This is the pre-peer reviewed version of the following article:

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Hannigan B. and Allen D. (2011) *Giving a fig about roles: policy, context*

and work in community mental health care,

which has been published in final form in the *Journal of Psychiatric and*

Mental Health Nursing **at:**

http://onlinelibrary.wiley.com/doi/10.1111/j.1365-

2850.2010.01631.x/abstract

Accessible summary

- In this paper we examine why some nurses, doctors and social workers in the UK are becoming increasingly worried that their contributions to the care of people with mental health problems are under threat.

- We first use data from a study of roles and responsibilities in community mental health care, completed in two contrasting research sites in Wales, to show how the roles of nurses and other professionals are moulded by features of the local workplaces in which they are employed. This shaping of roles results in members of the same occupational group doing different types of work in different settings. We particularly show how, in the site we call 'Midtown', local features encouraged large overlaps in the work of community mental health nurses and social workers.

- We then show how recent government policy is explicitly breaking down old assumptions about the work which professionals do, and is giving local NHS organisations a greater say in shaping the roles which professionals fulfil.

- We examine how these policy processes, and new pressures arising from the economic downturn, are promoting the wider emergence of workplaces like the one we found in Midtown in which the roles of mental health professionals become increasingly blurred. We examine some of the implications of this, for professionals, service users and for the mental health system as a whole.

Abstract

Across the UK, mental health professionals are strongly objecting to threats to their roles. Against this background we use ethnographic data from a study of roles and responsibilities in community care, undertaken across two contrasting sites in Wales, to demonstrate how work is sensitive to local organisational features and to show how gaps can grow between the public claims professions make about their contributions and the actual roles which their members fulfil in the workplace. We reveal how, in one of our two research sites, immediate contextual features shaped the work of nurses and social workers towards the fulfilment of expanded packages of activity. We then show how subsequent policy (including 'new ways of working'), combined with new pressures arising from the economic downturn, carry the potential to accelerate the wider creation of workplaces of this type. We examine some implications of these processes for nurses and others, and for the system of mental health care as a whole, and conclude with a call for closer attention to be paid to the potential, wider, impact of current developments.

Keywords

Introduction

Across the UK's mental health services members of professional groups are responding, in public and with vigour, to threats to their identities and their control over work. 'New ways of working' (Department of Health 2007) has been challenged by psychiatrists who have cited this policy's endorsement of distributed interprofessional responsibility as downgrading the particular contribution which medical practitioners make (Craddock *et al.* 2008). Social workers, in the context of recent changes to the law in England and Wales, have voiced concern over their future roles and the associated loss of a distinct social perspective (Rapaport & Manthorpe 2008). In the face of internal challenges within the wider profession of nursing to reduce their field of practice to a marginal, post-registration, speciality, some mental health nurses, too, have protested against threats to their identity and status (Hurley & Ramsay 2008, Stickley *et al.* 2009).

The relationships between, and within, occupational groups are of longstanding social scientific interest. Drawing on sociological ideas, and particularly the 'ecological' thinking of Hughes (1971) and Abbott (1988), Hannigan and Allen (2006) examine the complex and dynamic division of work found within the mental health field. There, as in other areas of health and social care, multiple groups compete for space in an interrelated system. Ecological ideas emphasise that, in these conditions, assertions of professional identity and role are entirely normal and expected, and are realised in a number of ways. It is usual, for example, for professions to defend their positions by routinely advancing, in public, what Abbott (1988) calls their 'jurisdictional claims'. 'Jurisdiction' in this context refers to the knowledge-based

appeals professions make to control tasks and activities against the claims of others. Recent public defences of the contributions of nurses, psychiatrists, social workers and others exemplify these processes in action.

A scanning of the mental health system's horizons reveals, however, a recent intensification of public jurisdictional assertions, of a type which points to an unusual degree of system instability. In seeking explanations in this paper for this heightening of unrest we first use data to illustrate the differences between the public claims professions make and the work their members do in the actual workplace. We also show how these differences can arise. For Abbott (1988) the workplace is an important arena, this being another sphere (along with the public and the legal) in which jurisdictions are advanced. Where representatives of professional groups work side-by-side in single organisations, Abbott observes how over time roles will come to bear little relation to formal job descriptions but will instead be realised through negotiation and custom. These, too, are usual processes, and will be recognised by practitioners working in the "knockabout environment" (Brown *et al.* 2000: 426) of the multidisciplinary mental health team who know that roles differ across different settings. Abbott adds, however, that in every instance where work passes from a professional group to one of its competitors the seeds of a larger threat are sown. These movements can happen both vertically (from a powerful to a less powerful group) and horizontally (across groups of similar standing) (Nancarrow & Borthwick 2005). When work seeps away in either direction groups face pressure to respond to the challenge, as they also do when they become attached to additional, but unwanted, tasks discarded by other groups. As we demonstrate

