Shaping Psychologically Informed Community Mental Health Teams: A Grounded Theory of How Clinical Psychologists Influence Practice

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THESIS PORTFOLIO: CANDIDATE DECLARATION

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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed:  Date: 29/04/25

Acknowledgements

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Thesis Abstract

This thesis explores how clinical psychologists grow psychological thinking within multidisciplinary teams (MDTs), offering both a novel contribution to the field and a synthesis of existing knowledge. It seeks to deepen understanding of how this process unfolds in practice, so that future efforts to embed psychological knowledge within teams can be better supported.

The first paper systematically reviews and critically examines existing research on how MDT members experience the indirect work carried out by clinical psychologists, such as consultation, supervision, reflective practice, and training. Drawing together insights from nine qualitative studies, it highlights that indirect work can strengthen team cohesion, build clinical understanding, and deepen empathy toward service users. It also identifies organisational barriers, such as limited time and resource constraints, that hinder the embedding of psychological approaches. Gaps in the evidence base are outlined, with a call for future research into the longer-term impact of indirect work, the inclusion of more diverse service contexts, and the exploration of wider systemic conditions.

The second paper contributes original knowledge by exploring how clinical psychologists influence Community Mental Health Teams (CMHTs) to become more psychologically informed. Using a Critical Constructivist Grounded Theory (CCGT) approach, interviews with twelve clinical psychologists were analysed to develop a conceptual model of influence. Relational security emerged as central to the process, with influence found to be most effective when adapted to the emotional and developmental readiness of individuals, teams, and systems, working within their Zone of Proximal Development (ZPD). The study offers new insights into how influence unfolds relationally and adaptively, within the realities of systemic pressures and constraints.

The third paper presents the research in an accessible executive summary, sharing key findings and practical recommendations. It aims to help clinical psychologists, service managers, trainees, and policymakers recognise, understand, and strengthen the contributions clinical psychologists make within CMHTs.

Paper One: Literature Review

Indirect Work with Clinical Psychologists: A Systematic Review of Multidisciplinary Team Perspectives

Word Count: 6,249

This literature review has been prepared in the style of articles published in the Journal of Psychology and Psychotherapy: Theory, Research and Practice, the intended journal for publication. Additional material, included to meet academic requirements, will be removed prior to final submission. The journal's publication guidelines are provided in Appendix A.

Abstract

Introduction: This systematic review aimed to explore the perspectives of multidisciplinary team members on the indirect work carried out by clinical psychologists within UK healthcare settings. The review focused on consultation, supervision, reflective practice, and training, examining their impact on multidisciplinary teams.

Method: A comprehensive search of relevant databases (APA PsycInfo, MEDLINE, CINAHL, and APA PsycArticles) was conducted using a systematic strategy. Studies published between 2007 and 2024, that examined multidisciplinary perspectives on indirect work carried out by clinical psychologists, were screened against predefined inclusion criteria. Nine qualitative studies were selected, critically appraised for quality, and thematically synthesised.

Results: Four overarching themes were identified: improved working relationships and team cohesion, increased understanding and empathy towards service users, development of clinical skills and changes in practice, and challenges and barriers in implementing indirect work. Multidisciplinary team members reported positive outcomes such as enhanced teamwork, deeper clinical insight, and greater empathy. However, barriers such as time constraints and resource limitations, were found to hinder the effectiveness of indirect interventions.

Conclusion: Indirect work carried out by clinical psychologists fosters team cohesion, enhances empathy and clinical skills, and promotes psychologically informed ways of working. However, its success depends on organisational factors such as protected time, adequate resources, and managerial support. Future research should explore the longer-term impact of indirect work, include diverse service contexts, and examine the systemic conditions that facilitate or hinder the embedding of psychological thinking within multidisciplinary teams.

Practitioner Points:

- Indirect interventions require protected time and sufficient resources to be effectively embedded within multidisciplinary teams.
- Leadership and managerial support are crucial for overcoming resistance and fostering a culture of openness to psychological thinking.

- Clinical psychologists should collaborate closely with team leaders to influence practice at a systemic level and sustain engagement with indirect interventions.

Keywords: Experience, multidisciplinary team, clinical psychologist, indirect work

Introduction

In recent years, the role of clinical psychologists working in UK healthcare teams has expanded beyond direct therapeutic interventions to include more indirect ways of working. Although direct therapeutic interventions, such as assessment, formulation, and treatment, remain central to practice (BPS, 2019), clinical psychologists are also trained to support their multidisciplinary colleagues. Indirect interventions, including consultation, supervision, reflective practice, and training, are designed to shape clinical practice and foster greater psychological thinking within teams (BPS, 2019).

The growing emphasis on indirect work reflects a broader debate that challenges traditional diagnostic frameworks (DCP, 2013) and advocates for psychological formulation (DCP, 2011). Neglecting psychological perspectives when planning treatment can inadvertently exacerbate clients' presenting difficulties (Macneil et al., 2012). In 'New Ways of Woking for Applied Psychologists in Health and Social Care', Onyett (2007) emphasises the importance of clinical psychologists actively engaging with the systems they work within to promote psychological thinking through training, supervision, and reflective practice. Similarly, the 'Core Purpose and Philosophy of the Profession' (DCP, 2010) highlights the role of clinical psychologists in guiding colleagues from other disciplines to apply psychological knowledge in clinical and organisational decision-making. Doctoral training courses are therefore encouraged to place greater emphasis on developing leadership skills in trainees, equipping them to influence clinical practices (BPS, 2019).

Research indicates that indirect work has positive outcomes across a variety of settings (Clarke & Wilson, 2009; Clarke et al., 2012; Craven-Staines et al., 2010; Kerfoot et al., 2012; Robson & Quayle, 2009). Nevertheless, the uptake of psychologically informed perspectives within multidisciplinary teams remains challenging (Mohtashemi et al., 2018). Christofides et al. (2011) found that clinical psychologists often share psychological hypotheses informally, rather than through more explicit forums such as case formulation meetings. While these informal contributions are valuable, they are rarely recognised by senior leadership and management, often resulting in psychological input being undervalued and underused.

Existing research on the role of clinical psychologists in multidisciplinary teams has largely focused on formulation, with systemic reviews being conducted on this area of practice (Bealey et al., 2021; Geach et al., 2017). However, formulation is just one form of indirect work. It is important to broaden the focus to consider the impact of other indirect interventions. This review aims to systematically synthesise what is known about multidisciplinary team members' experiences of indirect work provided by clinical psychologists, without limiting the focus to any single type of intervention. Through this synthesis, knowledge gaps will be identified, offering greater clarity on the current state of evidence in this area.

Method

Search Strategy

An initial scoping search was conducted to assess whether a systematic review of multidisciplinary perspectives on clinical psychologists' indirect work was warranted. This process also helped to refine relevant search terms, which were combined into the following search string: (experience* OR perspective* OR view*) AND (MDT OR "multidisciplinary team*" OR "multi-disciplinary team*" OR staff) AND (consult* OR supervis* OR formulation OR reflect* OR training OR lead* OR "indirect work*") AND "clinical psycholog*" AND (UK OR "united kingdom" OR brit* OR NHS). A comprehensive electronic search was then conducted on June 6, 2024, across the following databases: APA PsycInfo, MEDLINE, CINAHL and APA PsycArticles. Search parameters were restricted to peer-reviewed articles published in English between 2007 and 2024. This timeframe was chosen to capture research published after the publication of 'New Ways of Woking for Applied Psychologists in Health and Social Care' (Onyett, 2007), which also informed the selection of search terms used to describe the types of indirect work carried out by clinical psychologists within multidisciplinary teams. The database search yielded a total of 258 papers, which were then screened against the inclusion and exclusion criteria outlined in Table 1, below.

Following this, additional searches of grey literature were conducted using Google Scholar on August 5, 2024, and ProQuest on August 16, 2024, applying the same search string and date restrictions. On Google Scholar, the first 50 pages of results (500 papers) were screened by title and abstract. The ProQuest search yielded 3 papers, whose titles and abstracts were similarly screened against the inclusion criteria.

Screening Procedure

Results from the database search were consolidated into an Excel spreadsheet, where 68 duplicate papers were identified and removed. Titles and abstracts of the remaining 190 papers were screened against the inclusion and exclusion criteria. Following this, 32 full-text articles were screened in full. Their reference lists were also screened, but no further eligible

studies were identified. In total, nine studies met the inclusion criteria and were included in the review. Grey literature screening identified 503 papers, but none met the criteria for inclusion. A summary of the search and screening process is presented in a PRISMA flow diagram, in Figure 1, below.

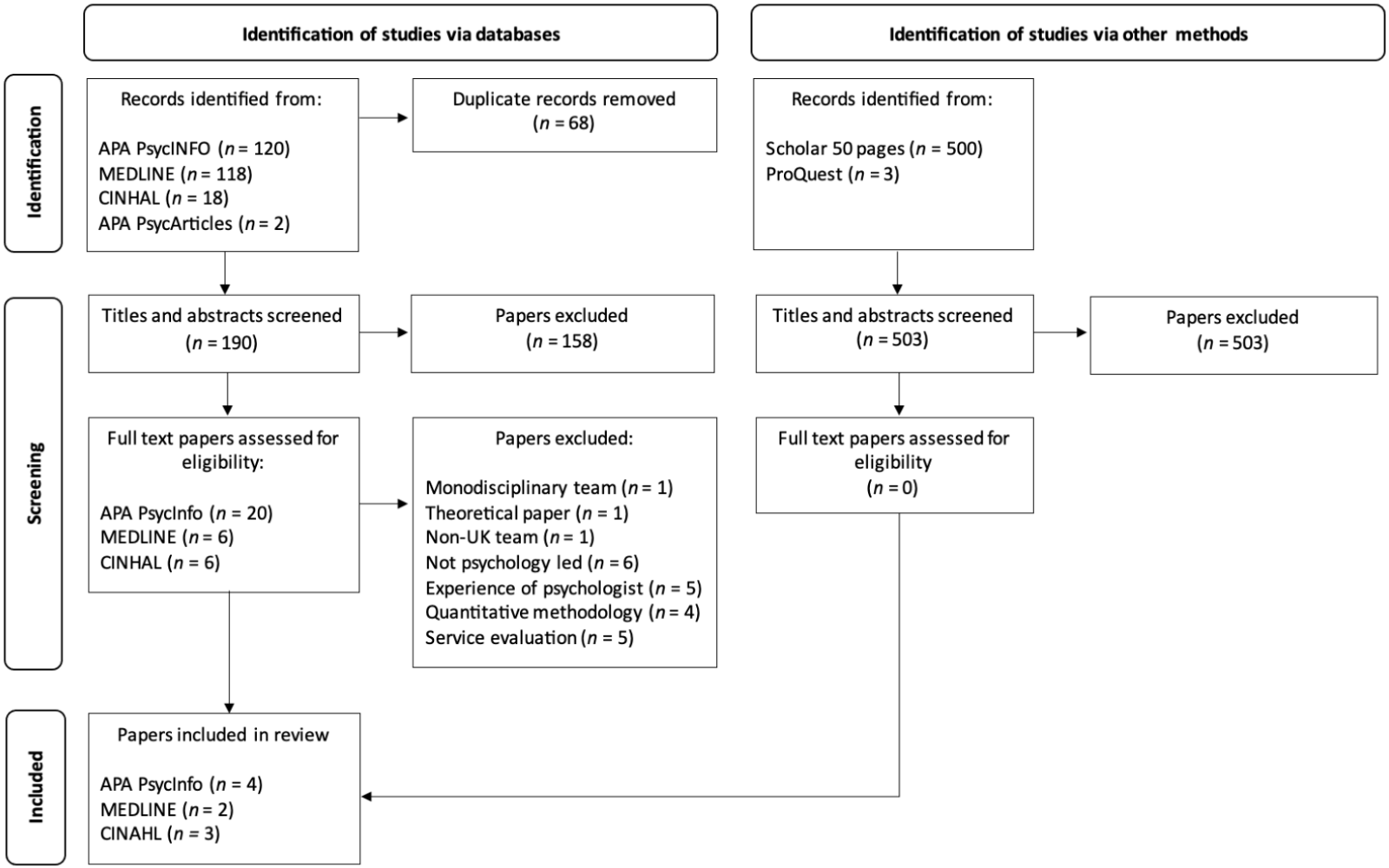
Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
• Multidisciplinary (minimum of two disciplines) • Indirect work carried out by a clinical psychologist • Qualitative or mixed methods • Indirect work (consultation or supervision or formulation or reflective practice or training or leadership) • UK teams • Written in English	• Experience of clinical psychologist • Theoretical papers

Figure 1

Search and Screening Process: PRISMA Flow Diagram



Critical Appraisal

The Clinical Appraisal Skills Programme (CASP, 2018) checklist for qualitative studies was used to assess the quality of the papers included in this review. The CASP was selected because it is specifically designed for appraising healthcare research. Although the CASP does not provide a formal quality score, a nominal scoring system was applied to reflect the perceived research value of each study. Papers were rated by assigning 2 points for 'yes' responses, 1 point for 'cannot tell', and 0 points for 'no' across the CASP questions. The same scoring system was applied to the final question, which asks for an overall judgment of the study's value. Studies judged to be 'very valuable' received 2 points, those rated as 'somewhat valuable' received 1 point, and those considered 'not valuable' received 0 points. The maximum possible score was 20 (see Appendix B for the table of scores).

Overview of Studies

Nine qualitative studies were included in this review. Table 2, below, summarises the key characteristics of these studies, alongside their main findings regarding multidisciplinary team members' perspectives on the indirect work carried out by clinical psychologists. The studies employed a range of methods across a number of healthcare settings. Most used semi-structured interviews to collect qualitative data (Berry et al., 2017; Donaghay-Spire et al., 2016; Douglas & Benson, 2015; Murphy et al., 2013; Steele et al, 2021; Stimpson et al., 2013; Waller et al., 2015). Thompson et al. (2008) adopted structured interviews, while Baker et al. (2021) used surveys. The type of indirect work explored across studies varied. Baker et al. (2021) examined reflective rounds; a form of group reflective practice open to all staff. Berry et al. (2017) focused specifically on team formulation, while Donaghay-Spire et al. (2016) explored both team formulation and reflective practice. Two studies focused on consultation, though the format differed: Douglas and Benson (2015) investigated psychosocial forums, a type of group consultation, while Murphy et al. (2013) explored one-to-one consultation. Training and supervision were also prominent. Steele et al. (2021) examined training in the Newcastle formulation model; Stimpson et al. (2013) focused on group-based CBT anger management training supplemented by supervision; and Thompson et al. (2008) explored introductory-level cognitive analytic therapy (CAT) training paired with supervision. Waller et al. (2015) examined training in low intensity cognitive behavioural therapy (CBT) for psychosis, also supported by supervision.

Healthcare settings varied considerably. Two studies were conducted within physical health teams (Baker et al., 2021; Douglas & Benson, 2015), five in mental health services (Berry et al., 2017; Donaghay-Spire et al., 2016; Murphy et al., 2013; Thompson et al., 2008; Waller et al., 2015), one within a dementia service (Steele et al., 2021), and one in a learning disabilities day service (Stimpson et al., 2013). The composition of multidisciplinary teams was broad, encompassing occupational therapists, occupational therapy technicians, physical and mental health nurses, nursing students, consultant psychiatrists, paediatricians, junior doctors, medical students, social workers, healthcare and nursing assistants, support staff, and ward managers.

