals share a common goal e.g. treatment of the patient- but little interaction or coordination of activities occurs between professional groups involved in the care pathway. Working in parallel and duplication of effort is common. Inter professional team working, however, is achieved in a more interactive and cooperative manner, where active coordination of activities takes place. A more detailed discussion of the above and other relevant terminology and its uses can be reviewed in discussion by (Miller *et al.*, 2001; Hall & Weaver, 2001; Thylefors *et al.*, 2005).

Cross professional teams are not necessarily only made up of HSC professionals. Police, lawyers, teachers, probation officers etc are also part of the wider cross professional team involved in the care of the client's needs.

Activity 4.1
Think of your own practice and identify and describe the aspects of your work that represent:

* uni professional team working
* multi professional team working
* inter professional team working

List the professionals involved in the team,
List the activities in which each professional group is involved
Describe the overlap between these activities.
Describe how this overlap is managed or coordinated by the team.

Read on and compare your answers with the rest of the chapter.

The Outcomes Of An Effective Cross Professional Team

As delivery and organisation of health and social care becomes increasingly dependent on team functioning, it is reassuring that evidence suggests that team working does improve patient care. Borrill et al. (2001), for example, investigated a sample of community health care teams, primary health care teams and secondary health care teams. They concluded that there is a significant and negative relationship between the percentage of staff working in teams and patient mortality. In other words, the more people who are members of a team in an organisation, the better the outcomes for the patient.

However, no single outcome can define whether a team is effective or not. Patient mortality is not the only outcome measure of an effective team and in some cases may be inappropriate (e.g. in a palliative care team where the patient's quality of life and well being are more appropriate measures of effectiveness). Patient focused outcomes are central but measurements of staff related factors, such as improved staff mental health, are also valid team outcomes (Borrill *et al.*, 2001)

There is surprisingly only limited research comparing the effectiveness of the cross professional

teams over uni- professional ones and the effectiveness of the interprofessional team over the less integrated multi professional teams. Thylefors et al. (2005) reviewed some of this evidence and showed further that the greater the level of integration within the cross professional team, the more likely were these teams to be rated highly in terms of perceived efficiency and team climate. A list of other positive outcomes from a cross-professional team is presented in Table 4.I:

Table 4.I: *Some outcomes of an effective cross professional team*

Direct benefits to patient (Miller et al., 2001)	Benefits to team-indirect benefits (Borrill & West, 2000; Borrill et al., 2001; Thylefors et al., 2005)
Continuity of care (e.g. being able to carryover care when the experts absent)	Decreased team member turnover
Reduction of ambiguity: No conflicting messages being given to patients	Good mental health within team members
Appropriate and timely referral: Each member has knowledge of another's professional roles and also of their boundaries. They were hence able to judge accurately when it is appropriate to refer a patient to another member of their team.	Good team climate
Action and decisions based in a holistic perspective: Discussion between members leads to a holistic view of the patient	Cost effectiveness
Actions and decisions based on problem solving: Discussion and dissemination of knowledge between members is possible.	High Self and external ratings of general team effectiveness
	High Self and external ratings of the quality of health care delivered by the team
	High Self and external ratings of innovation within the team's practice

Activity 4.2 - Cross professional team working
Think of the cross professional team within which you work and consider the following:

* Identify three patient related outcomes of the team and three staff related outcomes.
* How you might measure/evaluate the level of these outcomes?
* Would these outcomes be possible within a uni professional team?
* Which of these are only possible through cross-professional team working?

Read on and compare your answers with the rest of the chapter

How positive outcomes **are achieved within a cross professional team**

How do we as practitioners develop cross-professional teams that can achieve the positive outcomes outlined in Table 4.I? Unfortunately, this will not be a straightforward list of *"dos and don'ts"* as there will never be a definitive list of the ideal team composition or optimum processes that will make any individual team effective. This is because the concept of effectiveness has many dimensions. A team may be effective on one of these but not another. Therefore, the characteristics of a team that may be good at achieving one particular outcome may not be suitable if different outcomes are focused upon. For example, Borril et al. (2001) measured the effectiveness of a cross professional team through assessing levels of innovation shown by the team. In this instance, it is understandable that large teams with a diverse range of professions, each contributing a wealth of diverse ideas, would be better able to support and achieve this outcome. If the outcome measures had related to other outcomes, such as staff cohesion and mental health, the findings may have been very different where a smaller, more homogeneous team may have been perceived as more successful.

