

**Health and social care for people with
severe mental health problems:
an ethnographic study**

**Thesis submitted for the degree of
Doctor of Philosophy**

by

Ben Hannigan

**School of Nursing and Midwifery Studies
Cardiff University**

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SUMMARY

In the study reported in this thesis sociological theories were used to underpin an investigation into the organisation and delivery of community mental health care. Set against a background of accelerating change in the wider, macro-level, system of mental health work ethnographic data were first generated relating to the meso-level organisation of interagency services in two contrasting study sites. In each site interviews, observations and documentary analysis were also used to generate data relating to the micro-level care delivered to three exemplar service user case study subjects over a four to five month period.

Macro-level public services modernisation was triggering sustained upheaval at the meso-level at which local services were planned, commissioned and provided. Complex structural, historical and people-related factors combined together to both help and hinder efforts to reconstitute local systems of work.

Case study data were drawn on to examine the micro-level roles and responsibilities of paid and unpaid workers and the unfolding of complex service user trajectories, as these were played out in the two contrasting meso-level contexts. Findings exemplify the degree to which roles are realised in specific, interactive, workplaces. The work of psychiatrists, social workers, nurses, clinical psychologists, general practitioners, pharmacists, health and social care assistants and unpaid lay carers and service users was found to be highly sensitive to local particularities and to the 'lines of impact' running between macro, meso and micro-levels.

Features with consequences for the work of particular groups included: team composition and history; relative resource availabilities and arrangements for the funding of particular types of work; progress on the agreement of formal policies and procedures; spatial and temporal organisational factors; the localised exercise of occupational jurisdictional authority; differentiations and non-differentiations of roles and responsibilities made by recipients of services; and personal factors, including individual practitioners' levels of knowledge and skill.

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ABBREVIATIONS AND GLOSSARY

ASW	Approved social worker A qualified social worker who, having completed additional specific training, has a responsibility to make applications for the use of compulsory powers under the Mental Health Act 1983
CHI	Commission for Health Improvement A body, now superseded in this part of the UK by the Healthcare Inspectorate Wales, which had the responsibility during the conduct of fieldwork in this study for the inspection of healthcare organisations
CMHN	Community mental health nurse A qualified mental health nurse working in the community
CMHT	Community mental health team A team which exists to meet the mental health needs of a locality, typically funded by health and social care agencies and staffed by a range of mental health occupational groups
CPN	Community psychiatric nurse As CMHN above
GP	General practitioner A qualified medical practitioner working in primary care
HCA	Health care assistant A non-professionally prepared health care worker
MHA	Mental Health Act 1983 Legislation for England and Wales which relates to the reception, care and treatment of mentally disordered patients
MHAC	Mental Health Act Commission A body with specific responsibilities in relation to the operation of the Mental Health Act 1983
MHSW	Mental health social worker A qualified social worker, who may or may not also be an ASW, who works in the mental health field
OT	Occupational therapist A practitioner trained to assess and promote independent living
PSSO	Principal social services officer A senior social worker, usually with management responsibilities
RMO	Responsible medical officer A medical practitioner, usually a consultant psychiatrist, in charge of the treatment of a person subject to a section of the Mental Health Act 1983

1 INTRODUCTION

1.1 INTRODUCTION TO THE THESIS

This thesis is about work; specifically, the work of organising and delivering health and social care to meet the needs of people with severe mental health problems living in the community. Underpinning this investigation are sociological theories. These include the idea that the division of work is accomplished interactively, and the ecological idea of complex, interrelated, systems of work. Also underpinning this thesis, and framing its structure, is the idea of the negotiated order.

Important areas for analysis in this study include the connections between macro, meso and micro phenomena. Here, 'macro' is used to refer to a wider structural context which includes national level policy, 'meso' refers to the organisational level at which representatives of local health and social care bodies plan and organise for the provision of services, and 'micro' refers to the level at which actual care is negotiated and provided. A further focus in this study is on roles and responsibilities, including those of different agencies, organisations and occupational groups. This focus also encompasses analysis of the roles played by lay carers and service users themselves. A third key focus is on the management of complex and unpredictable service user trajectories. Finally, this thesis includes a practical focus on factors both helping and hindering the organisation and provision of mental health services.

This thesis has been produced during a period of sustained transition in health and social care. In Wales and throughout the UK new national and local strategies continue to be brought forward with the aim of 'modernising' services (for a recent example see: Welsh Assembly Government, 2005a). Mental health care remains a UK-wide priority area for development. In Wales this is reflected in the production of a national strategy for the improvement of mental health services for adults of working age (National Assembly for Wales, 2001a), an original (Welsh Assembly Government, 2002) and a revised (Welsh Assembly Government, 2005b) national service framework for mental health care delivery, and policy guidance directed at the coordination of individual care plans across professional and agency interfaces (Welsh Assembly Government, 2003a).

At all organisational levels from the macro through to the micro, accommodating and adjusting to expected new ways of delivering health and social care services is challenging. As the authors of the *Review of health and social care in Wales* put it, transitions can be especially testing in the context of interagency working:

Health and social care organisations frequently find change difficult, particularly where working across boundaries is required.

(Welsh Assembly Government, 2003b, p2)

Change is also challenging for health and social care occupational groups, particularly in circumstances where the relative roles and responsibilities of these groups are called into question. In conditions of rapid transition,

negotiations between representatives of different agencies and occupations are liable to increase, in order to (re)constitute systems for the organisation and delivery of services. However, multiple barriers to successful negotiation across agency and professional interfaces exist. Using interviews, observations and documentary analysis to explore interrelated systems of work at meso and micro levels, this study has generated evidence of the challenges associated with the management of transitions in the context of complex and interrelated systems of work. However, this study has also found evidence of considerable goodwill and mutuality, and illuminating examples of flexible and creative service delivery aimed at making the whole system of mental health care 'work'.

1.2 WHY STUDY THE ORGANISATION AND DELIVERY OF COMMUNITY MENTAL HEALTH CARE?

How community mental health care is organised and delivered is an important area of study. It is known that people with severe mental health problems are amongst the most vulnerable and excluded members of society (Perkins and Repper, 1996; Repper and Perkins, 2003). How care is delivered to this group is, then, a matter of considerable significance to policymakers, service managers, practitioners, the public and to service users and their carers.

Evidence of the importance attached to the way community mental health care is organised is reflected in the considerable efforts made in recent years to establish the characteristics of effective and acceptable models of service delivery. For example, systematic reviews have been completed on:

community mental health teams for people with severe mental illnesses and disordered personality (Tyrer et al., 1998); case management for people with severe mental disorders (Marshall et al., 1998); and on assertive community treatment for people with severe mental health problems (Marshall and Lockwood, 1998). At the policy and practice level, throughout Wales and the rest of the UK occupational groups and agencies with shared interests in the provision of mental health care are being brought together in new ways with the aim of improving services. New types of team, often providing 'functional specialist' services (Onyett, 2004), have appeared (Department of Health, 2001a; Welsh Assembly Government, 2005b). New types of worker have also been introduced into the workforce (Department of Health, 2002a; Department of Health, 2003a).

Despite these developments in research and policy, relatively little investigation has taken place into the functioning of 'whole systems' of community mental health care (Freeman et al., 2002; Onyett, 2003). An exception is Provan and Milward's US-based study of the effectiveness of interorganisational networks of care, which points to the importance of adequate resourcing and organisational stability (Provan and Milward, 1995). Generally, however, studies have not explored the work of specialist mental health service providers alongside the work of other organisations and groups (including lay carers and service users) who together contribute to overall service provision (Onyett, 2003). In addition, investigations into the organisation and delivery of mental health care have hitherto failed to make explicit links between the macro-level at which national policy and structures

are determined, the meso-level at which key agency representatives and lead professionals work together to interpret and enact macro-level features in their specific local contexts, and the micro-level at which face-to-face services are delivered (Griffiths, 2003).

In recent years general recognition has grown that the organisation of health and social care work, in all areas of service provision, is an important area of study. Alongside investigations into the development of new therapies and treatments, research is needed with the aim of exploring and establishing effective ways of delivering services (Fulop et al., 2001). This research need has been reflected locally through the establishment of a Cardiff University School of Nursing and Midwifery Studies' research programme, *The division of labour and the labour of division* (School of Nursing and Midwifery Studies Cardiff University, 2006). This thesis has been completed as part of this research theme's programme of work, and, as with other studies in this theme, has been concerned with improving understanding of the ways in which health and social care work is organised and delivered, and the implications of this for practitioners, managers, policymakers, educators, service users and carers.

1.3 THE RESEARCHER: AN INTRODUCTION

My interest in the organisation and delivery of community mental health care is longstanding. My practitioner background is in community mental health nursing, and before taking up my current education and research post in 1997 I worked as a member of a busy interprofessional community mental health

team (CMHT) in an inner London borough. My practice experiences stimulated my interest in the provision of community mental health care, and in the relationships between mental health policy and practice.

In addition to this practice background, I have benefited from the opportunity of studying the social sciences. My first degree, in Politics and Sociology, was completed before I entered nursing. During this time I developed an interest in macro-level social and political issues, including the construction of policy. Later, having by this time trained as a nurse and having started work as a community mental health practitioner, I enrolled for a part-time MA in Health and Social Policy. I used this opportunity as a means of bringing together my professional interests in mental health care, and my scholarly interests in policy (and, more broadly, the social sciences). I also used this first postgraduate experience to begin exploring alternatives to macro-level explanations of social organisation and social behaviour.

Much of the work I submitted for my MA I subsequently refashioned into papers for publication. I wrote, in particular, about the complex policy environment in which community mental health care is delivered (Hannigan, 1999a), about public attitudes towards people with mental health problems (Hannigan, 1999b), about the professional development of community mental health nursing (Hannigan, 1999c), and about education for mental health practice in community settings (Hannigan, 1999d). My continued interest in mental health care is demonstrated in this thesis. In addition, the work that I

have undertaken as a PhD student has significantly extended my knowledge and expertise in the field of community mental health services research.

1.4 HEALTH AND SOCIAL CARE WORK: SOME THEORETICAL ASSUMPTIONS

This thesis is underpinned by a number of theoretical assumptions, which are explored in detail in Chapter 2. First is the idea that the division of work can best be understood as the product of social interaction. As Freidson puts it:

...it seems accurate to see the division of labour as a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain and renew the tasks they perform and the relationships with others which their tasks presuppose.

(Freidson, 1976, p311)

Also underpinning this thesis is the idea that the work undertaken by a particular group is best understood by locating this within the overall division of labour as this is constituted in a given social setting. Hughes expresses this 'ecological' perspective thus:

...the different tasks and accomplishments are parts of a whole whose products all, in some degree, contribute to. And wholes, in the human social realm as in the rest of the biological and in the physical realm, have their essence in interaction.

(Hughes, 1971, p304)

Drawing on the work of Strauss and others, a third strand of the theoretical framework developed in this thesis is the idea of the negotiated order

(Strauss, 1978). Negotiated order theory permits conceptual links to be made between structure and human interaction, with, as Strauss puts it, “the lines of impact [running] *either way*” (Strauss, 1978, p101, emphasis in original).

Negotiations are an important, but not the only, way of ‘getting things done’ in social settings. Negotiated order theory is used in this thesis to underpin an analysis of the characteristics of, and the linkages between, the structural and negotiation contexts for community mental health care. This encompasses data-based analysis of the contextual factors ‘patterning’ negotiations (and non-negotiations) in each of the two study sites in which data were generated.

1.5 THE STUDY

Work leading to the production of this PhD thesis began with formal registration in 1999, and proceeded through a series of linked phases. The organisation and sequencing of these phases is summarised as a form of ‘audit trail’ in Appendix 1.

The investigation reported here involved the use of ethnographic case study methods to explore the micro-level delivery of community care to three mental health service users in each of two contrasting study sites. In each case study, I was able to follow the delivery of services over a period of four to five months. Through interviews with service users, professionals and lay carers, through direct observations of critical events (such as care planning meetings), and through accessing and analysing written practitioner records, I was able to generate a detailed picture of the negotiation (and non-negotiation) of service delivery and the management of roles and

responsibilities. This exploration of both the social relations between workers and the unfolding of events over time amounted to an in-depth mapping of each case study subject's trajectory, including into the range of health-related and organisational contingencies significant for each (Strauss et al., 1985). My analysis of these data also enabled identification of factors both helping, and militating against, the effective delivery of services.

In addition to generating case study data, my fieldwork strategy included the creation of data relating to the meso-level policy and practice context in each of my two selected study sites. Data were created through analysis of national and local policy documents, through interviews with key managers and senior practitioners in both health and social care agencies, and through observations of events such as regular community mental health team meetings. In this way I was able to construct an in-depth picture of the overarching and more immediate context within which micro-level community mental health care was delivered.

My intention is that this thesis makes a theoretically informed, data-based, contribution to understanding the processes and outcomes of community mental health services delivery. The study's findings will be made more widely known principally through the production of journal and book chapter publications, and by making presentations at international and national conferences. This process has already commenced (see Appendix 2), with the publication of a journal paper (Hannigan and Allen, 2003) and a book chapter (Allen and Hannigan, 2006) addressing research governance and

research ethics issues associated with the study, a book chapter focusing on data generation (Hannigan, 2006a), the preparation of a paper examining the themes of complexity and change in the UK's system of mental health work (Hannigan and Allen, 2006), and a paper analysing the implications of changes in the system of mental health work for practitioners (Hannigan, 2004a). Dissemination has, so far, also included the preparation and delivery of a series of conference papers, workshops, poster presentations and invited seminars drawing on research process issues and findings (Allen et al., 2001; Hannigan, 2001; Hannigan, 2002; Hannigan, 2003a; Hannigan, 2003b; Procter et al., 2003; Hannigan, 2004b; Hannigan, 2006b; Hannigan, 2006c; Hannigan, 2006d). This study has also revealed avenues for further research studies in the broad mental health service organisation and delivery field.

1.6 ORGANISATION OF THE THESIS

Chapter 2 begins this thesis proper. I discuss how my study replicated the design and methods pioneered in a joint Cardiff and Swansea research project, titled *Delivering health and social care: changing roles, responsibilities and relationships* (Allen et al., 2002; Allen et al., 2004a; Allen et al., 2004b). I consider the theoretical implications of adopting a research approach developed in a previous investigation, and use this as a stepping off point for an analysis of interactionist theories of work and the division of labour. I then progress to a more detailed presentation and critical analysis of a theoretical framework, the negotiated order perspective (Strauss, 1978). The work of Strauss and colleagues in this area, and the work of others who have since drawn on a 'negotiations' perspective, has been concerned with the processes

through which change in social orders occurs. Before concluding with a theoretical synthesis, Chapter 2 also includes an analysis of the concept of 'trajectory' as a means of understanding the unfolding over time of complex phenomena such as the experience of ill health and the social organisation of responses to this (Strauss et al., 1985).

In Chapter 3 I draw on this theoretical framework to analyse the 'structural context' for the organisation and delivery of contemporary community mental health care in Wales and beyond. My starting point in this Chapter is the observation of sustained flux and upheaval in mental health services. Here I discuss the historical emergence of community mental health care as an alternative to institutional provision, the emergence of the interprofessional and interagency community mental health team as the favoured vehicle for the delivery of 'specialist' services at the local level, and the more recent crisis of community care.

In Chapter 3 I also consider how the system of community mental health work has, in the last decade, adjusted to: the demands of public services modernisation; the challenge of increasing public and media scrutiny, particularly around the identification and management of risk; threats to the legitimacy of professional mental health knowledge and practice; the emergence of new areas of work, and the loss of others; and the changing fortunes of particular occupational groups. My specific focus in addressing these and other areas is to generate a detailed analysis of the extent of mental health services transition at a macro-level, against which the task of

analysing the work of providing everyday mental health care in each of my two study sites might be more completely understood.

Research process issues are addressed in Chapter 4. I discuss the development of research aims and objectives, and consider in detail the ethnographic case study mapping methodology employed during fieldwork. I make a link in this Chapter between the theoretical underpinnings of my study (as represented in Chapter 2) and the project's design and methods. In addition, I consider my approach to key philosophical and practical research process issues, including reliability, validity and generalisability in the context of in-depth qualitative research. This Chapter also includes an account of the research governance framework within which I conducted my study, focusing particularly on the strategies I adopted in seeking formal local research ethics committee approval, and in securing research access. I discuss my rationale for locating myself in a community mental health team as a research base in each of two selected study sites. I also demonstrate how 'getting permission' for my study and 'getting in' were both subject to processes of negotiation. Finally, in this Chapter I reflect on the extent to which my experiences of 'getting in' to my selected study sites revealed valuable data relating to the organisation of services in each area.

My aim in Chapter 5 is to describe, analyse, compare and contrast the characteristics of my two selected study sites. Taking care to protect, as far as possible, the identity of individuals, organisations and locations I draw on interview, observational and documentary data to support an analysis of the

general organisation and patterns of mental health services delivery in each locale. I consider the extent to which the localised system of mental health work in each area can be understood as the product of interactive processes, and the extent to which each can be understood in the light of the analysis developed in Chapter 3. Each locale is treated as a specific meso-level negotiation context, or meso-level system of work. My analysis here covers the general organisation and functioning of the two contrasting CMHTs in which I based myself for the duration of the data generation phase of the study, and the relationships between the different organisations and occupational groups sharing the responsibility to plan and provide mental health care.

A central concern in this study has been the exploration of the delivery of everyday mental health care to three exemplar users of community mental health services in each of my two study sites. From this particularly 'micro' vantage point, it is analytically possible to treat the meso-level negotiated order of mental health services delivery in each study site (as explored in Chapter 5) as now being part of an overarching structural context. For the purposes of this part of the thesis, from Chapter 6 onwards, I have elected to identify the micro-level negotiation contexts as encompassing the networks of care (or micro-level systems of work) as these specifically surrounded each of the six users of mental health services whose care I was able to follow during my period of data generation.

I begin Chapter 6 with an account of my case study subject selection strategy. I discuss how each person with mental health problems who participated in my project was identified, approached and recruited. Foreshadowing the themed data analysis Chapters which follow, I devote the larger part of Chapter 6 to an analytic overview of the characteristics of each case study subject micro-level negotiation context. Key negotiators and key events unfolding in each trajectory are highlighted.

Chapters 7, 8 and 9 contain analyses of key findings arising from exploration of all six micro-level networks of care. These three Chapters focus on the work of members of different occupational groups and on the work of unpaid carers, and on actual negotiations, reports of negotiations and non-negotiations through which the division of this work was accomplished. Analysis also focuses on the unfolding of complex service user trajectories. Chapter 7 centres on the work of members of the principal occupational groups involved in community mental health care provision in this study: psychiatry; social work; nursing; clinical psychology; and general medical practice. Chapter 8 addresses the work of representatives of marginalised and low status occupational groups, and on the contribution of unpaid lay carers and service users. Reflecting an ecological perspective, in both Chapters the micro-level contribution of representatives of each group is set in the context of work undertaken overall.

Chapter 9 is devoted to an analysis of transitions. This Chapter takes as its starting point the unfolding of critical events, rather than the contribution of

specific workers *per se*. Included here is analysis of the unfolding, and management, of complex service user trajectories (Strauss et al., 1985). Key events considered include, for example, transitions from home to hospital (and back again), and transitions precipitated by organisational contingencies such as the arrival and departure of key members of care teams.

Chapter 10 closes this thesis. Key lessons arising from the completed study are recapped, and the implications of this investigation for mental health policy, practice and education considered. The original contribution of the study is discussed, and lines of future enquiry considered.

2 DEVELOPING A THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This Chapter builds a theoretical framework with which the system of community mental health care at macro, meso and micro-levels might be better understood. Within the overall organisation of this thesis, the framework developed here is used to underpin the analysis of contemporary community mental health care presented in Chapter 3. The framework is then employed to help justify the design and methods used in the empirical phase of this PhD (Chapter 4). Theory explored and developed in this Chapter also underpins the data analysis presented from Chapter 5 onwards.

2.2 THE ORIGINS OF THE CURRENT STUDY

The design and methods used in the study reported in this thesis were developed in a joint Cardiff and Swansea research project, titled *Delivering health and social care: changing roles, responsibilities and relationships*.

Areas of particular analytic significance for this earlier research team were: the management of interprofessional and interagency interfaces (Allen et al., 2002); routine resource allocation (Allen et al., 2004a); and improving the understanding of complex caring trajectories (Allen et al., 2004b).

This earlier study was explicitly designed and executed as a sociologically informed research project, although subsequent dissemination has been aimed at both social scientific and health and social care practitioner audiences. The research team's approach to data generation grew directly

from the study's theoretical starting point. Consistent with its members' perspective on 'work as interaction', the *Delivering health and social care* team observed that the most appropriate means of investigating these interactions was by using in-depth qualitative research methods.

Correspondingly, ethnographic methods were employed to trace the networks of care surrounding eight exemplar case study subjects, each of whom had suffered a stroke.

The decision to replicate the design and methods of this earlier project was taken for a number of reasons. A first reason was strategic, and related to the building of research capacity and methodological expertise. Second, the current and emerging mental health policy and practice context in Wales and beyond made an in-depth, ethnographic, investigation into the organisation and delivery of care to people with severe mental health problems an appropriate and timely topic for a PhD.

Adopting the design and methods developed in the earlier project had important theoretical, methodological and practical implications for the current study. At the most practical level, it became possible to use information sheets and record of consent forms produced for the previous study as templates for this later investigation. More significantly, the decision to replicate *Delivering health and social care's* design and methods demanded a consideration, at length, of the theoretical and methodological assumptions underpinning this earlier project. It was also important to consider the degree to which these assumptions could be accommodated within this PhD. These related tasks

were necessary for a number of reasons. Decisions over what methods to use, how data should be analysed and how findings should be presented all reflect a variety of assumptions on the part of researchers, whether or not these are always acknowledged or made explicit. A reflexive stance is revealed, in part, by a careful consideration of the ways in which theoretical assumptions impinge on the research process.

2.3 TOWARDS A THEORETICAL FRAMEWORK: AN INTERACTIONIST PERSPECTIVE

Dawe uses the phrase 'the two sociologies' to capture the distinction (and the tension) between that part of sociology which is concerned with social structure, systems and constraint, and that part which is concerned with individual agency, subjectivity and human action (Dawe, 1970). My pre-PhD background was largely in the first of these traditions, making the explicitly interactionist perspective underpinning the *Delivering health and social care* study a relatively novel one.

The *Delivering health and social care* research team's theoretical and methodological emphases reflected established themes within the broad interactionist tradition. These include the significance attached to social processes, a recognition of the complex interrelationships between human action and social organisation and a commitment to empirical investigation using ethnographic methods (Atkinson and Housley, 2003). At the level of theory, interactionists have responded to criticisms levelled by more structure-and-constraint oriented sociologists by arguing that their focus on interaction

should not be confused with a denial of the significance of social structures.

For example, as the *Delivering health and social care* research team stated in the context of their study of work:

...interactionists recognise that formal organisational structures – such as job descriptions, policies and procedures – provide the framework in which services are delivered...

but also that an interactionist perspective:

...conceptualises the division of labour as dynamic and shifting and makes social interaction between workers central to its concerns.

(Lyne et al., 1997, p11)

2.4 'WORK AS INTERACTION' AND 'SYSTEMS OF WORK'

The world of work is an area in which interactionists have made important, and sustained, theoretical and empirical advances (Atkinson and Housley, 2003). Notable contributions have been made by Hughes (1971), Strauss (1978) and Abbott (1988), and it is their ideas which are particularly drawn on in this study.

How work is divided up – the division of labour – is ultimately a product of human interaction. For the Chicago sociologist Everett Hughes, this is “one of the most fundamental of all social processes” (Hughes, 1971, p285). Hughes also advances the idea that the world of work is best thought of as a dynamic and interrelated social system. This ecological perspective is particularly revealed in his writings on occupations. An occupation, for Hughes, refers to the part played by a group in the context of a larger system of work.

Occupations combine ‘task’ aspects (the “what I do”) with ‘role’ aspects (the

“who I am”) (Allen, 2001, p24). Hughes also introduces the concepts of ‘mandate’ and ‘licence’ to draw attention to occupations’ assertions about their status. An occupational mandate refers to the claims that a group makes about its particular contribution to society, whereas its licence refers to the actual terms of what members of that group are permitted to do distinct from the contribution of others.

Hughes considers systems of work to be in flux, and evolving in response to wider processes (such as advances in specific technologies, and economic and social developments). Evolution of systems means that the “bundle of tasks” (Hughes, 1971, p313) attached to particular occupational groups may change, as can their social character. Challenges might also be mounted to an occupational group’s licence and mandate, processes liable to lead to realignment of the boundaries between different occupational groups in an overall division of labour.

Hughes uses this ecological approach to analyse the work of nurses. For example, he writes that:

...it is impossible to describe the job of one kind of person without saying something about the work of others. Since most nurses do their work in hospitals, it is well to start a study of the nurse’s work by thinking of all the things which have to be done to make a hospital go. Seen in one way, the nurse’s job consists of all the things which have to be done in the hospital and which are not done by other kinds of people. Of each of these many tasks one must ask, “Why is this done by the nurse rather than by someone else?”. About the things done by other people, one should ask, “Why is this done by someone else rather than by the nurse?”. This kind of question sets one’s eyes on the frontiers between nurse’s work and the work of all the other kinds of

people in a hospital. There are as many of these frontiers as there are other kinds of people in the organization.

(Hughes, 1971, p312)

Abbott (1988) builds on Hughes' thinking. He also advances an ecological view of the world of work, but unlike Hughes is interested specifically in the system of professions. Building on the notions of licence and mandate, Abbott uses the term 'jurisdiction' to describe the control exercised by a professional group over an area of work. In dynamic systems jurisdictions are liable to change, in response to both internal and external forces. Like Hughes, Abbott implicates social, economic and technological changes as potential sources of system disturbance. System change can encompass the disappearance of some areas of work and the emergence of others, and a waxing and a waning in the fortunes of different groups. Abbott also emphasises the importance of interprofessional competition. Externally driven changes in systems, for example, can present as opportunities for occupational groups to seize control of existing or emergent areas of work.

For Abbott, what makes professions distinct is their appeal to the possession of abstract knowledge, which is used to advance occupational status claims. Abstract knowledge, Abbott argues, is not an absolute but a relative concept; what matters to a profession's survival is "abstraction effective enough to compete in a particular historical and social context" (Abbott, 1988, p9). Possession of abstract knowledge is distinct from possession of skills or techniques. Abbott argues that control of tasks in the absence of control of the

abstract knowledge underpinning these is a feature of crafts occupations, rather than the professions.

Abbott proposes that three arenas exist for the advancement of jurisdictional claims: the public; the legal; and the workplace. Claims to professional jurisdiction in the public sphere tend to be limited. For example, Abbott notes that in public arenas claims are limited to those between apparently homogenous, archetypal groups. More enduring jurisdictional claims are made in the legal arena. There, control over specific areas of work may be cemented, sometimes lasting for decades or longer. However, precisely worded legalistic settlements outlining the boundaries of professional work often bear little resemblance to the jurisdictions defended and advanced in real life, interactive, workplaces. This real life world of the workplace is Abbott's third arena for the advancement of professional claims. In situations where professionals work in organisations, the interprofessional division of labour is supplemented by an interorganisational division. Professionals in organisations are often required to assume new areas of work and give up others. Although job descriptions may attempt to delineate the boundaries between different groups, the actual work that professionals do is likely to bear little resemblance to what is enshrined on paper. As Abbott puts it:

In most professional work settings, actual divisions of labor are established, through negotiation and custom, that embody situation-specific rules of professional jurisdiction.

(Abbott, 1988, p65)

Taken together, Hughes' and Abbott's ecological ideas provide a powerful framework for investigations into the world of work. This approach can be summarised thus:

[T]he societal division of labour is conceived of as a social system. Work is defined as the activities that need to be done in a given society and is not limited to paid work in the public sphere. The world of work is dynamic. System disturbance may arise from a number of sources: social, technological, economic and organizational change. Because the system of work is constantly in flux, occupations change. Jurisdictions expand and contract and the boundaries between paid and unpaid work domains may shift. New occupations emerge, others fuse and some may decline or disappear totally. The value and status of activities undertaken by an occupation may be modified. It is against this ever-changing world that occupations vie to secure their standing.

(Allen, 2001, p41)

The idea that the world of work is a dynamic and complex ecological system represents an important theoretical building block for this study. However, both Hughes and Abbott are generally more concerned with establishing the contours of systems of work and the divisions of labour contained therein, rather than with the properties of actual work-oriented interactions taking place at a micro-sociological level. Both are less concerned with interactive processes *per se* than with their systemic outworkings.

The study reported in this thesis has included an investigation into the organisation of work at a micro-level. In advancing a theoretical framework for the purposes of this study, it has been useful to complement a 'whole systems' perspective with ideas that more readily accommodate the study of interactions 'as interactions'. This is accomplished by using a negotiated order perspective (Strauss, 1978). Negotiated order theory shares the broad domain

assumptions embedded in the ideas of 'work as interaction' and of 'systems of work'. Importantly, negotiated order ideas also offer the possibility of bridging the gap between the 'two sociologies' (Dawe, 1970), and have utility in framing theoretically founded investigations into social organisation at macro, meso and micro-levels.

2.5 THE NEGOTIATED ORDER

The term 'negotiated order' was introduced by Strauss and his associates over 40 years ago (Strauss et al., 1963) as a means of understanding how social order is maintained during periods of inevitable change (Maines, 1977). Introduction of the term was underpinned by several years of fieldwork undertaken in two North American psychiatric hospitals, in which Strauss and his colleagues investigated the organisation of services and the complex relationships between members of the hospitals' staff (Strauss et al., 1964).

In the book which introduces the negotiated order perspective there is criticism of ideas which overemphasise the formal features of organisations, and which portray social life as ordered and stable. For Strauss and his partners, a more accurate view of hospitals (hospitals being their study's particular object of analysis) is to see these as being in a state of constant flux, in which the apparently hard-and-fast, stable features of organisational life are continually being called into question. In such circumstances, the maintenance of social order needs always to be "worked at" (Strauss et al., 1963, p148).

With respect to the complexities of the hospital division of labour, Strauss and his colleagues draw attention to the multiplicity of different occupational groups working side-by-side, their members espousing and enacting different theoretical and ideological positions. Adding to the complexity are the existence of ideological differences within occupational groups, a phenomenon which Strauss had earlier referred to as 'segmentation' (Bucher and Strauss, 1961). In their hospital fieldwork, all that appeared to bring groups together was a single, vague, goal: "...to return patients to the outside world in better shape" (Strauss et al., 1963, p154). Even this shared aim, however, appeared open to interpretation. Being in 'better shape' could mean different things to different people. Even where 'being better' was commonly understood, different views existed on how patients could be assisted towards this.