Across the studies, several important findings emerged regarding multidisciplinary team members' experiences of indirect work. Reflective rounds were reported to improve working relationships, enhance understanding of colleagues' roles, and increase clinical insight (Baker et al., 2021). Formulation sessions contributed to care planning, strengthened team members' understanding of service users' difficulties, improved relationships with patients, and enhanced teamwork, confidence, and empathy (Berry et al., 2017; Donaghay-Spire et al., 2016). Consultation sessions were valued for supporting care planning and skill development in managing complex clinical situations (Douglas & Benson, 2015). Training and supervision were also viewed positively, with participants describing role expansion and improved skills for working with challenging behaviour and complex presentations. Training was found to increase awareness of alternatives to medication and enhance empathy toward service users (Murphy et al., 2013; Steele et al., 2021). Supervision was valued for offering advice, emotional support, and structured feedback, as well as developing skills and confidence in working with specific client groups (Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015). However, several barriers were noted, including lack of protected time, competing clinical demands, and difficulties organising supervision due to time pressures and limited understanding of its purpose (Murphy et al., 2013; Steele et al., 2021; Waller et al., 2015).

Table 2

Study Characteristics

Author(s) & Date	Title	Methodology & Design	Type of Indirect Work	Multidisciplinary Team Composition	Setting	Main Findings
Baker et al. (2021)	Implementation of multidisciplinary reflective rounds within a children's hospital before and during the COVID-19 pandemic	Qualitative, survey with free text box, unspecified method of analysis	Reflective rounds (Group reflective practice)	Consultant psychiatrist, nurse, junior doctor, social worker, medical student, healthcare assistant, nursing student, occupational therapist	Children's hospital (physical health)	Reflective rounds improved working relationships, enhanced understanding of team members' roles, and increased clinical insight.

Berry et al. (2017)	Understanding outcomes in a randomised controlled trial of a ward-based intervention of psychiatric inpatient wards: A qualitative analysis of staff and patient experiences	Qualitative, semi-structured interviews, thematic analysis	Team formulation	Nurse, support worker, other	Inpatient psychiatric rehabilitation ward	Team formulation improved relationships with patients, enhanced understanding of patient difficulties, improved teamworking, and increased confidence and empathy. Adopting a collaborative stance that recognised team strengths, along with management support, were important in overcoming initial team members' resistance.
Donaghay-Spire et al. (2016)	Exploring narratives of psychological input in the acute inpatient setting	Qualitative, semi-structured interviews, narrative analysis	Team formulation and reflective practice	Consultant psychiatrist, social worker, ward manager, occupational therapist, mental health nurse	Acute inpatient psychiatric wards	Formulation contributed to care planning and increased understanding of patient issues.

Douglas & Benson (2015)	Psychological consultation in a paediatric setting: A qualitative analysis of staff experiences of a psychosocial forum	Qualitative, semi-structured interviews, thematic analysis	Psychosocial forum (Group consultation)	Paediatrician, nurse, allied health professionals	Gastroenterology service	Psychosocial forums supported care planning of complex cases and development of skills for managing them. Some staff found it increased their sensitivity to psychological issues.
Murphy et al. (2013)	Psychological consultation in older adult inpatient settings: A qualitative investigation of the impact on staff's daily practice and the mechanisms of change	Qualitative, semi-structured interviews, thematic analysis	Individual consultation	Mental health nurses, nursing assistants, occupational therapy technicians	Older adult inpatient units	Consultation sessions increased empathy toward service users and developed skills for managing complex behaviour through better understanding of psychological processes. They were particularly useful when staff felt 'stuck'. Increased sense of value and empowerment. Challenges included lack of safeguarded time, competing demands and time-consuming nature of the sessions.

Steele et al. (2021)	Healthcare professionals' experiences of using a biopsychosocial approach to understand behavioural and psychological symptoms of dementia: A qualitative interview study	Qualitative, semi-structured interviews, thematic analysis	Training in the Newcastle formulation model	Psychiatric nurse, occupational therapist, occupational therapist assistant, social worker, assistant practitioner, support worker	Older adult community mental health dementia service	Training improved awareness of alternatives to medication and increased confidence. Some saw long-term benefits, others preferred quicker results from medication. Competing demands were a barrier to implementation. Suggested training be mandatory, added to assessments and databases. Support from managers was helpful for overcoming barriers.
Stimpson et al. (2013)	The experiences of staff taking on the role of lay therapist in a group-based CBT anger management intervention for people with intellectual disabilities	Qualitative, semi-structured interviews, Interpretative phenomenological analysis	Training in group-based CBT anger management and supervision	Manager, senior support worker, support worker	Intellectual disabilities day service	Team members welcomed the training as an opportunity to expand and diversify their roles. Supervision was seen as an opportunity to receive advice, support and feedback for complex issues and develop skills and confidence to deliver CBT.

Thompson et al. (2008)	Multidisciplinary community mental health team staff's experience of a 'skills level' training course in cognitive analytic therapy	Qualitative, structured interviews, thematic analysis	Training in introductory level CAT skills and supervision	Social worker, community psychiatric nurse	Community mental health team	Training improved team cohesion, fostered a shared model and language, informed clinical work and practice, increased confidence and reduced anxiety about complex cases. Supervision increased team cohesion. Workload was a barrier.
Waller et al. (2015)	Training frontline mental health staff to deliver low intensity psychological therapy for psychosis: A qualitative analysis of therapist and service user views on the therapy and its future implementation	Qualitative, semi-structured interviews, thematic analysis	Training in Low intensity CBTp training and supervision	Occupational therapist, mental health worker, nurse, social worker	Early intervention team and a recovery focused team	Staff were enthusiastic about learning new skills. Supervision supported this, but was hard to organise due to time commitments, making regular attendance difficult. Not all team members understood its purpose due to limited previous experience.

Critical Appraisal

Aims

Eight of the included studies (Berry et al., 2017; Donaghay-Spire et al., 2016; Douglas & Benson, 2015; Murphy et al., 2013; Steele et al., 2021; Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015) clearly stated their aims, addressing gaps within the existing research. In contrast, Baker et al. (2021) did not present a clear aim, which limited the study's overall contribution to the field.

Methodology and Design

Most studies appropriately adopted qualitative methodologies and clearly justified their research designs (Berry et al., 2017; Donaghay-Spire et al., 2016; Douglas & Benson 2015; Steele et al., 2021; Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015). However, two studies (Baker et al., 2021; Murphy et al., 2013) did not provide a rationale for their choice of qualitative methodology.

Recruitment

Recruitment strategies were generally appropriate across the studies, with purposive sampling being the most commonly used approach (Berry et al., 2017; Donaghay-Spire et al., 2016; Douglas & Benson, 2015; Murphy et al., 2013; Stimpson et al., 2013; Thompson et al., 2008). Some studies, such as Berry et al. (2017), acknowledged potential bias arising from high dropout rates, whereas others (Baker et al., 2021; Waller et al., 2015) did not address this, limiting the reliability of their findings. Data saturation was explicitly considered by Douglas and Benson (2015), Steele et al. (2021) and Stimpson et al. (2013); however, Murphy et al. (2013) did not discuss saturation, impacting the credibility of their findings.

Reflexivity

Several studies effectively addressed reflexivity by taking steps to minimise researcher bias. For example, Stimpson et al. (2013) and Thompson et al. (2008) used independent

interviewers to reduce researcher influence, while Douglas and Benson (2015) kept a reflective log and sought external feedback on their interview schedules. Steele et al. (2021) and Donaghay-Spire et al. (2016) enhanced the credibility of their findings through member checking and inter-rater reliability checks. Berry et al. (2017) mitigated bias by having their data independently analysed. Murphy et al. (2013) did not adequately address the relationship between researcher and participant, which may have impacted the validity of their findings. Baker et al. (2021) also failed to consider researcher bias, weakening the validity of their results.

Ethics

The ethical standards reported across the reviewed studies varied considerably. Some studies (Douglas & Benson, 2015; Steele et al., 2021; Thompson et al., 2008) provided comprehensive ethical protocols, including obtaining ethical approval and outlining measures to protect participant confidentiality and informed consent. In contrast, other studies (Baker et al., 2021; Berry et al., 2017; Murphy et al., 2013; Stimpson et al., 2013; Waller et al., 2015) did not adequately address ethical considerations, such as safeguarding participants' rights and wellbeing. This omission raises concerns regarding the robustness of their ethical procedures.

Analysis

The rigour of data analysis varied across the reviewed studies. Four studies (Douglas & Benson, 2015; Steele et al., 2021; Stimpson et al., 2013; Thompson et al., 2008) demonstrated robust analytic procedures, incorporating techniques such as data triangulation, member checking, and iterative thematic discussions to enhance reliability. Stimpson et al. (2013) followed interpretative phenomenological analysis (IPA) guidelines rigorously, with independent verification of emerging themes by other researchers. Similarly, Thompson et al. (2008) used independent auditing to validate their thematic analysis findings. In contrast, Baker et al. (2021) provided limited detail regarding theme generation, reducing the credibility of their findings.

Findings

All of the included studies, with the exception of Baker et al. (2021), clearly reported their findings and supported them with participant quotations. In contrast, the findings reported by Baker et al. (2021) were significantly limited by the absence of a comprehensive research design and reliable qualitative method of analysis, reducing the overall depth, reliability, and validity of the insights provided.

Value of the Research

The overall value of the included studies varied considerably. Three studies (Berry et al., 2017; Douglas & Benson, 2015; Steele et al., 2021) were considered very valuable, due to their methodological rigour, and significant contributions to both research and clinical practice. Five studies (Donaghay-Spire et al., 2016; Murphy et al., 2013; Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015) were rated somewhat valuable, as methodological limitations, impacted the reliability of their findings. In contrast, Barker et al. (2021) was not considered valuable due to a lack of methodological rigour, limited transparency in data analysis, and minimal attention to ethical considerations.

Synthesis of Themes

A textual analysis was performed by closely examining the results and discussion sections of each study. Findings were filtered to identify those most relevant to the review question. Pertinent findings were then transferred into a table (collated in Table 2, above), coded, and categorised into four overarching themes: (1) improvement in working relationships and team cohesion, (2) greater understanding and empathy, (3) development of clinical skills and changes in practice, and (4) challenges and barriers. A thematic table, showing the relevance of each study to each theme, is presented in Table 3, below.

Table 3

Thematic Table

Study	Improvement in Working Relationships and Team Cohesion	Greater Understanding and Empathy	Development of Clinical Skills and Changes in Practice	Challenges and Barriers
Baker et al. (2021)	x	x	x	
Berry et al. (2017)	x	x	x	x
Donaghay-Spire et al. (2016)		x		
Douglas & Benson (2015)		x	x	
Murphy et al. (2013)		x	x	x
Steele et al. (2021)	x	x		x
Stimpson et al. (2013)		x	x	
Thompson et al. (2008)	x	x	x	
Waller et al. (2015)		x		x

Improvement in Working Relationships and Team Cohesion

Several studies highlighted improvements in working relationships and team cohesion as key outcomes of indirect work carried out by clinical psychologists. Baker et al. (2021) found that reflective rounds helped strengthen working relationships and enhanced team members' understanding of each other's roles. These rounds created opportunities for open dialogue, sharing of experiences, and collaborative strategy development, fostering a stronger sense of cohesion. One participant noted that it was "helpful to have colleagues of all seniority share their experiences and own stories of vulnerability" (Baker et al., 2021, p. 1047), while another described the rounds as a "small step in a positive culture change" (Baker et al., 2021, p. 1047). Similarly, Thompson et al. (2008) observed that training sessions improved team cohesion by fostering a shared language and model of working, with supervision playing an important role in strengthening team dynamics through consistent professional support. Participants reflected that training had given them "a shared language and a model which contributes to a shared culture... This has impacted on the quality of the way we support each other" (Thompson et al., 2008, p. 135) and that "nobody is personalising problems; the team is now a source of strength rather than being defensive" (Thompson et al., 2008, p. 134). Berry et al. (2017) also found that team formulation sessions contributed to improved teamwork. One participant reflected, "It pulled us all together as a team, so it felt like it was more of a team approach, rather than sometimes if can feel like you're standing alone" (Berry et al., 2017, p. 1218). Psychologists' collaborative approaches, alongside managerial support, were seen as critical in overcoming initial resistance and building stronger, more cohesive teams.

Greater Understanding and Empathy

The development of greater understanding and empathy toward service users among multidisciplinary team members emerged as another key theme. Baker et al. (2021) noted that reflective rounds contributed to increased clinical insight. Thompson et al. (2008) similarly found that training sessions informed clinical practice, while Berry et al. (2017) highlighted that team formulation sessions helped deepen team members' understanding of service users. One participant reflected, "I think I got to appreciate the patients a bit better and understand what

they've been through and why they might be feeling like they are or acting like they do now" (Berry et al., 2017, p. 1217). Stimpson et al. (2013) emphasised that supervision provided a valuable platform for advice, support, and feedback around complex clinical issues, which contributed to improved understanding of service users. Murphy et al. (2013) reported that consultation sessions increased empathy toward service users, particularly when staff felt 'stuck'. One team member reflected, "You saw 'em in a different light really. You saw them as being people rather than patients" (Murphy et al., 2013, p. 444). Steele et al. (2021) noted that training enhanced team members' awareness of alternative ways of understanding behaviour, with some team participants recognising the value of psychological approaches compared to biological models. One participant explained, "Before the training... I would be thinking, 'oh it's just part of the dementia'. I wouldn't have thought deeply about it. After the training, I was thinking, 'there has got to be a reason why'" (Steele et al., 2021, p. 4). Douglas and Benson (2015) similarly found that psychosocial forums supported care planning for complex cases, increasing some team members' sensitivity to psychological issues. One participant reflected that participating in the forums "just gives you a much better understanding of where they're coming from and... it helps you modify how you might deal with them…" (Douglas & Benson, 2015, p. 479), and that "you become more sensitised to the psychological issues in families…" (Douglas & Benson, 2015, p. 480). Waller et al. (2015) also found that training helped clinicians empathise more deeply with service users' struggles. One participant described how it "made me think about my clients and their anxiety and understanding that it's really quite challenging having to do something you're really anxious about" (Waller et al., 2015, p. 303). Finally, Donaghay-Spire et al. (2016) reported that formulation contributed to care planning and supported the development of deeper empathy and clinical insight among team members.

Development of Clinical Skills and Changes in Practice

The development of clinical skills and changes in practice were widely reported across the reviewed studies. Berry et al. (2017) found that team formulation sessions improved team members' relationships with service users, as well as boosting their confidence. One participant described how the sessions led to a shift in approach: "We started letting him make more

decisions, not nagging him as much and the service user seems to be a lot more settled, less intrusive, less demanding of staff time, and I guess a lot of it comes from the sessions" (Berry et al., 2017, p. 1217). Baker et al. (2021) similarly found that reflective rounds were perceived to improve the quality of patient care. Thompson et al. (2008) reported that training sessions positively impacted practice, increasing confidence and reducing anxiety about working with complex cases. One participant reflected that "the training has lowered my anxiety levels with regard to working with complex needs clients also knowing that we have something to offer people who are often dismissed as having untreatable personality disorders" (Thompson et al., 2008, p. 135). Another team member highlighted that the training "helps my assessments...provides a clear structure for my work and my endings with clients" (Thompson et al., 2008, p. 135). Stimpson et al. (2013) also reported that training was welcomed by team members as an opportunity to expand and diversify their roles, with supervision providing further support for developing clinical skills and confidence. One participant reflected on the outcomes of training, explaining that it led to "recognising what anger is, recognising the physical effects, recognising triggers and understanding techniques for dealing with these emotions, physical feelings, and triggers and applying them" (Stimpson et al., 2013, p. 68). Murphy et al. (2013) found that training and consultation sessions supported the development of skills for managing challenging behaviour. Douglas and Benson (2015) similarly noted that psychosocial forums helped staff develop skills for managing complex clinical situations. Participants valued the opportunity to seek advice from senior staff, with one reflecting that it was "an opportunity... for us to… to take advice from [name of clinical psychologist] … on how we should deal with a particular situation…" (Douglas & Benson, 2015, p. 479). Another participant described how the forums helped to set clearer boundaries with parents, explaining, "I'm sorry but it's actually your responsibility to do some of it […] You need to support the rest of the way" (Douglas & Benson, 2015, p. 480).