below, across the UK new policy frameworks are fostering conditions in which features of the immediate workplace assume an enlarged part in shaping work, magnifying the discrepancies between actual roles and jurisdictions which are publicly claimed. These processes, through which the links between professions and their taken-for-granted activities become progressively loosened, need to be better understood not least as they signal the possibility of significant, lasting, transformation in the world of mental health work.

The study

Drawing on systems ideas (Hughes 1971, Abbott 1988) and set against a background of rapid policy-driven change in the mental health world (Hannigan & Allen 2006), in the study from which data are drawn in this paper ethnographic methods (Hammersley & Atkinson 1995) were used with the aims of investigating real-life roles and responsibilities in community care and the experiences of users as they move through services. The community care component of the wider mental health system was selected as the focus for the study as this is known to be a particularly complex arena, historically characterised by high levels of role diversity (Crawford *et al.* 2008). Access was secured to two contrasting sites in Wales, 'Midtown' and 'Northtown'. In each, statutory mental health services were provided by different NHS and local authority organisations. Following completion of applications for formal NHS research ethics and institutional approvals (Hannigan & Allen 2003), in each setting a research base was established in an interagency and interprofessional locality community mental health team (CMHT).

Methods and sampling

In each site, data on local context including the CMHT workplace were generated through semi-structured interviews conducted with purposively sampled NHS and local authority planners, managers and senior practitioners. Interviews centred on individual, group and organisational roles and responsibilities and the provision of services. Local policy documents were obtained and used as data, and fieldnotes made during observations of routine events such as CMHT meetings. In each site access was also secured to a purposive sample of three CMHT service users, each of whom agreed to become the starting point for an in-depth case study (Yin 2009). These case studies involved detailed exploration of the unfolding provision and receipt of services over a four to five month period. Semi-structured interviews were held with practitioners providing care for user participants, and with service users themselves and their lay carers. Snowball sampling was used as a means of exploring interrelated care networks (Coleman 1958), and continued until no more significant people in each case study could be found. During this process, contact with workers also enabled the identification of important junctures, such as formal planning meetings. Where possible these events were observed, and audiorecordings and/or fieldnotes made. Access was also secured to the written records maintained by health and social care workers providing services to the user participants, with these being used as additional sources of data.

Data management and analysis

All interviews were audiorecorded and transcribed verbatim, with the exception of one which at a participant's request was conducted without recording equipment.

Detailed contemporaneous notes were made on this occasion. Handwritten, expanded, observational fieldnotes and notes made from service user records were wordprocessed in preparation for analysis, and across all data names of people and places were replaced with pseudonyms. The study's total dataset included transcripts of 66 interviews, transcribed audiorecordings of interprofessional care planning meetings, multiple policy documents relating to service provision at different organisational levels, service user records and a set of extended fieldnotes from each site. Data were managed and analysed with the assistance of the computer software package Atlas.ti (Scientific Software Development/Scolari 1997, Lewins & Silver 2007). A detailed coding frame was constructed, with inductive and deductive codes reflecting theoretical, substantive and practical research process concerns (Dey 1993). Connections between codes were made with the help of Atlas.ti's Boolean search and network view capabilities. Both within-case and across-case approaches (Ayres *et al.* 2003) were used during analysis of participating service users' care.

Findings

Roles and enduring jurisdictions

As expected, aspects of the work which community mental health professionals did in the context of providing care to service user case study participants mirrored clearly their enduring public and legal jurisdictional claims. For example, reflecting their profession's close historic ties to psychiatry and appeals to the possession of sufficient biomedical knowledge to engage in medication-related (in addition to psychosocial) work (Godin 1996), nurses across both sites were observed (and

reported) fulfilling tasks in this area: securing service user participants' adherence to prescribed medication regimes; negotiating with lay carers over tablet storage and supply; administering long-acting drugs; and advising on medication modifications during periods of impending crisis. Social work roles similarly revealed the extent to which formal jurisdictions (in this case, jurisdictions cemented in the legal arena) helped shape work content. In both locales social workers fulfilled roles associated with the operation of the Mental Health Act, as members of the only professional group who at the time of data generation had access to 'approved' status (Evans *et al.* 2005). Psychiatrists exercised their jurisdictional authority to diagnose and to prescribe physical treatments, whilst in Northtown the single clinical psychologist participating in the study provided structured, time-limited, therapy.