A distinct feature of negotiated order theory from its inception has been its view of the relationship between social orders and interactive processes. In the context of their work on the organisation of psychiatric hospitals, Strauss and his colleagues define the 'social order' as comprising:

...rules and policies, along with agreements, understandings, pacts, contracts and other working arrangements.

(Strauss et al., 1963, p165)

The social order, then, represents the totality of organisational life, including formal structures. Strauss and his co-workers advance the idea that social orders play an important role in 'patterning' negotiations, such as those they

observed taking place in the psychiatric hospitals in their original study. However, from the outset negotiated order theorists also argued that, in turn, these negotiations have the potential to be 'felt' at a structural level. As Strauss later puts it, "the lines of impact can run *either way*" (Strauss, 1978, p101, emphasis in original). In this way, negotiated order theory contained from its inception a dialectical view of the relationship between the micro-level world of everyday interaction, and the macro-level world of organisational structure.

Problematically, Strauss and his partners have relatively little to say in their earliest work about the central concept of the 'negotiation'. In their view, negotiations can be both 'explicit' and 'implicit', with the latter possibly comprising no more than tacit agreements made with the minimum of actual interaction (Strauss et al., 1963). Negotiating, as an interactive activity, includes making (or reaching): "'agreement', 'understanding', 'contract', 'compact', 'pact'" (Strauss et al., 1963, p163). Compounding the problem of this rather vague early treatment of 'the negotiation', Strauss and his colleagues also draw on only limited fieldwork data to support their theoretical claims.

An elaboration and extension of negotiated order theory appears in Strauss' later book, *Negotiations: varieties, contexts, processes and social order* (Strauss, 1978). Here, Strauss acknowledges and addresses criticisms of negotiated order theory presented since the appearance of the perspective over a decade previously. Day and Day, for example, had earlier applauded

aspects of the negotiated order approach, and in particular what they saw as the perspective's significant potential in linking interactive processes to large-scale organisational change (Day and Day, 1977). However, Day and Day were also critical of negotiated order theory (and interactionist ideas in general) insofar as the perspective appeared to suffer, in their view, from a lack of appreciation of the significance of social structure.

Strauss' refinement of negotiated order theory in 1978 includes, first, an expanded consideration of the core concept of the 'negotiation'. Strauss begins by arguing that negotiation may take many different forms, including:

'bargaining', 'wheeling and dealing', 'compromising', 'making deals', 'reaching agreements after disagreements', 'making arrangements', 'getting tacit understandings', 'mediating', 'power brokering', 'trading off', 'exchanging', and 'engaging in collusion'.

(Strauss, 1978, p1)

Strauss advances the idea that 'negotiating', in all its varieties, is a universal feature of human life. As such, he argues that the study of negotiations is central to the study of human society and social organisation. In an acknowledgement of the structural critique of negotiated order theory, Strauss also makes clear that negotiations – as "one of the possible means of 'getting things accomplished'" (Strauss, 1978, p2) – ought to be studied in the context of the macro-level social settings in which they occur. Strauss also urges students of negotiated orders to focus on a full, rather than a narrow, range of 'negotiations', and to consider the alternatives to negotiation (such as coercion and manipulation) as these present themselves to social actors. He

also draws attention to the importance of the (often implicit) 'theories of negotiation' held by those engaged in social action. These implicit 'theories' can include, for example, ideas regarding who to negotiate with, when and how.

Further refinements of negotiated order theory proposed by Strauss in 1978 include the linked concepts of 'structural context' and 'negotiation context'.

Taken together, these ideas represent Strauss' attempt to make analytically clearer the dialectical relationship between negotiation processes and social structures. 'Structural context' refers to the larger, transcending, context "within which" negotiations take place, whilst 'negotiation context' refers to "the structural properties entering very directly *as conditions* in the course of the negotiation itself" (Strauss, 1978, pp237-8, emphases in original).

Negotiation contexts can be considered in terms of a number of key characteristics, which Strauss suggests are: the number of negotiators, their experience and who they represent; whether the negotiations are, for example, one-shot, repeated, sequential, or linked; the power balance existing between negotiators; the relative stakes held by negotiators; the degree of visibility of the negotiation processes; the complexity and variety of matters being negotiated; the clarity of legitimacy boundaries of the issues under negotiation; and actors' options to engage in alternatives to negotiation (Strauss, 1978, p238).

Strauss holds that structural properties help to 'pattern' negotiations via their entry into the negotiation context, but also that negotiations have the potential

to modify structural properties by working their way 'back up' through negotiation contexts. In this way, Strauss' ideas allow 'social structures' to be viewed as being – ultimately – 'in process'. As Maines and others have since been at pains to make clear (see for example: Maines, 1982; Fine, 1984), Strauss does not argue either that 'negotiation' is the only way to 'get things done', or that every aspect of a negotiated order is always and everywhere open to negotiation. Alternatives to negotiation in the world of work include, for example, the pursuit of coercion or persuasion, or simply engagement in rigidified, entrenched practices. This is so even though, as later writers have observed (Dingwall and Strong, 1985; Allen, 1997), that early accounts of the negotiated order lend support to the claim that Strauss and his associates at first saw every aspect of the negotiated order as being continually negotiable. In *Psychiatric ideologies and institutions*, for example, Strauss and others write that:

The realm of rules could then be usefully pictured as a tiny island of structured stability around which swirled and beat a vast ocean of negotiation. But we would push the metaphor further and assert what is already implicit in our discussion: that there is *only* vast ocean.

(Strauss et al., 1964, p313, emphasis in original)

Strauss' refinements of negotiated order theory in 1978 suggest that, whatever his initial view may have been, he had by this time oriented to the position that not all aspects of organisational life are negotiable at all times. Indeed, part of the task facing negotiated order theorists and researchers, Strauss argues, is "to discover just what *is* negotiable at any given time" (Strauss, 1978, p252, emphasis in original). Strauss is also clear that most of

the negotiations which occur in everyday organisational life have little chance of working their way back up to effect lasting change in overarching structural contexts. The most likely way in which such change can occur, he suggests, is through the cumulative effect of multiple negotiations taking place in numerous negotiation contexts. However, what Strauss does reaffirm here is his position that, to some degree, all social orders are negotiated orders; social organisation is simply not possible without some measure of negotiating between social actors taking place. Thus, he argues that negotiated order theory has utility as a framework to understand all types of social setting, from the 'micro' (such as specific workplaces) to the 'macro' (such as nation states).

In the context of this study, *Negotiations*, as the most detailed of Strauss' accounts of negotiated order theory, still leaves at least one crucial question unanswered. This relates to the central concept of the 'negotiation' itself. Strauss' list of synonyms and his general treatment of 'negotiation' (for example, his recommendation to focus on a 'full' rather than a 'narrow' range of negotiations, and his recognition of negotiations as including tacit understandings) begs the question: when is a 'negotiation' not a 'negotiation'? Or, as Maines and Charlton put it:

How are instances of negotiation different from other forms of interaction? How do we know when we see an instance of negotiation?

(Maines and Charlton, 1985, p293)

Questions of this type are particularly important for empirical studies undertaken in a negotiated order tradition, as the study reported in this thesis has been. The problem of the lack of precision surrounding the concept of the 'negotiation' has greatly vexed writers sympathetic to the general thrust of Strauss' thinking. Allen, for example, notes the lack of face-to-face negotiation in her study of the nursing/medical interface, but acknowledges that the everyday construction of interprofessional boundaries is clearly the product of the purposeful actions of those in the field (Allen, 1997). This raises, for her, the possibility that 'negotiations' can either refer to "diverse processes of social interaction" (p515), or, more narrowly, to a much more restricted type of interactive activity.

'Negotiation' in the sense in which Strauss and his collaborators use the term is firmly a *sociological* construct. In this specific disciplinary context, the term has to relate to "overall patterns of participation and the structured patterning of social orders" (Maines and Charlton, 1985, p294). 'Negotiating' is, therefore, different from (for example) the study of 'communicating' (a term belonging to the discipline of psychology, and one which does not connote a relationship between human interaction and the structural context within which this occurs). As I demonstrate in later Chapters in this thesis, in my interpretation of data generated in this study I have paid particular attention to the effects of 'structural patterning' on work-oriented interactions between representatives of different agencies and occupational groups. Use of a negotiated order perspective has also underpinned my examination of the 'lines of impact' (Strauss, 1978) running from 'structure' to 'interaction'. This

has encompassed exploration of the ways in which the overarching features associated with the world of mental health work have had significance in shaping actual interactions. I have also been mindful of ideas developed by Maines and Charlton in distinguishing instances of negotiation from other types of social event. I have assumed, for example, that negotiations can only take place in conditions characterised by neither complete consensus nor complete non-consensus. Second, I treat negotiations as always having a transactional quality; they are only not possible when there can be no exchange between social participants. Third, I consider that negotiation involves the use of particular 'strategies' (as opposed to, for example, the 'use of force' in coercion or the 'use of misrepresentation' in manipulation) (Maines and Charlton, 1985).

2.6 LEARNING FROM STUDIES INTO NEGOTIATED ORDERS

Having introduced the idea of the 'negotiated order', and having examined aspects in need of clarification for the purposes of this study, I consider in what follows the ways in which previous researchers have used negotiated order theory to inform their investigations. Selection of studies has been neither exhaustive nor confined to an analysis of investigations undertaken in health care settings. Identification of studies was assisted by a search (last updated in July 2005; see also Appendix 3) of two major social science databases, *Sociological Abstracts* and *Applied Social Sciences Index and Abstracts* (ASSIA), using the exact search phrase 'negotiated order'. The value of this exercise has not been to comprehensively review all previous studies undertaken in the negotiated order tradition (an impossible task in

itself), but rather to learn from selected previous researchers' attempts to use a negotiated order perspective to inform and underpin their empirical investigations, and to learn from their findings. For example, given the problematic nature of the term 'negotiation', it has been of interest and significance in the context of this study to consider how previous investigators have handled this concept, and to learn from this. Other concerns of theoretical and methodological interest have included, for example, the ways in which previous researchers have attempted to realise the dialectical relationship between negotiation processes and social structures, and the manner in which investigators have made use of the concepts of 'structural context' and 'negotiation context'. Similarly, a valuable task in the context of this study has been to reflect on the methodological approaches taken in the study of 'negotiations', and, again, to learn from this.

A fairly restricted range of studies are included here, and only investigations in which the researcher or researchers have directly claimed to have worked within a negotiated order tradition. This strategy has been a deliberate one, in order to circumvent the possible charge of subsuming too loose a collection of investigations under a 'negotiations' umbrella (*cf.* Benson's (1978) critique of Maines (1978), for including in his defence of the negotiated order a number of studies not explicitly embracing a 'negotiations' perspective).

An obvious place to start is with the study which first generated the negotiated order perspective. The most complete account of the work of Strauss and his associates on psychiatric hospitals is published in the book *Psychiatric*

ideologies and institutions (Strauss et al., 1964). Strauss and his colleagues' fieldwork strategy is described in Chapter 2 of this publication; this involved a team of investigators engaging in sustained, in-depth observational and interview activity in a number of different hospital settings, along with the administration of a questionnaire. By choice, Strauss and his associates use relatively little "illustration and quotation" (Strauss et al., 1964, p37) in presenting their findings. Although they advance a strong argument that the division of labour in the two hospitals they studied was a product of negotiations, their account therefore gives relatively little direct evidence of this in terms of data extracts.

In the later publication *Negotiations* (Strauss, 1978) Strauss returns to this original investigation, and presents as a case study his colleagues' Bucher and Schatzman's analysis of the negotiated division of psychiatric hospital labour. Again, Strauss relies more on analysis and inference and less on direct data extracts to support his argument. This later account is instructive, however, insofar as Strauss is explicit in analysing the organisation of hospital life using the then-new concepts of 'structural context' and 'negotiation context'. The former include, for example, the emergence of ideological rifts within North American psychiatry, along with challenges to authoritarian institutional care. These aspects of the overarching structural context were 'felt' in different ways in the particular negotiation contexts of the hospitals in Strauss and his colleagues' study. For example, different wards were staffed by psychiatric teams espousing different treatment ideologies; operationalising these ideologies, along with other factors such as the coming and going of

staff members, precipitated considerable negotiation in the ward-based division of labour.

In 1982 the journal *Urban Life* (now renamed as the *Journal of Contemporary Ethnography*) devoted an issue to the negotiated order perspective. The studies reported in this special edition are interesting for a variety of theoretical and methodological reasons. Sugrue, for example, reports on a diary-based, interview and documentary analysis study of one person's hospital care, and makes a case for including 'emotions' as a property of negotiation contexts (Sugrue, 1982). Sugrue's micro-sociological interests are revealed in her use of lengthy data extracts, illustrating (for example) actual negotiations between Sugrue's case study patient and a member of her medical team.

Levy's contribution includes using an in-depth investigation into negotiations between hospices and hospitals to advance a new dimension of negotiated order theory, that of 'staging'. This, she suggests, refers to:

attempts by participants to gain their objectives by defining the rules, assumptions, temporal sequence, and other special properties that form the context in which negotiations take place.

(Levy, 1982, p298)

Successful 'stagework', in Levy's analysis, allows social actors to skew negotiation contexts in such a way as to make it more likely that their interests, rather than those of their 'opponents', will predominate. Levy's use of data from her study is less extensive than Sugrue's; her idea of 'staging',

however, is supported through inclusion of empirical referents including extracts of conversations observed during her fieldwork.

Busch's contribution to the *Urban Life* special edition addresses the development of agricultural research in the US. Busch's approach is a historical, macro-sociological, one:

...it is argued here that negotiations may be used as a metaphor for history; that is, that history *is* negotiations.

(Busch, 1982, p368, emphasis in original)

Busch's focus spans a century-long period, and his data is derived largely from published conference proceedings, earlier analyses of the agricultural field, and original analysis of organisational change.

In *Negotiations* Strauss had earlier made a case for negotiated order investigators to consider in their studies the 'theories of negotiation' held by social actors (Strauss, 1978). Kleinman's contribution to the *Urban Life* special edition lies in this area (Kleinman, 1982). Her investigation into the organisation of a not-for-profit holistic health centre provides a vehicle for an analysis of differences in the importance accorded by actors to the health centre's 'rules'. For example, Kleinman notes, with support from data extracts, the presence of conflict between those who sought flexibility and those who sought to accomplish the work of the centre 'by-the-book'.

Hall and Spencer-Hall's contribution to the 1982 special edition of *Urban Life* is a particularly illuminating one, not least because their field of enquiry is in education rather than in health care (Hall and Spencer-Hall, 1982). Hall and Spencer-Hall's project is a comparative study of two US schools, and their study is guided by an interest in the exploration of factors affecting negotiations. Interestingly, in both settings Hall and Spencer-Hall found that the behaviour of participants was typically "habitual, routine, regularized, expected, and compliant in nature" (Hall and Spencer-Hall, 1982, p337). Hall and Spencer-Hall's explanations for this observation include their characterisation of daily school life as providing only intermittent opportunities for contact between teachers, and between teachers and principals. In contrast to health care work, where the 'unit of operational focus' is the individual with health needs, the central hub of schooling is the classroom. This 'collectivised' focus, Hall and Spencer-Hall argue, encourages a form of standardised group interaction. Other structural factors constraining work-based negotiation in the two schools included, in Hall and Spencer-Hall's analysis, a concentration of power at higher levels of the education system, an unequal distribution of sexes at the different levels of the hierarchy, and the significance of history and tradition. Methodologically, Hall and Spencer-Hall's paper also stands out in the *Urban Life* special edition for lacking the inclusion of any clear empirical referents to bolster the theoretical claims made.

The 1982 *Urban Life* special edition also carried non-empirical papers which explicitly sought to advance theoretical refinements to the negotiated order position. Maines, for example, took the opportunity to propose the concept of

'mesostructure', which he sees as existing 'in between' (and transcending) the macro and micro-levels (Maines, 1982). Writing on interorganisational negotiations, Strauss draws on case studies to reiterate many of the ideas (such as the distinction between structural contexts and negotiation contexts) originally advanced in more detailed form in *Negotiations* (Strauss, 1978).

Looking beyond the work produced by Strauss and his immediate collaborators and wider associates, and beyond the body of work published in the 1982 special edition of *Urban Life*, a reasonable observation is that the negotiated order perspective has continued to interest and influence a small, but continuing, body of researchers. Work has appeared in a variety of publications, and has addressed a range of substantive areas. Many negotiated order researchers, however, have demonstrated a particular interest (as Strauss and his colleagues did) in conducting their investigations in health care settings.

Regan, for example, explicitly uses negotiated order concepts to frame an investigation into the merger of three mental health care institutions in Canada (Regan, 1984). Regan's interest is similar to that of Hall and Spencer-Hall (1982), in that he, too, seeks to examine the limits to negotiation. Regan's account of the structural context for his study includes an analysis of the political economy of health care in Canada, and the transition of mental health services into general hospitals. Regan also includes as part of the overarching structural context an examination of the status of psychiatry in Canada, and the formal division of labour in mental health care. Regan's account of the

negotiation context includes analysis of “a mixture of stable and variable” properties, including as examples of the former the complexities of combining the principles of community care with the practical realities of inpatient psychiatry. Regan's approach to the study of the hospital as a negotiated order included a five year period of participant observation, interviewing and documentary analysis. During this period, Regan observed many ‘subprocesses’ of negotiation; his paper does not, however, include extensive data extracts to illustrate these.

Mesler's study of the negotiated order of clinical pharmacy in the US, like Regan's study of hospital merger, explicitly draws on Strauss' key concepts of ‘structural’ and ‘negotiation’ contexts (Mesler, 1989). The former, for example, includes a historical analysis of the development of clinical pharmacy, and of attempts by pharmacists to firmly establish themselves as members of the wider medical team. Mesler treats the ‘negotiation context’ as the locale in which he carried out his participant observation and interviews; specifically, a number of teaching hospitals associated with a north-eastern US university. Mesler's paper also includes an account of negotiation strategies used by participants in his study, supported by the inclusion of fieldwork extracts and other data.

In contrast to Regan's and Mesler's studies, Chua and Clegg's investigation into the professionalisation of nursing in the UK uses a much looser version of the negotiated order perspective (Chua and Clegg, 1989). For example, their paper does not present their analysis of issues such as the segmentation of

the nursing profession and changes in National Health Service (NHS) organisation as examples of an overarching structural context.

Methodologically, however, Chua and Clegg's study compares with the investigations already considered in this Chapter, with data being generated using a combination of qualitative methods.

Meehan's account of the policing of young people also adopts a loose version of the negotiated order perspective, insofar as only a limited account of an overarching structural context is included. In addition, little explicit use is made of negotiated order terminology (Meehan, 1992). Meehan's paper does, however, include extensive evidence of face-to-face interaction between police officers and young people illustrated through the inclusion of multiple data extracts. Examples include negotiations aimed at 'saving face', and negotiations which reveal policing as a highly situated activity.

A methodologically distinct study is that completed by Mellinger, whose focus is on the analysis of audiorecorded telephone conversations between US emergency room nurses and paramedics as examples of actual negotiations (Mellinger, 1994). Mellinger's paper is, accordingly, rich in interactive data, but is also limited in its analysis of an overarching context. Better in its treatment of large-scale structural and organisational features is Svensson's research into the negotiated order of relations between doctors and nurses (Svensson, 1996). Svensson's analysis of a 'negotiation context', however, reads more like an analysis of a 'structural context', dealing as it does with overarching issues such as the feminisation of medicine, the emergence of new ideas

within nursing, and the increase in patient expectations. Svensson's study is also methodologically limited, with data being generated only via interview.

Allen draws on data generated in an ethnographic study of the day-to-day accomplishment of nursing jurisdiction in two general hospital wards in the UK to investigate the boundary between nurses and doctors (Allen, 1997). Allen draws attention to a lack of overt negotiation, but acknowledges the extent to which interprofessional boundaries were produced through the purposeful actions of nurses and doctors. This raises for her, as has been noted earlier in this Chapter, theoretical and methodological questions relating to the core concept of the 'negotiation'. In a subsequent paper drawing on data generated in the same study, Allen presents an analysis of the 'boundary work' of nurse managers, noting how 'negotiations' were framed by elements of an overarching (and, from the micro-sociological perspective of the actors in the hospital in her study, apparently 'stable') context (Allen, 2000a). For Allen, 'structural properties' such as changes to junior doctors' working hours are constituted through interactive processes.

Two recent studies bring this section of this Chapter to a conclusion. Fineman uses ethnographic methods to investigate the micro-politics of environmental regulation (Fineman, 1998). Drawing on Lipsky's idea of street level bureaucracy (Lipsky, 1980), Fineman combines interviews and 'work shadowing' to explore the regulation of industry as a negotiated order. Fineman's paper is rich with data; he also makes interesting links between face-to-face negotiations and the overarching context within which

environmental regulation takes place. However, like many of the earlier studies reviewed here, Fineman's use of negotiated order concepts is rather loose and underdeveloped.

In the final paper considered in this section of the thesis, Currie completes an ethnographic case study of cultural change at the middle management level of a single UK hospital (Currie, 1998). Although Currie claims association with a negotiated order perspective, his use of negotiated order ideas – like others before him – is rather vague, with no explicit treatment of the relationship between structural and negotiation contexts.

Theoretical and methodological lessons can be learned from this review of previous, completed, negotiated order investigations. First, it is striking that health care emerges as a favoured area for negotiated order researchers. From Hall and Spencer-Hall comes the idea that the peculiarities of health settings (for example, the focus on the individual 'case' and the existence of an unusually large number of occupational groups) make negotiations a particularly likely feature of everyday health care work (Hall and Spencer-Hall, 1982).

In the hands of some investigators, negotiated order concepts have been treated as a given, with explicit use being made of terms like 'structural context' and 'negotiation context'. However, these two concepts – central to Strauss' view of the dialectical relationship between structural properties and human interactions – appear at first glance to mean different things to different

researchers. The idea of 'negotiation context' appears particularly prone to variations in interpretation. Sugrue, for example, refers to the 'negotiation context' as this relates to the delivery of health care to a single case study subject (Sugrue, 1982). In contrast, in Mesler's hands a single 'negotiation context' refers *in toto* to two hospitals associated with a single US university (Mesler, 1989). These apparent differences in interpretation can be reconciled conceptually, however, when attention is paid to the specific focus of each study. As Fine observes, negotiated order ideas have been successfully drawn on to frame investigations into both 'large scale' and 'small scale' negotiations (Fine, 1984). Unsurprisingly, the more 'micro' an investigation, the more 'micro' is likely to be that investigation's interpretation of the negotiation context. Viewed in this way, Sugrue's identification of a relatively 'small' negotiation context and Mesler's identification of a 'large' negotiation context are conceptually consistent, given their different analytic and investigative interests.

Some researchers whose work has been reviewed in this Chapter have concerned themselves with the modification and extension of negotiated order theory to accommodate empirically derived observations. This approach to the use of theory in research studies demonstrates laudable commitment to constant conceptual refinement in the light of data generation. More problematic is the 'negotiated order' research study which, whilst claiming association with the perspective, appears to make little (if any) explicit use of foundational 'negotiated order' concepts. Currie's investigation into cultural change in NHS middle management appears to suffer from this problem

(Currie, 1998), as does Mellinger's ethnomethodological study of nurse/paramedic interactions (Mellinger, 1994). Particularly missing in both are attempts to make the key negotiated order link between interactive processes and overarching structures. These differences may reflect, in part, subtly distinct analytic approaches to the sociological handling of 'structure'. For example, for Mellinger, as for the *Delivering health and social care* research team:

...social structures and constraints do not exist in some reified form, they have to be enacted. It is through their accounts of their actions and their sense-making activities that members instantiate structure as real and constraining.

(Allen et al., 2004a, p416)

In the context of this thesis I advance the view that, distinctively, the negotiated order perspective aims to bridge the divide between the 'two sociologies' (Dawe, 1970). A characteristic of negotiated order studies, then, must be their concern with the investigation of interactive processes and the linkages between these and the larger contexts in which they arise. The existence of a dialectical relationship between structure and interaction is key. This proposition is made here notwithstanding the position advanced by Strauss in one of his final publications, *Continual permutations of action*. Here, Strauss reviews and reflects on the origins of negotiated order theory and its subsequent development thus:

...the term *negotiated order* has developed a career of its own, after some years of use, mainly by symbolic interactionists, coming to stand for flexible organizational arrangements, the fluidity of overall

interactional patterns at any level of scale, and that social orders are forms of activity.

(Strauss, 1993, p254, emphasis in original)

In this publication Strauss also suggests (rather belatedly, as he himself observes) a new term for 'negotiated order': that of 'processual ordering'. 'Processual ordering' conveys, for Strauss, a better sense of the 'action' necessary to construct and maintain social order. Strauss' account of 'processual ordering' here seems rather less sympathetic to a dialectical view of the relationship between structure and interaction than is found in his earlier work on negotiated order. In *Continual permutations of action* Strauss appears to come down firmly in favour of 'interaction', devoting little space to the possible 'patterning' effects of overarching structures. In firmly identifying my own position as one which emphasises a dynamic relationship between 'structure' and 'interaction', I accept that I stand closer to what I interpret as Strauss' original thinking than to the, perhaps more commonly accepted, view of the 'negotiated order' perspective as summarised in the extract from *Continual permutations* above. This stance has had implications for my study. I have, for example, attempted in the data-based sections of this thesis to locate my analysis of negotiations (and non-negotiations) in the wider context within which they occurred, and to explore the 'lines of impact' (Strauss, 1978) running between macro, meso and micro-levels.

Having advanced this position I acknowledge, too, that when negotiated order theorists have tackled the relationship between interactive processes and structural properties they appear, for the most part, to have struggled to

demonstrate empirically the dialectic between the two. Showing how the apparently fixed features of organisational life, or a social setting's structural properties, help to pattern negotiations has generally been easier to illustrate than have the ways in which negotiations might 'work their way back up' to modify overarching structures. Discussion (if not empirical evidence) of the 'patterning' of negotiations feature in Hall and Spencer-Hall's investigation into two US schools, with their analysis pointing to significant, multiple, barriers to negotiation (Hall and Spencer-Hall, 1982). Similarly, structural limits to negotiation, in this case in the form of the power of the medical profession, feature strongly in Regan's study of hospital merger (Regan, 1984). As Strauss and his colleagues observe as part of an analysis of the relationships between macro and micro-level processes published in *Social organization of medical work* (Strauss et al., 1985):

Virtually all social science writing, if it combines macro and micro considerations, tends [...] to run the line of impact from macro conditions to micro consequences. But there can be feedback, with resulting two-directional impact.

(Strauss et al., 1985, p210)

Problematically, negotiated order researchers have tended to omit from their work extensive discussion of their understanding, and methodological handling, of the core construct of the 'negotiation'. In some studies, negotiations have been described as having occurred but have not been evidenced through the inclusion of multiple data extracts. The original negotiated order study by Strauss and his colleagues, involving the

completion of fieldwork in US psychiatric hospitals, is a good example of this phenomenon (Strauss et al., 1964).

What this review of negotiated order studies does reveal, however, is a high degree of methodological concurrence between researchers. Many have elected to generate data using interviews, observations and documentary analysis. This is not a surprising finding. Ethnographic methods are well-suited to the creation of data relating to human behaviour (including interactions) and social organisation. Single-method investigations, such as the interview study completed by Svensson (1996), are arguably less able to capture evidence of negotiation (and non-negotiation) (see Chapter 4 for a detailed discussion of methodological issues in the context of this study).

2.7 TRAJECTORIES

Before progressing to a conceptual summary in this Chapter, I turn to a further theoretical innovation developed by Strauss and his colleagues which I have found useful in underpinning my interpretation of data generated during fieldwork. The idea of the negotiated order grew out of Strauss and his collaborators' view of organisational life as being highly situated and processual, in which apparently hard-and-fast rules were always liable to be called into question. These same foundational assumptions underpinned the introduction, some 20 years after the introduction of the negotiated order perspective, of the concept of 'trajectory' (Strauss et al., 1985). Trajectory refers:

...not only to the physiological unfolding of a patient's disease but to the total *organization of work* done over that course, plus the *impact* on those involved with that work and its organization. For different illnesses, the trajectory will involve different medical and nursing actions, different kinds of skills and other resources, a different parceling out of tasks among the workers (including, perhaps, kin and the patient), and involving quite different relationships – instrumental and expressive both – among the workers.

(Strauss et al., 1985, p8, emphases in original)

In their work on trajectories Strauss and his colleagues (Strauss et al., 1985) suggest that these can be relatively straightforward, or relatively problematic. More problematic trajectories can unfold in response, for example, to organisational factors, including the personal and occupational characteristics of workers and the increasingly complex division of labour encountered in modern health and social care systems. Trajectories are also sensitive to the unpredictable contingencies associated with particular types of recurring illness, and are liable to evolve in unpredictable ways because care work is always 'people work'. In the context of this thesis, as I demonstrate in Chapter 9, this concept has particular utility in theoretically underpinning analyses of micro-level transitions.

2.8 PULLING TOGETHER THE THEORETICAL THREADS: TOWARDS A CONCEPTUAL FRAMEWORK FOR THE STUDY

This Chapter started with an account of the origins of this study, and considered the theoretical implications of replicating a research design pioneered in a previous investigation. Following this came an analysis of sociological theories which emphasise the ideas of work as interaction and systems of work. Noting that the main concern of Hughes (1971) and Abbott

(1988) is in the systemic outworkings of work-oriented interaction rather than in the characteristics of interactions *per se*, this Chapter then proceeded to an analysis of the negotiated order perspective as a framework for investigation into interactions 'as interactions'. Selected studies into the negotiated order were reviewed with the aim of learning from previous researchers' attempts at using a negotiations perspective to underpin and inform their empirical work. Finally, the idea of complex trajectories was introduced. In this closing section a theoretical synthesis is attempted. The intention here is to draw on the preceding analysis to construct a sound conceptual framework with which the work of delivering community mental health care might be better understood, and within which this study can be theoretically located.

A first theoretical proposition underpinning this study is that the division of work is accomplished interactively. However, work-oriented interaction is not an unfettered activity, but is one which occurs within particular contexts which constrain and frame action:

...however central social interaction is to the division of labour, it is also the case that abstract conceptions of roles and responsibilities *are* made – in formal organisational policy and, in the case of certain occupations, in state legislature – and while they may not determine work boundaries in a straightforward way, they certainly help to fashion their contours.

(Allen, 2000a, p328, emphasis in original)

This proposition is reflected in this study by an analytic stance which includes accounts of the 'patterning' effects of constraint on interaction, and of the

'lines of impact' running between macro, meso and micro-levels of organisation.