Challenges and Barriers

Although the studies reported a range of positive outcomes associated with indirect work provided by clinical psychologists, several challenges and barriers were also identified.

Steele et al. (2021) noted that some team members found the biopsychosocial approach time-consuming and preferred the quicker results associated with medication-based interventions. One participant reflected on the difficulty of finding time to implement the approach, saying, “Because you’ve got that more time-focused approach... With the best will in the world, I don’t always have time” (Steele et al., 2021, p. 6). Team members also described struggling to maintain psychological approaches when faced with competing service demands. Murphy et al. (2013) similarly highlighted the lack of protected time and prioritisation of other clinical duties as significant barriers. One participant reflected, “When the ward’s really busy and people are going into psychology sessions, I think it’s sort of sometimes hard for people to understand, some people, that it’s beneficial. When you could do with a man on the floor” (Murphy et al., 2013, p. 445). The time-consuming nature of training sessions was also reported to make it difficult for team members to fully engage and consolidate their learning. Berry et al. (2017) identified similar issues, noting that time pressures could be a barrier to participation in reflective rounds. One team member admitted, “I know at times I had on my mind how much longer because I’ve got x, y, and z to do. It might have been that it was just before the end of my shift and I had three other things to do sometimes that played on your mind while you’re doing it” (Berry et al., 2017, p. 1220). Waller et al. (2015) also reported that organising supervision sessions was often challenging due to other conflicting time commitments. In addition, not all team members fully understood the purpose of supervision, which limited engagement and uptake.

Discussion

The findings of this systematic review highlight the positive and wide-ranging impact of indirect work carried out by clinical psychologists within multidisciplinary teams. The reviewed studies suggest that indirect interventions such as reflective practice, consultation, supervision, and training contribute to the development of team cohesion, empathy, clinical reasoning, and clinical skills. Reflective practice, as described by Baker et al. (2021), was found to strengthen working relationships and deepen understanding of team members' roles. This finding is consistent with Thompson et al. (2008), who found that training sessions not only enhanced clinical practice but also promoted a shared language and model across the team. Together, these findings suggest that reflective practice and training can foster a supportive environment where team members feel more connected and aligned in their clinical approaches. The development of greater understanding and empathy toward service users also emerged as a significant outcome of indirect work. Murphy et al. (2013) found that training and formulation sessions helped increase empathy among team members, particularly when staff felt 'stuck' in their clinical approaches. Similarly, Berry et al. (2017) observed that team formulation sessions deepened team members' understanding of service users, positively influencing therapeutic relationships. These insights align with wider literature on the value of psychological formulation, from the perspective of clinical psychologists, which emphasises the importance of developing a comprehensive understanding of service users' difficulties when planning care (Johnstone, 2015; Johnstone, 2017).

Indirect work was also found to support the development of clinical skills, contributing to positive changes in practice. Douglas and Benson (2015) reported that psychosocial forums not only facilitated care planning but also helped team members develop skills to manage complex clinical situations. Stimpson et al. (2013) similarly found that supervision offered a valuable space for advice, support, and feedback, contributing to the growth of skills and confidence among staff. However, the implementation of indirect interventions was not without challenges. Several studies identified significant barriers, including time constraints and competing demands. Steele et al. (2021) noted that the time-consuming nature of psychological

approaches sometimes led team members to prefer quicker, medication-based solutions. Similarly, Murphy et al. (2013) highlighted that lack of protected time and competing priorities often obstructed engagement with training sessions. These findings point to the need for organisational support and adequate allocation of resources to ensure that indirect interventions can be successfully embedded within teams. Managerial support also emerged as a critical factor in overcoming resistance and promoting engagement with indirect work (Berry et al., 2017; Steele et al., 2021). Leadership was identified as essential for fostering a culture of openness to psychological thinking within multidisciplinary teams, a finding that echoes broader guidance within the profession (BPS, 2019; Onyett, 2007).

Limitations

While this review offers valuable insights into the role and impact of clinical psychologists' indirect work within multidisciplinary teams, several limitations must be acknowledged. First, potential biases introduced by the relationship between researchers and participants were not consistently considered across the included studies. For example, Murphy et al. (2013) did not fully explore the possibility that pre-existing professional relationships could have influenced data collection and interpretation. Similarly, reflexivity was not thoroughly addressed in all studies; Baker et al. (2021), for instance, lacked a comprehensive analysis of researcher bias, which may have impacted the validity of the findings. Ethical considerations represented another area of concern. Several studies failed to provide detailed accounts of their ethical procedures, raising questions about the overall rigour of their methods. There was also notable variability in the contexts, settings, and types of indirect work explored across studies. While this diversity offers a broad perspective, it limits the extent to which conclusions can be generalised across all multidisciplinary teams.

Despite a thorough search and screening process, it is possible that relevant studies were missed. The review was restricted to studies conducted in the UK and published in English. While this decision aligns with professional guidance from the BPS, DCP, and NHS, it may have excluded valuable perspectives from international or non-English language studies. As a result, the findings are specific to the UK and may not be generalisable to other countries.

Variations in the quality of the included studies, particularly regarding the rigour or data analysis and attention to ethical issues, also affect the strength of the review's conclusions. The selected timeframe presents a further limitation. Although the review focused on studies published following the release of key professional guidance (Onyett, 2007), earlier relevant studies may have been overlooked. Finally, this review was conducted by a single researcher, which may have introduced bias during the analysis and synthesis of themes. The researcher's background and experience as a member of a multidisciplinary team working indirectly with clinical psychologists may have influenced the interpretation of the findings.

Research Recommendations

As part of this review, a grey literature search was conducted; however, no additional studies meeting the inclusion criteria were identified. While this eliminated the potential for publication bias, it also highlighted a significant gap in the existing literature. The scarcity of relevant studies emphasises the need for more focused research in this area. Future research should aim to broaden the evidence base regarding the impact and outcomes of indirect work conducted by clinical psychologists across a wider variety of healthcare settings and multidisciplinary teams. Including perspectives from a broader range of healthcare professionals and service contexts could help capture more diverse experiences and highlight challenges associated with indirect work in different contexts. In addition, it would be valuable to investigate monodisciplinary perspectives and explore whether certain disciplines experience indirect work with clinical psychologists differently, as some disciplines may be more receptive than others to psychological approaches. There is also a need for more longitudinal research tracking the longer-term impact of indirect work within multidisciplinary teams. Such studies could provide important insights into the sustained effects and potential benefits of these interventions over time. Finally, future research should evaluate the organisational and systemic factors that facilitate, or hinder, the implementation of indirect work. A deeper understanding of the role of managerial support, resource allocation, and organisational culture could help identify strategies to overcome barriers and enhance the effectiveness and reach of psychological input within teams.

Clinical Implications and Recommendations for Practice

- Lack of protected time and competing priorities are significant barriers to engaging with indirect interventions. Services should ensure that adequate resources are allocated and that protected time is built into staff roles to support the successful implementation of indirect psychological work.
- Leadership and management support are crucial for overcoming resistance, encouraging greater uptake of psychologically informed approaches, and fostering a culture of openness to psychological thinking within multidisciplinary teams.
- Clinical psychologists should collaborate closely with team leaders. Strengthening psychologists' influence at a systemic level is key to sustaining engagement with indirect interventions.

Conclusion

This review highlights the significant and wide-ranging impact of clinical psychologists' indirect work on multidisciplinary team dynamics, the development of clinical skills, and the enhancement of empathy toward service users. Indirect interventions, such as consultation, supervision, reflective practice, and training were associated with improved working relationships and team cohesion, increased understanding of roles and team dynamics, greater empathy and deeper understanding of service users, and development of clinical skills and confidence. However, the implementation of indirect interventions is often constrained by systemic barriers such as time pressures, competing priorities, and limited understanding of the role, scope and intended purpose of indirect interventions among team members and managers. The findings emphasise the need for organisational support, adequate allocation of resources, and consistent managerial backing to overcome these challenges and enable the successful and sustainable integration of indirect psychological work. Strengthening leadership roles for clinical psychologists and fostering closer collaboration with team leaders are also essential for promoting a culture of openness to psychological thinking within multidisciplinary teams and embedding psychologically informed ways of working. Future research should aim to broaden the evidence base by including a wider range of healthcare settings and professional perspectives. Longitudinal studies are needed to explore the sustained impact and outcomes of indirect work over time, and further investigation is warranted into the organisational and systemic factors that support or hinder its effective.

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Paper Two: Empirical Paper

Shaping Psychologically Informed Community Mental Health Teams: A Grounded Theory of How Clinical Psychologists Influence Practice

Word Count: 7,998

This Paper has been prepared in the style of articles published in the Journal of Psychology and Psychotherapy: Theory, Research and Practice, the intended journal for publication. Additional material, included to meet academic requirements, will be removed prior to final submission. The journal's publication guidelines are provided in Appendix A.

Abstract

Introduction: National policy promotes trauma-informed, formulation-led care in NHS mental health services, positioning clinical psychologists as key to promoting psychologically informed practice. However, specific guidance for achieving this in Community Mental Health Teams (CMHTs) is lacking. This study addresses that gap by conceptualising how clinical psychologists influence CMHT Multidisciplinary Teams (MDTs) to become more psychologically informed.

Method: A qualitative design, underpinned by Critical Constructivist Grounded Theory (CCGT) was adopted. Twelve clinical psychologists with CMHT experience were interviewed using semi-structured interviews. Data was analysed to generate a theory and conceptual model, reviewed through member checking to enhance validity.

Results: A conceptual model of psychological influence was developed, with relational security emerging as the core category. Influence is thought to be most effective within the Zone of Proximal Development (ZPD) of MDT staff and systems, adapting responsively to systemic constraints.

Conclusion: The research offers original knowledge by shifting the focus from what clinical psychologists do to influence, to how it is done. It highlights relational attunement and systemic awareness, providing insights for practice, policy, and training.

Practitioner Points:

- Build relational security by being visible, approachable, and fostering collaboration with team members and managers
- Tailor influence using the ZPD by introducing ideas gradually, scaffolding skills, and targeting areas of openness to change
- Respond constructively to resistance through validation, reducing hierarchical barriers and pacing input
- Enhance systemic influence by engaging in decision-making and leadership roles

- Embed this knowledge in clinical psychology training through guidance on integration, relational security, and consideration of staff's ZPD
- Policy should reflect CMHT resource constraints and the relational work required for change

Keywords: Community mental health team, multidisciplinary team, clinical psychologist, indirect work, influence, relational security

Introduction

The role of clinical psychologists in community mental health multidisciplinary teams (CMHT MDTs) has evolved significantly in recent decades. Increasingly, their focus has shifted beyond delivering direct therapeutic work toward making more indirect contributions by consulting, supervising, training, facilitating reflective practice, and team formulation (Onyett, 2007). Through their doctoral training, clinical psychologists develop competencies in applying psychological theory, with skills in formulation, intervention, research, and critical evaluation (BPS, 2024). This specialist training enables them to influence thinking and decision-making across systems, supporting colleagues from other disciplines to embed psychological perspectives into their practice (BPS, 2024; DCP, 2010). This shift reflects broader UK policy changes in mental health services encouraging psychologists to adopt leadership roles and influence service cultures, aiming to move services away from the traditionally dominant medical model toward trauma-informed approaches (NHS England, 2019a, 2019b).

Research on formulation (Berry et al., 2017; Christofides et al., 2011; Donaghay-Spire et al., 2016; Kramarz et al., 2022; Mohtashemi et al., 2018; Riches et al., 2024), consultation (Douglas & Benson, 2015; Murphy et al., 2013), supervision, (Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015), reflective practice (Baker et al., 2021; Donaghay-Spire et al., 2016; Heneghan et al., 2014), and training (Steele et al., 2021; Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015) demonstrates that indirect work offers various benefits to multidisciplinary teams, although challenges remain. A systematic review of the literature exploring MDT members' perspectives found that indirect work improves working relationships, team cohesion, empathy toward service users, clinical skills and practice. However, barriers such as time constraints, a preference for fast-acting medicalised approaches, lack of managerial support, competing demands, and uncertainty around psychologists' roles were also identified (Cosentino, 2025). Studies exploring indirect work from psychologists' perspective similarly highlight both benefits and challenges. Christofides et al. (2011) found that formulation was mostly carried out informally, with the level of explicitness adapted based on staff experience and service context. Although valued, these contributions were not

acknowledged by management. In Heneghan et al. (2014), reflective practice groups were seen as valuable for team cohesion and promoting psychological perspectives, but effectiveness depended on engagement levels and managerial support. Riches et al. (2024) similarly found that team formulation fostered psychological mindedness, although inconsistent attendance, unclear expectations, and resource limitations constrained its overall impact.

Recent national policy, such as the NHS Long Term Plan (NHS England, 2019a) and Community Mental Health Framework (NHS England, 2019b), emphasises expanding access to personalised, trauma-informed, formulation-led care. However, CMHTs have received little guidance on how to operationalise these ambitions. In contrast to specialist teams, such as early intervention in psychosis and eating disorder services, CMHTs lack clear frameworks, leaving psychologists' roles poorly defined. These teams continue to operate within biomedical paradigms focused on diagnosis and pharmaceutical interventions (Cooke, 2017), contributing to a culture where psychological work is deprioritised, and protected time for training is limited (Couldwell & Stickley, 2007). Although clinical psychologists are uniquely positioned to lead this transformation, the cultural shift is substantial and complex (Brabban & Tiplady, 2024). While existing research highlights the benefits and challenges of indirect work, less is known about the process through which clinical psychologists build influence within CMHTs and foster psychologically informed cultures. This study addresses that gap by exploring how clinical psychologists integrate into CMHTs, grow influence, and promote psychologically informed practice. By conceptualising this process, the research aims to inform the development of clearer guidance, training pathways, and service-level strategies to better equip psychologists to lead cultural change and translate national policy ambitions into practice.

Aims of the Research

The aim of this research is to conceptualise the process by which clinical psychologists integrate into CMHTs to influence the practice of colleagues from other disciplines and support the development of more psychologically informed ways of working. Specifically, it explores how psychologists shape team culture and promote psychological ways of understanding, thinking, and working. The knowledge generated can inform the development of evidence-

based guidance, training, and service-level strategies to better equip clinical psychologists to lead cultural change within CMHTs.