Despite the fact that the type of team may have different optimum requirements, based on its own nature as well as the outcome measure used, there are common attributes of a good cross

professional team that arise. A useful classification of these may be achieved by superimposing the concept of social capital onto these conditions.

Social capital is a heuristic concept used to describe, understand and measure the advantages gained by individual(s) who are part of a social network (Hean *et al.*, 2002). The social network of interest here is the cross-professional team. The advantages of team membership are viewed in Table 4.I. The components of the team that need to be in place to achieve these benefits can be classified by: main components of social capital (Hean *et al.*, 2002) which are:

- The physical characteristics of the network (e.g. frequency of participation in network, size, homogeneity)
- The norms and rules that govern processes within it
- The external resources available to it (e.g. resources outside of the individual team member e.g., financial resources)
- Internal resources (resources within each team member e.g. self efficacy)
- Trust in other team members

A range of factors that fall under each of the above dimensions can be viewed in Table 4.2.

Activity 4.3
From your answer to activity 4.2 identify a desired outcome of your cross professional team.

* Describe your cross professional team in terms of the components of social capital outlined in Table 4.1.
* How might each of these components be improved to achieve the desired outcome of your team?

Read on and compare your answers with the rest of the chapter.

Table 4.2: *Examples of some components of social capital to consider when developing the multi-professional team (Borrill & West, 2000; Borrill et al., 2001; Miller et al., 2001; Thylefors et al., 2005).*

Network characteristics	Norms and rules	External resources	In
Frequency and nature of	Commitment to quality	Physical mechanisms to	Ap
participation in team;	Clarity of objectives	support goals of team	di
Heterogeneity/homogeneity of group	Clarity of leadership/	Peer support	kn
in terms of professional group	coordination	Strategies for Conflict	by
Longevity and stability of team	Shared values or	resolution:	us
Staff tenure (part time/full time)	philosophies of working	Financial resources	Fl
Size of team			va
Geographical location of team			pe
members			ch
			to
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Different Philosophies and Stereotyping: Challenges to Interprofessional Working

Despite best intentions, there are a variety of reasons that cross professional teams do not function optimally and the social capital potential of these teams is not achieved. The first relates to the *norms and rules* component of the network/team: the importance of a shared philosophy of working within the cross professional team. The second is the presence of inter-professional stereotypes that may limit the *internal resources* of cross professional flexibility, articulation and appreciation

Philosophies

Miller et al. (2001) identified through observations of cross-professional teams, three different team philosophies of working within them: a directive philosophy, an integrative philosophy and an elective philosophy. A directive philosophy was frequently held by members of the medical profession and non-specialist nurses and was characterised by the belief in the need for a hierarchy within a team and a clear leader. In contrast to this a more integrative philosophy in which team members saw collaborative working and being a team player as central to cross-professional team working. Members understood the importance and complexity of communication and the need for effective discussion. A philosophy often held by therapy and social work professions. Lastly, the authors describe an elective working philosophy within certain professionals. This was demonstrated by professionals who prefer to work autonomously and refer to other professionals only when they perceive the need. Miller et al. (2001) used mismatches in these philosophies among members of the cross professional team to explain team conflict and poor team outcomes.