Second, analysis in this study encompasses the idea that the world of work is best understood as an interrelated system. Reflecting ecological assumptions, analysis includes study of the contributions to systems of work made by paid and unpaid workers and by multiple agencies and organisations. Work undertaken by unpaid workers, including recipients of services, is often not thought of as being 'work' at all (Strauss et al., 1985). Here, however, an attempt is made to analyse the work of all principal workers, and to locate the contribution of each within the context of the whole.

A negotiated order perspective permits theoretical linkages to be made between everyday workplace interactions and the overarching structural context within which such interactions take place. 'Negotiating' is an enduring feature of human social organisation, but is not the only way in which 'things get done'. During times of upheaval and change, and in instances where the system of work encompasses multiple social actors drawn from a variety of backgrounds and organisations, the negotiated order perspective holds out particular promise as a framework for empirical investigation. Both these conditions applied in the context of the present study. The general treatment of the negotiated order perspective here is to use this as a tool for analysis and investigation into both micro-level interactive processes, and the macro-level structural features which frame and constrain those interactions.

Explicit use of a 'negotiations' perspective is made to drive forward an analysis of the overarching, and dynamic, structural context for the organisation and delivery of community mental health care. The largest-scale structural conditions within which services were organised in each of the two sites in which data were generated, and in which everyday community care was delivered, are ultimately the product of social interactions. However, from the vantage point of social actors participating in meso and micro-level systems of work these large-scale contours of mental health service organisation typically appear, in effect, to be 'constant'. In a different context and for different conceptual purposes, an adjustment of the analytic lens would permit the apparently fixed, or stable, structural parameters surrounding the everyday world of mental health care at meso and micro-levels to be treated as both mutable and subject to interactive processes.

In later data analysis Chapters, accounts of negotiations (and alternatives to negotiations) are located within the particular negotiation contexts in which these interactions took place. The review of negotiated order studies undertaken earlier in this Chapter reveals considerable differences in the interpretation of the term 'negotiation context', reconcilable only when the different analytic foci of each study are taken into account. In this study, the analytic focus and related data generation strategy has been a two-pronged one. First, in each of two study sites data were created relating to the general organisation of community mental health services. Through interviews with senior managers and practitioners employed in different agencies, through observations of community mental health team meetings, and through the

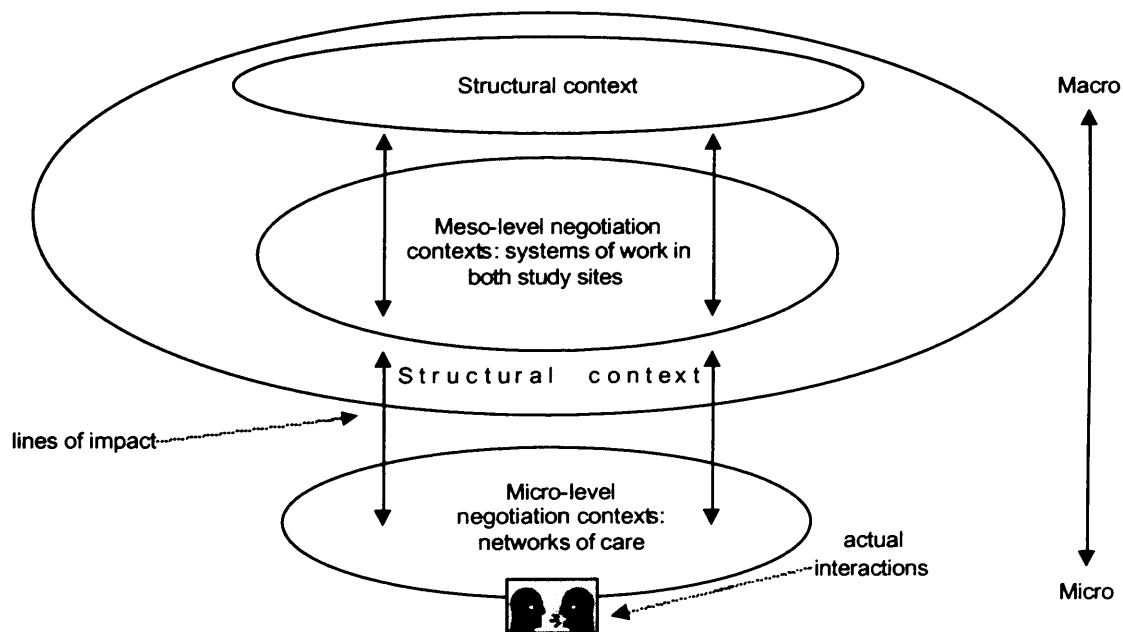
location and analysis of documents it became possible to compare and contrast two local ecologies of mental health work. These data are presented in Chapter 5, where these two local systems of work are described as constituting two contrasting 'meso-level negotiation contexts' (*cf.* Mesler's (1989) identification of the 'negotiation context' for his study of the negotiated order of clinical pharmacy as comprising the two hospitals in which he conducted his fieldwork).

In Chapter 5 it has been possible to explore the extent to which the structural context analysed in Chapter 3 helped pattern the interactions taking place in each study site 'meso-level negotiation context', and the extent to which local systems for organising mental health work reflected interactive and other processes. The term 'meso-level' is used here with care, in the sense that analysis of the system of mental health work in each study site 'sits between' analysis of the larger structural context (Chapter 3) and the more micro-level analysis of the networks of care surrounding each of the six case study subjects (Chapter 6 onwards).

Fieldwork in this study also focused on an exploration of the delivery of everyday mental health care to three exemplar users of community mental health services in each of two distinct study sites. From this, more micro, vantage point, it is analytically possible to treat the negotiated order of local mental health services delivery explored in Chapter 5 as now being part of an expanded and overarching structural context. For the purposes of this part of the analysis, the 'micro-level negotiation contexts' are the systems of work as

these specifically surrounded each of the exemplar users of mental health services whose care I was able to follow during periods of data generation (*cf.* Sugrue's (1982) description of a 'negotiation context' as the network of care surrounding her single case study subject). This approach means that, as the analytic lens shifts from the macro-level 'downwards', each negotiation context subsequently becomes subsumed within an expanded structural context as a new, more micro, negotiation context comes into view. Figure 2.1 below illustrates these relationships.

Figure 2.1
Structural and negotiation contexts



Handling of the problematic concept of the 'negotiation' has been informed by the work of Strauss and colleagues (Strauss, 1978), and by the thinking of Maines and Charlton. Their view has been noted in detail above, and includes the idea that 'negotiating' is a broadly defined sociological phenomenon which

takes place between social actors in conditions marked by the absence of either complete consensus or non-consensus, in which exchange is possible, and in which particular strategies are used (Maines and Charlton, 1985). I make the normative assumption that, in most circumstances, strategies of negotiation are preferable to the alternatives (such as the use of coercion) as a way of getting things done. To link this observation to the aims of my study, I advance the view here that negotiations are likely to be 'helpful' rather than 'hindering' in the context of community mental health care provision. Analysis has, then, encompassed particular consideration of the characteristics of negotiation contexts which either promote, or detract from, the likelihood of negotiations taking place. In this study I also characterise 'negotiations' as potentially encompassing a range of activities. These include face-to-face interactions between social participants, but also interactions mediated by advances in technology such as through the use of written records, telephones and computers.

2.9 CONCLUSION

This Chapter has advanced a conceptual framework with the aid of which the work of delivering community mental health care might be better understood, and within which the present study can be theoretically located. This framework embraces sociological insights into work, including the ideas of work as interaction and the idea of work as an ecological system. A case has been built for a processual, dynamic and situated analysis of work, albeit one which simultaneously recognises the ways in which structural constraints help contour work-oriented interactions. The negotiated order perspective has

been presented as a particularly useful framework from which to comprehend, and launch an empirical investigation into, the organisation and delivery of community mental health care.

The framework developed here is used in a number of ways throughout the remainder of this thesis. First, in Chapter 3, these ideas are used to underpin an analysis of the structural context for community mental health care. The research design and methods adopted in this study are discussed and defended in Chapter 4; here, too, ideas analysed in this Chapter are drawn on to justify the approach taken. From Chapter 5 onwards, findings from this study are presented and discussed. Here, ecological ideas are reflected in the attention given to a context-specific analysis of the work of representatives of different occupational groups and of unpaid carers. The work of particular groups is thus considered in the context of work undertaken as a whole. Examples are also given of the ways in which overarching structures serve to 'pattern' work, and the division of work, through their direct entry into negotiation contexts.

3 THE STRUCTURAL CONTEXT: CONTINUITY AND CHANGE IN THE SYSTEM OF MENTAL HEALTH CARE

3.1 INTRODUCTION

This third Chapter maps out the contours of the system of mental health work in their largest sense, against which the task of analysing the organisation and provision of everyday mental health care in each of this study's two research sites might be more completely understood. Analytically, this overarching structural context for community mental health care is viewed as being both complex and in process. In later Chapters, when the focus of analysis shifts to the investigation of systems of care at progressively more micro levels, these wider contours of the system of work are more usefully thought of as being a relatively stable constant.

An examination of the structural context for community mental health care is potentially an unwieldy task. Community care is a field with an extensive literature, and is an area of health and social care provision subject to intense policy attention. Production of this Chapter was assisted by the use of a wide-ranging literature search strategy (see Appendix 3) which included the scrutiny of ten health and social care and social science electronic databases: the Cumulative Index of Nursing and Allied Health Literature (CINAHL); MEDLINE; the Allied and Complementary Medicine Database (AMED); the British Nursing Index (BNI); ClinPsych; Embase; Health Management Information Consortium (HMIC); Social Sciences Citation Index (SSCI); Social Sciences Index and Abstracts (ASSIA); and Sociological Abstracts.

This Chapter has not, however, been produced with the (impossible) aim of providing an account of the macro-level contours of community mental health services organisation in their entirety. Rather, the scope of this analysis has been guided by this study's overarching aims, which include the investigation of agency and occupational roles and responsibilities encountered in the system of mental health work and the examination of factors enhancing and detracting from the provision of care. Analysis has also been conceptually guided by sociological ideas presented in Chapter 2 above. Finally, the scope of this Chapter reflects this study's particular focus on the system of community mental health work as this relates to the care of working age adults with mental health problems. No attempt is made to include in this Chapter any specific discussion of the organisation of services for older people with mental health problems, or of the system of work as this surrounds the care of children and young people with mental health needs.

This Chapter begins with an account of the emergence of a system of mental health work, before progressing to an examination of the system-wide appearance of community care as an alternative to institutional mental health care provision. Community mental health care is conceptualised as complex and dynamic, from its inception drawing on the combined efforts of different agencies, occupational groups and on the work of unpaid carers. The Chapter then focuses on an analysis of the more recent emergence of the multidisciplinary and multiagency community mental health team (CMHT) as the favoured vehicle for the delivery of 'specialist' services at the local level.

Foreshadowing key themes addressed in later data-based Chapters in this thesis, four key interfaces in community mental health care are then considered: the health and social care interface in community mental health services; the community mental health and primary care interface; the community mental health and psychiatric hospital interface; and the interface between paid workers and service users and their carers. Finally, present and future challenges for community mental health care are reviewed, including claims of the 'failure' of community care. This final section of the Chapter also considers the challenge of mental health services 'modernisation'.

3.2 BIOMEDICAL PSYCHIATRY AND THE EMERGENCE OF A SYSTEM OF MENTAL HEALTH WORK

The first organised, managed, responses to 'lunacy' in the United Kingdom began in the late eighteenth century with the start of the large-scale construction of institutions dedicated to the segregation of madness (Rogers and Pilgrim, 2001). The early nineteenth century onwards was the period from which the medical profession first began advancing jurisdictional claims (Abbott, 1988) in the mental health arena. Key to psychiatry's dominance was the profession's successful advancement of claims to possess abstract knowledge of 'lunacy' as a disease with biological origins (Scull, 1979). The jurisdiction claimed by 'mad doctors' was a wide-ranging one, encompassing the identification of mental disorder, and determination of its cause, natural history and cure (Rogers and Pilgrim, 2001).

The social organisation of psychiatry and its autonomy and power were consolidated in the 1840s with the founding of both a professional association and a journal (Scull, 1979). Particularly long-lasting claims to control areas of work can be secured in the legal arena (Abbott, 1988), and in the same decade psychiatry secured an advancement of its jurisdiction in this sphere with the passing of the 1845 Lunatics Act. This saw the establishment of a medically dominated Lunacy Commission, which, Scull (1979) observes, exerted a powerful influence against the running of asylums by lay people. The term 'psychiatry' was also introduced the following year (Rogers and Pilgrim, 2001). A decade later, as Rogers and Pilgrim note, the power of British psychiatry had been sufficiently consolidated for an editorial in the *Journal of Mental Science* (now the *British Journal of Psychiatry*) to declare that:

Insanity is purely a disease of the brain. The physician is now the responsible guardian of the lunatic and must ever remain so.

(cited in Rogers and Pilgrim 2001, p46)

Whilst doctors were successful in advancing their claim to the control of asylums and the management of the people contained within them, most of the day-to-day work in asylums was carried out by attendants. Medical jurisdiction faced little challenge from this low status group, however. No abstract body of knowledge existed to underpin their work, no training was available until the late nineteenth century, and many were employed solely on account of their practical skills or their physical strength (Nolan, 1993).

In the first half of the twentieth century a “new vocabulary of madness” appeared as asylums were redesignated as hospitals and attendants as nurses (Prior, 1993, p29). New terms were introduced into the language of psychiatry. The word ‘schizophrenia’, for example, was first used by the Swiss psychiatrist Bleuler in the early 1900s. Prior sees the extension of medical treatments – which included the use of psychosurgery, hydrotherapy, insulin coma therapy and, from the 1950s onwards, new drug therapies – as evidence of the medical profession’s success in advancing its claim not only to control, but also to comprehend and to cure, mental illness. This successful advancement of appeals to the possession of abstract knowledge relating to the disease and treatment of mental disorder (Pilgrim and Rogers, 1999), coupled with the designation of the mentally ill as patients and the identification of hospitals as being the most appropriate place for their treatment and care, represent a high point in the medical profession’s attempt to stamp its jurisdictional authority in the mental health sphere.

Ecological insights point to the dynamic character of systems of work, and highlight the ways in which system disruptions can arise from a variety of sources, both internal and external. Disturbance in the emergent system of mental health work from the end of the nineteenth century onwards was precipitated internally by advances in medical technologies. The greater use of physical treatments required an expansion to the training of attendants to enable them to better undertake medically delegated tasks (Dingwall et al., 1988). Formal education for attendants, redesignated as nurses, began at the end of the nineteenth century with the publication of *The handbook for the*

instruction of attendants on the insane, otherwise known as *The red handbook*, along with the introduction of the national Certificate in Nursing the Insane (Nolan, 1993). Both were important in the evolution of psychiatric nursing as a distinct occupation.

3.3 CHALLENGES TO PSYCHIATRIC JURISDICTION

Change in one part of a complex system can reverberate elsewhere, sometimes with significant and lasting consequences. For example, the expansion of medical technologies which began in the late nineteenth century was highly consequential for the development of psychiatric nursing. Early nursing occupied a clearly subordinate position *vis-à-vis* medicine, with its bundle of tasks (Hughes, 1971) representing a delegation of routine activities by biomedical psychiatry centring on the provision of physical treatments. Systems evolve, however, and over time less powerful occupational groups will often seek to advance their positions by engaging in professionalising strategies. By the middle of the last century claims were being made for the possession of a distinct abstract knowledge base for psychiatric nursing, and an independent jurisdiction centred on the idea of the therapeutic nurse/patient relationship (Peplau, 1952). Whilst nurses in the UK tended to be more pragmatic and less theoretically inclined than their North American counterparts (Tilley, 1999), the possibilities of a distinctly 'nursing' contribution to the system of mental health work nonetheless took root.

The emergence of new occupational groups, like psychiatric nursing, was one of a number of factors precipitating early disturbance in the mental health

system. A distinctive feature of the mental health arena remains the contested underpinning abstract knowledge base claimed by the system's dominant group, biomedical psychiatry. One early threat to biophysical ideas and practices was moral treatment (Scull, 1979). As practised in institutions such as the York Retreat from the end of the eighteenth century, moral treatment was predicated on an understanding of insanity as arising from a disorder of the environment (Rogers and Pilgrim, 2001). Psychological, rather than physical, abstractions of mental disorder also grew in prominence from the early years of the twentieth century. For example, psychoanalysis challenged many of biomedical psychiatry's assumptions, and advanced a wholly different set of treatment approaches centred on non-physical interventions. More recently, from the 1960s onwards, significant social scientific and philosophical challenges to psychiatric orthodoxies and practice have been advanced, sometimes led by dissident members of the profession itself (Crossley, 1998). Laing, for example, challenged orthodox views on 'schizophrenia' (Laing, 1960), Szasz typified mental illness as a 'myth' (Szasz, 1961), and Scheff proposed mental illness as an example of social rule breaking (Scheff, 1966).

The changing sites of mental health practice, including the emergence of non-institutional workplaces, have also presented threats to the dominance of psychiatric knowledge. The division of labour is socially accomplished, and the character of the specific workplaces where interactions happen is highly significant for occupations and their work (Hughes, 1971; Abbott, 1988). Over the last half century the jurisdictional authority of psychiatry has faced

pressure from the claims of other occupational groups to the possession of abstract knowledge and the control of aspects of mental health work (Prior, 1993). In particular, the emergence of a system of community care opened up new opportunities for interoccupational competition in the mental health field.

3.4 FROM INSTITUTIONAL TO COMMUNITY CARE

In line with much of the industrialised world, the large-scale deinstitutionalisation of the United Kingdom's (UK's) mental health services commenced in the immediate post-second world war years (Barham, 1997). The drivers for macro trends of this type are diverse, reflecting developments in technology, changing societal values and economic and political pressures. Carpenter draws attention to the range of explanations put forward to explain the particular phenomenon of community care (Carpenter, 2000); these include what Goodwin has termed both 'orthodox' and 'radical' accounts (Goodwin, 1997a).

Goodwin's orthodox accounts for community care include: the emergence of new psychiatric treatments (such as the synthesis of antipsychotic medications, which held out the promise of symptom control for people experiencing the more distressing and disabling features of disorders such as schizophrenia); the appearance of social psychiatry; the growth in influence of anti-psychiatry and the associated growth of civil rights movements; concern over declining standards of care in the mental asylums (and, in a more general sense, observations from scholars such as Goffman (1961) regarding the perils of life in closed institutions); an increased willingness on the part of

communities to tolerate the presence of people with mental health problems; the desire of people with mental illnesses to be cared for in their own homes; and the emergence of political and financial structures which had a direct impact on the provision of services. More radical explanations for deinstitutionalisation tend to emphasise the cost advantages to hard-pressed industrial capitalist societies of pursuing alternatives to expensive hospital care (Scull, 1984).

Although a world wide phenomenon, deinstitutionalisation has taken different shape in different countries. Law 180 in Italy, for example, initiated a clear move in 1978 towards community care by curtailing the admission of patients to state psychiatric hospitals (Jones and Poletti, 1985). In Britain, the journey from a predominantly institutional approach to mental health care to a largely community-oriented model proceeded in more of an *ad hoc* manner. For example, early initiatives by central government to replace the Victorian asylums, such as Minister for Health Enoch Powell's Hospital Plan of 1962, introduced the idea of psychiatric care relocating to a combination of district general hospitals and new community facilities (Rogers and Pilgrim, 2001).

From its earliest appearance in the immediate post-war years onwards, the system of community mental health care in the UK proved to be both complex and turbulent. The responsibility for delivering community mental health services has always been shared amongst a number of different agencies (principally health service organisations and local authority social services departments), and professional groups (including nurses, psychiatrists,

general medical practitioners, social workers, psychologists, and others). As Strauss and his colleagues found in their study of US psychiatric hospitals in the 1950s, considerable opportunities for work-oriented interactions are likely to exist where multiple occupational groups are required to cooperate together (Strauss et al., 1964). Moreover, the general organisational and work-related complexity typically encountered in all health and social care settings is likely to be magnified in the mental health context, where competing ideas regarding 'mental health' and 'mental illness' exist and where success in the delivery of services may be understood by different stakeholders in different ways.

One of the strengths of interactionist contributions to the study of work is the attention paid to the specific workplace. Large-scale, relatively enduring, system of work disturbances can originate in changes taking place in particularistic settings, where adjustments in local systems translate into opportunities for emergent groups to advance claims to control areas of work. Alternatively put, developments at micro or meso-level can sometimes work their way 'back up' to effect lasting change at macro-level (Strauss, 1978). It is in particular settings that organisational and occupational roles and responsibilities are, to use Strauss' phrase, "worked at" (Strauss et al., 1963, p148). As Abbott observes, the division of occupational and organisational labour as this is negotiated and enacted in any given locale is subject to highly contextualised factors (Abbott, 1988). Adopting a particularistic focus of this type provides a useful lens through which to analyse accounts of early developments in UK community mental health care.

The precursors to today's community mental health nurses (CMHNs) emerged, in very small numbers, from institutions in Surrey in 1954 and in Devon three years later. In the first of these locations, Warlingham Park Hospital, two nurses were seconded to undertake "extramural duties" (Hunter, 1974, p224). This early work was closely supervised by a consultant psychiatrist, through the forum of weekly case discussion meetings (May and Moore, 1963). Whilst the Warlingham Park nurses described one of their tasks as the reassurance of relatives, this did not extend to the purposeful investigation of the family circumstances of ex-patients, nor the active modification of the home environment. According to commentators of the time, this limited focus – plus the retention of a base within the hospital establishment – distinguished the work of these earliest community nurses from that of their psychiatric social worker and mental welfare officer colleagues (Hunter, 1974).

Reputedly embracing a more social approach to care was the initiative which appeared at Moorhaven Hospital in 1957. Four nurses were recruited to provide a service to both patients and their families. Central to the role was the development of therapeutic interpersonal relationships between nurse, patient and relatives. Unlike the service established in Surrey, therefore, the Moorhaven model was explicitly informed by the philosophy and practice of social work. It was, moreover, social workers rather than a psychiatrist who coordinated the Moorhaven service (Hunter, 1974).

3.5 OCCUPATIONAL AND ORGANISATIONAL COMPLEXITY IN THE EMERGING SYSTEM OF COMMUNITY MENTAL HEALTH WORK

Important differences exist between institutional systems of work and systems of work which are more dispersed. In institutions, the work undertaken by different occupational groups is relatively visible. Subordinates are more obviously subject to the jurisdictional authority of dominant professions. The gradual emergence of community care magnified considerably the potential for interoccupational complexity within the system of mental health work as a whole, and created new possibilities for challenges to the psychiatric profession.

The extension of mental health care into people's homes created opportunities for occupational groups not obviously associated with the hospital-oriented system of mental health work. Like the profession of psychiatry, social workers were a segmented (Bucher and Strauss, 1961) group. Training for social workers specialising in the mental health field had been available since the late 1920s, with early psychiatric social work practice being underpinned by the principles of psychoanalytic casework (McCrae et al., 2004). As an occupational group social workers were supportive of community care initiatives (Goodwin, 1989), with some claiming a particular mandate to deal with the practical social issues attendant to the provision of mental health care outside of hospitals (Hudson, 1982). Social workers had, for example, played an important part in influencing Moorhaven Hospital's family-oriented open door approach (Hunter, 1974).

Success in controlling areas of work is linked to success in advancing claims to the possession of underpinning knowledge (Abbott, 1988). In contrast to the biomedical assumptions which underpinned the jurisdictional authority of psychiatry, social work based its claims on an abstract knowledge base derived from the social sciences (Sheppard, 1991). Some social workers embraced a conceptual framework which acknowledged the biomedically derived imperative of diagnosing and treating mental illness, whilst simultaneously attending to the practical family and other social issues associated with the provision of care in the community (Hudson, 1982). As Hudson notes, however, social work also included practitioners highly sceptical of the assumptions underpinning biomedical psychiatry. Some, for example, advanced psychosocial models of mental illness derived from anti-psychiatric and other radical critiques of biomedical knowledge.

In complex systems of work even the most powerful professions may need to cede full jurisdiction (Abbott, 1988). Settlements between occupational groups can take a number of forms, from subordination of one group to another through to the construction of shared, interdependent, jurisdictions. The settlement between social work and the more powerful profession of psychiatry enabled social work practitioners to claim a subordinate jurisdiction dealing with the social practicalities associated with community care, and to participate in decision-making in the use of compulsory powers. Social work authority was cemented in the legal sphere in both the 1959 and 1983 Mental Health Acts for England and Wales. The 1959 Act created the mental welfare officer role, whilst the 1983 Act created the new role of approved social worker

with the responsibility for making applications for the compulsory admission of patients into hospital (McCrae et al., 2004). Both roles left unchallenged the psychiatric profession's jurisdictional authority to identify mental disorder, and to largely oversee the activities of other occupational groups in its treatment.

The system of community mental health work as this had emerged throughout the 1960s entered a period of externally driven upheaval at the start of the following decade, triggered by changes in the legal sphere centring on the organisation of social work services. With the passing of the Local Authorities Act in 1970 local authority mental welfare officers and hospital-based psychiatric social workers were incorporated into generic social services departments (Sheppard, 1991). The subsequent loss of significant numbers of mental health social workers created a gap, or what Abbott calls a 'jurisdictional vacancy' (Abbott, 1988), in the system of care (Wooff et al., 1988). The relative demise of specialist mental health social workers at this time, complete with their social science-derived body of abstract knowledge, provided psychiatrists with an opportunity to extend their influence over community care towards a more biomedical model. Thus the Royal Medico-Psychological Association (now the Royal College of Psychiatrists) argued in a circular distributed to its members in 1969 that:

It is likely that a new body of mental health social workers would have to be evolved to fill the gap left by the destruction of the present growing services, perhaps with an enhanced medical or nursing background.

(cited in Hunter, 1974, p228)

The jurisdictional vacancy caused by the disappearance of large numbers of mental health social workers presented itself as an opportunity for nurses to capture the social aspects of community mental health work. Unlike social work, the origins of mental health nursing lay in the asylum system, the power base for the profession of psychiatry (Nolan, 1993). Notwithstanding its efforts to generate an independent knowledge base and function, nursing largely shared biomedical psychiatry's focus on the clinical manifestations of mental illness, as opposed to the more family and environmentally oriented concerns of social work. For psychiatry, nursing was a subordinate group through which its authority could be advanced. In the community the bundle of tasks (Hughes, 1971) first attached to nursing was largely limited to the administration of long-acting medications and other routinised activities associated with biomedical approaches to the treatment of mental illness in individuals:

they [*psychiatrists*] perceived CPNs as useful and compliant para-professionals even more useful than social workers, for unlike social workers CPNs could administer the drugs psychiatrists prescribed.

(Godin, 1996, p929)

However, by the middle of the 1980s nursing was advancing claims to an expanded jurisdiction dealing with the family and environmental aspects of community care, underpinned by a new assertion to possess the requisite social scientific knowledge base (Simmons and Brooker, 1986).

The extension of mental health care into the community brought into sharp relief the interface between the system of mental health work and the system

of family-oriented primary care. In the latter, general medical practitioners (GPs) were the dominant occupational group. For many GPs the new availability of dedicated mental health services in the community presented an opportunity to share the care of people with common mental health problems such as depression and anxiety. Community mental health nurses were welcomed by GPs as useful new members of an extended primary care team able to take on work which GPs claimed an underpinning abstract knowledge for but were unable to do due to time constraints (Hannigan, 1997). For nursing, providing primary care based therapies served as a useful professionalising strategy which enabled its practitioners to negotiate an independent settlement with GPs, as a counter to the more subordinate position which they occupied with psychiatrists (Godin, 1996).

3.6 THE EMERGENCE OF THE COMMUNITY MENTAL HEALTH TEAM

The most significant mental health policy document of the 1970s was the Labour government's White Paper *Better services for the mentally ill* (Department of Health and Social Security, 1975). Published with a Foreword by the then Secretary of State for Social Services, Barbara Castle, the document began with an acknowledgement of the post-war drive towards community care; as the White Paper put it, this trend meant that, finally, "psychiatry was coming in out of the cold" (Department of Health and Social Security, 1975, p12). The document noted the many positive advances since the early 1960s in developing alternatives to asylum care. These included the emergence of the open door policy (as pioneered in hospitals such as Warlingham Park and Moorhaven). Also noted in the document, however, was

that “by and large the non-hospital community resources are still minimal” (Department of Health and Social Security, 1975, p14). The document drew attention, too, to the disparity in resources devoted to hospital care compared to the resources devoted to community care.

Better services has particular significance as the first document to look explicitly towards the establishment of locality-based, multidisciplinary community mental health teams (CMHTs). The CMHT, staffed by members of different occupational groups and often commissioned and managed by multiple agencies, became the key mental health services organisational innovation of the late 1970s onwards. CMHTs came to assume a position of central prominence in local mental health ecologies, and continue to play a major part in specialist community mental health care provision.

Key interprofessional and interagency interfaces are joined within CMHTs, making teams a potential site for interoccupational jurisdictional competition. However, CMHTs also offer the prospect of occupational differences being dissolved in the pursuit of shared goals. How roles and responsibilities are managed within teams of this type is likely to have a significant impact on the delivery of care to localities, and to individual users of community mental health services. Also important are the relationships between CMHTs and their members and other parts of localised systems of mental health work. Particularly significant are, for example, relationships between CMHTs and primary care services and between CMHTs and hospitals.

As Peck observes, *Better services for the mentally ill* set in train a process of locality 'sectorisation' (Peck, 2003). The White Paper contained a short, but significant, section on the specialist therapeutic team. This emphasised the importance of multiprofessional team work, which in a mental health context would be likely to draw on the efforts of psychiatrists, nurses, social workers, occupational and recreational therapists, and psychologists. Specialist therapeutic teams of this sort:

should see their responsibilities in terms of a commitment to the people and services of the 'district' as a whole, and not simply to the hospital.

(Department of Health and Social Security, 1975, p22)

Better services, then, clearly contained the aspiration that local populations in the future should be able to benefit from the provision of coordinated specialist mental health and social care. Heading up such teams would be members of the most powerful of the mental health professions: psychiatry. Throughout the country:

each consultant led team [would have] ultimate responsibility for a particular geographical sector.