Methodology

A qualitative research design, underpinned by grounded theory (GT) methodology, was chosen for this study. GT offers a systematic yet flexible approach for developing theory directly from data, allowing researchers to explore patterns, processes, and relationships as they emerge within specific contexts (Strauss & Corbin, 1998). GT is particularly well suited to research in areas where processes are poorly understood and new conceptual frameworks are needed (Schreiber, 2001), especially when shaped by structural and interpersonal systems (Glaser & Strauss, 1967). Constructivist GT recognises that data and analysis are co-constructed through the interaction between researcher and participants, and shaped by social context, the researcher's perspectives, assumptions, and reflexive engagement (Charmaz, 2014). Theory is therefore positioned as an interpretation, contingent on the researcher's stance and involvement in the process, rather than as an objective representation of events. More specifically, this study adopts a Critical Constructivist GT (CCGT) approach (Levitt, 2021), embedding a critical lens throughout the research process. CCGT ensures that power relations, ideology, and systemic inequalities are explicitly interrogated. It encourages researchers to explore how processes develop interpersonally, and to examine how experiences are shaped by systemic privilege, oppression, and broader contextual dynamics. This approach was particularly well suited to the research question, which sought to understand how clinical psychologists influence the culture of MDTs – an inherently relational and socially embedded process within organisations shaped by ideology and social norms. CCGT enabled the development of a theory that not only conceptualises the influencing process, but also critically examines and challenges the social and systemic structures that shape it.

Epistemological Position

This research adopts an epistemological stance that merges critical realism with critical constructivism (Bogna et al., 2020), forming a dialectical position. Critical realism argues that material and organisational forces, such as funding structures and professional hierarchies, exist independently of individual meaning-making and act as causal mechanisms that shape the

conditions within which individuals operate (Bhaskar, 1975). Critical constructivism complements this by recognising that meaning is socially constructed through interaction, shaped by culture and language (Vygotsky, 1978), while also attending to how power relations and systemic ideologies constrain and influence the construction of meaning (Kincheloe, 2008; Levitt, 2021). These material forces and social processes are understood to exist in a dialectical relationship, where structures shape meaning-making, but meaning-making simultaneously contributes to the reproduction or challenge of those structures (Bhaskar, 1993; Hegel, 1998). This dialectical stance supports a research process that highlights contradictions, promotes critical reflection, and identifies opportunities for systemic change.

Participants and Recruitment

A purposive sampling strategy was used to recruit clinical psychologists who had worked in UK-based CMHT MDTs for at least six months. This inclusion criteria ensured that participants were sufficiently familiar with team structures and dynamics. However, they did not need to be actively employed in a CMHT at the time of interview. An advert (see Appendix C) was shared on social media platforms (Facebook, Instagram, and LinkedIn), and circulated by email via personal and professional contacts, encouraging a snowball effect. Those who expressed interest were emailed a participant information sheet (see Appendix D) and a consent form (see Appendix E), and interviews were conducted once the consent form had been signed. Between November 2024 and March 2025, twelve clinical psychologists were interviewed. Recruitment stopped when no new insights emerged. This sample size aligns with guidance suggesting that twelve participants are often sufficient to identify key themes within homogeneous samples (Guest et al., 2006). Collectively, participants contributed over 130 years of experience across 26 CMHTs, with practice spanning from the late 1990s to the present. Although level of seniority varied, several participants in more senior positions reflected on their experience of working in CMHTs at more junior levels, allowing the study to capture insights across different stages of professional development. A summary of participant characteristics is presented in Table 1 below.

Table 1

Participant Characteristics (N = 12)

Characteristic	Category	(n)
Geographic region	South West	5
	North West	4
	West Midlands	2
	Yorkshire	1
Age group	30s	6
	40s	3
	50s	3
Gender	Female	10
	Male	2
Ethnicity	White British	11
	White Irish	1
Professional seniority	Consultant	2
	Principle	3
	Senior	6
	Main grade	1

Data Collection and Analysis

Data was collected through semi-structured interviews conducted on Microsoft Teams. In line with grounded theory methodology, the interview schedule evolved in response to emerging insights (Corbin & Strauss, 2015). Interviews were recorded using Microsoft Teams'

inbuilt transcription feature. After each interview, transcripts were reviewed for accuracy, anonymised, and uploaded to NVivo for analysis. Data collection and analysis occurred concurrently, allowing insights from earlier interviews to guide subsequent questioning (see Appendix F for a list of interview prompts). During initial coding, transcripts were broken down into discrete units of meaning, which were compared within and across interviews to form initial categories (see Appendix G for an example of a coded transcript page). Axial coding followed, establishing connections between categories and subcategories to develop a conceptual framework (Corbin & Strauss, 2015) (see Appendix H for examples of notes made during coding). Recruitment and interviews continued until theoretical saturation was reached. By the twelfth interview no new insights emerged and all new data aligned with existing categories (Glaser & Strauss, 1967). As a novice qualitative researcher, the data analysis procedure outlined by Corbin and Strauss (2015) was preferable due to its clearly defined and systematic steps. While Corbin and Strauss (2015) are not typically associated with constructivism, their approach remains compatible, as it acknowledges the researcher's role in shaping the emerging theory (Cullen & Brennan, 2021; Hunter et al., 2011).

Scientific Rigour

Although GT embeds rigour through systematic procedures (Glaser & Strauss, 1967), guidelines from Charmaz and Thornberg (2020) and Levitt (2021) informed planning and enhanced rigour. Methodological self-consciousness was achieved (Charmaz, 2017) through reflection on epistemological assumptions, immersion in the method, and regular supervision. A critical review of literature, in line with CCGT, increased theoretical sensitivity. Memo writing captured early observations, monitored saturation, and informed category development. Memos also supported reflexivity by encouraging reflection on relational dynamics between researcher and participants, often forming the basis for supervision discussions (see Appendix I). When data collection and analysis ended, the study was evaluated against Charmaz's (2014) constructivist criteria: credibility, originality, resonance, and usefulness. Credibility was supported by theoretical saturation, as no new categories emerged in the final two interviews. Theoretical coherence was illustrated diagrammatically, and participant quotations evidenced

claims. Originality lies in addressing an underexplored question and developing a conceptual framework illuminating interpersonal and systemic processes shaping psychological influence in MDTs, with implications for policy and practice. Resonance was assessed through member-checking, as the topic was considered accessible to participants, enabling sense-making alongside the researcher (Motulsky, 2021). Within a CCGT approach, member-checking also aimed to identify conceptual limitations (Levitt, 2021). Five participants provided feedback, noting that the model captured aspects they had not explicitly mentioned yet recognised as consistent with their experience. This indicates that the theory encompasses insights resonating beyond individual accounts. Finally, the usefulness lies in generating of practical recommendations for clinicians and policymakers, and directions for future research.

Reflexivity

Reflexivity was central to this study. With ten years of prior experience working in MDTs as an occupational therapist, the researcher's own practice had been shaped to varying degrees by the clinical psychologists she worked alongside. Those who were most influential played a key role in shaping her interest in this topic and her commitment to promoting psychologically informed care. The researcher also acknowledges personal frustration with the underfunding of NHS services. To enhance reflexive rigour with this single-researcher study, the researcher engaged in fifteen supervision sessions and maintained regular reflexive memos throughout the research process (Olmos-Vega et al., 2023). Following the development of the emergent theory, participants were invited to review the findings and share divergent views, ensuring the final theory reflected participants' experiences rather than being shaped primarily by the researcher's preconceptions.

Ethics

Ethical approval was granted by the University of Staffordshire Research and Ethics Committee (see Appendix J). All participants were provided with a participant Information sheet and consent form before agreeing to take part. These documents clearly outlined the purpose of the study, what participation would involve, and participants' right to withdraw

from the study at any time prior to, during, or up to one week following the completion of their interview. Informed consent was obtained from all participants before data collection commenced. To protect participant anonymity, pseudonyms were used in all interview transcripts, and any identifying information, such as names and locations, was removed or anonymised during transcription. Following each interview, participants were offered the opportunity to engage in an informal debrief. This provided a space for participants to reflect on their experiences of the interview and address any emotional responses that may have arisen. Furthermore, the participant information sheet included details of support services, in the eventuality of participants needing them. These ethical measures were designed to safeguard participants' rights, privacy and emotional wellbeing, in accordance with the BPS Code of Human Research Ethics (BPS, 2021).

Results

The final hierarchy of codes emerged through a six-month process of constant comparison and refinement, until no new insights were generated (see Appendix K for an extract from the final hierarchy of codes). The categories and subcategories that emerged are outlined in Table 2 below.

Table 2

Categories and Subcategories

Category	Subcategories
• Understanding the wider context	• Systemic pressure and emotional strain • 'Quick fix' medicalised culture • Legacy of disciplinary divisions
• Working within the zone of proximal development	• Drip feed and create a ripple • Space to slow down and think • Identify and fill gaps
• Relational security	• Be physically visible and available • Collaborate and build alliances • Validate and reduce threat

Understanding the Wider Context

Participants described working in CMHTs, and a broader NHS system, shaped by political, financial and cultural pressures. These systemic influences create barriers to psychologists' attempts to integrate and promote psychological thinking within their teams, placing them in a double bind of wanting to influence practice yet constrained by systems fundamentally misaligned with psychological principles and perspectives.

Systemic Pressure and Emotional Strain

Participants emphasised that the challenge of integrating psychological approaches is deeply rooted in systemic dynamics, primarily political and financial pressure that prioritise performance targets over psychologically informed care.

*"There was lots of political pressure. It floats down to NHS England, down to us, and down to me being given a load of s**t about my waiting lists when, at the time, I was the only psychologist for our whole pathway. At that point, it's not about trauma-informed care. It's about targets and people being shouted at by politicians."* (Samantha, 210-214).

The emphasis on quantifiable outcomes forces psychologists into an ongoing struggle to demonstrate their value within a system that prioritises direct clinical contacts, often undermining the broader contributions made through indirect work.

"We're in this dance of, 'We think you're worthy, but you need to demonstrate your worth. People seem to really want you around, but you can't prove that you're useful. How many people are you seeing?' There's a double bind that's being experienced on several layers in the organisation." (Rafael, 148-151).

The pressure to perform, experienced by both psychologists and MDT colleagues, is compounded by the emotionally demanding nature of the work itself. Participants described systems and teams that are traumatised by the emotional toll of repeatedly having to deny people access to appropriate support due to limited resources.

"'Sorry, we're not going to offer you anything'. That's a very painful business. As clinical psychologists we're trying to help formulate, to understand all behaviour as an attempt at survival, but maybe that's hard. Maybe it's easier to label people as 'antisocial PD' or 'drug user', to avoid thinking about trauma and survive signposting to something that isn't really adequate. It's harder to turn people away if we think of them as doing the best they can to survive life." (Judith, 109-114).

The emotional strain of being exposed to distress on a daily basis impacts staff wellbeing, fundamentally limiting their capacity to reflect and engage with psychological approaches.

"On a very basic level, it's difficult to witness and be in contact with pain every day. The normal response is to detach or avoid. The system doesn't set itself up to think about the effect on us, to think about vicarious trauma. There's no space for it. It's hard to be vulnerable." (Chloe, 116-119).

"It's hard to take on new things when people are already dealing with multiple things and their headspace is full, on an emotional level as well." (Beatrice, 93-95).

Across accounts, participants explained that the combination of systemic pressure and emotional strain can restrict MDT members' ability to engage with psychological ideas and skills development, as well as psychologists' ability to influence practice.

'Quick Fix' Medicalised Culture

The pervasive dominance of the medical model within CMHTs, and how deeply embedded it is across systemic structures and culture, presents another major obstacle. Many participants described the system as intrinsically geared toward diagnosis, prescriptive interventions, and localising problems within individuals.

"The ultimate barrier is that we work within a system that's medical model dominated. You cannot get away from that." (Susan, 231-232).

Participants highlighted a broader socio-cultural expectation for definitive assessments and prescriptive solutions, which contributes to the ongoing tensions between psychological and psychiatric paradigms in CMHTs.

"Society wants us to be making definitive assessments and predictions about people, where we want to be more open minded about possibilities. Psychological thinking is about continua, it's about uncertainty and change. Psychiatry is a bit more about labelling and certainty, 'This person has this disorder and the prognosis is that'" (Judith, 137-141).

Participants also discussed societal and systemic structures, such as giving psychiatrists clinical responsibility and financial privileges, which reinforce the medical model and give rise to hierarchical dynamics that devalue psychology.

"It's disappointing that, still, we don't have psychologists in formal positions on boards. That's a very clear message that psychology's still an add-on in the NHS. It's not core business." (Susan, 238-241).

"When a trust employs a medical professional to oversee all its psychological professionals there's something very telling about who's got permission to have power and influence, and where value is placed." (Katie, 89-92).

Additionally, participants spoke about the societal expectation that mental health difficulties can be addressed through quick, prescriptive, medication-based solutions. They noted that this expectation is also reflected within CMHTs, where some participants feel that staff can become frustrated by the slower, relational nature of psychological approaches compared to faster-acting, medication-based interventions.

"People come into the service and expect medication. It's endemic within our culture that we look for the answers as, 'what's wrong with me, and how do I fix that?'" (Ellie, 348-350).

"There was a mixture of wanting to be trained, but also wanting to fix people without that underlying, 'you can't do it quickly'" (Samantha, 54-55).

Legacy of Disciplinary Divisions

Participants identified the historical division between psychology and other disciplines as an ongoing barrier. Historically, psychologists worked separately, rather than collaboratively, within CMHTs.

"It felt like a psychology department. We would take referrals from the CMHT, and directly from GPs." (Nancy, 5-7).

Many participants reflected that this legacy of separation may be influencing how they are perceived by MDT staff. Some described a concern that they are viewed as elitist or aloof, having historically been seen as working in ivory towers.

"There is often this rhetoric around psychologists being in ivory towers because we are paid at a higher banding, and trainees are at a higher banding. There was, and to a degree still is, this perception of status that has created distance between ourselves and the rest of the MDT." (Anna, 10-13).

Participants reported that these perceptions can make attempts at integration and influence feel threatening, provoking resistance or pressure to conform to existing team cultures.

"When a psychologist comes in and tries to bring a mind to some of what is happening and agitate the system to work differently, it's really threatening. 'You've not been here long enough. You don't get it! Who do you think you are?' The system tries in different ways to force you to fit in." (Katie, 319-322).

In many cases, this resistance is expressed through professional territorialism, with psychological skills and perspectives seemingly perceived as a threat to staff's professional identities.

"We get nurses who aren't on board, who will say, 'I just want to practice as a nurse'. We'll have OTs saying, 'I feel like I'm losing my professional identity'. It's almost resentment toward anything that has the word psychology in it. That's a massive hinderance. The word psychology feels very sensitive, very loaded." (Anna, 223-227).

Nevertheless, participants have observed a gradual shift in culture, particularly among newly qualified staff. Unlike more experienced colleagues, who predominantly trained within the medical model and are less familiar with psychological approaches, newer staff are entering MDTs where psychologists are already embedded. As a result, they are less resistant to psychological perspectives and more open to developing new skills.

"For the new people coming in, that's the starting point. That's the culture. That's what we do here." (Nancy, 208-209).

Working Within the Zone of Proximal Development

Participants described how widening the reach of psychological thinking in CMHTs requires careful attunement to the readiness and limits of staff, teams, systems, and themselves. Rather than forcing change, psychologists work within their own Zone of Proximal Development (ZPD; Vygotsky 1978) and that of systems and individuals, offering appropriately paced, scaffolded support to gradually cultivate psychological understanding and influence. Participants explained that the ambitions of psychological influence often conflict with the realities of NHS structures and cultures. The desire to embed psychologically informed ways of thinking can clash with organisational priorities and the reactive, task-oriented focus of CMHTs. Attempting to influence beyond the team or organisation's ZPD is counterproductive, generating resistance, emotional burnout, and disengagement.