Although philosophical differences are often mediated by the individual personality, these may also be linked to the different forms of professional socialisation that occurs during training (Drinka & Clark, 2000). Certain professional groups are trained almost exclusively within a reductionist and scientific paradigm that contrasts with training of other professional groups in which a social and humanistic tradition is prevalent. In medical education, for instance, there is an emphasis on the former, a stress on the scientific basis of medicine to enhance professionality. This could be viewed, however, of over simplifying or narrowing the focus away from the overall picture of clients' needs. The education of nurses aims to develop a more holistic approach to patients, a less reductionist and more humanistic approach than the traditional medical model. Social workers can be perceived as at an even extreme position from medical education, where the values associated with the care of the client are at the very centre of social work practice. These very different systems may lead to the potential for poor communication. It is potentially resolved, not necessarily through a change in philosophy, but an understanding that other professionals have different perspectives of client care and that the contribution each of these perspectives should be equally valued (Drinka & Clark 2000)

Professional stereotyping

Another challenge to cross professional working is the occurrence of professional stereotypes. Stereotypes are "social categorical judgment(s)…of people in terms of their group memberships" (Turner, 1999) p. 26). It is seen as innately socially undesirable to hold stereotypes of the members of social groups other than one's own (the outgroup). However, stereotyping is a natural human process (Haslam *et al.*, 2002) and one that may have both positive and negative outcomes. Positively, individuals may use their established stereotypes to guide their intergroup behaviours. This is a valid mechanism whereby people make sense of their interactions with

other groups. They are a means to efficiently deal with an outgroup with minimum expenditure of energy (Haslam *et al.*, 2000; Haslam *et al.*, 2002). In the health arena, stereotyping has been recognized as a factor that mediates group interaction. It is a means by which health and social care professionals are able, for example, to take shortcuts and cope with the demands placed upon them during their interactions with both the client and the employing organisation (Kirkham *et al.*, 2002). The generalized and often accurate views that the practitioner and his/her peers hold of a particular patient group may guide the professional in an appropriate manner when facing an individual from this patient group for the first time.

However, stereotypes may also generate false or negative expectations of another group's attitudes or behaviours. It is possible that these negative expectations of a group create a reality through a process of self-fulfilling prophecy (Hilton & Von Hippel, 1996). For example, prior perceptions that doctors are arrogant may taint future interactions with this group. If other HSC professionals enter an interprofessional situation with these expectations in place, doctors may well begin to behave as expected. Alternatively, other professionals may misconstrue what otherwise would be interpreted as relatively benign behaviour. Further, if a professional group is faced with the stereotypes held of them by other groups, this may have an impact on their self image and output. Negative perceptions of the public stereotyping of nursing, for example, has been thought to influence the development of a poor collective self esteem, job satisfaction and performance in nursing professionals (Takase *et al.*, 2002).

For successful team working, members of cross professional teams need to develop or access the internal resources that will allow them to overcome negative stereotypes and appreciate how other disciplines understand , create and use knowledge. They need to have the flexibility to value other perspectives and embrace change and develop as reflexive practitioner (Schon, 2004). They also need to understand each other's role and where the role of one professional begins and the other begins. These internal resources should be built during their pre qualification training and topped up in post qualifying career development (Carpenter, 1995a; Carpenter, 1995b; Carpenter & Hewstone, 1996; Hean, 2006).

Interprofessional learning

The need for training on cross professional training has been recognised by the Department of Health in the UK, driven forward largely by the outcomes of the Bristol inquiry (Department of Health, 2001) and Laming reports (Department of Health, 2003). In the former inquiry into the deaths of children undergoing cardiac surgery at Bristol Royal Infirmary, it was recommended that health professionals (nurses, doctors and others) share education and training in order to improve their understanding and respect of each others professional roles and responsibilities (Department of Health, 2001) . Whilst this inquiry did not make explicit the expected outcomes of learning together, or their conception of 'shared learning', they did identify a range of areas that were viewed as crucially important to the care of patients. These key areas included communication skills with colleagues and patients and team working skills (Department of Health, 2001).

The need to promote effective team working across organisations and professions through interprofessional education has been substantiated further by the findings of the inquiry into the death of Victoria Climbié (Department of Health, 2003). It recommended not only the establishment of a National Agency for Children & Families but that such an agency encourage institutions responsible for the training of doctors, nurses, teachers, police officers etc to include some form of joint training within their training programmes (Department of Health,

2003)

Both inquiries have identified the need for, and have lead to the radical reform of, the education and training of a range of professionals to promote collaborative working focused on the patient or client (Humphris and Hean, 2004).