(Department of Health and Social Security, 1975, p22)

Multidisciplinary locality community mental health services began to appear throughout the UK from the middle of the 1970s. Initially termed community mental health centres (CMHCs) in the style of their US predecessors, teams were at first slow to take shape. Even by the middle of the 1980s, CMHCs were considered something of an innovation (Sayce et al., 1991). Sayce and

her colleagues report, however, a doubling in CMHC numbers every two years throughout the latter part of that decade. Since then, evidence of the sustained growth in CMHT numbers has been generated through nationwide surveys completed in both England and Wales. Over 500 CMHTs were found in England in the latter half of 1992 and at the beginning of 1993 (Onyett et al., 1994), compared to the total of 81 CMHCs in the whole of the UK in the late 1980s (Sayce et al., 1991). Data on organisation and functioning were obtained from 302 of these. Of these, almost 60% were jointly funded by health and local authority sources, and just under half were jointly managed by health and social services agencies. Mean team size was just over 11 individuals, with community mental health nurses appearing as the most frequently encountered occupational group, followed by social workers, administrative workers, 'other nurses', occupational therapists, generic/support workers, psychiatrists and clinical psychologists. Team leadership and management appeared to take a variety of forms. Most CMHTs participating in this study reported data suggesting a lack of clear strategic direction.

Two studies completed at the University of Wales Bangor in the mid-1990s replicated Onyett and colleagues' study in a Welsh context (Carter et al., 1995; Carter et al., 1997). The latter of these two investigations, undertaken in 1997 (and therefore just two years prior to the start of this PhD study) identified a total of 56 CMHTs in Wales, a rise of 10 since 1995. Unlike in England, a clear majority of teams (69%) were jointly managed by health and social services agencies. Welsh CMHTs in 1997 were, on average, larger

than English CMHTs had been in 1993, with a mean team size of 17 whole time equivalent workers. As in the English study, community mental health nurses were revealed as the most often-encountered occupational group, followed by social workers. The 1997 Bangor survey produced evidence of high staff turnover in Welsh CMHTs (see Chapter 9 for a data-based analysis of the importance of staff transitions of this type). Many team member respondents in this study were also unable to state how resources were prioritised and caseloads managed.

The rise of the interagency and interprofessional CMHT has not been without difficulty, however. Consistent with the approach set out in the *Better services* White Paper, early CMHCs and CMHTs aimed to offer a broadly based, accessible and coordinated service. This attempt at comprehensiveness meant that many early teams struggled to define their aims in anything but the vaguest of terms (Sayce et al., 1991). Some services demonstrated a tendency to drift away from work with people with longer-term mental health problems in favour of engaging in new areas of work with individuals referred through primary care services (Sayce et al., 1991; Patmore and Weaver, 1992). Peck suggests that the 'locality' rather than the 'functional' focus of CMHTs was a major contributor to this phenomenon (Peck, 2003). Other explanations include Godin's observation that, for the nascent profession of community mental health nursing in particular, provision of primary care-based therapies represented a much more desirable and higher-status form of work than engaging in the 'dirty business' of providing biomedically oriented care and treatments to people with severe mental illnesses (Godin, 2000).

In addition to the problem of primary care drift, other difficulties with the locality CMHT model were noted from the early years of the CMHC movement. Where they lacked a clear and shared purpose CMHTs were liable to become fulcrums for the playing out of ideological and occupational differences and competing abstractions of the concepts of mental health and illness. Nurses and social workers were the most frequently encountered groups in teams. The authority of social workers to formally participate in decision-making over the use of compulsory powers had been enshrined in the legal sphere since the end of the 1950s. The authority of nurses to carry out medically delegated tasks such as the administration and monitoring of medications was also well-established. Beyond these areas significant space existed for interoccupational competition, including over the provision of individual and family-oriented therapies and attention to the practical social tasks attendant to providing care in the community (Sheppard, 1991).

However, representatives of the less numerous groups, notably occupational therapists and clinical psychologists, were the first to express doubts about the locality CMHT model. Concerns voiced within occupational therapy related to the threats to professional identity (Hughes, 2001) and the erosion of a 'unique' professional contribution (Parker, 2001) posed by locating practitioners in teams of this type. Within clinical psychology – a group which had laid strong claims to the possession of an abstract knowledge base relating to both 'normal' and 'abnormal' psychological functioning – working in interprofessional CMHTs was seen by some as an unattractive career

aspiration (Gasiorek, 1998), with evidence emerging that psychologists were the occupational group most in favour of a return to single-profession teams (Mistral and Velleman, 1997).

The observations that CMHTs were in danger of failing to meet the needs of people with severe mental illnesses, and that teams were prone to organisational, interprofessional and ideological conflict, were not lost on policymakers. Nonetheless, despite evidence of problems with implementation of the model, the locality CMHT from the late 1980s on was to become the mainstay of community mental health services provision. Commitment to the model was demonstrated in England in 1995's *Building bridges* document (Department of Health, 1995). This clearly reaffirmed the position set out 20 years previously in the *Better services* White Paper to the specialist, interprofessional team as the most appropriate means of delivering locally accessible mental health care to communities. In Wales, a similar reaffirmation of the locality CMHT model appeared in 1996, with Welsh Office guidance setting out the position that "CMHTs are the cornerstone of the new pattern of care" (Welsh Office, 1996, p2).

3.7 COMMUNITY MENTAL HEALTH CARE AND THE NEW PUBLIC MANAGEMENT

Systems of work in which divisions of labour between occupations are supplemented by divisions between organisations or agencies are likely to be particularly unstable, with organisational imperatives exerting a powerful (and sometimes constraining) influence over professional jurisdictions (Abbott,

1988). With most CMHTs funded by both health and social care bodies, organisational changes at the agency level often had significant implications for groups and their bundles of tasks.

The Labour government's *Better services for the mentally ill* (Department of Health and Social Security, 1975), with its promise of newly revitalised community mental health services, appeared four years before the start of what was to become 18 years of unbroken Conservative administration. New public management policymaking was informed by a deeply sceptical stance towards public services bureaucracy, and from 1979 onwards policy was directed towards the creation of public services which were to become progressively more marketised, disaggregated, consumer-oriented and outcome-driven (Hood, 1991).

The problems of community mental health services delivery were aggravated by the Conservative's health and social care reforms. The NHS and Community Care Act in 1990 created three separate groups of purchasers: district health authorities, local authority social services departments and general practice (GP) fundholders (Kavanagh, 1997). However, the purchasing priorities of these groups often differed, and perverse incentives were introduced (Muijen and Ford, 1996). For example, district health authorities had a keen interest in the delivery of specialist mental health services to people with severe mental health problems; people who might, otherwise, require more intensive (and expensive) care in hospital environments. GP fundholders, on the other hand, often sought the provision

of a more primary care oriented service. GPs typically requested (and commissioned) community mental health team services directed towards meeting the needs of people with problems such as depression and anxiety. CMHTs in the early and mid-1990s often found themselves in the iniquitous position of having to develop a mixed bag of services in order to fulfil the requirements of competing policy priorities (Onyett et al., 1997; Lankshear, 2003).

The reforms of the first half of the last decade also did little to clarify the roles and responsibilities of different agencies and their employees. The early 1990s saw the parallel introduction in England of two systems for the delivery of care to users of mental health services: local authority-led care management (Department of Health, 1989), and the health-led care programme approach (CPA) (Department of Health, 1990). Whilst important differences between care management and the CPA existed (the former system included the construction of budgeted packages of care, the latter did not), the parallel operation of both precipitated considerable confusion and overlap (Hadley et al., 1996). Both were introduced as systems of care coordination, and as mechanisms for pulling together complex care plans drawing on the efforts of workers located in a variety of organisations. However, evidence generated in the mid-1990s suggested that, in most localities, integration of care management and the CPA was proving to be a difficult task to achieve (Hancock and Villeneuve, 1997). In addition, through the introduction of the system of care management social services departments were obliged to assume more of an enabling role and less of a

role in the direct provision of care (Hannigan, 1999a). For social workers this translated into a reduction in opportunities for therapeutic practice and an increase in administrative responsibilities (McCrae et al., 2004).

Under Conservative administration, in new public management style the task of solving the problems of mental health care delivery fell to local services, including to individual CMHTs (Wells, 1997). Division of work negotiations in specific workplaces therefore assumed particular significance. For example, having taken note of the possibility of primary care drift in specialist community mental health services (a problem aggravated by the exercise of GP fundholding), government clearly determined in England's *Building bridges* document of 1995 that specialist community mental health services should prioritise the care of people identified as having 'severe' mental health problems (Department of Health, 1995). Similar attempts to clarify the function of CMHTs were made in Wales at around the same time, with a key 1996 document stating that:

[t]he main objective for each CMHT is to meet the needs of people with severe mental illness living in the community.

(Welsh Office, 1996, p2).

However, reflecting new managerialist ideology, it was left to local stakeholders to operationalise locally applicable definitions of severe mental illness (Department of Health, 1995), and therefore criteria for priority access to specialist mental health services. Subsequent research found considerable

variation in formal definitions of 'severe', or 'serious', mental illness used by both research and service-providing organisations (Slade et al., 1997).

Wells, informed by a reading of Lipsky's work on street level bureaucracy (Lipsky, 1980), drew attention to the complex interplay at CMHT level between poorly articulated national policies, localised management imperatives and professional aspirations (Wells, 1997). Wells points to the highly politicised character of mental health services provision, and the subsequent difficulties faced by practitioners and managers in having to accomplish their work in conditions marked by continuous contradiction and challenge. Wells observes the difficulties faced by local workers in trying to agree, and apply, definitions of serious mental illness in ways which complied with broad national guidelines and which simultaneously met local needs and expectations. Similar observations regarding the problems encountered by CMHTs at the local level were made by Onyett and colleagues, who point to the singular challenges facing CMHTs and their managers in trying to resolve the difficulties associated with mental health care provision in a contradictory and complex policy and practice environment (Onyett et al., 1997).

The suspicion that locality-based multiprofessional and multiagency CMHTs were struggling to deliver made teams vulnerable to particularly trenchant criticism throughout the 1990s. Galvin and McCarthy argued that CMHTs were ill prepared for the magnitude of the task confronting them. Rather than being the vehicle for the seamless delivery of multidisciplinary care, their analysis is of CMHTs riven by interprofessional conflict and competing policy

imperatives (Galvin and McCarthy, 1994). A similar critique was raised by Paxton, who also typifies CMHTs as suffering from process problems, and of struggling beneath the burden of inconsistent policy demands and interoccupational tension (Paxton, 1995). Opening a *Journal of Mental Health* Special Section on CMHTs in the year the present study commenced, Peck – a long-time observer and researcher in the community mental health field – acknowledged criticisms of the locality CMHT model, and drew attention to an emerging policy shift in England away from the locality model in favour of multidisciplinary teams with an emphasis on specific ‘functions’ (such as providing home treatment, or assertive outreach) (Peck, 1999). Even mid-1990s policy documents supportive of the CMHT model contained cautionary sections acknowledging the challenges of team working, including the problems of absence of agreed purpose, poorly defined roles, lack of operational policies, poor leadership and support and lack of clarity over accountability arrangements (Department of Health, 1995).

3.8 UNDERSTANDING INTERRELATED SYSTEMS OF COMMUNITY MENTAL HEALTH CARE

Whilst CMHTs have typically occupied a central point in local systems of care, they do not comprise the totality of these systems. In addition to CMHTs, parts are played by primary health care teams, psychiatric hospitals, and, increasingly in both Wales and England, functional specialist mental health teams such as assertive community treatment and crisis intervention/home treatment teams. Contributions are also likely to be made by a variety of other statutory and non-statutory bodies. This combination of organisations,

agencies and occupations makes for highly complex local ecologies of mental health work.

Four key interfaces encountered in systems of mental health work are analysed here. These are the interfaces between: 'health' and 'social' care elements of specialist mental health services; specialist community mental health services and primary health care services; community mental health services and psychiatric hospitals; and mental health practitioners and service users and their carers. Focusing on these key areas looks forward to themes addressed in later data-based Chapters of this thesis.

3.8.1 Health and social care interfaces in community mental health services

The health/social care interface within the ecology of mental health work is a particularly complex one. In many public services contexts the relationship between health care and social care, at both an organisational and an occupational level, is often typified as being a strained one. Hiscock and Pearson, for example, draw on data generated in a qualitative study of practitioners' perceptions of community care to advance evidence of a 'Berlin Wall' (Hiscock and Pearson, 1999). In their view, the differences between health care and social care have been magnified by the organisational upheavals of the 1990s. They also emphasise cultural differences between health and social care workers, drawing attention to claims made by respondents in their study to considerable variation in organisational and professional philosophies, politics, traditions, languages, and priorities.

Ledwith, reporting an interview-based investigation into interagency working in one city, also draws attention to the complex mix of organisational, financial and person-related factors militating against effective collaboration, but notes, too, significant evidence of joint service development despite the barriers (Ledwith, 1999).

The exploration of cultural and other differences between health and social care organisations and between occupational groups in the mental health field has been an area of sustained interest for researchers and commentators. In an early study, Wooff and colleagues completed an observational investigation into the work of 17 community mental health nurses (CMHNs) and mental health social workers (MHSWs) in Salford (Wooff et al., 1988; Wooff and Goldberg, 1988). Reflecting their historical settlement with the profession of psychiatry, nurses were found to exemplify a biomedical approach to their work. This was particularly demonstrated by the high number of contacts with service users in which medication was administered. In his study, which combined the analysis of 400 referrals made to a CMHC with interviews with service users, Sheppard explored 'theory' and 'practice' in community mental health nursing and mental health social work (Sheppard, 1991). Like Wooff and her colleagues, Sheppard, too, found evidence of considerable difference in the content of nurses' and social workers' activities.

More recent research has focused on the interrelationships between organisational structures and organisational change, and the values, philosophies and cultural factors associated with multidisciplinary working.

Johnson and colleagues, for example, interviewed senior health and social services managers in England to establish factors associated with both success and failure in joint working in community care (Johnson et al., 2003). Specific organisational barriers to effective joint working between health and social care agencies were identified by interviewees; these included, for example, the problem of cost shifting whereby one organisation seeks to pass on the costs of care to another. Data in this study were generated during the years of GP fundholding; this, plus other aspects of the purchaser/provider split, were described as a factor militating against effective working across the health and social care interface. In addition to structural barriers to working together, senior managers in Johnson and colleagues' study also identified professional culture and managerial style obstacles.

In their study on teamwork in mental health, Stark and colleagues commence with the observation of contextual turbulence in mental health services (Stark et al., 2002). Despite the rhetoric of interprofessional and interagency collaboration, Stark and her associates found evidence, from interviews, observations and focus groups involving over 1,800 participants, of interprofessional competition and of attempts to defend and advance jurisdictional claims.

'Teamwork' in mental health is also the focus of the study undertaken by Brown and colleagues (Brown et al., 2000). In their in-depth qualitative interview investigation, Brown and his co-authors studied the boundaries (and the blurring of these) in the context of three interprofessional CMHTs in

England. Noting the policy emphasis on the erosion of professional boundaries as being a desirable thing, Brown and colleagues found evidence that, paradoxically, the more the blurring of roles was encouraged the more practitioners were likely to defend their jurisdictional claims. In a further paper arising from the same study, Brown and Crawford use the term 'deep management' to describe the ways in which practitioners working in CMHTs were governed, in the absence of the teams having any "manifest structure for regulation" (Brown and Crawford, 2002, p73).

In a further recent study, Norman and Peck used interviews to investigate interprofessional working (Norman and Peck, 1999; Peck and Norman, 1999). Distinguishing 'interprofessional' from 'multiprofessional', where the latter is taken to mean arrangements where workers assume generic roles, Norman and Peck report findings generated from a dialogue held between members of a National Reference Group and between practitioners working in parts of London's mental health services. Both parts of this dialogue revolved around interprofessional working in adult community mental health services. National-level participants identified a number of reasons why CMHTs were not working, notably: loss of faith in the system by practitioners; strong adherence to professional cultures; absence of a shared philosophy; and mistrust of managerial solutions (Norman and Peck, 1999). Peck and Norman also report findings from a study of 61 practitioners in which CMHT staff explored perceptions of their own and of other practitioners' work, with findings being presented as a series of professional 'stories' and responses to these (Peck and Norman, 1999). Cultural and value differences between different

professional groups are revealed in this study, leading Peck and Norman to advance the view that:

...improving interprofessional working in adult community mental health requires active participation by clinical staff themselves. It cannot be achieved solely through prescriptions of government or directives from professional organisations.

(Peck and Norman, 1999, p242)

Over 100 health and social care workers participated in Carpenter and colleagues' questionnaire-based investigation into the impact of working in multidisciplinary CMHTs (Carpenter et al., 2003). Respondents were generally in favour of the aims of community care. However, in areas where services were not fully integrated staff perceived lower levels of effective team functioning and greater role conflict.

Griffiths' observational research undertaken in community mental health workplaces reveals how micro-level decision-making in the context of interprofessional CMHT meetings leads to *de facto* rationing of services, often under the rubric of sifting the severely mentally ill from the inappropriate referral (Griffiths, 2001). Other papers by Griffiths, again derived from her in-depth observational investigation into community mental health team working, reveal the importance of 'talk' in the negotiation of interprofessional relations and the categorisation of new patients (Griffiths, 1997), and of humour as a means used by non-medical CMHT workers to challenge the dominance of psychiatrists (Griffiths, 1998).

3.8.2 Community mental health and primary health care interfaces

As with the health/social care interface within community mental health services, the relationship between specialist community mental health teams and primary health care services is a complex one. Most mental health care in the UK is provided in the community, and is delivered through primary care services (Goldberg and Gournay, 1997). The existence of an organisational split in community services between primary care and secondary or specialist care makes the interface between the two parts a problematic, and sometimes contested, one. The expected division of work set out in recent policy frameworks is that specialist services (notably CMHTs, and now many of the newer functional teams such as those providing crisis intervention and home treatment for people experiencing mental illnesses) devote their resources to the care of people with severe mental health problems.

Studies have found tension at the specialist mental health/primary care interface. The reversal of primary care drift encouraged by the policy of prioritising the severely ill from the 1990s onwards has raised concern amongst some general medical practitioners (GPs) that specialist services are being lost for needy, but not 'seriously ill', patients (Hannigan et al., 1997). Studies have, however, found evidence of poor role differentiation by GPs when considering who to refer service users with less severe mental health difficulties to (Corney, 1999). In other investigations, evidence has been generated of a widespread growth in primary-care based mental health work, but undertaken by practitioners with variable (or even unknown) levels of mental health expertise (Sibbald et al., 1993; Mead et al., 1997).

Various organisational and care delivery strategies have been proposed to ensure that the twin aims of meeting the needs of severely mentally ill people, and delivering appropriate primary-care based services to less seriously ill people, can be achieved (Gask et al., 1997). Specific ideas have included: expanding the liaison and consultation role of mental health practitioners (Secker et al., 2000a); maintaining shared registers of service users known to experience mental health difficulties (Bonner et al., 2002); strengthening the part played by primary care workers in meeting the physical health needs of people with severe mental health problems (Beecroft et al., 2001); geographically aligning the populations served by primary care teams and specialist mental health services (Goldberg and Gournay, 1997); and encouraging non-mental health workers (such as practice nurses) to take on a much greater role in the delivery of mental health services to less severely ill people (Goldberg and Gournay, 1997).

3.8.3 Community mental health and psychiatric hospital interfaces

Although deinstitutionalisation has been the most significant policy and practice shift in mental health services over the last half century, in most local ecologies of mental health care psychiatric hospitals still maintain a key place (Thorncroft and Tansella, 2004). Hospital care has come under fire, however. Service users in psychiatric hospitals, typically experiencing high levels of ill health, are sometimes cared for in outdated environments which compromise their dignity and which offer little opportunity for therapeutic activity (Standing Nursing and Midwifery Advisory Committee, 1999; Warner et al., 2002). The

attention paid to community care has also led to a relative neglect of hospital services and the staff working therein. The fragmentation of inpatient from community care also increases the potential for failures in communication between these two parts of the mental health system (Standing Nursing and Midwifery Advisory Committee, 1999).

A whole chapter in a recent Department of Health policy implementation guide on adult acute inpatient hospital care is devoted to the relationship between hospital services and other parts of the whole system of mental health care (Department of Health, 2002b). As this document puts it:

Too often there is a lack of system coordination with many inpatient services having become isolated from the communities they serve and their current and developing community mental health services.

It is now accepted that mental health services are most effective when delivery is within the context of the service users' local community. It is important that inpatient services maximise their connections to community services and supports and vice versa. Strong community links are particularly beneficial in the context of cultural sensitivity and responsiveness. The inpatient service can have a more positive impact if it develops partnerships and maintains liaison and communication arrangements with key agencies in the community (housing, benefits, employment, education, leisure).

(Department of Health, 2002b, p6)

3.8.4 The interface between community mental health practitioners and service users and carers

Social movements have exerted a powerful influence in many health and social care systems (Brown and Zavestoski, 2005). The system of community mental health care, once dominated by health and social care occupational groups and their employing agencies, has been required to adjust to the

growing demands of increasingly organised mental health service user and carer movements. Bottom-up pressure for greater involvement in decision-making in the mental health field (Peck and Barker, 1997) has been augmented by the new managerialist theme of consumerism, and the expectation that users of services should be increasingly involved in processes of care.

For many mental health practitioners, the idea of forging closer and more equal working relationships with users and carers remains an appealing one. In addition to the rewards to be derived from working in this way (Onyett et al., 1995), for mental health occupations such as nursing which are attempting to develop jurisdictions independent from medicine, consumerism also presents itself as a potential opportunity to align with users of services in resistance to medical dominance. Nonetheless, in day-to-day services evidence still suggests that active participation of users in their care is patchy, with user perceptions of interprofessional teams clearly pointing to the existence of occupational hierarchies (Warne and Stark, 2004).

As with the shift in attention to the needs and aspirations of mental health service users, the structural context for community mental health care has also needed to adjust to accommodate the demands of informal carers. Even in the early years of community mental health care, concerns were expressed regarding the under-recognition and under-acknowledgement of the role played by unpaid carers. Indeed, *Better services for the mentally ill* in 1975 urged paid workers to devote more attention to the needs of family members:

Those who work in the health and social services fields have to recognise that families and relatives, and indeed the public at large cannot be expected to tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an unbearable burden in the lives of their relatives.

(Department of Health and Social Security, 1975, pp18-19)

3.8.5 Understanding interrelated systems: a summary

Systems of community mental health care are, then, highly complex. Intra-team agency and occupational boundaries are often unclear. The boundaries existing between mental health and primary care services are both complex and contested. Community and hospital-based mental health services can become dislocated. The contribution of service users and lay carers can, still, be relatively overlooked. Recognition of continued problems of this type has led to renewed efforts by policymakers to exert greater control over the mental health system of work, with the aim of improving services.

3.9 COMMUNITY CARE AT THE TURN OF THE CENTURY: STATE

INTERVENTION AS A DRIVER FOR CHANGE

From the 1990s onwards mental health care has been subject to increasingly intense scrutiny by the state. Contemporary mental health 'modernisation', for example, represents an attempt from the centre to manage a highly complex system of work with the aim of meeting need in more efficient and user-centred ways. This development is significant for a number of reasons. At a theoretical level, extensive and direct state intervention with the aim of

improving the day-to-day functioning of systems is an eventuality not particularly envisaged by either Hughes (1971) or Abbott (1988), for whom work-based ecologies are largely self-regulating. However, intervention from the state is now a major source of disturbance in the UK's system of work, albeit driven by the intention of improving the service user experience.

By the start of the 1990s UK community mental health care was widely perceived to be in crisis. Jurisdictions were unclear and often contested, and services were under-resourced (Audit Commission, 1994). Serious questions were also being asked of the capacity of the community mental health system to deliver safe and effective care to vulnerable, and sometimes dangerous, groups of service users (see for example: Coid, 1994; McFadyen and Farrington, 1996). Local service failures were widely reported in the national media, with poor communication and lack of role clarity within different parts of the system typically being cited as key to understanding these. Tragic micro-level events – such as the killing of Jonathan Zito by Christopher Clunis (Ritchie et al., 1994) – precipitated major system-wide disturbance and substantial change at the macro-level.

One of the principal purposes of the earlier hospital-based system of mental health care had been the segregation and control of mentally ill people. These themes rose to new prominence in the community care context with the enactment of measures extending mental health professionals' jurisdiction in the assessment and neutralisation of risk. For example, early policy and practice responses to the crisis of confidence in community care included an

extension to the care programme approach through the introduction of supervision registers in England (National Health Service Management Executive, 1994), and the introduction in Wales and England of supervised discharge via the Mental Health (Patients in the Community) Act (1995).

Whilst exerting greater control over the lives of mental health service users came to assume an enlarged place in community mental health work (Godin, 2000), the shift towards the more rigorous management of risk sat uneasily with the contradictory expectation that teams and practitioners take into account the expressed wishes of recipients of their services and their aspirations to live their lives free from coercion (Goodwin, 1997b).

During its general election campaign in 1997 New Labour promised a 'third way' for the UK's public services. This third way aimed to tread a path between old left and right divisions. In his Fabian Society pamphlet of 1998, Prime Minister Tony Blair's account of the third way included a commitment to:

the values which have guided progressive politics for more than a century – democracy, liberty, justice, mutual obligation and internationalism. But it is a *third* way because it moves decisively beyond an Old Left preoccupied by state control, high taxation and producer interests; and a New Right treating public investment, and often the very notions of 'society' and collective endeavour, as evils to be undone.

(Blair, 1998, p1, emphasis in original)

In Labour's general election manifesto of 1997, the third way for health care meant taking action to both "save and modernise" the NHS. Policy was to be aimed at steering a path between "top-down management" and the

Conservative-initiated internal market (Labour Party, 1997, p20). This thinking was further developed in the newly elected Labour government's White Paper for the NHS in England, *The new NHS: modern, dependable* (Secretary of State for Health, 1997). At the start of this document, the government wrote:

In paving the way for the new NHS the Government is committed to building on what has worked, but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s. That approach stifled innovation and put the needs of institutions ahead of the needs of patients. But nor will there be a continuation of the divisive internal market system of the 1990s. That approach which was intended to make the NHS more efficient ended up fragmenting decision-making and distorting incentives to such an extent that unfairness and bureaucracy became its defining features.

(Secretary of State for Health, 1997, para. 2.1)

Central intervention in the system of mental health work has expanded considerably since 1997, in Wales as elsewhere in the UK. New Labour has been hyperactive in its public services modernisation programme (6 and Peck, 2004a), with mental health care emerging as a priority area for development (6 and Peck, 2004b). Like other parts of the modernisation programme, reform of mental health care is being driven by a policymaking version of a whole systems approach. England's *Mental health policy implementation guide*, for example, includes discussion of the need for system-wide change involving all agencies, occupational groups and other parties with a stake in mental health care provision (Department of Health, 2001a).

An early indication of New Labour's approach to the modernisation of mental health services, and to community mental health care in particular, came with the release of a Press Release from then Secretary of State for Health, Frank

Dobson. Emphasised in this document was the government's view, as had been the view of its predecessor, that large parts of the mental health system were continuing to fail. Included was the following section:

Care in the community has failed. Discharging people from institutions has brought benefits to some. But it has left many vulnerable patients to try to cope on their own. Others have been left to become a danger to themselves and a nuisance to others. Too many confused and sick people have been left wandering the streets and sleeping rough. A small but significant minority have become a danger to the public as well as themselves.

(Dobson, 1998, p1)

Modernising mental health services: safe, sound and supportive (Department of Health, 1998a) became the new administration's first major mental health policy initiative. The document was controversial for repeating the claim that care in the community had failed. This bold assertion, produced with only limited supportive evidence, provoked an outcry amongst members of the mental health service user community and in some segments of the mental health professions. For example, Margaret Pedler, Head of Legal and Policy Development in the mental health charity MIND, questioned government assertions by arguing that this:

ignores the fact that for many thousands of people the switch to community services has brought, and continues to bring, enormous benefits.

(Pedler, 1998, p4)

Influential academic commentators, in turn, drew attention to the difficulties in assessing the success or otherwise of community care given local variations

in the provision of services and historic problems of under-funding (Thornicroft and Goldberg, 1998).

Under New Labour the modernisation of mental health care has now expanded to include: an increase in resources (see for example: Department of Health, 1998a; Welsh Assembly Government, 2005a); the introduction of evidence-based national service frameworks (NSFs) (see for example: Department of Health, 1999; Welsh Assembly Government, 2005b) and national guidelines (see for example: National Institute for Clinical Excellence, 2002); the instigation of new procedures for the inspection of services, led by the Healthcare Commission since the passing of the Health and Social Care (Community Health and Standards) Act 2003 and the Healthcare Inspectorate Wales; the setting up of new functional specialist teams in the community (see for example: Department of Health, 2001a; Welsh Assembly Government, 2005b); explicit attention to the composition of the mental health workforce (see for example: Department of Health, 2001b) and the roles and responsibilities of different occupational groups (see for example: Royal College of Psychiatrists et al., 2005; Department of Health, 2006a); the redefinition of the organisational relationships between health and social care bodies (see for example: Department of Health, 2005); a reinvigorated focus on the management of risk led by a review of the mental health legislative framework (see for example: Department of Health, 2004a; Department of Health, 2006b); action to improve the availability of psychological therapies (Department of Health, 2004b); and a continued emphasis on support for a lay

contribution to mental health work (see for example: Department of Health, 2001a).

With the twin aims of improving quality and containing costs, national service frameworks (NSFs) and national guidelines attempt to more closely prescribe arrangements for the delivery of services at the meso and micro-levels (Allen and Pilnick, 2006a). NSFs focus on particular client groups or on areas of health care delivery, and outline national standards for the provision of services and measures to be used to assess progress in the development of these. NSFs are explicitly aimed at reducing regional variations in health care provision, and at raising the general standard of health and social care services to the level of the best. In England, frustration with the locality CMHT model and the search for solutions to the 'failure' of community mental health care have led to the emergence of large numbers of functional specialist teams (Peck, 2003). Unlike sectorised CMHTs, functional specialist services such as assertive outreach, and crisis intervention/home treatment teams, eschew comprehensiveness in favour of the selective care and treatment of closely defined groups of people. Teams of this type offer practitioners from diverse occupational backgrounds new opportunities to unite around clear sets of goals, in ways which were often seen to be lacking in locality CMHTs. However, functional specialist teams also increase the potential for inter-team barriers to effective whole systems working (Peck, 2003).

National differences in health and social care organisation have always existed between the four countries of the UK. These differences have been

magnified by the devolution of policymaking to assemblies and parliaments in Wales, Scotland and Northern Ireland. In Wales, for example, policymakers initially cast doubt on the small caseload, intensive model of care practised by assertive community treatment teams. Wales' Adult Mental Health Services Strategy contains the following statement:

The term Assertive Community Treatment (ACT) has become associated with a particular model of care in which each key-worker has very low caseloads of about 12-15 clients. The Advisory Group [which made recommendations on the construction of the Strategy] concluded that such small caseloads are not justified [...] though it recognised the controversies surrounding this area.