"There's a tension between what the CMHT staff might want, and what we want. That can inhibit how much we're able to influence the psychological thinking in the team." (Chloe, 43-45).

This tension, between the ambitions of psychological influence and the reality of the system, is particularly apparent in MDT meetings, where diagnosis-driven discussions dominate, and space for psychological thinking is constrained.

"It's very medically driven. A NICE Guidelines type approach of, 'this person has this diagnosis, and we need to give them this'. When I attend the MDT meetings, I feel like I'm battling against that medical, psychiatrist led model." (James, 5-7).

Participants also highlighted a disconnect between the ambitions of national frameworks and financial realities. While BPS and NHS documents promote trauma-informed, psychologically led care, these aspirations are often constrained by limited funding and capacity on the ground.

"There is this gap between what the guidance says, and all the limitations of the NHS trusts. Funding, primarily. 'We'd love to, but we can't. There's no money.' That's the bottom line." (Anna, 67-69).

In light of these tensions, participants described adopting pragmatic approaches, tailoring their influence to meet individuals and teams where they are emotionally and developmentally. This involves adjusting pace, language, and depth of theoretical content to match staff's readiness.

"Working within their zone of proximal development. That's the key. Sometimes there's a lot of theoretical language and colleagues switch off if you're not meeting them where they're at and then gradually growing." (Ellie, 147-149).

Offering psychologically informed perspectives in small, scaffolded steps is seen as vital given staff's limited emotional and cognitive capacities.

"Everyone has different levels of comfort with thinking or working psychologically. I try to hold that in mind when working with staff members – what their point of reference, window of tolerance, and zone of proximal development is, and how I can scaffold them to build psychological thinking." (Chloe, 60-63).

Participants also described focusing energy where change is most possible, prioritising work with colleagues who are more receptive, rather than pushing against resistance.

"There's a person I spent an hour with going through the idea of personality disorder formulation, and she still just goes, 'They're very PD'. She really likes that phrase, medicalising them. It's picking who, and when." (Samantha, 263-265).

Similarly, participants spoke of monitoring shifts in the wider system and aligning their efforts with organisational priorities.

"You have to know where the discussions are, what the trusts are talking about and then see where the opportunities are. I end up seeing what changes are happening, systemically, that I can hook onto and ride through, and see if we can get some changes and shifts there." (Ellie, 453-456).

Others framed this approach in terms of strategic compromise, aimed at conserving energy and ensuring psychological influence is sustainable over time.

"We work in a very powerful system. It's that radical acceptance of 'this bit I cannot change. What's the stuff I can change? What going to be effective?'. Sometimes it's saying, 'this is the way the wind is blowing right now. I'm going to have to tack with it because it's just too exhausting'. If you capsize your boat you're buggered." (Samantha, 315-319).

Drip Feed and Create a Ripple

A widely used approach described by participants is to drip feed psychological thinking. Psychologists introduce psychological perspectives gradually and consistently in ways that are manageable and non-threatening, aiming to create a ripple effect that continues beyond their direct involvement.

"I am always trying to drop bits of psychoed into the wider conversation." (Samantha, 179-180).

"The more opportunities you take to introduce a different perspective, the more likely people are to talk about it, and then shift happens." (Rafael, 24-26).

"Being quite tenacious, repeating very steadily. Having your end goal in sight, but very steadily influencing things." (Susan, 200-201).

"My hope and intention is to support the whole team so, even if a patient isn't directly seeing a psychologist, they're having a psychological perspective within their care." (Hannah, 45-47).

Several participants also highlighted the strategic importance of targeting team leaders and senior clinicians, who have a ripple effect of their own on team culture and can encourage greater staff buy-in.

"The seniors, including the medics, have quite a lot of power in creating a culture that sees psychological thinking as a strength. Having buy-in at that level will filter down." (Chloe, 161-163).

Space to Slow Down and Think

Participants highlighted that staff function under intense pressure, often relying on prescriptive guidelines and quick decision-making. Psychologists, therefore, work to slow down the pace of discussions and carve out time and opportunities for psychologically informed thinking.

"Getting people to slow things down a bit. Rather than wanting the outcome, or what the intervention was going to be, trying to think about the formulation and creating space for the MDT member to think about their reactions and feelings." (Beatrice, 141-144).

Most opportunities for this are informally initiated through office conversations or arranged as follow-ups outside of the fast-paced nature of MDT meetings.

"Sometimes I message people separately to say, 'could I link in with you about that case that you brought [to the MDT meeting]?' or suggest a formulation session." (Hannah, 86-87).

Other opportunities are more structured, such as replacing the traditional psychology referrals model with one-to-one consultation spaces.

"They used to be called referral slots, which is basically saying, 'come to this if you want to discuss referring someone to psychology'. I've changed it to consultation slot because we might decide to offer a psychological therapy, but it's a slot to come and talk to a psychologist and think together about a psychological point of view." (Nancy, 173-177).

For these spaces to be engaged with and well attended, participants emphasised the importance of management support, both culturally and practically.

"Making sure that everyone's on board, in terms of management supporting and carving out time in people's diaries. Making sure people have protected time – practical support." (Beatrice, 88-90).

Some participants insightfully reflected that their own ZPD, or capacity to influence, was at times limited by contextual pressures, and that they too needed space to slow down and think.

"The MDT meetings are pretty busy; there's not always time to slow down. You're maybe more stressed and overwhelmed because of how fast it is." (Chloe, 70-71).

Identify and Fill Gaps

Participants described identifying and filling gaps across the workforce and wider system as a key part of the influencing process. These efforts serve as a form of systemic scaffolding to strategically support and grow the influence of psychological thinking. Several participants highlighted the importance of having psychologists embedded at all levels of the organisational structure. For psychological thinking to be integrated across the system, participants stressed the need for a ladder of psychologists who can provide leadership and support, not only to MDT colleagues and operational leads, but also to psychologists in more junior positions.

"Psychologists prefer to move into jobs where there is a consultant, a principle and a senior so you've got the structure for development, career progression and support." (Anna, 54-56).

"In this pattern of upward promoting internally and not caring what vacancy is left behind, the infrastructure is not there - you're never going to get change at a bigger level." (Katie, 338-340).

Another strategy described is to identify and fill gaps in psychological representation within decision-making spaces.

"How do we work within a system that is medically dominated? By getting ourselves into all the meetings that we can." (Ellie, 300-301).

These meetings were also seen as opportunities to identify further systemic gaps that might otherwise go unnoticed.

"The MDT meeting feeds into my own thinking on a strategic level, highlighting the gaps within the service." (Hannah, 95-96).

Participants emphasised the importance of representation at senior decision-making levels, to ensure that the value of indirect psychological work is recognised, as it is often not appreciated or understood.

"Where we really benefit, is from having psychologists in those meetings higher up […] addressing that to people who may not always be fully aware and able to appreciate the extra stuff, the other stuff that is core." (Susan, 273-277).

Participants also stressed the importance of having a psychological presence at all stages of the clinical pathway to scaffold psychologically informed conversations, shape pathways, and influence practice.

"Making sure that psychologists are there, at every stage of a patient's journey. It's important for us to be at the assessment, looking at referrals, being there when decisions are made." (Susan, 362-364).

Finally, participants described identifying and filling gaps in the psychological skillset of MDT colleagues. This includes conducting skills audits to map existing competencies against service priorities and designing training that aligns with both service needs and staff development.

"I've been able to do a skills audit, then share and look through it with the collective leads. 'These are the skills that people have got. These are the interventions that we want to offer. Who's going to offer those? How can we support them? What kind of training is needed?'" (Susan, 170-174).

Relational Security

Relational security was described by participants as the foundation for integration and influence in CMHTs. Rather than relying on professional status or expertise, the ability to build trust, create emotional safety, and foster collaborative relationships is fundamental to embedding psychological thinking. Across interviews, participants consistently emphasised that influence is dependent on the quality of everyday interactions and relationships with team members and senior leadership.

"I have this urge to tell you all the things that I do, like team formulations and consultation meetings, that encourage people to think differently. It's interesting that I want to

present all my tangible outcomes, because the real difference in changing the culture of the team is just existing." (Rafael, 289-292).

Be Physically Visible and Available

Relational security is fostered through psychologists' physical presence in the daily life of the team. All participants reflected on the importance of being visible and available within team spaces, by choosing to sit in shared offices and spend time in communal areas.

"You absolutely need to be alongside and available to people. I was quite quick to plonk myself in a room with other professionals." (Hannah, 21-23).

"Being visible in the office, in the kitchen, before the meetings, in the meetings, and after the meetings has really helped." (Chloe, 28-30).

Several participants described how sharing an office and interacting informally helps to build the foundation for psychological influence. Being a visible, trusted presence within the team is seen as offering opportunities that are more difficult to come across when only offering indirect sessions.

"It creates a relational context within which all sorts of other stuff can be processed. It helps to build trust, open communication, and approachability." (Judith, 18-20).

"Building relationships informally, as well as offering consultations or being present at MDTs and sharing those views." (Beatrice, 100-101).

Collaborate and Build Alliances

Participants emphasised that influence occurs through trust-based collaboration, not only with staff, but also with leadership.

"Being very skilful in how we build relationships with the other senior people in the team, how we build trust, and make developments in a collaborative way rather than a conflictual way." (Judith, 79-81).

"Just seeing that we were willing to be alongside them with the complex work, to struggle and be alongside them made a massive difference." (Susan,103-105).

Building collaborative relationships with senior colleagues, allows psychologists to advocate for greater recognition and resourcing for the less tangible aspects of their role.

"On the ground, people really appreciate that work and see the benefit of it. Translating that for people higher up really relies on a good relationship between the more senior psychologists and the heads of services." (Susan, 279-281).

Validate and Reduce Threat

Many participants described how psychological input can initially be perceived as threatening. Reducing this threat by validating staff efforts and struggles is seen as crucial to supporting integration and influence.

"They're doing their best. Naming and validating that reduces the battle a little bit. It can be really helpful to just give validation to the staff member, 'It sounds like it's been really hard to work with this person'" (Chloe, 79-81).

Participants also reflected on how they intentionally present themselves within the team, choosing not to use their doctor titles and avoiding assertions of expertise, in order to maximise approachability and reduce barriers.

"Psychologists are called by their first names. We're never referred to as 'doctor so and so'. I never refer to myself as that. We're about decreasing barriers." (Samantha, 292-294).

Conceptual Model

The dynamic interplay between wider contextual forces and the process of psychological influence is illustrated in a conceptual model in Figure 1, below.

Figure 1

Conceptual Model of Psychological Influence in CMHTs

Relational security, shown in white at the centre of the model, forms the core upon which psychological influence depends. The surrounding light blue area represents the ZPD, where key influencing processes take place. Encircling this, the dark blue outer layer reflects the wider context, comprising the structural and cultural forces that shape practice within CMHTs and can constrain psychologically informed work. The arrows in the model reflect both the dynamic, adaptive nature of psychological influence and the tensions between influencing ambitions and the reality of the wider context. Psychological influence is not achieved through fixed strategies, but through flexible, context-sensitive processes that shift in response to systemic demands and pressures, professional dynamics, and emotional needs. When efforts to influence extend beyond what individuals, teams, or systems are ready to engage with, or when relational foundations are not secure, influencing is less effective.

Discussion

This study set out to conceptualise the process by which clinical psychologists integrate into CMHT MDTs to influence the practice of colleagues from other disciplines and support the development of more psychologically informed ways of working. The findings offer a conceptual model that frames psychological influence as a relational and dynamic process, occurring within the ZPD of individuals, teams, and systems, that responds to contextual constraints. This framing emphasises the importance of attuned, developmentally appropriate interventions that are scaffolded to align with staff readiness, emotional needs, and organisational priorities. The findings support and add to previous literature, shifting the focus from what psychologists do to influence, toward a deeper understanding of how influence is carried out and sustained.

Participants consistently described systemic barriers to embedding psychological ways of working. These included high caseloads, performance targets, and insufficient resources. These findings echo previous studies in which MDT staff identified time constraints and competing service demands as significant barriers to engaging in indirect work with psychologists (Cosentino, 2025). Similarly, Riches et al. (2024) found that limited resources impacted on effective provision of team formulation. Participants also highlighted a disconnect between national policy ambitions, such as trauma-informed, formulation-led care (NHS England, 2019a; NHS England, 2019b), and the realities of underfunded services. A novel contribution of this study is that it highlights the emotional strain of vicarious trauma, moral injury, and burnout as barriers to psychological influence. These findings can be understood through frameworks such as the window of tolerance (Siegel, 1999) and the stress-vulnerability model (Zubin & Spring, 1977), which suggest that emotional overload narrows cognitive capacity for new information. The findings also build on May et al. (2024), who explored the presence of empathy-based stress in mental health workers, caused by burnout, vicarious trauma, compassion fatigue, and secondary traumatic stress. The ongoing dominance of a ‘quick fix’ medicalised culture, underpinned by hierarchical structures privileging medical professionals and diagnostic thinking, was also widely reported by participants. These

observations reinforce longstanding critiques of psychiatric paradigms in mental health services (BPS, 2011; Cooke, 2017; Couldwell & Stickley, 2007; Cosentino, 2025; DCP, 2013; DCP, 2015; Macneil et al., 2012) and build on findings of Wood et al. (2018) that psychology is often not regarded as first-line treatment. Furthermore, participants highlighted a broader socio-cultural demand for definitive assessments and prescriptive solutions that permeates into CMHTs. This pattern is also evident in the findings of Mattan and Isherwood (2009), where MDT staff reported viewing psychologists as expert solution holders. This phenomenon may reflect the psychological discomfort that humans experience in the face of uncertainty, which has been linked with increased distress (Kienzler et al., 2025). Participants also described the ongoing challenge of evidencing the value of indirect work, particularly when it occurs informally, within systems that prioritise direct clinical contacts. Although MDT colleagues often appreciate these contributions, they are rarely acknowledged or resourced by the wider system. These findings build on Christofides et al. (2011), who similarly found that informal formulations were not recognised by the systems psychologists worked in. Participants also reflected on the lingering effects of disciplinary divisions between psychology and other professions. Psychologists described feeling perceived as distant or elitist, which they believe could provoke resistance or professional territorialism within MDTs. These findings build on previous studies that identified MDT staff uncertainty about psychologists' role and remit as a barrier to influence (Cosentino, 2025; Riches et al., 2024; Wood et al., 2018).