Roles in the local workplace

Where professional roles in Northtown stayed close to those asserted in formal jurisdictions, in Midtown we found considerable divergence from these with both nurses and social workers being attached to enlarged 'bundles of work' (Hughes 1971). These differences across the two sites can be understood with reference to local organisational features, which were sufficiently powerful to exert what Strauss (1978) calls a 'patterning' effect. Forces shaping roles in contrasting (but locally recognisable) ways were differing workplace histories of interagency and interprofessional relations, which served as precursors to differing degrees of current commitment to new, more 'modern', ways of working. Other patterning factors included practical contextual features such as the size of NHS and local

authority organisations, and the availability (or not) of new members of staff to fill gaps in the workforce.

Interview respondents in Northtown spoke of a history of strained interagency and interprofessional working. A social worker in the research base CMHT said:

> *Social worker:* […] Here there was a tortuous history […] and real sort of interprofessional tensions were part of it. It actually ended up, one Friday a group of social workers actually just upped and left and went back to a central social services base […]. (Interview, social worker, Northtown)

Whilst people had since moved on and new members of staff had joined the Northtown team, against this broader background progress had been slow in developing local policies and practices reflecting, for example, the non-occupationally specific role of care coordinator (Welsh Assembly Government 2003). During fieldwork nurses, social workers, psychiatrists, a clinical psychologist, an occupational therapist and care support staff were co-located in the CMHT workplace. In the wider Northtown area, NHS and local authority care provider organisations were large in size, having responsibilities to meet the needs of a significant population. The large pool of workers in local agencies made it possible to manage short-term contingencies (such as the departure of staff) by moving practitioners from one part of the system to others. The presence of a large number of workers drawn from a range of groups in the Northtown CMHT was associated with the attachment of multiple practitioners to the care of individual service users,

each fulfilling relatively circumscribed roles reflecting formal jurisdictional claims. For example, nurses provided supportive psychosocial care and managed medicines, but had no role in overseeing funded social care packages.

Midtown was different. There, health and local authority organisations served the needs of a population which was smaller and more economically disadvantaged compared to that in Northtown, and which enjoyed poorer health. Consistent with Hart's (1971) observations on health services often being least available to those needing them most, recruitment to positions in Midtown was difficult. As a result, during fieldwork vacancies in the research base CMHT existed for a clinical psychologist and an occupational therapist. Physically located in the team were nurses, social workers, and health and social care support staff. Psychiatrists were attached to the CMHT, but were based in the local hospital. In a context of limited resources and a less complex division of professional labour, over time a workplace had emerged which promoted a high degree of occupational boundary blurring between nurses and social workers and the fulfilment of generalist roles. The culture of mental health workplaces has a significant bearing on interprofessional practices (Peck *et al.* 2001), and for respondents in Midtown their attachment to what was commonly termed a 'joint working' approach was not only a resource-driven necessity but a distinct and desirable feature of the CMHT which had evolved over time. A nurse in the team said:

> *CMHN:* I think one of the things that is pertinent to the team here is the fact that there's been this long history of the services joint working. You're talking

about it going back to 1979 […] there's a few of us who kind of go back, you know, to the mid/early 80s and through, and then other people who have come in. So I think the fact that there is this long history of very close joint working within the team means that, that there is, there is a rich mixture here and that *there isn't a rigid demarcation between what the CPNs* [community psychiatric nurses] *and the social workers do* [our emphasis]. (Interview, nurse, Midtown)

A similar view was expressed by a CMHT-based social worker, who spoke of the limited differences in occupational roles other than with regard to the fulfilment of tasks over which core, formalised, jurisdictions held sway:

Social worker: I think the two most distinguishing differences are clearly the approved social worker role in terms of mental health assessment and a statutory involvement in relation to that, and the medical role in relation to medication, and not even monitoring, it's a bit, injections and apart from those two things *basically we all do, and can all do, the same thing* [our emphasis]. (Interview, social worker, Midtown)

The history and culture of close interagency working in Midtown also favoured the construction of specific policies and practices cementing non-occupationally specific roles. A notable example was the negotiation of a joint NHS/local authority policy aimed at promoting continuity of care (Freeman et al. 2002) and improving the micro-level organisation of services. This local agreement identified the key role of

'case manager', or care coordinator (Welsh Assembly Government 2003), the tasks

associated with which could be (and were) fulfilled equally by nurses and social

workers. In Midtown, where practitioners were scarce, being identified as a case

study subject's care coordinator meant being the *only* CMHT professional to be

involved in direct, ongoing, service provision.