(National Assembly for Wales, 2001a, p26)

A further specific example of New Labour's drive to modernise mental health care has been the construction of clinical guidelines issued under the auspices of the National Institute for Health and Clinical Excellence (NICE). NICE guidelines exist, for example, on the delivery of interventions to people with schizophrenia (National Institute for Clinical Excellence, 2002). To the degree that NSF and NICE guidelines seek to prescribe patterns of service delivery, and even to determine the character of face-to-face practitioner interventions, these aspects of modernisation can be seen as an attempt to impose more standardised, top down, frameworks on fragmented, turbulent local workplaces.

The potential for greater intra-occupational segmentation (Bucher and Strauss, 1961) is also magnified by the NSF-driven proliferation of specialist mental health teams in the community. Within occupations divisions of labour

can reflect differentiations amongst those on the receiving end of that group's collective services (Abbott, 1988). New areas of work, such as that of providing more assertive services to vulnerable and risky people, can appear particularly attractive to practitioners. New work and new teams increase the potential for the development of intra-group hierarchies of prestige, with certain types of work appealing at the expense of others. In the context of a static or diminishing workforce, depleting established teams to staff new services carries the risk of creating significant gaps in overall systems of work and the downgrading of the work of generic service providers.

The development of new types of specialist services also creates conditions within which new occupational groups can emerge. New Labour has brought forward specific policy initiatives aimed at modernising the mental health workforce. In this area, the current administration has revealed itself to be as capable as any of its predecessors in challenging professional jurisdiction. An indicator of government thinking in this area appears in the document *A health service of all the talents* (Department of Health, 2000a). This publication is critical of rigid, highly demarcated occupational boundaries. In the future, it continues, much greater flexibility in working arrangements can be expected. Practitioners should be better prepared and willing to work across traditional boundaries. Education and training should be focused less on the narrowly defined requirements of particular occupational groups. Instead, greater emphasis should be placed on multidisciplinary education programmes which aim to prepare practitioners – of whatever ilk – to undertake the necessary work in order that service users' needs be met.

With specific respect to the mental health workforce, *A health service of all the talents* recognises the problem of under-staffing, but also points towards changes expected in the future:

For example, to achieve what we want in mental health services requires more doctors, nurses, social workers and therapists but it also means we need them to work in different ways. [...] Any mental health user knows that psychiatric nurses and social workers must work closely together, but rigid regulatory frameworks make this difficult, and organisational barriers get in the way of good care.

(Department of Health, 2000a, p9)

Shortly after the publication of *A health service of all the talents*, a similar call for greater flexibility in working arrangements came from the Workforce Action Team (WAT). In its final report on the mental health workforce to the Department of Health, this group sets out recommendations to tackle under-recruitment and low rates of retention, poor workforce planning, and fragmented education and training (Department of Health, 2001b).

Subsequently, the system of community mental health care is now in the process of adjusting to far-reaching changes in the composition and character of the mental health workforce. Roles and responsibilities are subject to review and (re)negotiation, and new occupational groups are emerging; much as, perhaps, community mental health nurses were in the early 1950s. The loss of specialist mental health social worker expertise following the Local Authorities Act of 1970 opened up a jurisdictional vacancy in the mental health system, ultimately filled by nurses. The more recent gap in primary care based

mental health services caused by the refocusing of the work of community mental health nurses (and others) towards meeting the needs of people with severe mental health problems is, in England, being partially filled by a new type of primary care mental health practitioner (Department of Health, 2000b). Specific plans have been laid to recruit and prepare 1,000 graduate primary care workers:

trained in brief therapy techniques of proven effectiveness, [and] employed to help GPs manage and treat common mental health problems in all age groups, including children.

(Department of Health, 2003a, p4)

Early evaluations suggest that these new workers, however, are struggling to find a distinct place in the overall system of community mental health work, with evidence emerging of considerable uncertainty over the extent of their workplace jurisdiction (Bower et al., 2004).

England's Department of Health has also produced guidance for another non-professionally aligned group, known as support, time and recovery (STR) workers (Department of Health, 2003b). In local ecologies, adjustments to systems of work are happening in response to particular, situation-specific, needs. As a local solution to the problem of a depleted mental health workforce, in Hampshire graduates already holding health or social care-related degrees can now follow a two-year University of Southampton postgraduate diploma leading to qualification as (Associate) Mental Health Practitioner (AMHP) (University of Southampton, 2006).

Modernisation of the mental health workforce, in addition to creating the conditions for the emergence of new occupational groups, is redefining the association of specific tasks with specific occupations. Hughes uses the terms licence and mandate, where the former refers to the claims made by members of an occupational group for the right to perform particular activities different from those performed by others, whilst the latter refers to an occupation's claim to define proper conduct with respect to their work (Hughes, 1971). Hughes makes the point that, over time, human interaction and other processes (such as advances in specific technologies) are liable to precipitate realignments in the "bundle of tasks" (Hughes, 1971, p313) attached to particular occupational groups. Modernisation is encompassing task realignment and modifications of the licence to undertake particular areas of work in the way Hughes describes. Abstract legal codifications of occupations and their work often lag behind what is enacted in the workplace (Abbott, 1988). For example, in community mental health work settings nurses have long exerted an influence on the prescription of medication. The extension of nurse prescribing to include those working in the mental health field points towards an end, established in the legal arena, to the medical profession's sole and exclusive licence in this area (Department of Health, 2006c).

A further example of changes in the legal sphere altering the relationship between occupations and their work is in the field of mental health law. Part of New Labour's solution to the problem of managing risk has been to produce draft legislation for England and Wales which, if enacted, promises to

introduce compulsory treatment orders for some people with mental health problems living in the community (Department of Health, 2006d). These proposed legal changes also identify that social workers, who since the 1959 Mental Health Act have shared with medical practitioners the responsibility to recommend and apply for the use of compulsory treatment, will lose their particular occupational licence in this area (Department of Health, 2006e).

Lack of clarity surrounding health service and local authority jurisdictions was frequently cited as key to understanding the organisational problems associated with community mental health care delivery. Through the Health Act (1999) and the Health and Social Care Act (2001) New Labour has provided a framework permitting organisational divisions between mental health-providing NHS trusts and mental health-providing local authorities to be dissolved through the creation of care trusts (Department of Health, 2006f). In some parts of England, staff traditionally employed by separate agencies have been brought together to maximise opportunities for the development of more fully integrated services. In Somerset, the Centre for Mental Health Services Development (CMHSD) has evaluated the joint commissioning and provision of the health and social aspects of mental health care since the beginning of the decade (see for example: Gulliver et al., 2000a; Gulliver et al., 2000b; Peck et al., 2001; Peck et al., 2002). One key finding, however, has been that structural change does not necessarily make for changed professional practice.

New Labour's mental health modernisation agenda, then, has far-reaching implications for local service providers, practitioners, and, ultimately, for service users and their carers. National standards have the potential to closely prescribe the character of service provision at the local level. New organisational structures and occupational realignments are altering relationships between the health and social care dimensions of mental health service organisation. New groups are appearing in the workforce, and will seek jurisdictional spaces in an already complex division of mental health labour.

3.10 CONCLUSION

This Chapter began with an account of the post-war origins of community mental health care in the UK. Initially community care progressed in rather piecemeal fashion, with early developments taking place in highly situated locales. From the outset, deinstitutionalisation drew on the efforts of a number of occupational groups and public services agencies. The emerging system of community mental health work evolved, from the 1950s onwards, to take in new occupational groups (notably community mental health nursing), and adjusted to the relative loss of others (notably specialist mental health social workers following the formation of generic social services departments at the start of the 1970s).

Interprofessional and interagency team working has proved central to the delivery of community mental health services. Locality community mental health teams emerged as a significant service innovation from the mid-1970s

onwards. CMHTS, whilst by no means comprising the totality of local ecologies of community mental health care, nonetheless came to fulfil a central place within them. However, the CMHT model has been subjected to considerable criticism. Problems associated with a lack of agency and occupational clarity within teams were magnified by aspects of the new public managerialism.

This Chapter has also foreshadowed later data-based parts of this thesis by introducing four key interfaces associated with the organisation and delivery of interagency and interprofessional community mental health care: the health and social care interface in specialist community mental health services; the specialist community mental health and primary care interface; the community mental health and psychiatric hospital interface; and the interface between paid and unpaid workers. Finally, this Chapter has considered the challenges facing recent and contemporary community mental health services, including: under-resourcing; perceptions of failure with regard to the delivery of effective services; and, now, the emergence of a mental health modernisation agenda.

This Chapter has, then, established key aspects of the wider structural context for community mental health care. Subsequent Chapters of this thesis address directly the detail of the empirical part of this PhD investigation, beginning in Chapter 4 with an analytic account of research process issues.

4 RESEARCH PROCESS

4.1 INTRODUCTION

This Chapter focuses on research process issues. A rationale for a study of the type reported in this thesis is made, followed by the presentation of specific research objectives. The project's design and methods are described and defended. The approach taken to reliability, validity and generalisability is also discussed.

The Chapter also includes an account of the research governance and ethics review frameworks within which this study was undertaken. Particularly focused on are the strategies adopted in seeking formal local research ethics committee (LREC) approval, and in negotiating institutional access to study sites. Also considered are the ethical issues raised by research which proposes to include vulnerable people, such as people (as in this study) with severe mental health problems. This Chapter includes discussion, too, of the rationale for negotiating access to community mental health teams (CMHTs) as research bases in each study site. Also demonstrated is the interrelatedness of 'getting permission' (applying for formal ethical approval) and 'getting in' (obtaining institutional approval).

4.2 RATIONALE AND SPECIFIC OBJECTIVES

People with mental health problems are amongst the most vulnerable and excluded members of society (Perkins and Repper, 2003). Chapter 3 has shown that the delivery of care to this group is a complex and turbulent

business, taking place in conditions of sustained political and public scrutiny. Concerns over the 'failure' of community care have led to the emergence of new policy and practice frameworks which are explicitly attempting to determine the character of service delivery at both the meso-level and at the micro-level where care delivery to individual service users is negotiated.

In these circumstances the generation of new knowledge of the functioning of systems of community mental health care has been an appropriate and timely aim for a PhD-level study. This is particularly so given the absence of attention hitherto paid to the investigation of the work of paid 'specialist' mental health service providers alongside investigation into the work of other organisations and groups (including lay carers and service users) who together contribute to overall patterns of service provision.

This study's complete objectives are reproduced below. These were to:

1. undertake six detailed case studies of the ways in which health and social care professionals manage their respective roles and responsibilities in the delivery of community mental health services;
2. map the network of health and social care providers involved in each of the case study subjects over a four to five month period;
3. identify the range of factors related to interprofessional and interagency collaboration which, in the opinion of local stakeholders, contribute to or

detract from the effectiveness and quality of service provision in the study settings;

4. locate the research findings within the local and national policy context;
5. feed back the findings to the study settings, enabling critical reflection on the delivery of care and assisting in future service planning;
6. use these findings to make recommendations concerning the development of roles and responsibilities in the provision of community mental health care;
7. use these findings as a starting point for further studies;
8. develop the ethnographic 'mapping' approach as a method for increasing understanding of the complex interprofessional and interagency interfaces involved in the delivery of community mental health care;
9. share and disseminate research findings to a multidisciplinary audience;
10. provide a comprehensive research training and produce a PhD thesis.

4.3 RESEARCH DESIGN AND METHODS

4.3.1 Overview

This study broadly replicated the design and methods developed in the *Delivering health and social care* project (Allen et al., 2002; Allen et al., 2004a; Allen et al., 2004b). In two contrasting sites access was negotiated to a single interprofessional and interagency community mental health team. In each, in collaboration with CMHT practitioners three service users were purposively selected and approached with a view to becoming the starting point for the completion of a series of in-depth case studies. In each case study, snowball sampling was used as a means of exploring interrelated networks of care. Key informants, such as community mental health nurses or mental health social workers, were used to put me in touch with other key informants. This process continued until no more key players could be identified, and therefore until the web of care surrounding each case study subject was fully laid out. During this process contact with care providers also enabled me to identify key junctures, or critical events, in the delivery of care to case study subjects. Examples of key junctures included formal face-to-face care planning meetings, admissions to hospital and discharges home.

In each of these case studies, or what I have interchangeably termed 'micro-level negotiation contexts' or 'micro-level systems of work', data were generated using a combination of ethnographic methods. These included: interviews with identified key negotiators; observations of significant events; and analysis of written practitioner records. Guiding the data creation process

were my concerns with the negotiation of roles and responsibilities, and with factors helping and hindering the care delivery process.

In this study an explicit attempt was also made to generate a significant body of data relating to 'meso-level systems' of mental health care, or 'meso-level negotiation contexts'. In each site interviews were conducted with senior managers and practitioners, and observations were made of events such as regular CMHT meetings. Local policy documents were also accessed and analysed. During analysis and interpretation of data, attempts were made to investigate the linkages between macro, meso and micro-levels.

4.3.2 Mapping case study networks of care

The in-depth 'mapping' of networks of care in selected case studies in the manner outlined above was a significant data generation innovation pioneered by the *Delivering health and social care* research team. Hitherto this technique does not appear to have been attempted in a community mental health context.

Yin's view is that case study research has particular value in circumstances where 'how' and 'why' questions are being asked (such as, in the present study, 'how are roles and responsibilities managed in the provision of interagency and interprofessional community mental health care?'). Case study research is also suited in situations where the researcher has little or no control over behaviours and events under investigation, and when the focus of enquiry is on contemporary, rather than on only historical, phenomena (Yin,

1994). The characteristically pluralistic approach to data generation in case studies also enables investigation to proceed into areas where complex questions have to be asked in complex sets of circumstances (Keen and Packwood, 1995).

Case study research is also well-suited as a means of improving understanding of organisations (Ferlie, 2001). The latter half of Strauss' *Negotiations*, for example, contains a series of organisational case studies, all illustrative in some way of aspects of the negotiated order perspective (Strauss, 1978). Similarly, Strauss' contribution to the *Urban Life* Special Edition on the negotiated order perspective (referred to in Chapter 2 above) includes the presentation of two case studies of interorganisational negotiation, first in the context of a US government laboratory and the second in the context of private industry (Strauss, 1982).

In case study research it is important to clarify the boundaries of the 'case' being investigated (Dopson, 2003). The boundaries of each micro-level case study in this investigation were determined by the use of the 'mapping' exercise. Snowball sampling (Coleman, 1958) was the principal means through which this mapping was taken forward. Beginning with an identified case study subject, it was possible to trace each network of care by contacting and interviewing all the key individuals involved in the provision of services. Conceptually this case study mapping approach enabled investigation to proceed into complex service user trajectories (Strauss et al., 1985; Allen et al., 2004b). Mapping facilitated the creation of data relating to individual

worker contributions, the social relationships between these workers, and the unfolding of events over time and the negotiation of relative roles and responsibilities in responding to these.

4.3.3 Participating in the field

As in all types of investigation, in case study research careful attention needs to be paid to the selection of data generation methods (Dopson, 2003).

Ethnographic methods – specifically interviews, observations and the analysis of documents – were particularly well-suited as a means of generating data in this study, given its focus on interrelated systems, interaction and negotiation.

In this study the phrase 'data generation' is used in preference to the phrases 'data collection' or 'data gathering' to draw attention to the active role played by the researcher. With respect to the relationship between data and the social world to which these relate, I take the view that "there is a 'there' out there" (Wolcott, 2001, p33). Thus, in the context of this study, workplace negotiations over the division of community mental health labour either happen, or they do not. They also happen (or they do not) whether or not I am there as a researcher to investigate them. However, I reject the assumption that researchers can generate 'objective' data about social phenomena without the very act of their social participation modifying these phenomena and their understanding of them (Hammersley and Atkinson, 1995).

Knowledge of the social world is not just 'out there' waiting to be picked up by the passing researcher. Understanding has to be worked at, and is, to some

degree, socially constructed. Accomplishing this demands an active role on the part of the researcher.

The purposeful actions of the researcher in the field, and the extent to which understandings of the world are affected by these actions and by researcher perceptions, make reflexivity an important principle in qualitative research. Reflexivity refers to the active awareness of the circumstances in, and the practicalities through, which data are produced (Allen, 2004a). A reflexive stance also acknowledges the significance of the researcher's values, attitudes and other aspects of personal and professional biography in shaping the character of the data produced. Part of my biography is having a practitioner background in community mental health nursing. During fieldwork participation it was important to exercise care to avoid slipping into previous, perhaps more comfortable, roles. Self-conscious, reflexive, effort can sometimes be necessary to 'make the familiar strange' and to maintain an analytic edge during data generation (Burgess, 1984).

During all phases of fieldwork site visits were always undertaken with a specific purpose. My fieldwork style was never just to arrive at, for example, a CMHT base and 'hang out'. Rather, visits were explicitly directed towards specific purposes, typically: to negotiate access; to observe a particular interactive event; to access written documents; to interview a key informant; or to accomplish a combination of these activities. This not only helped with my personal management of the discomfitures associated with the fieldwork role, but was also a necessary strategy in the context of being a part-time PhD

student. Equally importantly, it also made the maintenance of a clear focus a central component of my ongoing fieldwork.

4.3.4 Interviews

Interviews were extensively employed as a means of creating data relating both to the meso-level negotiation context in each study site, and as a method of generating micro-level, case study, data. For example, interviews with key local policymakers and service managers provided opportunities to enquire about interagency relations, and to discover how local organisations were responding to features of the overarching structural context. Interviews with workers identified during the mapping of case study subject trajectories were opportunities to explore relative roles and responsibilities. Where possible, all interviews were audiorecorded.

The interview in its various guises (structured, semi-structured and unstructured) is well-established as a method of data generation in both qualitative and quantitative enquiry (Burgess, 1984). As Burgess notes, as interactive events interviews present researchers with opportunities to seek clarification and expansion, and to generate data about events which are closed or otherwise inaccessible. Interviews also permit access to personal insights and experiences. However, interviews take place in particular contexts. The character of data produced reflects aspects of the researcher's personal biography, their role, and the relationships between him or her and their interviewees (Hammersley and Atkinson, 1995). My view of the 'status' of interview data generated in this investigation, then, is to see these as having

been co-constructed, and interpretable as contextualised versions of the world and of social relations within it (Silverman, 2001).

In this study, as in most in-depth investigations into complex social phenomena, decisions about interviewing style and strategy needed to be made both before and during fieldwork. It was not possible for me to interview every significant social actor working in my two selected study sites. Even had such a thing been possible, decisions would still need to have been taken with respect to the topics to be focused on in each interview. In this investigation, whilst interview guides were constructed and used (see Appendix 4), interviews were never conducted in a slavish, fully predetermined, fashion.

4.3.5 Observations

Observational methods were a means of creating data relating to the meso-level organisation of services. For example, observations took place of everyday work in the two community mental health teams which I used as my research bases. During the mapping of service user trajectories observations permitted the generation of data relating to events such as interprofessional and interagency care planning meetings, where future work was likely to be agreed and divided up.

Observation, with or without participation, has a long history in qualitative enquiry. Observational fieldwork was developed as a method of generating data in urban settings by scholars based at the University of Chicago (Atkinson and Housley, 2003). Chicago students were encouraged to “bring

anthropology home" (Van Maanen, 1988, p18) by immersing themselves, and participating, in the diverse cultures of the city which lay at the university's doorstep.

Observational methods permit direct access to social life (Burgess, 1984). As with interviews, investigators employing observational methods have to make important decisions both before entering the field and thereafter. Fieldwork roles also have to be 'worked at'. Key considerations include the degree to which observation is to be accompanied by participation. Gold, for example, produced a celebrated typology over 40 years ago, encompassing a spectrum of fieldwork roles from 'complete participant' through to 'complete observer' (Gold, 1958). By not assuming the role of practising community mental health nurse during fieldwork I did not 'participate' in a practitioner sense. However, I certainly 'participated' in the sense of interacting with significant social actors throughout periods of fieldwork.

Whatever the stance of the researcher with regard to observation and participation it is also the case that no researcher can aspire to generate observational data on all events taking place in a given social setting (Wolcott, 2001). As with decision-making over the conduct of interviews, researchers thus have to select what to observe and/or participate in. Researchers using observational methods also need to give thought to the development of strategies for recording their observations. In this study, observational fieldnotes were made as contemporaneously as possible, and with attention to the recording of interactive detail (Emerson et al., 1995).

Observational data, like interview data, have a particular status. Behaviour observed during fieldwork is liable to immediate filtering; as Wolcott puts it, “what we see tends to be interpreted even as we see it” (Wolcott, 2001, p32, emphasis in original). Awareness of the dangers of drawing premature inferences is, therefore, an important feature of fieldwork practice. During fieldwork in this study my aim was to record interactive detail in a descriptive manner, leaving analysis to follow later.

4.3.6 Documentary acquisition and analysis

Local policy documents, including strategic plans and operational policies, were accessed as sources of data relating to meso-level systems of care. At micro-level access to written practitioner records enabled the generation of data related to significant historical events, such as past hospital admissions. Letters, care plans and other documents also acted as a source of information on networks of care and on ways in which work was negotiated and divided up in each case study.

Wolcott likens documentary analysis to ‘examining’, in contradistinction to ‘experiencing’ (observing) and ‘enquiring’ (interviewing) (Wolcott, 2001).

Written records are a valuable source of data in investigations taking place in any literate social setting (Burgess, 1984). Like interviews, documentary access and analysis permits a form of investigation into events otherwise inaccessible, or no longer contemporaneous. However, documents come in many different forms, and are produced for different purposes and for different

audiences. The status of private documents (such as letters) is thus quite different from that of public documents (such as published statements of an organisation's policy or its strategic aspirations) (Burgess, 1984). Once again, decisions need to be made by researchers with respect to the selection of documents to be accessed and subjected to analysis, and with respect to the status ascribed to written accounts and the context in which they were produced.

4.3.7 Methods of data generation: a summary

Together, observations, interviews and the access and analysis of written documents are the three most commonly encountered methods of data generation in ethnographic investigation. Indeed, it is the use of this combination of methods that warrants the use of the word 'ethnographic' in the title of this thesis. Each method has strengths and weaknesses. Used side-by-side in a single study, considerable advantages accrue. A pluralistic approach to data generation holds out the promise of rich, multifaceted descriptions and analysis of diverse social phenomena.

4.3.8 Sampling

Sampling took place at a number of levels and in a number of contexts. A first task was to purposively sample two meso-level study sites. Operationally in the context of this project, one study site was distinguished from the other by having its statutory health and social services for people with mental health problems provided by a different NHS trust and a different local authority

social services department. This cross-site design therefore required the interactive negotiation of institutional project approval in two separate health care and two separate social services organisations.

The decision to conduct fieldwork in two organisationally distinct sites was made to enable comparison and contrast. Whilst in both sites the overarching structural context in its largest sense and as discussed in Chapter 3 was the same, local meso-level agency responses to the challenges of Welsh health and social care modernisation were likely to vary. Structures, histories and cultures were likely to differ, as were locally enacted occupational roles and responsibilities. Micro-level networks of care were likely to reflect important, and analytically interesting, differences in meso-level patterns of organising services.

Chapter 3 made a particular case for the community mental health team (CMHT) as a central part of local ecologies of mental health care. More than one CMHT existed in each study site, and having secured institutional access a second task was to negotiate access to a particular CMHT in each locale. The plan to sample a CMHT in each site and to base myself there was made for a number of reasons. CMHTs in Wales have the clear responsibility to act as the cornerstone of community mental health care in their localities (National Assembly for Wales, 2001a; Welsh Assembly Government, 2005b). An investigation into systems of community mental health work and into factors influencing the delivery of services would, invariably, need to include a focus on the work of CMHTs and on the activities of the practitioners based

within them. Moreover, CMHTs are themselves a contested model, and are a place in which multiple interagency and interprofessional interfaces are joined. This makes CMHTs excellent places within which to begin an investigation into the management of roles and responsibilities. Finally, the practical decision was made that a CMHT in each study site would be the most suitable base from which to begin the process of identifying possible mental health service users who could become the starting point for each of the case studies.

The fieldwork strategy, once access had been negotiated to the two selected study sites and to one CMHT in each, began with the development of a research role and the establishment of relations with practitioners and others in each locale. Fieldwork initially encompassed the generation of interview, observational and documentary data relating to the meso-level organisation of care in each locality. This was undertaken whilst negotiations were simultaneously taking place centred on the identification of users of CMHT services who might agree to become the starting point for each of the case studies. Researching on a part-time basis made it unfeasible to attempt to generate data in both study sites simultaneously. Fieldwork therefore proceeded in sequential fashion, beginning in the locality I have called 'Midtown' before moving on to 'Northtown'.

Sampling decisions needed to be made in order to generate data relating to meso-level systems of work. For example, decisions needed to be made regarding who to interview and how, what to observe, and what to read. Self-

conscious, reflexive, practitioner knowledge was important here, as was, over time, my emerging awareness of significant people and intra and interorganisational relations in each site. For example, I knew from my community nursing experiences that in order to generate an understanding of the routine activities, and the natural rhythm, of each CMHT, my observational strategy should include the sampling of each team's regular interprofessional clinical and business meetings. Sampling these events allowed me to develop an understanding of how each team made service organisation decisions, shared information, negotiated roles and responsibilities and processed newly referred and discharged service users.

Sampling interviewees in the course of generating data relating to meso-level systems of work was akin to a type of theoretical sampling (Glaser and Strauss, 1967). An early interviewee in Midtown was the local NHS Trust's senior manager with responsibility for the provision of mental health services. Given the study's focus on interagency relations, and my knowledge of the significance of health and social care interfaces, an important later interviewee had to be this NHS-employed individual's equivalent in Midtown's Social Services Department. Knowledge of health care commissioning arrangements led me to Northtown Local Health Group's mental health manager, and knowledge of the responsibilities of the Health Authority within which both sites were located led me to request an interview with a manager working there.

Documents selected with the aim of informing my analysis of meso-level systems of work included interagency policy documents relating to, for example, the operation of CMHTs. Strategic plans were also obtained, including those produced by different meso-level organisations such as NHS trusts and local authorities.

During the course of generating data associated with the meso-level provision of care in each study site I simultaneously pursued the aim of identifying and recruiting service users able and willing to become case study subjects.

Discussion of the detail of the recruitment of each case study subject and the analysis of his or her surrounding network of care as a discrete micro-level system of work is reserved for Chapter 6. My observational strategy with regard to the generation of case study data included accompanying practitioners on home visits, and sampling critical events as these arose in the context of each service user's trajectory of care. Critical events included, for example, interprofessional and interagency care planning meetings in which discussions over service delivery and the negotiation of roles and responsibilities took place.

Generating observational data relating to the care delivered to case study subjects proved a challenge. The observational sampling strategy at case study level included a particular attempt on my part to be present at critical meetings where practitioner knowledge led me to believe that key interprofessional and interagency interfaces would be joined. For example, I was able to observe and record discussion taking place at a number of

formalised care planning meetings, attended by representatives from a range of agencies. Observing less formalised interaction taking place between workers, often based in geographically dispersed locations, was less easy to achieve. Interviews with key informants and analysis of case notes revealed, for example, that interprofessional interfaces in the care of case study subjects were routinely joined not through face-to-face interaction but through, for example, telephone calls, letters or faxes. Intra-CMHT interprofessional interactions regarding case study subject care took place on an informal basis. Not knowing when such interactions were likely to occur made sampling them difficult. This was particularly the case given my fieldwork strategy to undertake site visits only when a clear, prior, purpose could be identified.

These reflections raise an important methodological point relating to spatial relations, and an equally important point about the problem of coordinating community care. In closely delimited, geographically defined, study sites, the generation of data arising from observations of interactions and behaviour may be achieved in a reasonably straightforward manner. For example, observational research confined to a hospital ward or within an individual community team setting allows the ethnographic researcher to stay put. Here, each of my case study mapping exercises started in a community mental health team base but then took me to a wide variety of other settings: service users' homes; hospitals; residential facilities; mental health day centres; primary health care team bases; high street pharmacies; medical records departments; the offices of various health, social services and voluntary sector

organisations; and so forth. Being present in all locations simultaneously, in order to observe and thus record the full range of case study-related interactions and behaviours, was clearly not a possibility. Interviews and analysis of written notes after the event thus became, often, the only way to generate data related to care delivery and work-related interactions.

The challenges of generating data in dispersed locations are instructive. Having to work around the problem of producing data in circumstances such as these is analogous to the challenge faced by community mental health practitioners in trying to coordinate packages of care contributed to by workers in geographically distant locations. The organisation of community care to people with mental health difficulties is made harder by the fact that contributions are made by workers located in a variety of places; it should hardly be surprising, then, to encounter problems of a similar sort when trying to investigate the organisation and patterning of community care.

With respect to interviewing, by using the snowball sampling technique a first interviewee was always likely to be the CMHT practitioner who had initially directed me towards the particular case study subject. From her or him I would gather details of other key negotiators, and thus continue the mapping exercise. Finally, the strategy for the identification and analysis of written documents at case study level encompassed accessing practitioner records, including ongoing casenotes, formalised care plans, letters, and – where used – electronic notes.

4.4 DATA MANAGEMENT AND ANALYSIS

All audiorecorded interviews in this study were transcribed in full by a research secretary using funds obtained through acquisition of a Smith and Nephew Foundation Nursing Research Fellowship in 2000. The computer aided qualitative data analysis software package Atlas.ti (Scientific Software Development/Scolari, 1997) was used as an aid to data management. Atlas.ti has powerful coding and search-and-retrieve facilities, and has the capacity to generate visual representations of relationships identified in datasets.

Interview transcripts, along with the fully transcribed audiorecordings of key junctures such as care planning meetings, and my fully written-up and wordprocessed fieldnotes, were entered into a single 'hermeneutic unit' in version 4.2/build 061 of Atlas.ti. Extracts from written records, including practitioner casenotes and policy documents, were, where possible, also directly entered into the programme. Each interview, transcript of a meeting, casenotes extract and policy document, and each running set of fieldnotes generated in Midtown and Northtown, were assigned the Atlas.ti status of 'primary document', thus preserving the integrity and 'wholeness' of each item.