A key contribution of this study is its application of the ZPD to conceptualise how psychologists influence MDTs. Several participants explicitly referred to the ZPD of the MDT staff they were working with, when describing how they adapted their influencing strategies. The researcher's theoretical sensitivity, and recognition of the relevance of this concept when first mentioned by a participant, was supported by prior interest in relational therapies. As more participants referenced the ZPD, around the midpoint of data collection, the hierarchy of data was revised using the ZPD as a sensitising concept. This process highlighted that even participants who had not used the term 'ZPD' were describing strategies that closely aligned with Vygotsky's (1978) theory of learning and closely related principles from cognitive analytic therapy, such as "push where it moves" and scaffolding the development of new knowledge

and skills (Ryle, 1995; Wood et al., 1976). Participants described adjusting their input based on the emotional and developmental readiness of individuals and systems, echoing Christofides et al. (2011), who observed that psychologists adjusted the explicitness of formulations depending on staff familiarity. Similarly, participants spoke of targeting influence where change was most likely to occur, aligning efforts with systemic priorities and shifts in policy, and drip-feeding psychological ideas at a pace that could be tolerated to maximise impact. Other frameworks, such as Siegel's (1999) window of tolerance, were also considered during analysis (see Appendix L for exploratory drawings of models considered during the analysis). While relevant, these did not fully capture the developmental or relational nature of influencing described by participants. In contrast, the ZPD provided a useful frame for interpreting these adaptive strategies and allowed the final model to capture the dynamic, contingent nature of psychological influence. It also helped explain why efforts to influence sometimes failed, when attempts extended beyond what individuals, teams, or systems were ready to engage with, or when relational foundations were insufficiently established. This interpretive lens strengthened both the depth of analysis and the explanatory power of the model. Participants also described creating space for staff to slow down and engage in psychological thinking. These findings closely align with those of Mattan and Isherwood (2009), whose participants reported attending psychological consultations to access space and time for reflection within the fast-paced demands of their roles. The importance of managerial support in securing protected time for psychological thinking was also emphasised, echoing Cosentino (2025) and Heneghan et al. (2014). Targeting team leaders and senior managers to encourage a wider, cultural ripple effect was seen as a crucial influencing strategy. Participants described maintaining a presence in decision-making meetings and stepping into operational leadership roles to bring psychological perspectives into service planning and workforce selection. This strategy represents a form of systemic scaffolding, illustrating how psychologists extend their influence at a structural level in CMHTs. Across all strategies, relational security was consistently identified as foundational. Participants described fostering trust with team members and managers through everyday presence, collaboration, and validation. These findings align with previous research demonstrating that indirect work gains more traction when clinical psychologists are embedded

in the team (Christofides et al., 2011). They also mirror core principles of effective therapeutic change, where collaboration, strong therapeutic alliances and validation are key factors (Norcross & Wampold, 2018; and Wotton & Johnston, 2023).

Clinical Implications and Recommendations for Practice

This study offers an original contribution by conceptualising the process through which clinical psychologists influence CMHT MDTs to become more psychologically informed and embed psychological approaches. While national policy and frameworks increasingly promote trauma-informed, formulation-led care, this study highlights a significant gap between these ambitions and the realities of practice. Psychologists are expected to support cultural change within systems that are under resourced, emotionally strained, and dominated by medicalised paradigms. Policymakers should take these systemic constraints into account when setting expectations and develop more realistic, context-sensitive goals. The findings also have practical implications for service development, clinical psychology doctoral training programs, and practice guidance. The conceptual model of psychological influence developed in this study provides a framework for understanding how influence is carried out in CMHTs. It could inform the development of more specific guidance for psychologists working in these settings and be integrated into doctoral training to better prepare clinical psychologists for working within MDTs.

At a practice level, the primary recommendation is to prioritise relational security. Psychologists should focus on being visible, available and approachable to build trust with both team members and leadership. Tailoring input to the team's ZPD is essential, adapting pace, language, and theoretical depth to match staff readiness, emotional needs, and systemic priorities. Where resistance arises, it may signal relational threat, emotional overwhelm, or a clash of paradigms. Finally, psychologists should seek to influence at a systemic level by taking on leadership roles and maintaining a presence in decision-making meetings to ensure psychological thinking is embedded in broader service-level planning and strategy.

Limitations and Recommendations for Future Research

While this study provides novel insights, it also has certain limitations. It was conducted by a lone researcher, and although reflexivity, memoing, supervision, and member checking supported the validity of the results, data analysis and interpretation were ultimately shaped by a single perspective. Additionally, the findings are situated within the context of current national policy and frameworks, which will soon be replaced by a new NHS Long Term Plan. Although participants were recruited from a range of geographical regions across England, the sample did not include representation from all areas. Given the variability in how NHS trusts are organised and resourced, the possibility of regional variation cannot be excluded. Furthermore, the interview dynamics may have been influenced by participants' varying levels of prior knowledge about the researcher's experience of working in CMHTs. Participants who were former colleagues may have felt more comfortable in sharing their views, potentially supporting greater authenticity in the data. Others, who were unaware of the researcher's clinical background, may have engaged differently. Across all interviews, there is also the possibility that social desirability bias influenced responses. Some participants may have wished to present themselves as effective in psychologically influencing their MDTs. These dynamics could have subtly shaped what participants chose to disclose or emphasise. A GT study aims to generate theory that can be empirically tested and provide more generalisable explanations for phenomena (Glaser & Strauss, 1967). Future research could explore the applicability of this model in other service contexts beyond CMHTs. It may also be valuable to revisit the model's relevance in light of new national policies once published and assess its generalisability across CMHTs in other parts of the UK. Finally, future research should consider the potential for ethical issues arising when interviewing staff about professional practice, particularly within the pressured context of the NHS. While no concerns were riased in this study, it is important to acknowledge that participants may raise concerns about clinical practice. This study did not explicitly address such possibilities within its participant information sheet or ethical protocol. Researchers undertaking similar qualitative studies should therefore consider the implications of such disclosures in advance, including how these would be managed, making it clear to participants from the outset.

Conclusion

This study set out to conceptualise the process through which clinical psychologists integrate into CMHTs and influence MDTs to become more psychologically informed. Using a critical constructivist grounded theory approach, it generated a model of psychological influence with relational security at its core. The findings highlight that influence is a dynamic process, occurring within the ZPD of individuals, teams, and systems, responsively adapting to contextual constraints. This research offers an original contribution to the literature by shifting the focus from what psychologists do to influence teams, toward a deeper understanding of how it is done. It exposes the significant gap between national policy ambitions and the everyday realities clinical psychologists encounter, offering a challenge to policymakers to develop more context-sensitive frameworks that recognise systemic constrains. The study also provides several recommendations for practice. Influence should begin by establishing relational security, being visible, approachable and building trust with both staff and leadership. Psychological input should be paced and adapted to staff readiness, emotional needs, and organisational priorities. Resistance may signal relational threat, emotional overwhelm, or a clash of paradigms. Future research could explore the applicability of the model to other service contexts and assess its generalisability across different parts of the UK.

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Paper Three: Executive Summary

Shaping Psychologically Informed Community Mental Health Teams: A Grounded Theory of How Clinical Psychologists Influence Practice

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Executive Summary

This executive summary has been completed to provide an accessible overview of the study, including its findings, recommendations for practice and future research. It is primarily intended for the clinical psychologists who participated in the research, and multidisciplinary professionals working in Community Mental Health Teams (CMHTs). It may also be of interest to psychologist in other service contexts, as well as clinical psychology trainees. In addition, the summary may be useful for operational leads and service managers seeking to better understand the contributions clinical psychologists make, and for policy makers aiming to develop realistic, context-sensitive guidance to support the implementation of psychologically informed practice in CMHTs. The clinical psychologists who participated in the study were invited to review the emerging theory and provide feedback, enhancing the trustworthiness and co-production of the research.

Introduction

The role of clinical psychologists in Community Mental Health Teams (CMHTs) has undergone a significant shift over recent decades. While direct therapeutic work remains an essential part of the role, clinical psychologists are increasingly contributing to CMHTs through more indirect contributions to systems and teams. These contributions are made through consultation, supervision, team formulation, reflective practice, and training with the aim of influencing how the team functions, the clinical decisions that are made and how care is delivered, embedding psychological thinking into team culture (Onyett, 2007). These changes in the role of clinical psychologists in CMHTs reflect broader national policy ambitions. Documents such as the NHS Long Term Plan (NHS England, 2019a) and the Community Mental Health Framework (NHS England, 2019b) encourage services to become more trauma-informed and formulation-led. There is a clear drive toward person-centred care and these policies highlight the importance of increasing access to psychological therapies and psychologically informed care. Given their doctoral training, clinical psychologists are uniquely placed to support this shift. Training provides them with skills in research, critical evaluation of evidence, organisational and systemic leadership and the application of psychological theory (BPS, 2024).

While the benefits and challenges of indirect psychological work have been documented, such as research on formulation (Berry et al., 2017; Christofides et al., 2011; Donaghay-Spire et al., 2016; Kramarz et al., 2022; Mohtashemi et al., 2018; Riches et al., 2024), consultation (Douglas & Benson, 2015; Murphy et al., 2013), supervision, (Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015), reflective practice (Baker et al., 2021; Donaghay-Spire et al., 2016; Heneghan et al., 2014), and training (Steele et al., 2021; Stimpson et al., 2013; Thompson et al., 2008; Waller et al., 2015), far less is known about the process through which psychologists integrate into, and influence CMHT MDTs, as the existing literature focuses on what clinical psychologists offer, rather than how psychological influence is enacted in practice. This study addressed this gap, exploring how clinical psychologists in CMHTs shape the thinking and practice of MDT colleagues, and how they influence systems to be more psychologically informed. By generating a conceptual model for this process, the study provides insights that can inform training, policy, and practice.

Aims of the Research

The study set out to explore the experiences of clinical psychologists in CMHTs. Specifically, it aimed to understand the process by which clinical psychologists integrate into MDTs to influence the practice of colleagues and support the development of more psychologically informed ways of working. The research aimed not only to understand the steps and strategies clinical psychologists use to shape MDT culture, but also to gain a deeper understanding of the broader systemic and ideological context of CMHT MDTs, within which psychological influencing occurs. A further aim was to generate a conceptual model that could inform training, practice and policy.

Method

A qualitative research design was used, underpinned by a Critical Constructivist Grounded Theory (CCGT) methodology. This methodology was chosen because it allows for the exploration of processes that are not well understood and benefit from conceptual frameworks to make sense of them. CCGT is particularly well suited to researching processes that are shaped by structural and interpersonal systems, maintaining a focus on the influence of

ideology, power relations and systemic inequalities. This approach aligned well with the aims of the study and recognises that the work of clinical psychologists within teams is inherently shaped by professional hierarchies, ideological paradigms, and wider social, political, and economic forces.

Participants

Twelve clinical psychologists were interviewed between November 2024 and March 2025. Participants were recruited from several regions of England: five from the South West, four from the North West, two from the West Midlands, and one from Yorkshire. Six participants were in their 30s, three in their 40s, and three in their 50s. Ten participants identified as female, and two as male. Eleven participants identified as White British, and one as White Irish. Collectively participants' experience working in CMHTs spanned from the late 1990s to the present day, contributing over 130 years of combined experience across 26 CMHTs. Two participants held consultant positions, three held principal positions, six held senior level positions, and one held a main grade position. While only one participant was working at main grade, several participants in more senior roles reflected on earlier experiences of working in CMHTs at more junior levels. This allowed the research to capture insights across different stages of professional development and range of roles.

Results

A grounded theory was developed which conceptualises psychological influence in CMHT MDTs as relational, dynamic, and responsive to contextual constraints. Influence occurs within the Zone of Proximal Development (ZPD) of individuals, teams, and systems, and is shaped by structural and cultural forces. Three main categories were identified, each containing three subcategories that represent component parts of this process.

1. Understanding the Wider Context

CMHTs, and the broader NHS system, is shaped by political, financial and cultural pressures that can pose significant barriers to clinical psychologists' attempts at integration and promotion of psychological approaches.

a. *Systemic Pressure and Emotional Strain*

Clinical psychologists and MDT staff in CMHTs are under significant pressure. High caseloads, limited resources, performance targets, and the emotional impact of moral injury and vicarious trauma can all restrict MDT staff's capacity to engage with psychologically informed thinking and the uptake of new skills, as well as psychologists' ability to provide influence.

b. *'Quick Fix' Medicalised Culture*

CMHTs remain embedded within a medicalised model that favours prescriptive interventions and quick solutions. Broader societal expectations that mental health difficulties can be resolved through fast-acting, medication-based interventions can lead to frustration with the slower pace of psychological approaches. In addition, hierarchical structures tend to privilege medical professionals and can devalue the systemic contributions of clinical psychologists, reflecting a wider tension between psychiatric and psychological paradigms.

c. *Legacy of Disciplinary Divisions*

The historical separation of psychology from the CMHT MDT may shape how some MDT staff perceive clinical psychologists, as distant or elitists, which can provoke resistance or professional territorialism when clinical psychologists attempt to influence their practice. However, newer staff appear more accustomed to working with clinical psychologists and more open to psychological ways of working, suggesting a generational shift in culture.

2. Working within the Zone of Proximal Development

The ZPD refers to the space between what individuals can achieve independently and what they can accomplish with appropriate support and guidance (Vygotsky, 1978). Learning and change occur most effectively within this zone, where challenges are manageable and growth is supported through scaffolding (Wood et al., 1976). This approach aligns with principles such as "push where it moves" (Ryle, 1995), which involves identifying areas of openness to learning, and building gradually from there. Influence therefore requires ongoing flexibility, pragmatism, and attunement to the emotional and developmental readiness of staff

and the wider system, and of psychologists themselves. If influence is not tailored or aligned with the system's organisational priorities, clinical psychologists can encounter resistance, disengagement, or burnout.

a. ***Drip Feed and Create a Ripple***

Psychological perspectives are introduced gradually, in a way that is attuned to the team's needs and tolerance for them, drip-feeding ideas in a manageable and non-threatening manner to encourage a ripple effect that extends beyond direct involvement. Targeting team leaders and senior managers is a key strategy to create cultural ripple effects and greater buy-in from the team.

b. ***Space to Slow Down and Think***

In the fast-paced, reactive context of CMHTs, clinical psychologists create space for reflection and psychological thinking. These opportunities arise both informally and through structured forums such as consultation, reflective practice, supervision, formulation and training. Protected time and managerial support are essential for these spaces to be sustained and well attended.

c. ***Identify and Fill Gaps***

Clinical psychologists increase their influence by identifying and addressing gaps across the system. This includes ensuring that psychologists are present at all levels of the organisational structure, maintaining involvement in decision-making spaces, across all stages of the clinical pathway, and conducting skills audits to map workforce competencies against service priorities and design training that meets both service needs and staff development goals.

3. Relational Security

Influence is rooted in relationships. Relational security is fundamental to embedding psychological thinking and shaping team culture.

a. *Be Physically Visible and Available*

Being visible in shared spaces and available for informal conversations helps build familiarity, trust, and supports integration.

b. *Collaborate and Build Alliances*

Influence takes place through trust-based collaborative working relationships with team members, operational leads and managers. Building alliances with senior colleagues is especially important for securing managerial buy-in.

c. *Validate and Reduce Threat*

Psychological input can initially be experienced as threatening. Clinical psychologists mitigate this by validating staff experiences and recognising the emotional strain they are under. Avoiding formal titles or asserting expertise further reduces barriers with staff, maximising approachability and engagement.

Conceptual Model of Psychological Influence in CMHTs

Relational security, shown in white at the centre of the model, forms the foundation upon which psychological influence depends. Surrounding this, the light blue area represents the ZPD, where key influencing processes take place. Encircling the ZPD, the dark blue outer layer reflects the wider context, the structural and cultural forces that shape practice within CMHTs and can constrain psychological influence. The arrows within the model reflect the dynamic, adaptive nature of psychological influence and the tensions between influencing ambitions and the realities of the wider context. Influence is not achieved through fixed stages but through flexible, context-sensitive processes that shift in response to systemic pressures, professional dynamics and emotional needs. When influence extends beyond what individuals, teams, or systems are ready for, or when relational foundations are not secure, psychological influence is less effective.

Conclusion

This study explored how clinical psychologists integrate into CMHTs and influence MDTs to become more psychologically informed. Using a CCGT approach, a conceptual model of psychological influence, with relational security at its core, was developed. Influence is framed as a dynamic, relational process that occurs within the ZPD of individuals, teams, and systems, and adapts to emotional, developmental, and systemic needs. The study shifts the focus from what clinical psychologists do to influence, to how they do it, making an original contribution to the literature. It also highlights a gap between national policy ambitions and the realities of practice, calling for more context-sensitive frameworks.