Terminology in cross professional learning

As in cross professional working, terminology around multi professional or interprofessional learning must again be clarified. Students can learn about the role of other professionals in a uni-professional environment in which no contact or interaction with other student groups or professionals takes place. They may also learn multi professionally where multiprofessional education is defined as:

"Occasions when two or more professions learn side by side for whatever reason" (Barr et al., 2002, p6).

Multi-professional learning often involves large numbers of students being taught together at the same time, in the same space and about the same topic. Whilst there may be efficiency savings, Carpenter & Hewstone have indicated that '*simply putting students together in mixed classes…*(may be)*…. unproductive*'(Carpenter & Hewstone, 1996, p241)*.*

On the other hand, interprofessional learning is defined as

"Occasions when two of more professions learn with, from and about one another to improve collaboration and the quality of care (Barr, 2002, p6)

Interprofessional learning necessitates that students learn '*with, from and about one another'* (Barr, 2002, p6) and in, operational terms, this leads logically to a model of small group learning rather than large group didactic teaching. It is in this environment, that students may be able to develop the internal resources they require to be good cross professional team members.

Interagency working

The above discussion of a cross-professional team and its members largely takes place from a micro or even meso level of analysis. However, in a patient's care pathway, interactions between professionals often occur at a more macro level of work organisation. Multiple agencies can be involved and both agency and professional boundaries negotiated.

Case study 4.1 Cross professional working

The prevalence of mental health issues in the prison population (Joint Prison Service and National Health Service Executive, 1999; Reed, 2003; Department of Health, 2007) may partially be attributed to prisoners not being screened effectively for mental illness during earlier contact with the criminal justice system (CJS). For defendants to be effectively screened when passing through court, cooperation between the CJS and mental health services is required. One dimension of this is the transfer of information on the mental health of the defendant between services in the form of written reports. Reports follow the assessment of the defendant by the MHS usually at the request of the court or other party. The report should enable the defendant to access the treatment they require and/or assist the sentencer in making an informed decision on

an appropriate means of disposal. This dimension of interagency working has proved difficult in the past as might be expected of working between two public services so distinct in their expectations, priorities and working culture. In response to these difficulties, a partnership between the Criminal Justice System and The Mental Health Services was formed in a region of the SW of England and a pilot project was funded (South West Mental Health Assessment Pilot; 2007-2009) to implement a formal Service Level agreement (SLA) between the MHS and CJS to optimise the provision of reports.

In case study 4.1 a host of agencies are involved in ensuring that defendants with mental health issues receive the support they require when passing through the court system, being diverted from the Criminal Justice system if necessary. The courts and the mental health services are two of these. Professionals in the Courts (e.g. lawyers, judges, and probation officers) work in partnership with those in the mental health services (e.g. psychiatrists, community psychiatric nurses, psychologists,)

Case study 4.1 also illustrates the distinction between multi and interagency working. As in previous distinctions made between multi and inter professional working and learning, inter and multi agency working refers to the level of integration in working across agency boundaries.

> *"Multi agency working implies more than one agency working with a client but not necessarily jointly. Multi agency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper interagency co-ordination"* (Warmington *et al.*, 2004, p14).

Interagency working, on the other hand, is where one or more agencies work together but where these working relationships are in a *" planned and formal way, rather than simply through informal networking* "(Warmington *et al.*, 2004 p14).

Case study 4.1 is illustrative of how two services have moved from multiagency working to interagency working through the introduction of a service level agreement (SLA) in which formalized relationships between agencies were established to optimise the provision of reports. Prior to the formalisation of the relationship between agencies, informal networking between agencies meant court outcomes were well below optimum with delays in report provision, inappropriate report content and high, unanticipated costs being some of the poor outcomes of previous multi agency interaction (Hean *et al.*, 2008). The SLA between the criminal justice system and the mental health services means that formal arrangements now govern report provision and improved interagency working.