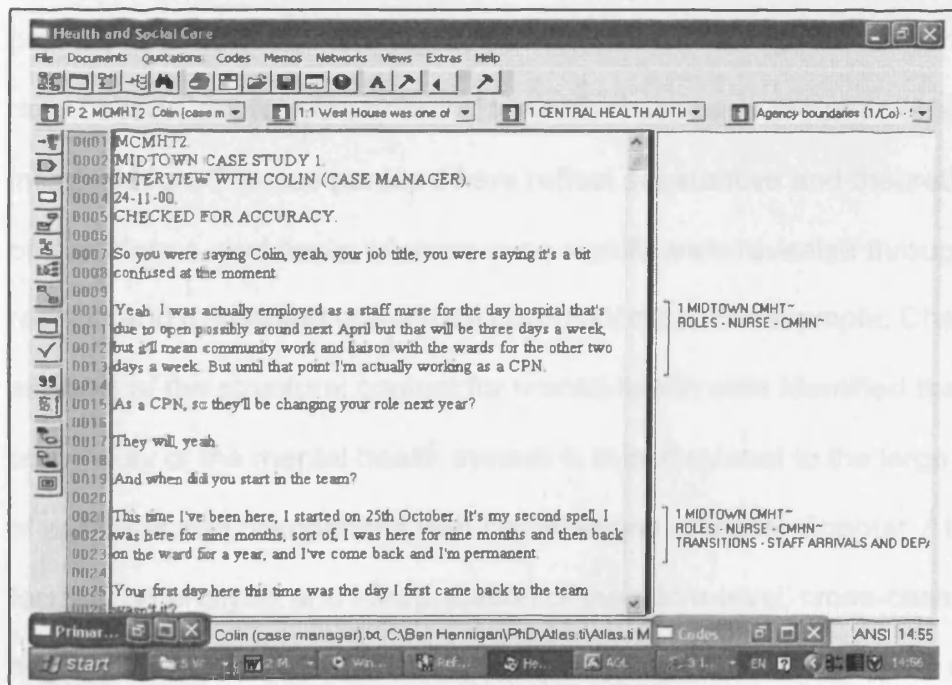
By the end of the data generation phase of this study the total dataset comprised 103 'primary documents': 66 semi-structured audiorecorded interviews (32 completed in the first study site, 33 in the second and 1 relating to both); 3 audiorecorded care planning meetings (2 from site one, 1 from site two); 21 casenote extracts (12 from site one, 9 from site two); and 11 policy

documents (all from site one). Other policy documents, relating to site two and to both sites equally, were obtained in paper form, and could not, therefore, be entered into Atlas.ti in the way electronic documents could. Completing the dataset were two sets of extended fieldnotes, one from each study site, together totalling over 38,000 words. Information contained in each 'primary document' which identified individuals and locations was removed or disguised, as far as possible, prior to entry of each document into Atlas.ti. Pseudonyms were used for all case study subjects and other individuals, including lay carers, practitioners and managers. Names of places were similarly changed.

Atlas.ti was principally used as a vehicle for containing and managing the total dataset. The programme's coding and retrieving facility enabled navigation and interrogation of data in different ways for different purposes. An initial coding frame was piloted with data generated in the first of the two study sites. This coding frame was refined (Appendix 5), in the light of the specific objectives of this study, areas of emerging interest and the approach to coding developed by the *Delivering health and social care* research team (Allen et al., 2000). In Atlas.ti the term 'quotation' is used to refer to a discrete data extract, such as, for example, part of an interview or a section of fieldnotes. To enable ease of navigation, each data quotation was coded with contextual information. For example, each quotation derived from the body of data generated during the exploration of care provided for the first case study subject in the Midtown site received a code identifying it as such (in this case, 'MCS1', denoting 'Midtown Case Study 1'). Other codes were generated and

refined throughout the process of data analysis, and included codes derived from: the study's theoretical framework (for example, codes were developed to identify instances of negotiation and non-negotiation); areas of substantive analytic interest (for example, codes were used to identify different occupational groups, and different types of mental health work); research process issues (for example, a specific code was used to identify the process of identifying and recruiting service users as case study subjects); and my specific research objectives (for example, codes were attached to examples of helpful and hindering factors identified in the data). Multiple codes were typically applied to quotations derived from each primary document, as the following Atlas.ti screenshot illustrates:

Figure 4.1
Illustrative Atlas.ti 'screenshot'



In this example, the left hand side of the split screen contains part of the transcription of an interview with 'Colin', a community nurse in the Midtown area. On the right are attached codes, relating to quotations identified in parentheses in the data. Atlas.ti enables data extracts to be precisely located, by use of the unique primary document identifier (in this case, 'MCMHT2', signifying this as the second primary document from the Midtown area), and by the use of exact line references (running on the left hand side of the screen).

Analysis and interpretation of data beyond the construction and use of a coding frame proceeded in different ways for different purposes. For example, case study data are first presented in Chapter 6, where each of the six mapped networks of care is presented as a discrete, bounded, micro-level negotiation context. Interpretation and presentation of these data has preserved a focus on the integrity of each micro-level system of work. Later data-based Chapters are oriented towards cross-case thematic analysis and interpretation. Themes pursued here reflect substantive and theoretical areas of importance, and areas of cross-case significance revealed through close reading and re-reading of the total corpus of data. For example, Chapter 3's analysis of the structural context for mental health care identified that the complexity of the mental health system is in part related to the large number of agencies and occupations with contributions to make. Chapter 7 thus focuses on analysis and interpretation of the micro-level, cross-case, negotiation (and non-negotiation) of agency and occupational roles and responsibilities. As a second example, the concept of 'trajectories' is used to

underpin the cross-case analysis presented in Chapter 9, where the focus is on the management of micro-level service user and organisational transitions. In these and related examples the linking of data generated at individual case study level to cross-cutting themes was made possible by thematically informed interrogation of the total dataset, assisted by use of the Atlas.ti coding and retrieving facility and particularly its Boolean search capability.

Dangers exist with the use of computer aided qualitative data analysis software programmes. Barry, for example, cautions researchers against the possibility of 'losing sight' of their data in their use of new technology (Barry, 1998). Coding data – which, as Dey puts it, is akin to breaking eggs prior to making an omelette – can lead to highly fragmented datasets. The use of computers can also encourage a mechanical approach to the handling of data, at the expense of the exercise of analytic skills (Dey, 1993). Barry, too, reports hearing novice researchers erroneously describe software programmes as being their “methods of data analysis” (Barry, 1998, 2.6).

My view is that the degrees of sophistication, creativity and depth applied to the process of qualitative data analysis and interpretation are unrelated to the use (or non-use) of computer software programmes. The researcher employing a literal cut-and-paste or index card approach to data management is as likely, or unlikely, to be mechanical in their analysis as is the researcher making use of a software programme. Data analysis and interpretation, then, is less a function of technique and the use of tools than of the exercise of critical thinking and creativity, and the careful comparison of data-derived

ideas with theory, previous research and other forms of knowledge relating to the field being investigated. In this study, the real work of data analysis and interpretation has taken place outside of Atlas.ti. In my analysis I have embraced the idea of a dialectical relationship between 'ideas' and 'data' (Dey, 1993). Both theory (particularly, interactionist theories of work) and my familiarity with community mental health practice and the substantive literature in this area informed my approach to data analysis and interpretation. In turn, my theoretical ideas and knowledge of community care have been developed by analysis of the data generated in this study. I have also been mindful of the importance, having 'broken up' my data, of reconstituting it in meaningful and insightful ways.

4.5 QUALITY IN QUALITATIVE RESEARCH

Considerable debate surrounds the assessment of quality in qualitative research (Murphy et al., 1998). Hammersley summarises three broad positions on this issue. First is the idea that qualitative research should be assessed using the same criteria as those commonly used to assess the quality of quantitative research. Second is the view that, given the possibility of paradigmatic differences between qualitative and quantitative research, different criteria should be used to assess quality. Finally is the view that no set criteria can be used to judge the quality of qualitative enquiry (Hammersley, 1992).

The last of these propositions is a particularly unhelpful one, as it offers no basis on which distinctions can be made between valuable and less valuable

accounts of social settings (Hammersley, 1992). With respect to the second of the perspectives outlined by Hammersley, a question immediately raised is: what should the 'alternative' criteria for quality assessment in qualitative research be? A number of different standards have been put forward, by, for example the Loflands (1995, pp149-168) and Miles and Huberman (1994, pp278-280); for a discussion see Hammersley (1992, pp61-65). Alternative criteria for the assessment of quality in qualitative research appear remarkably similar to the criteria of reliability, validity and generalisability commonly used in the assessment of quality in quantitative studies, albeit presented using different language. With respect to the third of Hammersley's propositions – that criteria used to judge the quality of quantitative research are also applicable in the assessment of qualitative research – Silverman has this to say:

Unless you can show your audience the procedures you used to ensure that your methods were reliable and your conclusions valid, there is little point in aiming to conclude a research dissertation. Having good intentions, or the correct political attitude, is unfortunately never the point. Short of reliable methods and valid conclusions, research descends into a bedlam where the only battles that are won are by those who shout the loudest.

(Silverman, 2000, p175)

Underpinning this position is the view that the differences between qualitative and quantitative "styles" (to use Silverman's term) of research are frequently overstated (Silverman, 2001, p223). Silverman's concern in this context is with establishing the characteristics of credible qualitative research, including taking measures necessary to avoid the charge of anecdotalism. Reliability and validity are key to this process.

Measures taken to promote reliability in this study have included the use of a 'low inference' style of fieldnotes during data generation (Silverman, 2001). Observations and informal interactions were recorded in a 'flat' manner, with analysis and interpretation following later. An explicit effort has also been made to support the claims advanced from Chapter 5 onwards with more than just "brief, persuasive data extracts" (Silverman, 2001, p227). Also aiding reliability has been the audiorecording of all interviews conducted at both meso and micro-level, with the exception of one in response to a specific request from the interviewee (a service user case study subject). Care has also been taken to distinguish my assumptions and inferences as data generator and interpreter from those of the people participating in my study.

Respondent validation, which involves taking findings back to study participants in order to refine an emerging analysis, is sometimes given as a means of enhancing validity. This has not been attempted in this study. First, requesting participants' responses to the analysis of previously generated data accords a form of privileged status to those respondents (Silverman, 2001). Rather than improving validity, respondent validation is perhaps better seen as a means of generating additional data. A second reason why respondent validation was not attempted here relates to the practical difficulties which would have attended this process (Bryman, 1988). Re-contacting one-off interviewees identified during case study mapping exercises would have been both difficult and, sometimes, inappropriate.

Whilst multiple methods of data generation have been used in this study no claims are made here that triangulation has been employed to promote validity. The generation of data using a variety of different methods has much to commend it, but does not bring the researcher nearer to an essential 'truth' (Silverman, 2001). Interview data, for example, is not able to fill in the gaps in knowledge left unfilled by observational data; both are simply types of data, each with their own uses and limitations.

Extended data extracts included in this thesis are intended to circumvent the charge of anecdotalism. In addition, thematic analysis has meant testing emergent ideas across different portions of the overall dataset. This has led to the identification of 'deviant cases' (Silverman, 2000; Silverman, 2001) or 'singularities' (Dey, 1993) in the data, including instances where themes identified in the context of one case study have not been realised in the context of another.

A common charge levelled against qualitative enquiry is that its products cannot be generalised from the context in which data were generated. However, the lack of statistical tests in qualitative enquiry does not mean that findings generated in one context will necessarily be of little or no value in another. A degree of representativeness has been aimed for in this study through, first, the purposive sampling of research sites and case study subjects. The Midtown and Northtown study sites, and the CMHTs I based myself in during fieldwork, bear comparison with other settings in which mental health care is organised and delivered. Selection of mental health

service users who became the starting point for each of the in-depth case studies was also informed by a purposive sampling strategy. This, too, assisted in enhancing the generalisability of this study's findings. Finally, presentation and analysis of data has included sufficient contextual detail to enable the reader to draw his or her own conclusions over what can, and what cannot, be generalised.

4.6 'GETTING PERMISSION' AND 'GETTING IN'

4.6.1 Negotiating NHS research ethics committee approval

Considerable attention is now being paid to the ways in which health and social care research is undertaken and regulated. New research governance frameworks have appeared in the UK outlining the key responsibilities of all stakeholders involved in health and social care research (see for example: Department of Health, 2001c; Wales Office of Research and Development for Health and Social Care, 2001). These governance frameworks are comparable to other approaches to quality improvement and regulation in the health and social care field, such as the framework for clinical governance (Department of Health, 1998b), in that they aim to raise the general standard of practice to the level of the leading edge.

The Department of Health framework reasserts that the primary consideration in studies should be the dignity, rights, safety and wellbeing of research participants, and that NHS research ethics committees (NHS RECs) have a key role to play in this area (Department of Health, 2001c). An early goal for

this project, in common with all health and social care studies which propose to include users of services, staff, or health or social care resources, was to secure approval from the appropriate local NHS REC (Wales Office of Research and Development for Health and Social Care, 2001). This work was started in the Autumn of 1999. Associated with this task was the more general requirement to think through, very carefully, the ethical dimensions of this study.

This project raised a number of significant ethical issues. It is usual to regard people experiencing mental illnesses as being particularly vulnerable research participants (Koivisto et al., 2001). People with major mental illnesses such as schizophrenia are often considered to lack the capacity needed to give their informed consent to participate in research studies. 'Capacity' in this context refers to the ability of individuals to exercise autonomy and self-determination (Drane, 1984). The individual who is without capacity is one who is judged to be:

1. unable by reason of mental disability to make a decision on the matter in question, or
2. unable to communicate a decision on that matter because he or she is unconscious or for any other reason.

(Law Commission, 1995)

'Mental disability' in this context is defined as:

a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.

(Law Commission, 1995)

One approach to the protection of people with mental illness is to exclude all those with “impairment or disturbance of mental functioning” from participating in research studies. However, this approach would lead to the unnecessary protection of individuals who, whilst experiencing some degree of mental impairment or disturbance, also possess the ability to give consent (Usher and Holmes, 1997). Many people with mental health problems might also object to being automatically excluded from research studies, and fear that not having the choice of participating would lead to their views and experiences remaining unknown. Finally, it is important to note that an individual’s capacity is not an absolute. The ability to exercise autonomy and to make informed decisions – for all people, and not just those with mental health difficulties – is liable to fluctuation.

In addition, I specifically wanted ethics committee permission to include in this project people detained under sections of the English and Welsh Mental Health Act 1983. The Act establishes the conditions under, and the procedures through, which people with mental disorders can be compulsorily admitted to hospital for the purposes of assessment and treatment. The Act also sets out the broad principles for the provision of aftercare. In addition, an amendment, the Mental Health (Patients in the Community) Act 1995, brought in a new power of supervised discharge. This means that individuals previously detained in hospital under certain treatment sections of the 1983 Act can, in some circumstances, be obliged to reside in a specified place,

attend specified venues for treatment or other activities, and allow access to named mental health professionals.

The inclusion in research studies of people subject to sections of the Mental Health Act needs to be done with extreme care. People whose care and treatment is organised under sections of the Act are under a form of constraint. This places an additional obligation on researchers to ensure that those who participate in studies give true informed consent (Wing et al., 1999). Guidance on the inclusion in studies of detained patients does exist, but seems contradictory. Local guidance produced by the NHS REC to which I made my application for ethical approval includes a document addressing research involving patients unable to give informed consent. Included in this document is a section which indicates that people detained under the Mental Health Act “should not participate in research in normal circumstances”. The document does not consider the possibility of detained patients being able to give informed consent.

In contrast to this local guidance, the position of the body charged with overseeing the operation of the Mental Health Act and of protecting the rights of detained patients in England and Wales is that people subject to sections of the Act should be able to participate in both ‘therapeutic’ and ‘non-therapeutic’ research, subject to certain conditions being met (Mental Health Act Commission, 1997). In the case of non-therapeutic research, such as the project reported in this thesis, the Commission states that “the position *in law*

for the detained patient is the same as for other citizens” (Mental Health Act Commission, 1997, p6, emphasis in original).

Practitioner knowledge sharpened my awareness of the ethical issues raised by my research proposal, including issues around capacity, informed consent, and the implications of planning to approach detained individuals with a view to requesting their agreement to take part in research. In addressing these issues and in preparing my proposal for NHS REC scrutiny, I was able to draw on my professional knowledge and skills in a number of ways. In particular, I made a specific point about the significance, and the value, of my dual practitioner and researcher background. I also included proposed criteria for the selection of case study subjects.

My initial application for NHS REC approval was unsuccessful. The ethics committee declared itself unsure of the degree to which the agreement of practitioners in both study sites had been secured, and also declared itself unsure of arrangements for obtaining the informed consent of possible service user case study subjects. The NHS REC also expressed the general view that the objectives of the study could not be met, despite the fact that the application had stressed that the proposed investigation was a replication of an earlier, successful, study.

The REC’s response here raised important questions regarding the control of research access to health service users. The committee in this case stated that only a medical practitioner could assess the capacity of individual patients

to give informed consent. This statement granted a powerful research gatekeeping role to members of the medical profession (Service Users' Experiences Research Group School of Nursing and Midwifery Studies University of Wales College of Medicine, 2000), which appeared to run counter to current trends in health and social care delivery in the UK. In the contemporary NHS, the importance of partnership between the professions, and between the professions and users of their services, is increasingly recognised (Department of Health, 1998b). The view of the ethics committee in their response to this first application for approval also suggested that access negotiations should have been well advanced before an application was made for ethical approval. However, as later experiences in negotiating institutional access demonstrated, one of the first questions which health and social care gatekeepers typically ask is whether formal ethical approval has been obtained.

A resubmitted application, forwarded to the NHS REC some six months after submission of the first version (in July 2000), was designed to address the committee's concerns. A covering letter outlined developments since the first REC submission. The study's objectives were condensed with the aim of improving clarity, and the relationship between this project and the *Delivering health and social care* study (Allen et al., 2000) was more strongly emphasised. In addition, the long tradition of ethnographic research and its capacity to generate important data associated with the provision of health and social care was underlined. In response to the NHS REC's concerns and in preparation for submitting a new application for ethical scrutiny, access

negotiations with key individuals in each of the two selected study sites were brought forward. The process of negotiating access was complex, involving contact with multiple gatekeepers. An important task was to secure letters of support from senior professionals, which were later attached to the resubmitted NHS REC application as evidence of collaboration. Over the course of these negotiations the interdependence of negotiating research access and achieving ethical approval was explicitly discussed with study participants, some of whom became partners in the process of securing the NHS REC's agreement for my study to proceed.

Considerable work was also undertaken to address the NHS REC's concerns regarding the possible inclusion of people subject to sections of the Mental Health Act, and to address the concerns regarding the assessment of suitability to take part in the study. The REC's suggestion that it might be necessary to obtain the opinion of independent doctors regarding the suitability of people subject to sections of the Act to take part in this study appeared to run contrary to the position of the Mental Health Act Commission (MHAC), as outlined above. The second NHS REC application included information directly extracted from the MHAC's position paper on research involving detained patients (Mental Health Act Commission, 1997). Material was also included from the then current Mental Health Act Code of Practice (Department of Health and Welsh Office, 1999). The information from these two sources addressed a number of important issues relating to mental illness, capacity and research participation. The new application for ethical approval also included explicit information regarding the selection of service

users to take part in the study, the assessment of their suitability, and the processes through which they would be recruited. Figure 4.2 includes key extracts from this second application.

Figure 4.2
Extracts from second application for NHS REC approval

The final report arising from the *Delivering health and social care* project has been favourably received, and has demonstrated the value of in-depth qualitative research methods as a means of generating answers to important questions associated with the provision of health and social care.

Principal objectives for this study are to:

1. investigate the ways in which health and social care professionals manage their respective roles and responsibilities in the delivery of services to eight case study subjects with severe mental health problems;
2. map the network of health and social care providers involved in each of the case study subjects over a four month period;
3. identify the factors which, in the opinion of local stakeholders, contribute to or detract from the effectiveness of interagency and interprofessional collaboration in the study settings;
4. locate the research findings within the local and national policy context.

Subjects will be purposively selected in consultation with the responsible consultant psychiatrists and with other health and social care professionals. One criterion for subject selection will be the responsible consultant's assessment of the capacity of identified clients to give informed consent. The enclosed letters from [names of two consultant psychiatrists] indicate that they have agreed to take on this responsibility. Once potential subjects have been identified, the initial invitation to participate will be made on behalf of the principal researcher by appropriately placed practitioners.

The aims and objectives of the study determine that access may be sought to individuals who are subject to sections of the Mental Health Act 1983. How care is delivered to people whose care and treatment is organised under sections of the Act is of particular analytic interest. Providing aftercare services under section 117, for example, is a critical test of the ability of different professionals and agencies to collaborate effectively. It is of equal analytic interest to gain an understanding of how well services work together when sections of the Mental Health Act are first applied for, and when individuals are formally admitted to hospital. It is also possible that some of the selected subjects may experience episodes of acute mental illness during their participation in the study.

These issues raise important ethical concerns. In the most recent edition of the Mental Health Act Code of Practice (Department of Health and Welsh

Office 1999), it is stated that “mental disorder does not necessarily make a patient incapable of giving or refusing consent” (section 15.12). In its position paper on research involving patients detained under the Mental Health Act 1983, moreover, the Mental Health Act Commission (1997) has proposed that, “if a patient has capacity to consent to participation in research, and does in fact give actual and informed consent, then participation should not be prevented unless (a) involvement conflicts with any provision of the 1983 Act; (b) involvement is inconsistent with treatment being received as a detained patient”.

In seeking REC approval to include in this study people detained under the Mental Health Act 1983, and to include people who may experience episodes of acute mental illness during the period of their participation, the following criteria are offered:

- patients approached to participate in the study will only include those who have been assessed by the responsible consultant psychiatrist as having capacity to consent; only patients who have capacity to consent and who actually give informed consent will be included; patients will only enter the study with the explicit agreement of the responsible consultant; no individuals suffering from an acute episode of mental illness will be approached in order to request their participation in the study;
- the agreement of the responsible consultant to the continued participation of case study subjects who become acutely ill will be obtained;
- where an individual participating in the study becomes acutely ill, the assent of the nearest relative and/or significant other to the continued following of the service user's care will be sought;
- following guidance from the Mental Health Act Commission (1997), the Approved Social Worker (ASW) and other involved mental health professionals working with detained patients will be consulted prior to an approach being made to the patients to participate in the study;
- hospital inpatients detained under the Act will only be approached to participate as they are preparing for discharge into the community;
- in the case of individuals subject to sections of the Act and approaching hospital discharge, in addition to the obtaining of the patient's informed consent the assent of the nearest relative and/or significant other will be sought, subject to the patient's agreement to this approach being made.

Throughout this study, the background of the principal researcher as a qualified and experienced community mental health nurse will be invaluable in ensuring that the clinical needs of case study subjects remain paramount, and in ensuring that professional judgement and sensitivity is maintained.

This new application was submitted to the same panel that had scrutinised, and rejected, the first submission. The panel's response was most unexpected. The committee wrote that it had:

...agreed that your proposal was a survey and as such was outside the remit of the research ethics committee.

This was a surprising outcome, given the range of questions tabled by the panel in its first deliberation. Many of the issues raised in the first application had been addressed in the resubmitted proposal. Nonetheless, it was still not expected to hear that the planned research was, from the REC's perspective, either not 'research' at all, or not 'research' which required NHS REC approval. However, at a pragmatic level this decision meant that the study could proceed. As is discussed in Chapter 6, my approach to the recruitment of case study subjects followed the procedure detailed in the resubmitted REC application and summarised here in Figure 4.2 above .

4.6.2 Negotiating institutional access

The experience of preparing to resubmit an application for ethical scrutiny underscored the interrelated character of negotiating ethical approval (getting permission) and negotiating access to study sites (getting in). Identification of two possible meso-level study sites, each located within the boundary of the single health authority to whose REC I was preparing an application for ethical scrutiny, was one of the tasks achieved at the very outset of my study.

Midtown and Northtown were identified following contact in Autumn 1999 with a Senior Nurse working at health authority level, who pointed to the distinctive and contrasting characteristics of each locale (see Chapter 5). As with the applications for REC approval, I approached my institutional access negotiations in each site openly declaring my experience as a practitioner.

The information sheet which introduced the study and my experiences described me as having “a background in community mental health nursing”, and added that:

since Autumn 1997 I have been working as a Lecturer in the School of Nursing and Midwifery Studies, UWCM, teaching and researching in the field of community mental health.

(also see Appendix 6)

My experience during these early negotiations was that the possession of ‘insider’ knowledge, gained through having a dual background as both researcher and mental health practitioner, had a significant bearing on the character of my access negotiations, just as it later did on fieldwork relations. Gerrish, drawing on the work of Hammersley and Atkinson (1995), describes her role as a participant observer of the work of district nurses as akin to that of a ‘marginal native’ (Gerrish, 1997). This phrase aptly sums up the role I fulfilled during my access negotiations and thereafter; ‘native’ in that I was knowledgeable and experienced in community mental health care, ‘marginal’ in the context of service provision in each of my two selected study sites.

A first, important, access negotiation meeting was with a senior mental health services manager working in Midtown’s NHS Trust, who had been forwarded a copy of my initial introductory letter by the Trust’s Director of Nursing. This meeting took place on February 8th 2000. In this important face-to-face event I drew on both my practitioner and research experiences in order to discuss, amongst other items, my reasons for wanting to base myself in a community mental health team; my reasons for needing access to team members and to

users of the CMHT; and the ways in which findings from my study would be useful to people involved in the local provision of community mental health care. Throughout initial institutional access negotiations such as these, in both Midtown and Northtown, I was aware – and made clear – that ‘access’ would be a constant feature of my study. I knew that, once I had obtained institutional approval for my investigation from key individuals located in the NHS trust and social services department in each study site, I would then need to negotiate access to a CMHT research base in both areas (see Chapter 5). From there, I would need to negotiate access to individual service users who might become the starting point for each of the case studies (see Chapter 6). The snowball sampling methodology would then take me to a range of different people in a variety of different locations, all of whom I would need to negotiate access with.

4.7 CONCLUSION

This Chapter has addressed key research process issues associated with this study. The Chapter began with a defence of the need for the project, in part by pointing to the complex, in flux, character of community mental health services delivery. Objectives for the study were outlined and discussed, and the development and use of the ethnographic case study ‘mapping’ methodology presented.

This Chapter then focused on a critique and defence of, first, case study research and, second, the use of ethnographic methods. In discussing the research methods used in the study reported in this thesis I have eschewed a

lengthy discussion of similarities and differences between, for example, qualitative and quantitative methodologies. Instead, this Chapter has contained a more closely honed analysis of the specific methods used in this investigation: interviews, observations and documentary acquisition and analysis. I discussed the particular strengths and weaknesses of each of these methods, noting the importance of interview data in the total data corpus generated in this investigation. Following this, the Chapter turned to an analysis of the assessment of quality in qualitative research, with this section ending with an account of the steps taken in this investigation to promote validity, reliability and generalisability.

This Chapter has also addressed two important and interrelated research governance issues: the negotiation of research ethics committee approval, and the negotiation of institutional access. In considering my applications for NHS REC approval I also discussed, and reflected on, the broader ethical aspects of my study: research involving vulnerable patients; capacity in the context of mental illness; and research involving people detained under sections of the Mental Health Act 1983. In considering my approach to negotiating both ethical approval and initial access to my two selected study sites, Midtown and Northtown, I emphasised the ways in which I drew on my joint practitioner/researcher background. I ended by observing how access negotiations would be a constant feature of my data generation strategy.

The following Chapters in this thesis build on this and on previous Chapters, beginning in Chapter 5 with an analysis of Midtown and Northtown as two

contrasting meso-level negotiation contexts. This Chapter draws extensively on data generated in interviews with key local policy makers, operational managers and senior practitioners, from observations of the routine workings of the two community mental health teams in which I based myself, and from my analysis of national and local documents. Chapter 6 onwards draws on interview, observational and documentary data generated during the completion of the six case studies.

5 MESO-LEVEL MENTAL HEALTH SERVICES IN MIDTOWN AND NORTHTOWN

5.1 INTRODUCTION

Building on Chapter 4's focus on the research process this Chapter commences with an overview of the strategies used to negotiate research access to the Midtown and Northtown study sites, and to each identified CMHT research base in these locales. The larger part of this Chapter is then devoted to a data-based comparative analysis of the meso-level systems of mental health work in the two study sites. Included are data generated in interviews with senior managers working in health authority, NHS trust, local authority and local health group (LHG) organisations in both study sites, and with senior community mental health team (CMHT) practitioners drawn from a range of health and social care disciplines. Data were also generated through acquisition and analysis of health authority, NHS trust, LHG and local authority documents, and through observations of everyday activities such as CMHT business and clinical meetings.

5.2 NEGOTIATING RESEARCH ACCESS TO MIDTOWN AND NORTHTOWN

Both the Midtown and Northtown study sites were located within the boundaries of the single health authority (HA) to which my applications for NHS research ethics committee (REC) approval were made. For the purposes of this thesis I have called this 'Central HA'. This body, following

reorganisation of the NHS in Wales, no longer exists (National Assembly for Wales, 2001b). Negotiation of institutional research access was undertaken alongside negotiation of REC approval, with negotiations with key individuals in the two sites being accelerated as a response to the REC's comments on the first application for ethical approval (see Chapter 4 above). Obtaining institutional access encompassed the negotiation of permission to conduct fieldwork with senior managers and practitioners in Midtown NHS Trust and in Midtown Social Services Department, and in the equivalent agencies in the Northtown area.

A first face-to-face research access meeting in Midtown (the first of the two sites in which fieldwork was conducted) took place in February 2000, with the Midtown NHS Trust's senior manager for mental health services. This is the event briefly referred to towards the end of Chapter 4 above. This senior manager proved keen on my plans. On my behalf she was able to secure the agreement of practitioner and other colleagues in her organisation, and in Midtown Local Authority Social Services Department. A possible CMHT research base within the Midtown area was also identified at this first meeting. Entry into this team was significantly helped by the Midtown NHS Trust manager's support, and her tabling of my proposal at the CMHT's next management meeting. I made a first visit to the Midtown CMHT in early April 2000, and during one of the team's regular meetings presented my research plans (see Appendix 5) and fielded questions. I left this meeting having secured team members' agreement to consider my proposal, and the following month learned of the CMHT workers' agreement in principle to being

a research base. During April and May of that year I also secured institutional approval for my project from the Director of Midtown Social Services. As part of my work on producing a second application for REC approval, I also secured written support for my study from one of Midtown CMHT's consultant psychiatrists. Notification of my project with the Midtown NHS Trust's Research and Development Office took place in Autumn 2000, following the decision of the REC to classify my project as 'not research'. Preparation for fieldwork in Midtown was, then, completed by October 2000.