Recommendations for Practice

- Prioritise relational security: Clinical psychologists should build trust by being physically present in shared offices and meetings, being approachable, and fostering collaborative relationships with both team members and management

- Tailor influence using the ZPD: Adapt psychological input to the developmental readiness of staff, teams, and systems. This involves introducing ideas gradually, scaffolding new skills, and targeting areas of openness to change.

- Respond constructively to resistance: Recognise that resistance may signal resource limitations, emotional overwhelm, or perceived threats to professional identity. Strategies include validating staff experiences, avoiding formal titles, and pacing input to maintain engagement.

- Enhance systemic influence: Seek opportunities to participate in decision-making spaces and leadership roles, influencing workforce planning, service design, and training.

- Embed this knowledge in doctoral training: Clinical psychology training programmes should provide guidance on integrating into MDTs, referencing the historical context of multidisciplinary working, highlighting of the importance of relational security, and consideration of staff's ZPD.

- Inform policy expectations: Policy makers should account for the structural constraints of CMHTs when setting targets, recognising the resource limitations and relational work required for sustainable change.

Limitations and Recommendations for Further Research

- Findings are situated within current policy frameworks, which may shift with the introduction of a new NHS Long Term Plan. Further research could review the model's applicability to the new NHS Long Term Plan

- Although participants were recruited from a range of regions in England, not all areas were represented. Given differences in how NHS trusts are structured and resourced, future research could assess the model's generalisability across the UK.

- Future studies could examine the applicability of the model to other service contexts, beyond CMHTs, to explore its wider relevance

Dissemination

- The study will be submitted for publication in the BPS Journal of Psychology and Psychotherapy: Theory, Research and Practice

- The executive summary will be shared with the clinical psychologists who participated in the study

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Appendix A

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social processes that underlie the development and improvement of psychological problems and mental wellbeing, including:

• theoretical and research development in the understanding of cognitive and emotional factors in psychological problems;
• behaviour and relationships; vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological distresses;
• psychological therapies, including digital therapies, with a focus on understanding the processes which affect outcomes where mental health is concerned.

The journal places particular emphasis on the importance of theoretical advancement and we request that authors frame their empirical analysis in a wider theoretical context and present the theoretical interpretations of empirical findings.

We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds both within the UK and internationally.

In addition to more traditional, empirical, clinical research we welcome the submission of

• systematic reviews following replicable protocols and established methods of synthesis
• qualitative and other research which applies rigorous methods
• high quality analogue studies where the findings have direct relevance to clinical models or practice.

Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in *Psychology and Psychotherapy: Theory, Research and Practice* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

Research articles: 5000 words

Qualitative papers: 8000 words

Review papers: 6000 words

Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

• Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (if you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

• The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

• An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at https://wiley.atyponrex.com/journal/PAPT and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain:

• A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

• A short running title of less than 40 characters;

• The full names of the authors;

• The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

• Abstract;

• Keywords;

• Data availability statement (see Data Sharing and Data Accessibility Policy);

• Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach

revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the LaTex Main Document should be uploaded as a “LaTeX Supplementary File.”

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

• PDF of the finalized source manuscript files compiled without any errors.

• The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.

• Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

• A short informative title containing the major key words. The title should not contain abbreviations;

• Abstract structured (intro/methods/results/conclusion);

• Up to seven keywords;

• Practitioner Points Authors will need to provide 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;

• Main body: formatted as introduction, materials & methods, results, discussion, conclusion;

• References;

• Tables (each table complete with title and footnotes);

• Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below);

• Statement of Contribution.

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

• As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.

• The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

• **Language**: Authors must avoid the use of sexist or any other discriminatory language.

• **Abbreviations**: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

• **Units of measurement**: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

• **Effect size**: In normal circumstances, effect size should be incorporated.

• **Numbers**: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils)

Appendix B

Table of CASP Scores

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	SCORE Total / 20
Barker et al. (2021)	0	1	1	1	1	0	0	0	0	0	4
Berry et al. (2017)	2	2	2	2	1	2	2	2	2	2	19
Donaghay-Spire et al. (2016)	2	2	2	1	2	2	1	2	2	1	17
Douglas & Benson (2015)	2	2	2	2	2	2	2	2	2	2	20
Murphy et al. (2013)	2	1	1	1	1	0	1	2	2	1	12
Steele et al. (2021)	2	2	2	2	2	2	2	2	2	2	20
Stimpson et al. (2013)	2	2	2	1	2	2	0	2	2	1	16
Thompson et al. (2008)	2	2	2	1	2	1	2	2	2	1	17
Waller et al. (2015)	2	2	2	1	1	0	0	1	2	1	12

Appendix C

Study Advert

Have you worked in an adult CMHT in the UK? Were you part of an MDT? Did you work there for at least 6 months?

I am looking for volunteers to take part in a clinical psychology doctoral study exploring how Clinical Psychologists help MDTs work in a more psychologically informed way

Participation involves taking part in a Microsoft Teams interview to discuss your experience

It is entirely voluntary, anonymous and confidential and you can withdraw at any point until a week has passed following your interview

If you have answered 'Yes' to all the above questions please email c025037k@student.staffs.ac.uk to express interest

Thank you!

University of Staffordshire

This study has been approved by Staffordshire University Research Ethics Committee
Approval ID: SU_23_031

Appendix D

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of the study
Growing the influence of psychological thinking: How clinical psychologists shape multidisciplinary teams.

Introduction
The purpose of this study is to explore and conceptualise the process undergone by clinical psychologists of integrating themselves in MDTs to influence decision making and support other disciplines to use psychological knowledge in their practice. You have been invited to take part because of your professional background and experience of working in a community mental health MDT.

What will I need to do?
With your consent, you will be asked to participate in a Microsoft Teams interview for approximately one hour, during which you will be asked about the growth of psychological knowledge and influence on clinical practice, in the MDT you have worked in. You will be offered an informal debrief at the end of the interview and can withdraw your consent to participate in the study at any time, until a week after completion of your interview. You have the choice to be contacted after the research project is completed, to provide feedback on the research project or to receive a summary of the research project itself. You can select 'Yes' or 'No' on the Consent Form to indicate your choice.

What are the benefits and disadvantages of taking part?
There is no direct benefit to you as an individual, but the information you provide can support the development of more evidence-based training and guidance, to work toward better integration of clinical psychologists in MDTs and ensure that psychological knowledge informs clinical decision making, alongside or instead of psychiatric diagnosis. Participating in the Microsoft Teams interview is expected to take approximately an hour of your time.

How will my information be kept confidential?
Your participation in the study will be completely anonymous. Microsoft Teams interviews will be recorded, so they can then be transcribed by the researcher, and will be immediately destroyed following transcription. The transcript of your interview will be password protected and stored in a secure database for 10 years, in accordance with Staffordshire University regulations, before it is then destroyed. Your data will be processed in accordance with the data

protection law and will comply with the General Data Protection Regulation 2016 (GDPR). Unnecessary data, or data that is irrelevant to the purpose of the study, will not be collected. The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you/ You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What will happen if I don't want to continue with this study?
You are free to withdraw your consent at any point, until a week has passed following completion of your interview. If you choose to withdraw from the study within the allocated timeframe, you can do this by informing the principal researcher via email, or by contacting the research supervisor. The information you provided will then be destroyed.

What will happen with the results of the study?
The overall conclusions will be written up in a paper for publication in a research journal.

Further information
This study has been reviewed and approved by the University Research Ethics Committee at Staffordshire University.

If you have any further questions or feel the need to raise concerns about this study, you can contact the principal researcher, the research supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information. Their contact details are listed below.
Following participation, if you feel you would benefit from support with your wellbeing, you can contact NHS staff wellbeing services. The means through which to do so are included at the bottom of this form.

Professor Sarahjane Jones
Chair
University Research Ethics Committee
Staffordshire University
32 Leek Road
Stoke-on-Trent
ST4 2AR
Email: sarahjane.jones@staffs.ac.uk

Researchers Contact Details

Emily Cosentino
Trainee Clinical Psychologist and Principal Researcher
Staffordshire University
32 Leek Road
Stoke-on-Trent
ST4 2AR
Email: c025037k@student.staffs.ac.uk

Dr Gary Lee
Senior Lecturer and Research Supervisor
School of Health, Science and Wellbeing
Staffordshire University
32 Leek Road
Stoke-on-Trent
ST4 2AR
Email: gary.lee@staffs.ac.uk

Support for NHS staff

Text: FRONTLINE to 85258
Visit: https://www.england.nhs.uk/supporting-our-nhs-people/

Appendix E

Consent Form

CONSENT FORM

Approval has been granted by the University Research Ethics Committee at the University of Staffordshire for this study to be carried out between August 2024 and September 2025.

Please confirm the following:	**Yes**	**No**
I have read the Participant Information Sheet and had the opportunity to ask questions		
I understand that I can withdraw my consent to participation in the study at any point, up until a week has passed from completion of my interview		
I agree to take part in this study and give consent to my answers being used anonymously for the purpose of this research		
I confirm that I have worked in a community mental health MDT for a minimum of six months		
I would like to be contacted after the research is complete		
Print and sign name:		

Please return the completed consent form to c025037k@student.staffs.ac.uk

Appendix F

Interview Prompts

- **Could you tell me about the process of integrating in the MDT?**
    - What was it like, and what did you do to integrate?
- **What strategies do you employ to encourage greater psychological thinking across the MDT?**
    - In meetings and 1:1?
- **What have the challenges or barriers been, to growing psychological thinking in the team?**
    - Do you have any thoughts on the role played by the wider system in maintaining or reinforcing those barriers?
        - Medical model?
    - Have you encountered any resistance from team members?
        - How do you make sense of that?
- **At a systemic or systems level, what are your thoughts on what could, or does, promote the growth and integration of psychological thinking?**
    - Psychologist in more senior positions?
        - How/why does holding a more senior position support influence?
- **What role does team management and organizational leadership play, in facilitating or inhibiting your ability to influence?**
    - What is your relationship with them like?
    - How do you get buy-in from them?
- **What aspects of your leadership style and individual characteristics do you think might be more or less helpful, in influencing the team?**
    - What might be making *you* more or less influential?

Appendix G

Coded Transcript Page

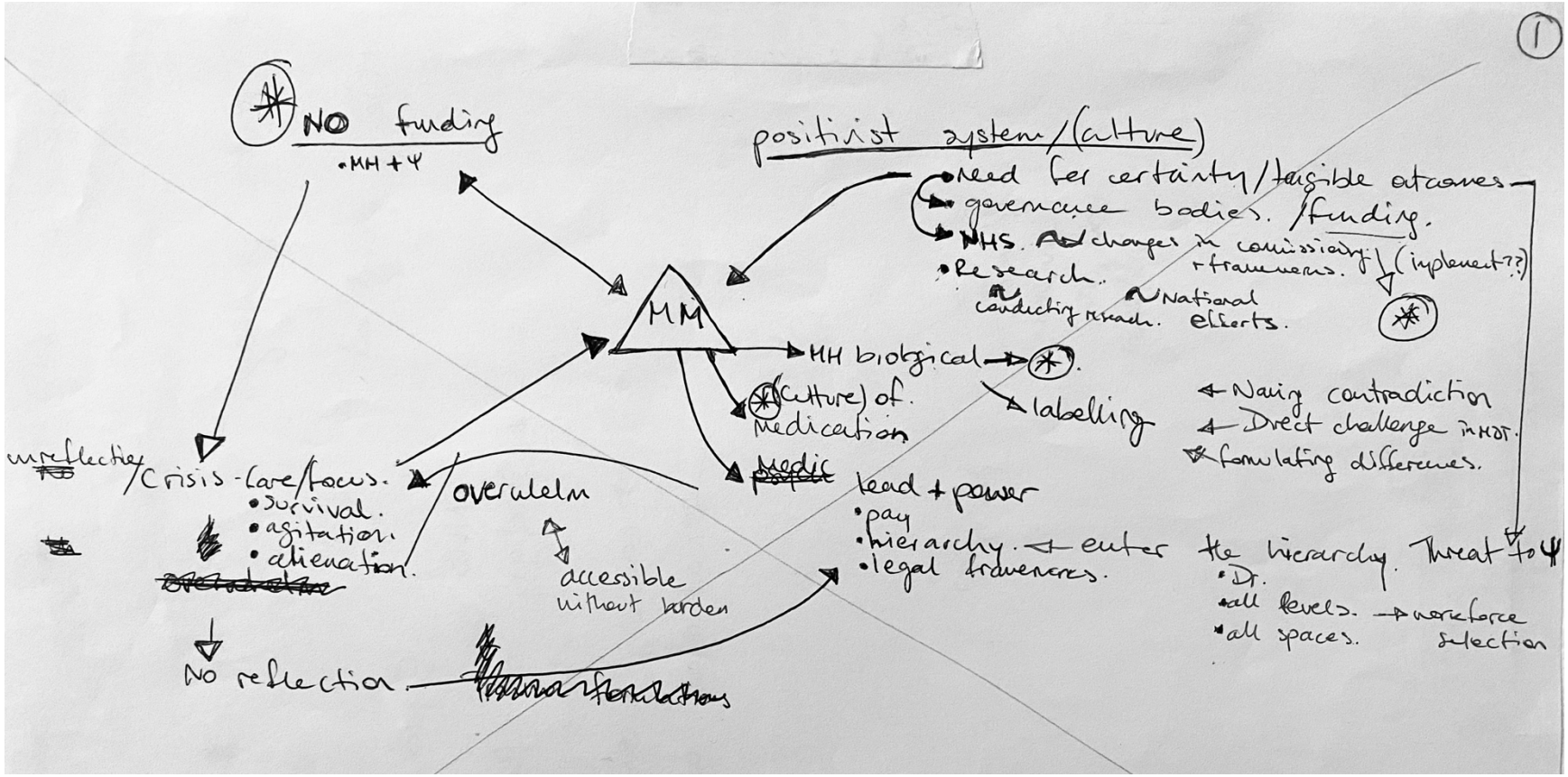
Moving up, into more leadership positions, felt like I could influence things better. When I was at the 8a level, a lot of the emphasis was seeing lots of people for therapy. I didn't have much of an opportunity to influence the wider team. The position I have been in, as an 8b and an 8c, has given me a lot more scope to do more influencing of the team. **{T9.10 Moving into leadership positions at 8b and 8c provided greater opportunities to influence the wider team}** Over time, I have definitely seen a massive change in how psychology is viewed and supported in the teams, which has been brilliant. **{T9.11 Over time, there has been a significant positive shift in how psychology is viewed and supported within teams}** I remember one day, standing at the photocopier, a support worker said, "You know, we've just realised how great the psychology team is now. We've discovered that you're actually quite normal, aren't you?". Well, I felt like going, "Oh, my God. We've made it! We've integrated, finally, because they see us as normal!". **{T9.12 A support worker's comment about psychologists being "normal" felt like a breakthrough in integration and acceptance within the team}**