Roles in Midtown in the context of care provided to the service user case study

participants were patterned by this distinct combination of organisational features.

As Allen (2000) shows in the context of nurse managers, in settings where role

boundaries are under pressure professionals may engage in forms of 'identity work'

to support their positions. In the Midtown environment with its blurring of nursing

and social work roles, practitioners looked to their professions' larger jurisdictions to

underpin their appeals to coordinate and provide care against the claims of potential

competitors. These appeals could be to specific knowledge underpinning particular

tasks, or to more general knowledge, values or principles claimed by the professions

of which they were members. As an example of the former, the community mental

health nurse who cared for 'Jim' (a service user participant) directly cited his

occupationally distinct understanding of medicines as the basis of his appeal to act

as case manager:

> *Researcher:* Could anybody theoretically do what you do with Jim, would it
>
> have to be a CPN?

Nurse: No, I think with Jim it would be a CPN at the moment because of the issues with his medicine, which is not a kind of social worker's role really to, but Jim, yeah, always has been with Jim, CPN involvement because, like I said, because of the issues basically are specific to nursing as opposed to social. (Interview, nurse, Midtown)

His care coordinating position secured, as the sole CMHT professional to work with Jim this nurse's contribution expanded far beyond medication management to encompass a bundle of activities which included the tasks of negotiating with independent providers of domiciliary care services and meals-on-wheels, and liaising with both the local authority's housing department and an agency concerned with financial benefits. In a second example, a Midtown CMHT social worker who provided a service to 'Lenny' underpinned his claim to act as care coordinator and provider of formal individual and family therapy with reference to a wider, more values-based, jurisdiction to fulfil a holistic role:

Social worker: I think that social work brings a perspective to case management which other services don't. I think that nursing is trying to get hold of this, but I think historically social work has a better angle on it because we see things as a whole more readily, more historically and our historical deposit of knowledge is more towards holism and not pathologising but looking at systems. (Interview, social worker, Midtown)

Discussion

Community mental health practitioners in their day-to-day work have considerable autonomy, of a degree which Wells (1997) considers necessary to accommodate competing professional, policy and managerial demands. This latitude which 'street level' (Lipsky 1980) workers possess is not unbounded, however, and even in dispersed settings which lie beyond direct managerial reach the activities of mental health staff are shaped by self-regulation (Brown & Crawford 2003). In this paper we have examined another way in which work is shaped, with our data (both selectively reproduced here and represented more fully across the study's total dataset) demonstrating the sensitivity of roles to features of the workplace. We have shown that this shaping is recognisably 'patterned' (Strauss 1978) by distinct constellations of local factors exerting an effect on the work which is done, and by whom. Thus in Midtown, the relatively small size of health and social care provider bodies, the limited pool of workers drawn from a narrow range of professions and an interagency and interprofessional culture of 'joint working' were together associated with the fulfilment of roles which were more generalist than those found in Northtown.

These findings have added significance when set in a wider context. An emerging policymaking interest in the 'modernisation' of health and social care roles was evident prior to the generation of the data drawn on in this paper (see for example: Department of Health 2000). As the subsequent policy of 'new ways of working' (Department of Health 2007) attests, the roles of mental health professionals have been subjected to particularly sustained policymaking scrutiny. Reviews across the UK have now been conducted into the work of mental health nurses (Department of

Health 2006, Scottish Executive 2006) and psychiatrists (Department of Health 2005). Greater flexibility in working practices is being explicitly encouraged, and notable examples exist of tasks passing between groups in both vertical and horizontal directions (Nancarrow & Borthwick 2005). Mental health nurses can prescribe medication (Jones 2009), and following changes to English and Welsh law act as approved mental health professionals and as responsible clinicians (Mental Health Act 2007). For policymakers, it is the achievement of competency rather than the possession of particular professional backgrounds which determines practitioners' eligibility to fulfil these expanded roles.