Negotiation of institutional research access in the Northtown study site was less straightforward. I opened informal discussions with a senior nurse with responsibility for community mental health care in September 1999. This led to the presentation of my research plans to Northtown NHS Trust's Nursing Research and Development Committee. This event took place in October 2000, and concluded with an offer of support and with a suggestion for a possible CMHT study site. Agreement in principle for this team to become a research base was secured from the manager of the Northtown CMHT (a nurse) in December 1999. In March 2000, following the REC's initial decision to refuse approval for the study, I secured a Northtown CMHT consultant psychiatrist's support for me to conduct fieldwork with service users for whom she had medical responsibility. A first meeting with the Northtown CMHT took place at the start of the following month. This ended with the agreement of those present for me to conduct my study with their team as my research base.

Securing institutional approval for my study from Northtown Social Services Department proved more problematic. Initial letters to two key managers went unanswered. From a third manager in Northtown Local Authority Social Services Community Care Section I finally received, at the end of July 2000, confirmation of institutional support for my study. With this process complete, preparation for fieldwork in Northtown was concluded.

5.3 MIDTOWN AND NORTHTOWN: AN OVERVIEW OF TWO CONTRASTING MESO-LEVEL NEGOTIATION CONTEXTS

Effective interagency working at meso-level is difficult to accomplish. Powerful structural and procedural barriers exist, including the fragmentation of responsibilities, a lack of shared geographical boundaries and differences in funding sources and cycles (Hudson et al., 1999). Organisational instability and inadequate resourcing, and a lack of close integration between component parts, are also factors likely to militate against effective interagency working in meso-level systems of mental health work (Provan and Milward, 1995).

Structural and processual factors of this type hindered efforts to plan and organise for interagency mental health care in both Midtown and Northtown. In addition, macro-level structural context changes were working their way down to the meso-level negotiation contexts in both sites, and were proving themselves to be powerful sources of system disturbance. Thus health and social care agencies in both locales were in the midst of major organisational change driven, in part, by the emerging contours of Welsh health and social

care modernisation (Secker et al., 2000b; Jones et al., 2004). Representatives of established and newer bodies were required to work together to reconstitute meso-level systems of work in both sites. However, power, responsibility and resources were not equally distributed amongst key negotiating parties. Moreover, unlike in England, structural NHS reform was not extending to the creation of single-speciality mental health provider trusts in either site (Peck and Hills, 2000); rather, mental health care was only one of a number of priorities facing Midtown's and Northtown's health and local authority organisations.

Like all health authorities (HAs) (Huxley, 1997), Central Health Authority had the significant responsibility to commission NHS trusts to provide locally accessible and specialist community and hospital-based mental health services. The final version of Central HA's mental health strategic framework was published during the time that institutional research access for this study was being negotiated in 2000 (Central Health Authority, 2000). This document provided the overarching structural outline for the provision of NHS mental health services to working age adults in both Midtown and Northtown throughout the period in which data were being generated. Macro-level structural features had clearly influenced the construction of this strategy, with the framework reflecting many of the themes discussed in Chapter 3 above. These included those of partnership working across agency and organisational boundaries, and the HA's endorsement of the key role in meso-level systems of work of the interprofessional and interagency community mental health team. For example, the document stated that:

The community mental health team (CMHT) is central to this [*the HA's*] model of service delivery. The CMHT supports primary care in the diagnosis and management of patients presenting with mental health problems and acts as a gatekeeper to other services.

(Central Health Authority, 2000, p27)

And:

Sectorisation of mental health services continues to be the preferred model for service provision [...]. This approach ensures that a multi-disciplinary team provides all (or most) services for those with mental health problems within a limited geographical area, or a population defined by general practice lists.

(Central Health Authority, 2000, p33)

The Health Authority's influence in shaping service development had particularly been felt in the wider Northtown locality in the months prior to the commencement of fieldwork. Through the work of its strategic mental health manager, Central HA had brokered the establishment of (and part-commissioned) a new locality CMHT for working age adults, jointly run by Northtown NHS Trust and the second of the two local authorities with which the Trust worked. Future plans for Northtown included the aim of improving, and making more cost-effective, inpatient mental health services. Whilst playing a major role in the meso-level Northtown and Midtown systems of work, Central HA's influence was also tempered by knowledge of its imminent disappearance in favour of expanded local health groups (LHGs), which were to be given commissioning responsibilities and renamed as local health boards (LHBs) (National Assembly for Wales, 2001b). Reflecting this planned reorganisation of NHS structures in Wales, the LHGs in both Midtown and

Northtown were becoming increasingly significant in influencing the planning and provision of services (World Health Organization, 2004; Greer, 2005).

A distinctive, shared, feature of both meso-level systems of work was that interagency planning and service development were required to take place in conditions characterised by the possession of only partial knowledge on the part of key players. All the significant interagency negotiators were aware that modernisation of national mental health policy would bring forward a new overarching policy and legal framework, which they would be required to explicitly draw on in (re)developing services at the local level. None, at the time of fieldwork, knew what these national policies and guidelines would be (see for example: National Assembly for Wales, 2001a; Welsh Assembly Government, 2002; Welsh Assembly Government, 2005b; Department of Health, 2006b).

Features of the Midtown and Northtown sites thus bore comparison. In both locales new bodies were emerging, established bodies were disappearing, and new frameworks for the organisation and delivery of services were being felt via their entry into the meso-level negotiation contexts. However, Midtown and Northtown were also highly distinct settings. Health and social care organisations in both areas differed in terms of the forms they took, their size, their histories and the composition of their workforces. A significant meso-level negotiation context characteristic in Midtown, for example, was the small size of the NHS Trust and the Local Authority. This distinctive factor both helped and hindered meso-level interagency working, and also proved to be

highly consequential for the micro-level provision of actual services. After a period of significant personnel transition and a consequent lack of leadership, negotiators located in key Midtown bodies were also beginning to forge highly effective working relationships across agency interfaces. This was resulting in rapid progress in the construction of new, more 'modernised', frameworks for the provision of services. This positive culture of interagency working across the health and social care interface was also reflected in the Midtown CMHT, which benefited from a long tradition of bringing different occupational groups together.

In contrast, health and social care bodies in Northtown were particularly large organisations, reflecting the size of the populations they served. Distinctively, key stakeholders' accounts also suggested a strained history of interagency working. Northtown Local Authority staff described themselves as the NHS Trust's 'poor relation', a feature compounded by a lack of Local Authority investment in mental health services over the years. In sharp contrast to the Midtown CMHT, the history of the Northtown CMHT was also one of fractured and conflict-ridden interagency and interprofessional relations.

5.4 THE SYSTEM OF WORK IN MIDTOWN

5.4.1 The Midtown community

Like many other parts of Wales, having lost its traditional industrial base Midtown was an economically deprived locality. This had negative implications for the health and wellbeing of its population (Williams, 2003). Census data

from 2001 underscored the degree to which the Midtown community compared unfavourably with that of wider Northtown (National Statistics, 2006). Using data based on local authority boundaries, as a percentage around twice as many Midtown as Northtown residents described their health in 2001 as 'not good'. Proportionately many more Midtown than Northtown residents also declared long-term illnesses, were more likely to be unpaid carers, and were unemployed. People in the wider Northtown area, in contrast, tended to be better educated, and were less likely to be living in local authority housing.

Midtown staff typically drew attention to the challenges of providing services to an economically deprived, and sometimes challenging, clientele. Large numbers of the mental health service user community in Midtown were unemployed and lived in inadequate housing on limited incomes. Increasingly, practitioners informed me, service users were compounding their difficulties with substance misuse.

5.4.2 Agencies and teams in Midtown

The relatively small population size of the community served in Midtown was consequential for the size of the area's care providing organisations. This made the provision of some services difficult to achieve. Key parts of the Midtown meso-level system of mental health care included a single psychiatric hospital, and a single locality CMHT for working age adults. This CMHT – my research base during fieldwork – was funded and staffed jointly by Midtown NHS Trust and Midtown Local Authority. Other components of the mental

health care system included a Local Authority-funded round-the-clock residential home for people with severe mental health problems. The Midtown system of mental health work also included a day service, which aimed to help mental health service users develop their daily living skills and their independence. People with mental health problems also had access to general health and social care services, including a Local Authority resettlement team which aimed to help manage the transition from supported to independent living. Care was additionally provided by other statutory and non-statutory organisations, including primary care teams. Workers located in CMHT, hospital, residential, resettlement, day care and primary care services all featured prominently in the networks of care surrounding the three Midtown service user case study subjects.

The unusually small size of Midtown's agencies both helped and hindered service planning and delivery. Relatively few levels of internal organisation existed in Midtown's NHS Trust and Local Authority Social Services Department. This feature helped management of the intra-organisational interfaces between workers responsible for strategy and workers responsible for care delivery. Midtown CMHT's senior social worker, for example, described the benefits of direct negotiation between frontline staff and senior managers, in a way which might have challenged a larger, more complex, organisation. Less helpful for the provision of comprehensive services in Midtown was the inability of its small agencies to provide the full range of services many believed were necessary to meet community needs. Lack of organisational economies of scale meant that, for example, services were

generally underdeveloped for the growing population of people with substance misuse problems. The small size of Midtown organisations also made them particularly vulnerable to the loss of already scarce human resources.

Midtown struggled to recruit workers. When staff left, finding replacements internally or externally proved difficult. One consequence of this, with clear implications for the micro-level delivery of services, was an almost total absence of clinical psychology provision throughout the period of fieldwork.

Population and agency size differences were also reflected in the organisation of Midtown's community mental health services. As the only CMHT of its kind serving the needs of working age adults in the Midtown Local Authority area, the Midtown CMHT was the first resource for secondary mental health care for a population of just under 60,000. This compared to the average Welsh CMHT catchment population in 1997 of 40,000 (Carter et al., 1997). Reflecting the lack of shared organisational boundaries, Midtown NHS Trust, however, also operated a second CMHT in partnership with a second unitary authority.

5.4.3 Negotiators, negotiations and limits to negotiation in Midtown

Within the Midtown locale negotiation between key actors located in, and able to represent, different agencies provided the foundation for the (re)organisation of community mental health services during a period of considerable change. Negotiators with experience of working together in order to plan modernised services across agency boundaries included senior managers located in Midtown's NHS Trust, the Local Health Group, the Unitary Authority's Social Services Department, and senior practitioners

located in or attached to Midtown's CMHT. Many of these key actors participated in interviews during fieldwork. Data relating to the meso-level provision of services were also generated through analysis of NHS Trust, Local Authority and Local Health Group documents.

Issues actively being negotiated in Midtown included health and social care agency roles and responsibilities in an era of 'modernisation', the management of Midtown CMHT, criteria for access to CMHT services and processes for the intra-team coordination of care. The emergence of these as topics for negotiation reflected, first, the patterning of negotiations by aspects of the macro-level structural context directly entering into the Midtown meso-level negotiation context. At macro-level, the role and functioning of CMHTs was an area actively under review (a process which, since the cessation of data generation, has led to the emergence in multiple sites of 'functional specialist' teams as adjuncts to locality CMHTs (Welsh Assembly Government, 2005b)). Mechanisms to improve the coordination of complex care plans across agency and occupational interfaces was also a significant macro-level issue (Welsh Assembly Government, 2003a). Macro to meso 'lines of impact' (Strauss, 1978) meant that both topics, then, emerged as important areas for meso-level negotiation.

Significant non-negotiable factors also existed. Whilst reorientations in national mental health policy were precipitating negotiations over agency and occupational roles and responsibilities, the needs of the communities served in Midtown remained unchanged. Whilst managerial-level workers were

negotiating new interagency relationships, at everyday practice level practitioners were required to continue providing services to needy local populations.

The relatively small sizes of Midtown's NHS Trust and Local Authority facilitated both intra and interagency negotiation. However, working across the NHS Trust/Local Authority meso-level interface in Midtown had historically been hindered by high levels of management staff turnover and lack of leadership. For example, in Midtown NHS Trust in the years immediately preceding fieldwork two members of senior staff with responsibility for mental health services both experienced long periods of ill health and, consequently, absences from their posts. This had clear negative implications for planning services across interagency interfaces, and in the expressed view of Midtown Social Services' senior mental health manager was a leadership problem only recently resolved by the appointment of a new, and highly motivated, Trust manager.

During fieldwork, relations between the senior mental health manager in Midtown Local Authority Social Services department and the relatively new senior mental health manager in Midtown NHS Trust were described by both as cordial and effective, with positive implications for service development. Forging and maintaining good relations of this sort in order that interagency planning could progress needed active working at, and was vulnerable to organisational and personnel change. This was clearly articulated by the Trust's senior mental health services manager in the context of a wide-ranging

interview focusing on interagency working in the Midtown area. Here, this key worker described her contact with her local authority counterparts, the difficulties she faced in opening and sustaining negotiations across organisational boundaries and the problems of personnel transition:

BH: What's the hardest thing about your job?

Midtown NHS Trust manager: The hardest thing about my job really is, is to get this joint working under, the joint planning, not the joint working [...] Well, the joint planning, to enable them to work together is the highest step I think, OK. Now, I guess if it was easy I probably would've cracked it by now, yeah? That is the most difficult thing. Now I still feel I'm fairly new, even after a year on I still feel as if I'm fairly new, but we're now going into a phase where Christine [*local authority counterpart*] is retiring, well I think Christine is retiring, I haven't heard definitively, because I was off last week I mean it was going to the committee last week and so is Christine's senior colleague. [...] So I'm now into a new ball game again, with two new people perhaps, or somebody new in Midtown. There's been four changes in the other local authority since I've been here in a year and I still haven't worked out who's who. It's absolutely incredible.

BH: Fragmented, by the sounds of it.

Manager: Yeah. So how can you actually even attempt to get joint working and joint planning when you really can't even work your way around the system to find out who's who? [...] I've beaten myself a little bit about we should be further on with joint working but as I say, if I pick up the phone with Christine or Christine picks up the phone with me there's absolutely no problem at all, but it's not like that in the other Social Services Department. And I feel very hampered by trying to make sure that both my community teams develop to the same level when I know I can develop one and can't do the other one.

(Interview, NHS Manager, Midtown – 32: 749-781)

This manager's comments here point to, first, the necessity of knowing who to engage in negotiations with in partner organisations and, second, the hindrance to effective interagency planning and service provision brought about by a lack of shared boundaries. Absence of coterminosity has often

been cited as a barrier to interagency working (see for example: Hannigan, 1999a; Peck and Hills, 2000; Johnson et al., 2003). Senior negotiators in Midtown NHS Trust, like the mental health services manager here, were obliged to work with representatives of multiple partner agencies (in this case two local authorities). As she made clear, maintaining good working relations with staff in partner agencies during conditions of high personnel turnover and organisational complexity was problematic.

The appearance of new agencies introduced as part of Welsh health and social services modernisation was significant in influencing the character of negotiations, and helped alter the relative balance of power between different negotiating parties. The Midtown Local Health Group, set up in April 1999 (Welsh Office, 1998), was a new partner for both the Trust and the Local Authority. All three bodies had a stake in the development of an integrated, comprehensive mental health strategy for the Midtown locality. Working towards this involved negotiating and bargain-making. As Central Health Authority's strategic manager with responsibility for mental health services indicated, an important face-to-face forum for bringing together all the key negotiators in each local authority/LHG area was the mental health locality steering group, of which one existed in Midtown. During an interview held in the central offices of Midtown Local Authority, Midtown Social Services' senior mental health manager described her work in bringing together her organisation's strategic-level social care plan with the new LHG's plan for mental health care through that forum. As the following extended data extract illustrates, the commitment (and requirement) to negotiate across the

health/local authority interface had led to necessary compromise with respect to specific planning details:

BH: What are the kind of frameworks that determine how community mental health care, in all its forms as you've described them, are provided?

Midtown Social Services manager: I mean, I suppose the, let me think, how I can put this, I mean there's a, the framework is through the social care plan where the Department identifies its priorities and last year the social care plan was kind of amalgamated, I think is the word, with a Health Service Plan, the LHG, the Local Health Group plan. So that meant, that was quite good in a sense, but it also meant it became less kind of concerned with annual objectives, became a bit more sort of overarching. I mean that is the process through which things will be achieved in future and that plan will get more focused, you know, those two organisations coming closer together.

BH: Right. So this is quite a new thing now, this is the coterminous health and local authority?

Manager: Local Health Group and the Local Authority. Which I think will be significant. Well, is significant and will become more and more significant [...]. At the moment, I mean the social care plan was an annual plan, well with a sort of three, you know, perhaps a sort of longest perspective, but annual objectives. The joint plan will take that sort of format too. At the moment it's, as I say, it is a bit sort of, it's a bit airy, I think at the moment. And not sufficiently focused.

(Interview, Social Services Manager, Midtown – 18: 93-118)

Here, this experienced local authority negotiator clearly pointed towards the necessity of her agency ceding its preferred style of constructing strategic plans (which hitherto had been very objective-driven) in order to successfully negotiate a jointly owned plan in partnership with its new collaborator, the LHG. Significantly, her answer also hinted at the likelihood of continued interagency bartering in order that future plans become – in her words – more “focused”.

For its part, Midtown's new LHG recognised that it could only achieve its strategic aspirations in negotiation with other agencies, as this extract from its mental health action plan of 2001 reveals:

Mental health is a priority area for service enhancement in Midtown. The LHG has a clear understanding that to achieve this area of priority it will have to work closely with its partner organisations, both statutory and non-statutory.

(Midtown Local Health Group, 2001, p2)

Agreeing interagency policies, like the Local Authority/LHG plan, was seen by many Midtown managers and practitioners as an important, and highly visible, product of successful negotiation across agency interfaces. Interagency policies were produced by different people for different purposes. Some, such as the joint LHG/Local Authority plan, were strategic and intended to address broad issues. Others, such as those produced by members of Midtown CMHT and discussed below, addressed routine everyday practice issues. All, however, were produced through processes of negotiation, and often required compromises to be made.

Modernisation has seen the introduction of new mechanisms for the scrutiny of the quality of health and social care services provided, and for monitoring the use of public resources (Welsh Office, 1998). Two external reviews took place during the data generation period in Midtown. These were, first, a joint review of Midtown Social Services undertaken on behalf of the National Assembly for Wales and the Audit Commission (National Assembly for Wales/Audit Commission, 2001). Second was a clinical governance review of

Midtown NHS Trust completed by the Commission for Health Improvement (CHI) (Commission for Health Improvement, 2001), a body which has now been expanded and renamed in this part of the UK as the Healthcare Inspectorate Wales.

External reviews have become significant, and non-negotiable, events for meso-level health service organisations in the UK (Walshe et al., 2001).

Responding to the demands of Midtown's external reviews had implications for managers and practitioners, and for interagency working. Staff at different organisational levels recognised the importance of external scrutiny, but also indicated that preparing for and participating in reviews took them away from other important areas of work. For meso-level negotiators intent on driving forward service developments, the reports arising from external reviews could be important documents with which to generate leverage. Levy refers to this process as 'staging' (Levy, 1982); social actors may engage in negotiation subprocesses of this type in order to influence the outcome of negotiations. In this example, non-negotiable, externally generated, critical comments could be tabled as a means of urging agency partners to attend to the task of service improvement.

A lack of shared organisational boundaries meant that Midtown NHS Trust's senior mental health manager was required to negotiate the development of services with representatives of two local authorities. She contrasted progress in collaborating with partners in Midtown Social Services Department with problems encountered in working with her organisation's other local authority

partner. Relations between frontline workers employed by Midtown NHS Trust and this second local authority were reportedly positive; however, interagency relations at service planning and management level were described by this key informant as poor. As this following interview extract illustrates, in circumstances of this kind external reviews held out the prospect of driving forward meso-level developments:

Midtown NHS Trust manager: It really does help us focus our mind to think that we picked up these issues, we now need to take them forward and I suppose it adds a bit of weight to it really.

BH: I was going to ask what are the implications of CHI noting things and alerting you to them when you know those things in the first place? What's the extra weight that that, what's the significance?

Manager: I think the extra weight is with other partners. I mean I'm only really talking about mental health at the minute, I mean the issues on the acute side were very different. But joint working, there is a perception in one of the CMHTs, not so much the Midtown one, that joint working stops at the level on the ground and that social services and health are miles apart.

(Interview, NHS Manager, Midtown – 32: 73-85)

Senior Midtown negotiators were able to identify specific sources of tension existing at the interface between different agencies. For example, Central HA's mental health strategy document clearly endorsed the importance of prioritising care for the severely mentally ill; this reflected macro-level expectations regarding the focus of mental health service providers. 'Serious mental illness' needed to be operationalised within the Midtown locale, however. Whilst access to services is ultimately a product of complex interactive processes taking place in specific workplaces (McEvoy, 2000; Griffiths, 2001), statements agreed by all agencies relating to eligibility criteria

to jointly funded resources serve as important affirmations of success in brokering interagency frameworks. Local agreements on access also serve to contextualise, and potentially pattern, workplace access negotiations. As with the example given above relating to a joint Local Authority/LHG strategic plan, accomplishing eligibility criteria agreement across agency interfaces, and expressing this as part of the Midtown CMHT's operational policy, meant making compromises. Midtown Local Authority's senior Social Services manager described this process thus:

BH: [...] what is the eligibility criteria for the CMHT? How is that agreed?

Midtown Social Services manager: Well, it's in the operational policy and it was agreed, we wrote it within, there were various other documents the team has sort of worked to. We pulled stuff out of those documents and then we took it to the, now what was it called at that point, I think it was called something like the Joint Coordinating Mental Health Team, or something like that, and it went there and was discussed at that level, amended and sent back to the team who worked on it and brought it back. It took months to do actually.

BH: Yeah.

Manager: And it's still, I'm not totally happy with it. But there we are.

BH: What is it you're not happy with?

Manager: Well, I think it's very, it's an extremely medical type, it's an extremely, of eligibility criteria, you know, I think mental health and is, I mean I know that, you know, I think it's a very much mental illness oriented policy rather than mental health oriented eligibility criteria.

(Interview, Social Services Manager, Midtown – 18: 297-317)

In addition to the generation of data relating to the making of agreements across agency interfaces in Midtown, meso-level data were also generated relating to the organisation of work within Midtown CMHT. Multiple health and

social care interfaces were joined within this team, and access to case study subjects was also negotiated there.

Midtown CMHT was a long-established interprofessional team, home to professionally qualified and unqualified health and social care practitioners employed by both Midtown NHS Trust and Midtown Unitary Authority.

Throughout the period of fieldwork, which stretched from October 2000 to May 2001, team membership included: a senior community mental health nurse (CMHN) and a senior mental health social worker (MHSW); six qualified MHSWs; seven CMHNs; one unqualified Social Services-employed community care worker; one health care assistant; and two administrative workers. Not all of these were at work during the total fieldwork period due to sickness and staff departures. Two consultant psychiatrists worked with the team, but were not physically based with other team members at the CMHT base. The team was also carrying a long-term vacancy for a clinical psychologist. Only recently had 'grade mix' been introduced amongst the team's qualified nurses, all historically having been 'G' grade senior clinicians. The social workers, too, were differentiated by grade. Midtown CMHT was in its second home, a fairly modern (but leaking) building situated a few miles from the local town centre. In addition to shared offices, clinical and interview rooms and rooms used for the storage of case notes, a large meeting room served the team for a number of purposes. In the middle of the day members would often congregate for lunch and general social interaction. Clinical and business meetings were held there, along with service user reviews.

Staff in Midtown CMHT were conscious of the team's unusually long interprofessional and interagency history, with some expressing the view that the length of time NHS and local authority staff had worked together had contributed to an erosion of rigid occupational boundaries. The team's longstanding senior community mental health nurse (CMHN), for example, had this to say:

Senior 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, so obviously although there are new people who have come into the team and I don't think there's, there isn't anybody in the team who actually goes, well there is actually, there is one person, one person who's on sick leave who goes back to that time, who was an original member of the team when it started, at West House when it started in '79. But 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.

(Interview, Senior CMHN, Midtown – 1: 92-98)

The Midtown CMHT approach to interoccupational working was not a given, however. Team culture required reconstituting during periods of organisational and personnel turnover. As an interactive workplace, roles and responsibilities in the team were also subject to modification reflecting wider macro-level changes in the work of particular occupational groups. A clear example of macro-level structural context changes impacting on the enactment of roles at meso-level was given by the CMHT's senior CMHN, who linked specific developments in the jurisdiction of social workers to their evolving role in the Midtown workplace:

Senior CMHN: I mean, obviously, there are different focuses in terms of the social workers, their area of expertise being about, you know, the kind of social side of things, of, people need housing sorting out and benefits and other services in place, and obviously part of our role more specifically is about monitoring medication and administering it in terms of the depot clinics, but also doing more individual work with them – because one of the things that's happened over the years is the change in the social work role between being a provider of services and now an assessor of services, that's had quite a big impact on the team, in that one time at West House [*the Midtown CMHT's original base*] the social workers used to run groups, they used to do individual work with people and now their role is much more being assessors of care and, you know, case managing.

(Interview, Senior CMHN, Midtown – 1: 386-397)

Locally specific factors also directly influenced the division of work within the team. Over a period of years, different workers had developed differential sets of knowledge and skill, and were now associated with contrasting bundles of tasks. For example, the team's senior CMHN gave an account of having forged a special interest in the provision of care to people with eating disorders. Informally her role now included acting as the team's specialist in this area. For the social workers within the CMHT a significant, formalised, differentiation of work existed, with implications for case study subject micro-level care delivery. Population and agency sizes in Midtown were insufficiently large to permit a whole team to be established to meet the needs of people with substance misuse problems. Substance misuse was perceived as a growing challenge in the locality, however. A Midtown Local Authority response to meeting the needs of the substance using population involved identifying one of the social work positions in the team as being designated for work with this client group. In addition, non-negotiable factors such as staff sickness and the inability to recruit to vacant posts had had implications for

the division of work. With resources limited, team members were required – or had opportunities – to expand their work to encompass a wide range of tasks.

Community care is typically provided by paid and unpaid workers in dispersed locations. Coordinating care plans, particularly for people with complex health and social needs, is a significant task for community mental health practitioners (Simpson, 2005) and is subject now to specific national policy guidance (Welsh Assembly Government, 2003a). Care coordination, or as the Midtown team in its internal policies called it, 'case management', was an activity undertaken equally by CMHNs and MHSWs. Case management was seen by some key informants as an important means to not only knit together plans of care, but also to close the gap between health care and social care practice. In his formal and informal accounts the CMHT's senior social worker, for example, expressed enthusiasm for the erosion of rigid occupational boundaries, and described how 'case management' had helped to close the gap between 'health care' and 'social care'. In Midtown, the adoption of a localised version of care coordination had provided meso-level negotiators with the opportunity to replace uniprofessional care plans with a single, whole-team, set of documentation. This had also meant Midtown Social Services Department agreeing to commit resources, where necessary, to meet needs following service user assessments undertaken by nursing (rather than just social work) members of the team.

Face-to-face team meetings can fulfil a number of significant functions in meso-level systems of community mental health care (Larkin and Callaghan,

2005). Both informal and formal meetings punctuated the daily and weekly rhythms of the Midtown CMHT. Informal interactive events (for example, those taking place in the team's large meeting room at lunchtimes) were observed to be important fora for the ongoing discussion of service user-related issues. In addition, team members came together formally for particular purposes. The team's key weekly meeting took place every Monday morning, during which new referrals were received and discussed and information on ongoing work of concern to all shared. It was at one of these meetings that I first met with the team to present my research proposal. During fieldwork I participated in a number of these regular meetings in order to generate data relating to the processing of client work and the intra-team negotiation of the division of labour. As interactive events, formal team meetings served as a forum in which occupational roles and responsibilities could be realised, as this extended extract from an interview held with the CMHT's senior social worker reveals:

Senior MHSW: The idea of the business meeting, then, apart from team business, is in relation to referrals and allocations. Referrals are read out, information in relation to the referrals is read out. Feedback from assessments of the referrals is read out, shared amongst the team and more often than not, I guess, people who do the assessment generally, probably, take the case on because some rapport or some contact has been established and often people pick it up because they've actually started something or got some, you know, a sufficient amount of information and they start a relationship with a client or patient. But I guess in some cases there may be particular skills that individual workers have and particular interests that individual workers have that may, may sort of like decide that they would be more appropriate.

BH: Would those kind of particular interests be to do with core professional training or could it be to do with other things, entirely other things as well?

Senior MHSW: It could be any number of things and again there's no reason why there should be any particular professional training that gives somebody the edge on that as it were.

(Interview, Senior MHSW, Midtown – 12: 322-340)

As this account suggests, the process of allocating newly referred service users to workers was accomplished interactively. The occupational background of practitioners was only one of a number of variables influencing this process.

One of the advantages of bringing together workers in locality-based CMHTs is that, over time, teams are able to build up local knowledge of their communities served, resources available and service user characteristics (Aggett and Goldberg, 2005). Collectively, Midtown CMHT members displayed a well-developed knowledge of this type during the course of their Monday meetings, as this extended fieldnote extract from one of my earliest meetings reveals:

Tim [*MHSW*] has got hold of a large red box file, and says he is reading out details of clients who have either been admitted or discharged from Midtown Psychiatric Hospital that week. This takes c.15 minutes, with team members chipping in. Then Tim says that it is time to do the duty referrals. Team members, who I conclude have assessed newly referred individuals on a 'duty' basis in the previous week, take it in turns to present their assessments. Tim starts, and describes a heroin using body builder with an anger management problem. Tim says that he thinks this man is not a suitable client for the CMHT. The client didn't like hearing this, Tim says. Others in the team then present their assessments. Some are confident, others faltering. Both nurses and MHSWs seem to do these duty assessments, and information is provided in a non-discipline specific way. Information typically includes: the referrer (often a GP), the presenting problem, some brief personal and mental health history, the person's presentation on the day, and the action taken. One duty assessment, a suicidal woman, was referred immediately to Midtown Psychiatric Hospital, where she remains.

At one point, Tim says:

Tim: If people try to get clients admitted to hospital and there are no beds, make a note of it in the book [indicating client information book].

A number of the arranged duty assessments evidently failed to attend. Two staff members record information in a book, locating clients by name and record number. Decisions are recorded: e.g. offered new appointment, followed up. Throughout the various presentations there are frequent comments from other team members. For example:

Team member: Wasn't she the woman who used to run the Red Lion pub?

And:

Tony: [Senior MHSW, who joined the meeting after c. one hour]: Oh, she's a Jones! Phil Jones, Peter Jones, now Mary Jones!

Team member: I used to see her sister. Has the father died?

Ellen: [MHSW] Only closed that case earlier this year!