A framework to understand interagency working

Interagency working is complex and as such is difficult to manage and evaluate. A framework that has proved useful in making sense of this is that of the Activity System (Engestrom, 2001)

The activity system as framework is an evolution of socio cultural learning theory (Vygotsky, 1978). The basic tenet of the latter is that the meaning we make of an activity, or the learning that takes place during this activity, is a function not only of the individual's own cognition, ability or dedication. It is also mediated and influenced by factors external to the individual within the social world as well (Engestrom, 2001). Activity systems build on this individual level of analysis to take a more macro level approach (Hean et al., i*n press)*. Figures 4.1 and 4.2 (adapted from (Hopwood & McAlpine, 2007) illustrate two activity systems that are present in case study 4.1.

Figure 4.1 represents a single activity that takes place within the activity system-the CJS. Figure 4.2 represents a single activity that occurs within a second agency – the mental health service

[pic]

Figure 4.1: *An activity system surrounding the requests for psychiatric reports made by the Criminal Justice system*

In figure 4.1, the subject is the person within an agency undertaking a particular activity. The objective is the purpose of this activity. In the court activity system, the subject is illustrated by a magistrate dealing with a defendant identified as having potential mental health issue. In the interest of the defendant, and to inform sentencing (the object), the magistrate requests an assessment and report on the mental health of the defendant (the activity). In order to achieve this, the magistrate may complete a written assessment request or negotiate with legal advisors or liaison workers in court to make these requests. The latter are tools that mediate the activity. Surrounding this mediated activity are a range of other variables that may have influence. These include both the unwritten social norms and formal rules that govern the way in which the CJS function, e.g., government imposed targets that specify the times in which court cases need to be completed. Also surrounding the activity are members of the wider CJS community who include liaison workers, defence lawyers, probation officers, court ushers, other magistrates, and security personnel. Each of these members may fulfil a particular role within the CJS that will dictate how the activity under focus can be achieved (division of labour). The outcome of this activity is mediated by the complex structures that surround it. Prior to the implementation of the SLA, these outcomes were problematical caused by a range of contradictions within the activity system. For example, there is a contradiction in the activity system (figure 4.1) between the need to request a report (object) and governing rules that stipulate that court cases need to be completed in a set time frame. As reports are often delayed, this contradiction means that magistrates were sometimes loathe to request reports as the delays the report introduces, compromises the government time targets they are trying to achieve.

[pic]

Figure 4.2: *An activity system surrounding the provision of psychiatric reports by the mental health services*

In figure 4.2 the subject is a psychiatrist undertaking an assessment and making a report on a service user in contact with the CJS. The psychiatrist does this using the assessment tools available to her/him as part of their normal practice. The way in which the report is written may be underpinned by several norms and rules, e.g.:

- psychiatrists view that their first responsibility is to the defendant and his/her treatment (and not punishment)
- Patient confidentiality.
- Psychiatrists are expected to complete reports for the court on a private consultancy basis over and above their current work load.

The community, who surrounds the report writing activity undertaken, by the psychiatrist include other psychiatrists, community psychiatric nurses and social workers. A clear cut division of labour arises in report writing with psychiatrists being responsible for the full assessment and psychiatric reports required of the more seriously mentally ill or more serious offenders.

Abbreviated health and social circumstance or screening reports are conducted by other health professionals. The outcomes of this activity can be challenging in that information from the courts on a patient are not easily accessible and expectations of report content and timeframes are not clearly communicated (Hean *et al.*, 2008).

In considering inter agency working, we need to look beyond the two separate activity systems in isolation and review them in parallel, identifying how the objects of each activity are synchronous. We also need to articulate a new joint shared outcomes of these two agencies working together (figure 4.3). To optimize this joint outcome, the tensions or contradictions between the components of the each system need to be identified and resolved to achieve improved joint agency outcomes (Figure 4.3). Resolutions are produced and piloted by both agencies in partnership and agencies learn together to develop ways in which to effectively work together (Engestrom, 2001). In case study 4.1, the mental health services and the CJS formed a working partnership to achieve just this. Representatives from each agency came together in a project steering group. The objects of each system were identified (figures 4.1 and 4.2). Through a range of meetings between agency representatives and an evaluation of interagency challenges (Hean *et al.*, 2008), the group identified that, although they are involved in different activities, in terms of interagency working, they share a common overarching object -the transfer of information about a defendant with mental health issue between the two agencies. Initial joint outcomes were below optimum, the evaluation showing that there was no shared expectation of agreed time scales and that too many psychiatric reports being requested inappropriately (Figure 4.3).