In addition, policy has consistently promoted the use of national strategies and standards (see for example: National Assembly for Wales 2001, Welsh Assembly Government 2005), but has simultaneously given a degree of space to local NHS organisations and their partners to determine how these should be met (Klein 2010). This was particularly evident during fieldwork for this study in post-devolution Wales, where traditions of 'localism' were reflected in the explicit authority of individual bodies to determine priorities and commission services in line with meeting overarching standards (Greer 2005, Drakeford 2006). Under arrangements of this type local organisations are able to assume more prominent positions in shaping the work which professionals in their employ undertake. Flexible, boundary-blurring, professionals competent to carry out multiple tasks may find favour with managers concerned with meeting local needs in local ways, consistent with the pursuit of national goals. Processes of these types are likely to be fuelled in conditions of austerity (Royal College of Psychiatrists *et al.* 2009), where

professionals able to fulfil enlarged bundles of activities present themselves as one

way of securing cost savings. Taken together, as *New Ways of Working for Everyone*

makes clear, these possibilities point to a magnification of complexity and

uncertainty in the developing workplace:

> In the future, with the emphasis on competences and capabilities, workforce
>
> planning will become more complex. For example, it will no longer be
>
> appropriate simply to say we have a nurse or occupational therapist staff
>
> vacancy, so we should automatically recruit another nurse or occupational
>
> therapist. With the move to advertisements based on competences and
>
> capabilities […] a more service user-led approach will be required. Filling
>
> vacancies, for example, may mean having existing staff extend their practice,
>
> having a new role introduced – or, indeed, replacing like with like. But this
>
> last option should no longer be the *automatic* choice, as it is now perhaps
>
> [original emphasis] (Department of Health 2007: 26).

It is because of policy-driven developments of the type outlined here, allied now to

new economic constraints, that we envisage the wider emergence of workplaces

more akin to those encountered in Midtown than in Northtown, characterised by

greater blurring in the roles fulfilled by professionals. This has significant

implications, for workers and for users of services. For example, whilst continuity

(Freeman *et al.* 2002) may be helped where relatively few practitioners (each

carrying out a wide range of tasks) are involved in the care of individuals, the

attachment of single or small numbers may also encourage staff to undertake tasks

which stretch their capability. In this study, whilst an interview conducted with Lenny and his mother confirmed the value they placed on the therapy provided by Lenny's social worker this may, in other circumstances, have proved ineffective (or worse) in the hands of a less able practitioner. The felt experience of service user continuity is also likely to be compromised when single workers, fulfilling enlarged roles, leave their posts. Precisely this happened during Lenny's participation in this study, with his single CMHT worker leaving the team before finishing his therapeutic work. This had longer-term implications for Lenny's care, moreover, as finding a replacement practitioner with a similar constellation of skills proved impossible. Scenarios of the type we portray here also focus attention on the future of professional training. Models of education premised on the preparation of new practitioners for professionally distinct roles, to be accomplished in any locale, are challenged by the shift towards an environment in which greater weight is placed on workers' possession of skills valued in particular local contexts. This may fragment mental health professional groups, as the tasks required of (for example) nurses (and thus their local preparation for these) increasingly vary from one locality to another. This, in turn, may give rise to more explicitly localist, interprofessional, programmes of preparation, or even reinvigorate pressure for the creation of the 'generic mental health worker'.

The developments we outline here represent a major collective challenge to professions and their jurisdictions, and it is this observation which takes us back to our paper's starting point. We have shown that, even for practitioners in the Midtown workplace with its distinct history and preferred culture of blurred

boundaries, knowledge and professional identity were important for workers including for the purpose of advancing initial access to enlarged roles. The widespread appearance of workplaces of this type brings both threats and opportunities for nurses and members of the other mental health professions. For example, whilst the nursing space in the division of mental health labour may have been cemented by access to new tasks such as medication prescribing and formal participation in Mental Health Act decision-making, these advances have been secured only at the expense of other groups' previously exclusive jurisdictions. The acquisition of new areas of work has, moreover, been a source of internal debate within nursing, as the disquiet over medication prescribing in some segments of the profession confirms (see for example: Cutcliffe 2002). As assumptions about 'who does what' erode, and as policy continues to promote the uncoupling of the ties between groups and their tasks, conditions therefore ripen for the further intensification of jurisdictional claims (and counter-claims) as professions simultaneously respond to threats to their authority and seek to make gains at the expense of their competitors. In this way can some of the recent statements made by nurses, social workers, psychiatrists and others (and referred to at the start of this paper) be best understood: as attempts to publicly defend space in a complex system of work at a time of unprecedented change and uncertainty. The longer-term consequences of these processes cannot be known in advance, for individual professions or for the system overall. At the very least, considerable energy can expect to be spent, including in the workplace, by members of professional groups engaged in (re)negotiations over relative roles and responsibilities in a context in which larger jurisdictions no longer contour work in the way they once did. With all

this in mind we urge all parties (policymakers, managers, professionals) to pay closer attention to the wider system effects which potentially emanate from current developments.

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