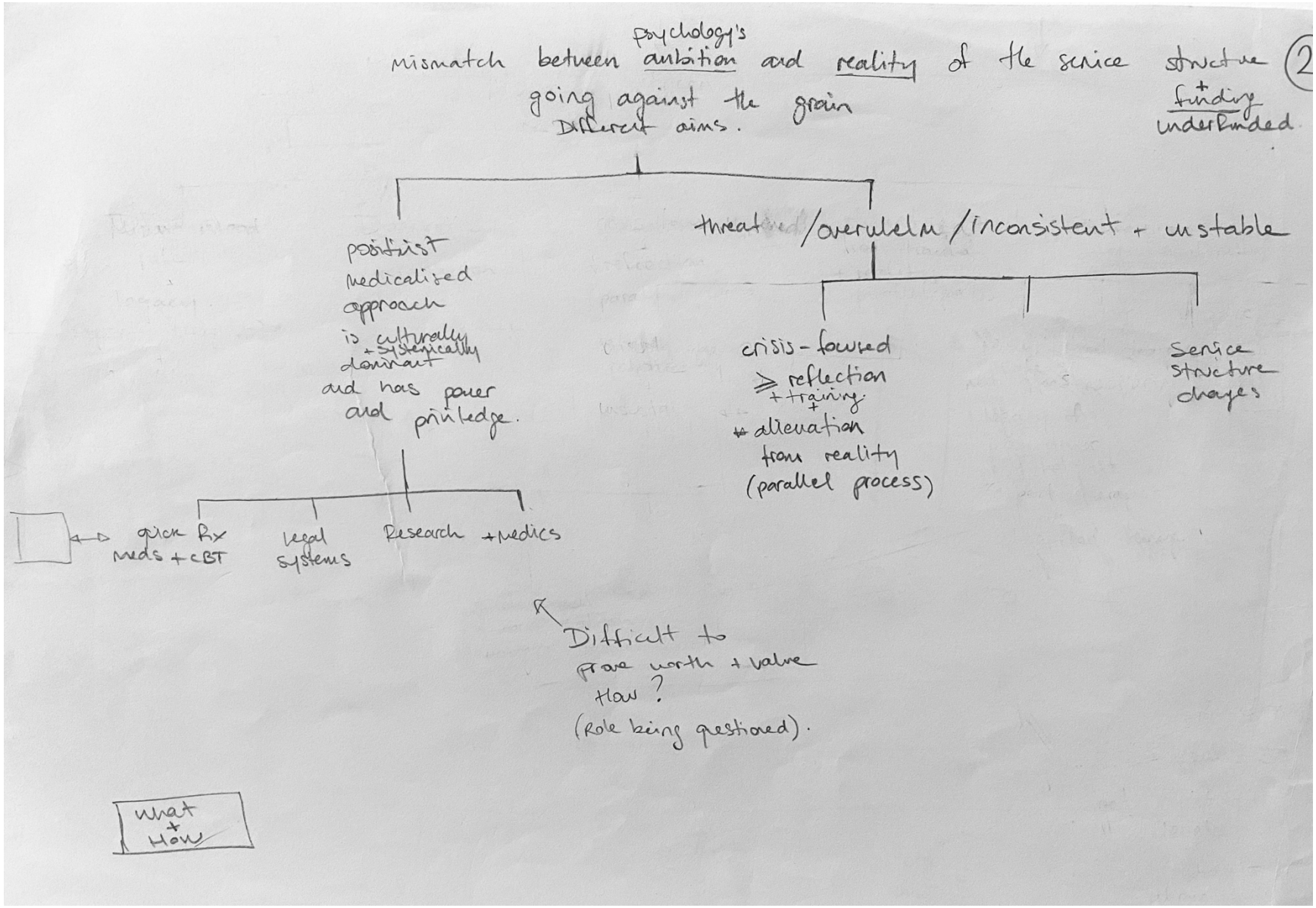
Interviewer: What do you think made that shift happen?

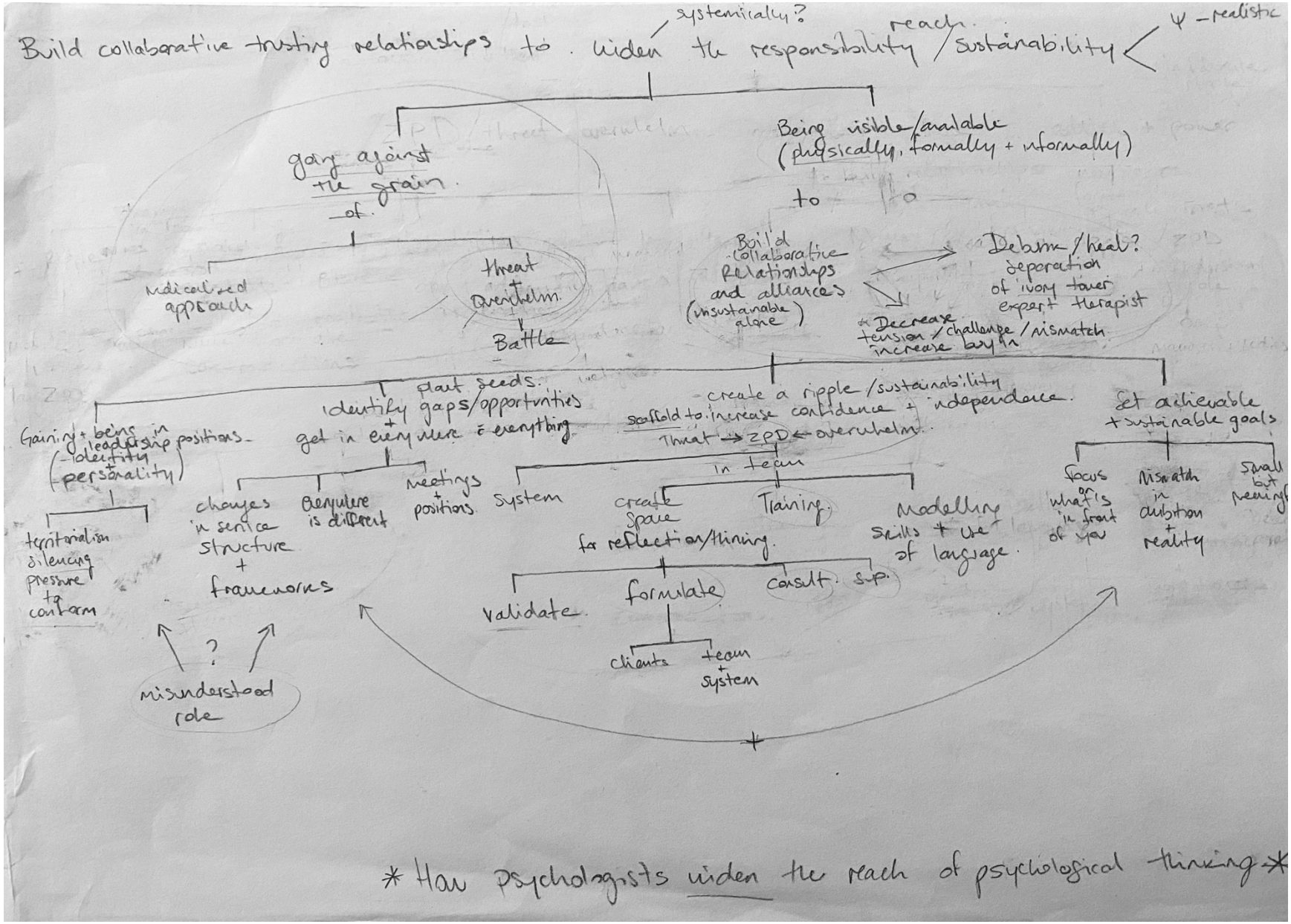
Susan: I think it was about us being present. As a principal psychologist I was able to speak to the team lead about moving psychology into the main office, so we physically shifted and were part of the wider team and sat in the wider office. **{T9.13 Physically relocating psychology into the main office facilitated integration and presence within the wider team}** Rather than just having referrals for therapy, we did a lot more joint working. We identified that staff were struggling with people who weren't suitable for therapy, but were really struggling, so we did a lot more complex case joint working so the staff could see what we did. We were helping them out with the stuff that they were struggling with. **{T9.14 Increasing joint working on complex cases helped staff see psychology's role beyond therapy and provided support for challenging cases}** Using our psychology skills properly, not just being therapists. Showing staff the full range of what psychologists offer. We were offering more consultation. I set up a consultation model where, rather than people being referred for therapy, they would first come and have a consultation session with us. **{T9.15 Replacing referrals for therapy with a consultation model, allowed staff to engage with psychological thinking}**

Appendix H

Coding Notes




mismatch between psychology's ambition and reality of the service
structure + funding underfunded
2
going against the grain
Different aims.
positivist medicalised approach is culturally + systemically dominant and has power and privilege.
threatened/overwhelm/inconsistent + unstable
crisis-focused
⇒ reflection + training + alleviation from reality (parallel process)
service structure changes
give Rx meds + CBT
legal systems
Research + medics
Difficult to prove worth + value How?
(Role being questioned).
what + How


Build collaborative trusting relationships to . widen the responsibility / sustainability
systemically?
reach.
Ψ-realistic
gang against the grain of
medicalised approach
threat + overwhelm
Battle
Being visible/available (physically, formally + informally)
to
Build collaborative Relationships and alliances (unsustainable alone)
Debrief / heal? separation of ivory tower expert therapist
Decrease tension / challenge / mismatch increase buy in
Gaining + being in leadership positions (-identity +personality)
territorialism silencing pressure to conform
plant seeds. identify gaps/opportunities + get in everywhere & everything
changes in service structure + frameworks
departure is different
meetings + positions
misunderstood role
create a ripple / sustainability
scaffold to increase confidence + independence.
Thrive → ZPD ← overwhelm
in team
system
create space for reflection/thinking
validate
formulate
consult. sup.
clients
team + system
Training
Modelling skills + use of language.
Set achievable + sustainable goals
focus on what's in front of you
Mismatch in ambition + reality
Small but meaningful
* How psychologists widen the reach of psychological thinking *

Appendix I

Example Memos

04/12/24 - Noticing a pattern where interviewees seem deflated and dissatisfied by the end. Wondering if it's not just the interviews — maybe reflects a wider frustration psychologists feel when trying to influence teams? Struck by how much discomfort there is when they are unable to clearly define what it is that they do, or find this challenging —Is this touching on something deeper around feeling the need to 'prove'?

05/12/24 - Realising conversations are drifting toward talking about wider systemic issues. Worrying that I might be steering it that way, but it also feels important. The whole system (funding, policy) reinforces a medicalised view of mental health difficulties. Maybe the process of trying to grow psychological thinking will forever be ongoing – There can't be a 'finish line' or a measurable / achievable goal. What are the implications of this?

03/01/25 - Participant 4 said psychologists don't need to have "more influence" than others. I'm struggling with this. I can see that my view is shaping my response. My position is that if psychologists don't make a conscious effort to encourage culture change and have more influence than the medical model, the power dynamic will not shift.

14/02/25 - Power seems to operate at two levels — the big, distal stuff (models, funding) and the day-to-day proximal stuff (hierarchies, team dynamics). Participants are talking about having to focus on what's possible and realistic, within the demands and constraints of the system.

15/02/25 - Starting to see that working within staff's ZPD is what makes psychological influence more sustainable. It's about making sure new ways of thinking align with what MDT can tolerate but also with the capacity and insight of the psychologist.

17/2/25 - Feels like there's a parallel process — teams are overwhelmed (cuts, demand) and too busy to think about changing, but so are psychologists — too stretched to properly reflect on the system they're working in.

Appendix J

Ethical Approval

School of Health, Education, Policing and Sciences

ETHICAL APPROVAL FEEDBACK

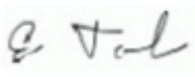
Researcher name:	Emily Cosentino
Title of Study:	Growing the influence of psychological thinking: How clinical psychologists shape multidisciplinary teams.
Status of approval:	Approved

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Ethics Panel, and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

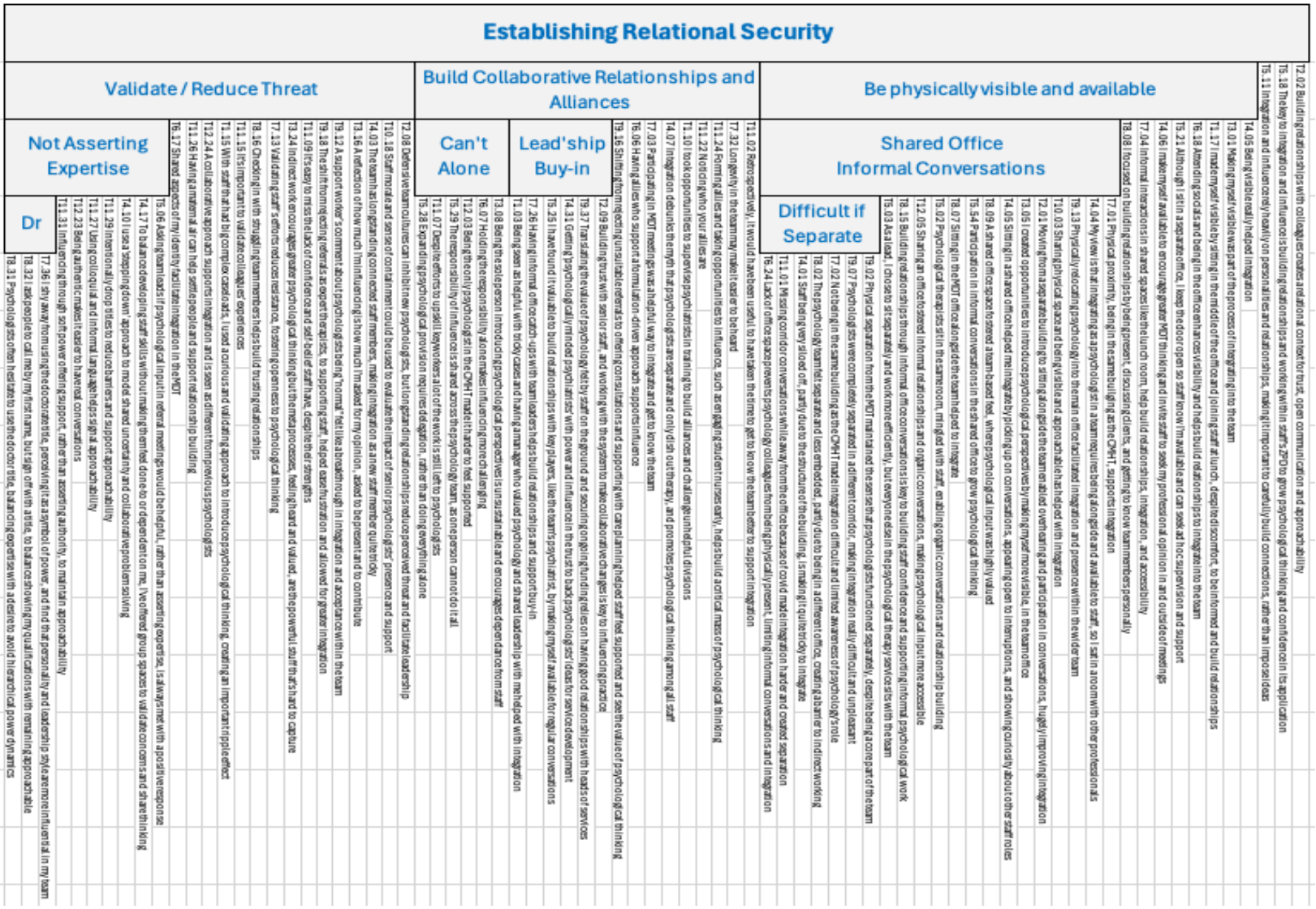
Signed: **Date: 05.08.2024**



Dr. Edward Tolhurst
Ethics Co-ordinator - HEPS

Appendix K

Extract from Hierarchy of Codes



Appendix L

Exploratory Drawings of Models