Facilitated by a project manager, contradictions within each system were identified, and a resolution put in place and tested. The jointly engineered solution was the introduction of a service level agreement in which the mental health service are commissioned to provide 'brief screening reports' on all defendants referred to them or already known to them. These were to be done on the day or within one working day of the referral. If further information was required a Health and Social Circumstances Report or a psychiatric report will be provided to agreed timescales.

|[pic] | |[pic]

Figure 4.3: *Interaction of the Activity systems of the criminal Justice system and mental health services respectively*

Activity 4.4
(Adapted from Hopwood & McAlpine, 2007)

Think of the service /agency in which you currently work. Use the activity system diagram to describe your service by:

* Identifying a relevant subject and object
* Describing the communities, rules, divisions of labour and mediating factors that surround this activity
* Asking are there any contradictions within your system

Now think of another service /agency with whom your service interacts. Use the activity system diagram to describe this service.

How are your activities synchronous and describe the joint activity you are working together to achieve?

What are the joint outcomes of this joint activity as they now stand?

How could these be improved?

Conclusion

The chapter has briefly introduced the concepts of multi versus inter professional team working and leaning and multi and inter agency working. Evidence points towards the benefits of more inter professional working, learning and interagency working as key goals in practice development. However, it is clear that for a cross professional team to work together effectively will depend on the context and objective of each individual team. We hope the chapter has provided some insight into the issues that should be considered when thinking how to optimise the functioning of one's own cross professional team and to have provided some frameworks with which to articulate what you see in your own practice. Clarity is the first step in achieving positive action that is key to practice development.

Key points

. There are benefits to cross professional/agency working and learning but the benefits, and ways of maximising, these vary by the purpose and context of each individual team.
. There are challenges to cross professional/agency working including poor interprofessional stereotyping.

. It is important for practitioners clearly articulate their practice, including that part of their practice that involves cross professional or cross agency working.
. The use of activity and social capital theories are tools that practitioners may find useful in this process.

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Useful links

http://www.caipe.org.uk/
http://ihcs.bournemouth.ac.uk/etipe/who.html

Initial Outcome:

Current outcome: lengthy delays, content of report often not useful, costs of reports. All prevent reports being requested. Screening, assessment and treatment compromised and little info to magistrates for an effective disposal

Mediating tools
Liaison worker, request form

Rules
Cost effectiveness; targets on disposal times

Subject
Magistrate

Community
Legal advisors, liaison workers, defence lawyers, probation, judges, magistrates, reliance

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Division of labour
between of probation, defence, liaison and legal advisors, magistrate

Object: Activity:
Defendants are referred to the mental health services who supply a report on defendants condition and treatment

Mediating tools
Assessment tools

Rules
Issues of confidentiality

Subject
Psychiatrist

Object: Activity:
Assessment and report provision on defendants referred to the mental health services by the courts

Community
Defendant/patient, liaison workers, other health and social care professionals working in mental health services,

Initial Outcome:
Current outcome: difficult to get information on defendant from court; inappropriate requests for

full psychiatric reports; work commitments that take priority over and report requests, sown on own time.

Division of labour
between of Psychiatrist and Community psychiatric nurses, liaison workers

Mediating tools
Liaison workers, assessment requests

Rules
Cost effectiveness; targets on disposal times

Subject
Magistrate

Community
Legal advisors, liaison workers, defence lawyers, probation, judges, magistrates, reliance

Division of labour
between of probation, defence, liaison and legal advisors, magistrate

Object: Activity:
Defendants are referred to the mental health services who supply a report on defendant’s condition and treatment

Outcome: delays in report writing, discoordnation between services, inappropriate requests for psychiatric reports

Assessment tools

Rules
Issues of confidentiality

Subject
Psychiatrist

Object: Activity:
Assessment and report provision on defendants referred to the mental health services by the courts; request for information on patient

Community
Defendant/patient, liaison workers, other health and social care professionals working in mental health services,

Division of labour
between of Psychiatrist and Community psychiatric nurses, liaison workers