(Fieldnotes, Midtown – 34: 390-429)

To summarise the Midtown meso-level negotiation context, data generated during fieldwork revealed that, first, good working relations between key negotiators were helpful in bridging the health and social care agency divide. Strategically placed workers clearly demonstrated a commitment to the principle of working together. Negotiations had resulted in the production of jointly agreed local frameworks, although accomplishing these meant compromises often needed to be made. These successes had taken place in the absence of organisational stability, and in the absence of complete knowledge of the macro-level contours of the mental health system in its largest sense. Midtown CMHT, as a specific workplace, was a long-established service characterised by staff as lacking rigid occupational

boundaries. Considerable local knowledge was embodied in the team, although human and other resources were limited.

5.5 THE SYSTEM OF WORK IN NORTHTOWN

5.5.1 The Northtown community

In terms of both population size and geographical area Northtown was significantly larger than Midtown. This had major consequences for service organisation. Data from Central Health Authority's Mental Health Strategic Framework revealed that, using local authority boundaries, the population of the wider Northtown area was around five times that of Midtown (Central Health Authority, 2000). Northtown's size meant that, within its local authority boundary, significant social and economic differences existed within pockets of the community. That part of the wider Northtown locality which was served by the team I have called 'Northtown CMHT' was, for example, relatively underprivileged. This was reflected in the ways workers there spoke about the CMHT's clientele. Many drew my attention to the high levels of mental health need found amongst the team's service user community, and pointed to the high rates of homelessness encountered in the immediate locality.

5.5.2 Agencies and teams in Northtown

In Northtown, reflecting the size of its population, health and social care organisations were relatively large. Northtown NHS Trust provided inpatient mental health care on two hospital sites, and had plans to develop services in a third. The Trust operated multiple community mental health teams serving

the needs of working age adults, and did so in partnership with two local authorities. Hospital-based day services and residential rehabilitative care were also provided. Reflecting the size of the population served, Northtown agencies were able to provide a relatively differentiated range of services. For example, in addition to locality CMHTs specialist teams existed for children and young people with mental health problems and for adults with particular needs such as substance misuse difficulties. As in Midtown, general NHS and local authority care services were also available to people with mental health problems, as were services delivered by primary health care teams and non-statutory sector bodies. Workers based in the CMHT, in both hospitals providing mental health services, in non-statutory agencies and in primary care all had major parts to play in the delivery of care to the three Northtown case study subjects.

Northtown's size brought benefits. Differentiated service provision was possible only because of the size of the local population and the correspondingly large size of health and local authority organisations. Whilst vacancies in the Northtown mental health workforce existed, managing staff turnover was easier than in Midtown as, for example, workers could be moved from one CMHT to cover gaps in another. Large agencies also brought difficulties, however. As I found during my protracted Northtown access negotiations, finding out who the 'right' person was for a particular purpose could be difficult. Decision-making could be relatively slow, and opportunities for interaction between workers responsible for strategy and workers responsible for day-to-day care delivery were fewer than in Midtown.

Operating inpatient mental health services on two sites was also organisationally problematic, and was a source of service discontinuity. These meso-level features all had implications for care provision at micro-level, as I demonstrate in later Chapters.

The team in which I was based during fieldwork – Northtown CMHT – provided services to a catchment area numbering 80,000 (Central Health Authority, 2000). This had implications for intra-team working, with the large size of the community served bringing organisational economies of scale. Northtown CMHT was home to a relatively large number, and broad occupational mix, of workers. This brought benefits in terms of the team's capacity to provide a fuller range of services, but in the view of at least one respondent also created considerable potential for intra-team confusion over roles and responsibilities.

5.5.3 Negotiators, negotiations and limits to negotiation in Northtown

Senior staff interviewed in this study included managers working in Northtown Social Services Department, an LHG manager, a senior manager for community services in Northtown NHS Trust and the senior mental health nurse with responsibility for the day-to-day management of Northtown CMHT. Locally significant documents were also obtained and analysed, with data relating to the meso-level organisation of services extracted.

Lack of shared boundaries, high levels of senior staff turnover and tensions at the NHS/local authority interface were all hindrances to effective interagency

working reported by key informants in Midtown. These were significant issues in Northtown, too. A powerful new meso-level body was the Northtown Local Health Group, which, in partnership with Northtown Local Authority, was preparing to assume the role of commissioning mental health services.

However, the sheer size of agencies in Northtown compounded the challenges of managing these large-scale transitions. One medium-term task for meso-level negotiators was to agree a shared, interagency, way of dividing the wider Northtown locality into smaller population and organisational units, in order to better communicate with the community and to achieve more integrated service planning and provision.

Other significant issues actively being negotiated at meso-level in Northtown included the organisational relationship between health and social care agencies in the locality. This encompassed the construction of shared policies, and leadership in CMHTs. Compared to Midtown, Northtown workers were less progressed with this work. For example, key negotiators were not able to immediately produce up-to-date local policy documents (such as CMHT operational policies, or frameworks for the organisation of care coordination) in the way which Midtown workers were.

A distinctive characteristic of the Northtown locale, which helped explain the difficulties faced by meso-level negotiators in working across the health and social care agency and occupational interface, was the site's history of particularly strained interagency relations. Senior negotiators in Northtown Local Authority, for example, gave accounts of their agency as historically

having been cast as Northtown NHS Trust's 'poor relation'. In the course of an interview conducted towards the end of fieldwork, an experienced and long-standing senior Social Services manager spoke candidly of the historic difficulties his agency had faced in forging a more equal relationship with its NHS partner, compounded by the lack of Local Authority investment in mental health services compared to the investment made by the Trust and its predecessor bodies:

Northtown Social Services manager: The community mental health teams in the Northtown area came about, I suppose, in the late eighties when we centralised, and discussions with health about joint teams etc. I suppose it's fair to say that that relationship has always been a rocky one in the sense that I think from, certainly from the Social Services or the social workers' perspective. The Social Services' perspective is that, you know, they've always been seen as the Cinderella service.

BH: The social workers in the CMHTs, yeah.

Manager: Yeah, and you know it's almost as though, we do what health tells us and we have no identity of our own to some extent. There're obviously champions within the service who resisted that, and would probably question that statement as well, but I think it's a fairly true statement personally. I think the other thing to say is, and I think this is recognised certainly by the current senior management team, is that the Northtown area has significantly underinvested over the years in mental health and in that sense it is a very Cinderella service.

(Interview, Social Services Manager, Northtown – 91: 13-30)

One of the consequences of the greater investment made in mental health services by Northtown NHS Trust and its predecessor bodies was a general assumption of the Trust's automatic right to assume 'lead agency' responsibility in the organisation of mental health services for working age adults, a meso-level feature characteristic of other locales in the UK (Villeneuve et al., 2001). For some local authority workers, such as the principal social

services officer who worked in both Northtown CMHT and in a second team in the wider locality, this was accepted as a logical consequence of their agency's failure to prioritise mental health care. Nonetheless, this prevailing view of a lack of an equal partnership between agencies was cited by some as a hindrance to service development at meso-level. For example, key informants were able to identify meso-level NHS Trust developments being undertaken in a unilateral, non-negotiated, manner. A review of mental health day services by Northtown NHS Trust drew criticism from a manager in Northtown LHG, who observed that the Trust – through its senior managers – had unhelpfully neglected to involve representatives of the Local Authority throughout this process:

LHG Manager: I think that the next twelve months of planning, hopefully will become much more sort of integrated really. Because the Trust, it's difficult to know what the Trust's responsibilities are when it comes to things like supported accommodation, day services, which is after all very much a Local Authority led service. You see, they did a review of day services and the senior nurse for community services did this actually, and they didn't even involve the Local Authority. So I mean it's very much, they're looking at their own piece of the jigsaw...

BH: And not how it fits in the with the whole.

Manager: Yes.

BH: Yes.

Manager: So I think that's really what we've got to try and get a handle on, you know, is to, not expect them to do everything but to just accept that the final plan for Northtown is bigger than just the Trust and it's got to involve these other organisations.

(Interview, Local Health Group Manager, Northtown – 86: 490-509)

In a way similar to that described by Midtown informants, achieving effective service planning across agency interfaces in Northtown was considerably

hindered by a lack of shared organisational boundaries. This helped explain the difficulties in reviewing the operational policy for each of the wider Northtown locale's CMHTs. In a wide-ranging interview, the Trust's senior nurse for community mental health services – whose role required him to work with representatives of multiple agencies – described the difficulties his organisation faced in negotiating with two local authorities. In particular, the different organisational structures within these two partner agencies militated against the construction of shared statements about the expected contributions of specific grades of worker. For example, whilst Northtown Social Services Department embraced the role of principal social services officer, the NHS Trust's other partner local authority elected not to employ staff with this title.

Despite the large size of its agencies and the potential for organisational economies of scale, resource limitations in Northtown – as in Midtown – were a major source of constraint. Like many comparable institutions (Glasby and Lester, 2005) Northtown psychiatric hospital was large and costly, consuming resources disproportionate to the number of people cared for there. Given this, the development of more effective ways of meeting needs during periods of crisis was high on the agenda of meso-level negotiators. One of the locality's jointly funded CMHTs, for example, was in the process of piloting an extended hours service to provide care to people with mental health problems beyond the five day per week, nine-to-five model.

During the period of fieldwork in the Northtown CMHT, from April 2001 to July 2002, the day-to-day management and coordination of the team's activities was undertaken by a senior nurse (who also had responsibility for a second CMHT). Resources available for team leadership had steadily been eroded, with the senior nurse's work of simultaneously managing two teams adding considerably to his organisational responsibilities. The large size of the team's catchment area, and agency economies of scale, enabled the CMHT to be staffed by workers from a wider range of occupational groups than had been the case in Midtown.

Physically based in the team were: three psychiatrists, two of whom were at consultant level; one clinical psychologist; seven CMHNs working at different grades from 'E' to 'G', one of whom left and one of whom arrived during fieldwork; a nursing auxiliary; an occupational therapist; a principal social services officer, whose responsibilities also encompassed social work leadership in a second, more specialist, CMHT; a senior MHSW; four other full-time MHSWs and one part-time; a team administrator; and four secretaries. A physiotherapist also worked on a sessional basis with the team, although her base was elsewhere. Offices were peopled by health and social services staff together, with other rooms being used for the purposes of clinical work, storage of service user case notes, and for business and clinical meetings. A major helpful factor for intra-team negotiation was the location of psychiatrists as full members of the CMHT in the team's shared base. A hindrance to face-to-face negotiation was that Northtown CMHT lacked a room able to accommodate all team members simultaneously.

Historically, meso-level interagency tensions had particularly revealed themselves within the Northtown CMHT. Compared to the Midtown team, this CMHT had a much more recent history. Workers there made no claims to have inherited a strong culture of close interprofessional working. Where longstanding members of the Midtown CMHT had spoken of a favourable, relatively harmonious interagency and interprofessional culture, longer-serving Northtown CMHT staff spoke of a fractured and conflictual team history. The theories of negotiation held by former team members had extended to the use of non-negotiation as a strategy for the management of the interface between the health and social care parts of the team. This troubled history was clearly described by the team's principal social services officer:

Principal social services officer [PSSO]: [...] Here there was a tortuous history that social workers came from another office and there was massive industrial action, 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 [...]. There were personality clashes, and eventually a different set of people, and they just moved in they got on with it. That bit of it is a historical thing [...]. Most of the social workers here are not a part of that group, but it was a very heavy, acrimonious, type of, you know, the thing that you read about in booklets.

(Interview, Social Services PSSO, Northtown – 82: 96-110)

The recognition by this worker of the need to 'get on with' the task of rebuilding the team in the wake of an early breakdown of relations was echoed by the longstanding administrator of the Northtown CMHT. Whilst acknowledging the team's early difficulties, she also described changes in more recent years:

Administrator: At the outset of the Northtown CMHT there were social workers, and then they moved out and they were in another part of the city, and then they were introduced back into the team.

[...]

BH: They moved out. How was it they moved out and then moved back in again?

Administrator: It's very difficult for me to say. When I started with the team I was part-time so I was only getting bits of this. I think the easiest thing to say was there was a bit of a disagreement, personality clashes between certain strong-minded people.

[...]

There were two very strong people who primarily caused the rift so to speak, that's probably not a good word to use but, anyway, the social workers basically moved out.

BH: They moved out, right.

Administrator: But then in the fullness of time, you know, it's, the logic of them working together is so much better.

[...]

So the team came back in, and it's worked really well ever since. It's been really good, and I mean the social workers we have are really, really nice and we all get on really incredibly well.

(Interview, Administrator, Northtown – 63: 245-295)

Strategies of non-negotiation had, then, once been pursued by strong-minded managers and practitioners in the earlier phases of the Northtown CMHT's existence. However, the macro and meso-level imperative of bringing health and social services workers together in integrated community mental health teams, and the gradual reconstitution of the team's workforce, meant that this early breakdown of relations had passed into history by the time fieldwork commenced. Nonetheless, in the view of some key informants Northtown

CMHT was still a fulcrum for a lower-intensity form of interagency and interprofessional dispute. Relative newcomers to the team with experience of community work elsewhere, for example, were able to draw unfavourable comparisons with services in other localities. A senior social worker had joined the team in the previous year, having spent 10 years in another CMHT in a different town. In the context of an interview conducted in the team's premises she compared her current with her past experiences by drawing attention to what was, in her view, the unequal relationship between health and social care agencies in the Northtown service:

Senior social worker: The team here is a much larger team [*compared to the team she previously worked in*] and it's more multidisciplinary, there's more different disciplines, there are more disciplines working here and the doctors are based here, which is good. Health very much take the lead here. In Westtown [*previous workplace*] it was, it was a town centre team again, but a smaller team, primarily comprising CPNs and social workers [...] it felt more of an equal partnership between health and social services [...].

(Interview, Senior Social Worker, Northtown – 76: 78-90)

The mix of occupations located in the Northtown CMHT meant that users of the team's services potentially had access to a fuller range of differentiated care and treatment options than had users of the Midtown CMHT. For the team's newly appointed senior social worker whose words are reproduced above, working in such a diverse service also brought potential problems. In her interview account, for example, she described the advantages to service users of having access to a rich mix of workers, each with particular constellations of knowledge and skills. Working in a team staffed by a wide range of practitioners, she thought, also brought advantages for practitioners,

who had everyday opportunities to increase their practice-based learning.

However, this experienced social worker also described the Northtown CMHT as a “melting pot”, characterised by an absence of clarity over relative roles and responsibilities.

As in Midtown, modernisation of services was focusing attention on, amongst other areas, the importance of effective care coordination for people with severe mental health problems using dispersed services. Data generated during fieldwork indicated that processes for coordinating care in the Northtown CMHT were less formalised than in the Midtown team, with consequences for micro-level care provision (see Chapters 6 and 7 below). Given the complex mix of workers located in the Northtown CMHT, negotiating a jointly agreed system for the coordination of services was a pressing priority. This was recognised by the CMHT’s senior nurse and *de facto* team leader, who acknowledged that in the process of undertaking a snapshot audit of the team’s caseload:

Senior Nurse: [...] it became evident that we weren’t sure among ourselves who the keyworker was sometimes. I don’t think that’s helpful. I think we need to know that.

(Interview, Senior CMHT Nurse, Northtown – 60: 966-968)

Multiple formal meetings were held in the Northtown CMHT, but none which all members were able to attend. In a weekly clinical meeting, practitioners who had assessed newly referred service users were required to inform colleagues of their findings, and also to update team members of ‘at risk’ users who all in the team needed to be aware of. More general organisation of

work issues, sometimes contentious or disputed, were often aired at these meetings. The expectation that the team attend to its ability to respond to crises had made the setting up of a duty system a hot topic for intra-team negotiation, as this fieldnote extract records:

Bob, the CPN who takes the lead in chairing the meeting, invites me to update people with my study, which I do. The meeting itself begins with a discussion of new referrals: three in total, two of which are judged to be inappropriate. One is for 'stress counselling', the other for relationship work. The last person is to be assessed by Tamsin, the psychiatrist. There then ensues a general discussion over the operation of the duty worker and 'safety worker' system. Tamsin, staff grade psychiatrist, says she is in favour of a duty system, but that this can only be achieved with a full complement of staff. The senior social work practitioner, Sally, says the team should have a duty system, as they are an urban CMHT and many other teams have operated such systems for years. She appears angry at one point, and asks whether people have the motivation to run such a system. Tamsin says that the duty officer system is discussed at every meeting the team ever hold – and that a decision has to be made one way or another. Others suggest that decisions need to be revisited, a view expressed by Taylor [*Senior CMHN*].

(Fieldnotes, Northtown – 93: 273-281)

As in Midtown, in the absence of expanded resources for the provision of a wider range of interventions Northtown staff were expected to prioritise services for seriously mentally ill people. Pressure on the team to distinguish between types of potential client impinged on team negotiations. As in the meeting recorded above, this could culminate in the team rejecting new referrals as 'inappropriate'. Scarce resources and high levels of mental ill health in the locality served by the team made it likely that – as in the example here – many new referrals would be rejected before assessment. This enacted operation of strict eligibility criteria for access to the team's services had consequences for the CMHT's relationship with workers located in other

parts of the local system of mental health work. In particular, the combination of a high weekly volume of new referrals and the active screening out of many of these on the sole basis of referrer information had contributed to an erosion of good relations with primary care colleagues. The 'official' line in the Northtown site was that the rejection of new referrals prior to the completion of an assessment, in the way observed above, should not be pursued where possible. This was put to me by Northtown NHS Trust's senior mental health nurse with responsibility for community services:

Senior Nurse for Community Mental Health Services: [...] there was an underpinning principle really that they [*the CMHTs*] concentrated on the clients with serious enduring mental health problems. That by and large has been the case [...]. I think over the years, particularly in some of the neighbourhoods, we've learnt that rigidly applying that principle is not a good idea really, and that we've learnt to look at acceptance criteria more on need rather than diagnosis, so we've softened the boundaries a bit.

[...]

A few years ago we had some patchy relationships with GPs because of this very issue, and I think what GPs dislike more than anything is for referrals to sort of be bounced at the paper stage, and what we're trying to do now is say wherever possible if a referral comes in, unless it's outrageously out of our catchment area, you know, too old, too young or clearly forensic, you know the risk element, we should assess them and provide a report back whether we take them on or not.

(Interview, Senior Mental Health Nurse, Northtown – 84: 80-111)

In reality, observational data generated during fieldwork suggested that pressure on the Northtown CMHT meant that services could rarely be extended to all those who were referred to it.

To summarise the meso-level negotiation context in Northtown, a first observation – in marked contrast to the experience encountered in Midtown – is that the site had been characterised by difficult, and sometimes traumatic, interagency relations. Key informants expressed the view that historical events coloured contemporary negotiations, and helped generate a view of an unequal partnership between health and social care agencies and professionals. During fieldwork, considerable work was needed to broker agreements across agency interfaces. Much work lay ahead to negotiate shared strategies, including for the leadership and operation of CMHTs and for the coordination of care.

5.6 CONCLUSION

This Chapter commenced with an account of the processes through which research access was negotiated in Midtown and Northtown. Access negotiations were important not only as a necessary activity prior to data generation proper, but also insofar as they revealed early, valuable, data relating to organisational arrangements and interagency relations in the two sites.

In both the Midtown and Northtown meso-level negotiation contexts the planning, management and organisation of interagency mental health services were taking place against a background of sustained macro-level upheaval. Workers were obliged to collaborate in the absence of complete information, knowing that new national frameworks for health and social care provision were being prepared but not knowing the details of these. Representatives of

established agencies (NHS trusts and local authorities), new agencies (like the Midtown and Northtown Local Health Groups), and representatives of agencies which were scheduled for disbandment (Central Health Authority), were required to work together. Hindering this process were high levels of senior staff turnover and poorly developed or strained relations between key workers. Also constraining the ability of key negotiators to progress were structural hindrances such as unshared agency boundaries.

Factors likely to both promote and inhibit effective interprofessional and interagency working were found in the Midtown and Northtown CMHTs. Organisational and personnel instability was in evidence in both. Neither team was headed by a single, clearly defined, manager. In Midtown, management responsibilities were shared by the team's senior CMHN and senior MHSW, whilst in Northtown the senior CMHN took *de facto* responsibility for the day-to-day running of the service but was also required to negotiate with a principal social services officer. Neither team had been able to agree a single geographical or other boundary for the acceptance of new referrals. Health staff in both teams were nominally attached to GP practice boundaries, whereas social services staff were geographically aligned. A non-negotiable reality for both teams was the requirement to provide services for socially and economically deprived communities, with limited resources.

More positive indicators of team working included recognition in both sites of the importance of integrated meetings, in which health and social services staff could negotiate service user-related and other matters. In both CMHTs

considerable local knowledge was revealed during these events. These also served as a place for the airing and negotiating of what could, at times, be contentious issues. With the notable exception of the absence of psychiatrists in the Midtown CMHT, both teams also physically brought together representatives of key practitioner groups, thus increasing the opportunity for both formal and informal face-to-face exchanges.

Midtown and Northtown CMHTs also differed in a number of significant ways. The teams sharply contrasted in terms of their histories, and in terms of the mix of occupational groups contained within them. The Midtown team had generated more formal evidence of effective interagency working through the production of recently reviewed and endorsed operational, case management and other locally applicable policies. The accounts given by senior key informants in Midtown also indicated some success in bringing together the health and social care elements of the team, in terms of agreeing activities such as care coordination and duty work. In Northtown CMHT, informants recognised the work which needed to be done in these and related areas, but were less well-advanced in accomplishing this.

6 EXPLORING NETWORKS OF CARE

6.1 INTRODUCTION

This Chapter describes and analyses the micro-level negotiation contexts as these surrounded the six service user case study subjects who participated in this investigation. From this vantage point, with a focus on direct service provision and the factors helping and hindering care delivery at the everyday practice level, it becomes analytically possible to treat the meso-level negotiated orders of mental health services delivery in Midtown and Northtown as now being part of an expanded structural context.

The Chapter begins with an account of my case study subject selection strategy. Where Chapters 7 to 9 are thematic, containing analyses which cross-cut all six case studies, this Chapter gives an account of each case study as a discrete, micro-level system of work. In each, key negotiators are introduced, and key events unfolding in each service user's trajectory are highlighted. Events and social relationships which became the foci of data generation and analysis are introduced. 'Lines of impact' (Strauss, 1978) between micro-level negotiation contexts and the structural context within which each existed are examined.

6.2 NEGOTIATING ACCESS TO CASE STUDY SUBJECTS

Access was sought to potential service user case study subjects who CMHT workers identified as having 'severe and enduring mental health problems'. This aim was made clear in the study's information sheet for managers and

practitioners (see Appendix 6). Invitations to participate were made only to service users whose needs were sufficiently complex to mean that their care was provided – as a minimum – by a combination of workers employed by NHS trust, local authority and primary care organisations. In each case study this would permit the examination of roles and responsibilities, and the interfaces between, at least three paid workers located in three key agencies.

Decisions relating to the final selection of service users to be approached with a view to inviting their participation took place in the context of detailed discussions with CMHT practitioners, including psychiatrists. The more 'complex' was each user's network of care, the more I was interested in inviting their participation in the study. The greater the range of workers and agencies involved in each case study, the more roles there would be to examine and the greater the range of significant interfaces to explore. A further factor considered in finally identifying potential service user case study subjects was knowledge of significant historical and recent care trajectories, such as admissions to hospital or experience of having been treated under sections of the Mental Health Act 1983. Finally, practical factors, such as the geographical location of service users, also played a part in final selection. In all instances a key consideration was team members' estimation, including that of psychiatrists, of the capacity of service users to understand the aims of the study and what taking part would mean.

During these case study selection processes, and thereafter during case study-related data generation, I was mindful that involving people with severe

mental health problems in research studies needs to be done with care, for the reasons given in Chapter 4 above. Although Central Health Authority's research ethics committee (REC) had ultimately judged my project not to be 'research' at all, my aim from the start of fieldwork was to negotiate access to, and recruit, service users in exactly the manner outlined in my second application for REC approval (see Figure 4.2 above).

Initial discussions regarding the recruitment of case study subjects were made at routine CMHT meetings in Midtown and Northtown. The information sheet used to introduce the study to workers outlined the aims of the investigation, along with the expected benefits for future service provision arising from the study's findings. The ethnographic case study mapping approach was also described. General overview and information-providing events (which often had to be repeated at multiple meetings and again to individuals in both CMHTs) were followed up by making specific contact with practitioners expressing an initial willingness to help identify potential service user participants. Having identified a potential case study subject through discussion with one or more practitioners, I then sought the opinion of the service user's consultant psychiatrist regarding the individual's capacity to give (or withhold) their consent to take part in the study.

Following the purposeful selection of a potential case study subject, and having negotiated the agreement of CMHT workers to invite participation, a first introduction to my study to each service user was made by a suitably placed CMHT worker with responsibility for care provision. In most cases, the

CMHT practitioner with whom service user access negotiations had opened became the person to first introduce my study. For this purpose a second, more simplified, information sheet was used (see Appendix 7). Following these meetings practitioners informed me of each potential case study subject's willingness, or not, to find more out from me about participation. For those willing to consider taking part, these same CMHT practitioners set up meetings for me to explain my study. At these events I explained my plans and answered questions. Where service users agreed to participate I obtained a signed record of their consent to this.

In total, three men using community mental health services in Midtown agreed to take part in the study, along with three women in Northtown. All have been given pseudonyms in this thesis and have had other essential items of personal information altered to help preserve their anonymity. A total of four users were approached in Midtown to participate in the study, with one (who would have been a third and final case study subject) agreeing to meet me to discuss my plans, but on the basis of this exercising his right not to take part. Negotiating the agreement of three service users in Northtown to take part in the study was a more protracted process than had been the case in Midtown. Fieldwork in Midtown preceded fieldwork in Northtown; having gained support for this study from senior managers and practitioners in Northtown in the middle of 2000, it was not until April 2001 that contact was renewed with Northtown CMHT workers to prepare the ground for fieldwork proper from June 2001 onwards. Time elapsed meant that initial overviews relating to the

study had largely been forgotten; visiting Northtown CMHT in early summer 2001 felt akin to visiting for the first time.

In Northtown meetings with CMHT workers in the second half of 2001 generated lists of potential case study subjects. Some I ruled out on the basis of, for example, an apparent absence of significant interoccupational and interorganisational interfaces existing in their networks of care. Eventually it was necessary to formally approach five service users to invite their participation in order to secure the involvement of three. One of these five service users, who after two meetings decided not to take part, had recently been referred to the CMHT for the first time. All three user participants in Northtown were women, and all were existing rather than 'new' CMHT service recipients.

6.3 JIM – MIDTOWN CASE STUDY SUBJECT 1

Jim was suggested in early November 2000 as a potential case study subject by a community mental health nurse who also acted as Jim's care coordinator. Jim agreed to become the starting point for a case study in that month, and his network of care was explored from then until April 2001.

Jim was an older man who, following the death of his wife, lived alone in housing association accommodation. Primary care records indicated that he had first used mental health services in the late 1950s, when a diagnosis of schizophrenia had been made. This had since been amended to a severe mood disorder. Tracing Jim's network of care began with an exploration of the

work of Jim's community mental health nurse/care coordinator. Other significant contributions to the work of caring for Jim were made by: Jim himself; Jim's neighbour and principal carer; a hospital-based consultant psychiatrist; a GP; an unqualified health care worker based in the Midtown CMHT; a Midtown CMHT MHSW; a community pharmacist who supplied Jim with his prescribed medication; a Midtown psychiatric hospital staff nurse who was instrumental in managing Jim's discharge home from a hospital admission; and a hospital-based occupational therapist (OT) who played a part in preparing Jim for his return home.

Jim's increasingly complex trajectory drew in a wide range of paid and unpaid workers, located in multiple and geographically dispersed settings. Whilst psychiatrists remain the most powerful of the mental health professions, the social organisation of psychiatry in the Midtown site – which involved members of this occupational group being physically based outside of the CMHT base – had implications in Jim's case. Jim's hospital-based psychiatrist interpreted his role relatively narrowly, and confined his contribution largely to the management of Jim's trajectory during periods of inpatient care. His view was that, where possible, primary health care colleagues should assume a greater responsibility for the care of mentally ill people living in the community. This micro-level enactment of psychiatric work meant that, whilst at home, Jim's principal paid worker was his CMHN/care coordinator. Negotiations between these two key workers centred largely on effecting a transition of day-to-day responsibilities as Jim moved from home to hospital and back again.

The network of care surrounding Jim in the community drew most significantly on the contributions of three key workers: Jim's CMHN/care coordinator; Jim's neighbour and main lay carer; and the CMHT's health care assistant (HCA) whose involvement was requested by the CMHN. The work of Jim's unpaid carer, and the social relations between her and the paid practitioners also involved in Jim's network of care, was a first focus for data generation and analysis in Jim's case. All three workers were committed to negotiation as a way of achieving the goal of supporting Jim, as was his wish, in his own home. Frequent face-to-face interactions took place between all three, typically when either the CMHN or the HCA visited first Jim, and then his neighbour. These negotiations, some of which were observed during fieldwork and some of which were reported in the context of semi-structured interviews, focused on a range of topics. These included identifying the work which needed to be done to support Jim in his home, and negotiating a division of labour in relation to these. Work associated with medication management was one area prioritised by both paid and unpaid workers, for example. However, Jim also needed help in managing his finances, maintaining the state of his home, having prepared meals delivered, and attending his multiple primary care and outpatients appointments with regard to both his mental and physical health needs. Negotiations centred on dividing up these tasks took place. There was also a negotiated division of work associated with the task of identifying the early warning signs of Jim's deteriorating mental health. In this last area, Jim's neighbour and main carer revealed considerable lay knowledge. This was, however, also an area in which unequal power relations

between negotiators were revealed and in which the limits to negotiation were demonstrated, as is explored in depth in Chapter 8 below.

Jim was well-known both to the paid workers who provided services to him and to members of his local community. Practitioners had had experiences in the past of successfully responding to acute crises in Jim's mental health, and in enabling him to return home, with support, to live on his own. Being both well-known and well-supported favoured a relatively straightforward trajectory. However, in the months leading up to Jim's participation in the study his trajectory had become significantly more problematic. Jim joined the study immediately following a two month admission to hospital, which had been organised using a treatment section of the Mental Health Act 1983. This admission had followed a similar, compulsory, admission the year before. In addition to his recurring mental illness, Jim also experienced multiple physical health problems. These further complicated Jim's trajectory of care, and demanded responses from his care team.

Prior to his most recent hospital stay Jim's mental health had dramatically, and quickly, deteriorated. This key event in Jim's trajectory – his acute episode of ill health, and the organisation of his transfer to hospital – was the second focus for (retrospective) data generation. A third focus was the management of his transition home, an event which was unfolding at the time Jim formally joined the study.

At meso-level, representatives of Midtown NHS Trust and Local Authority Social Services Department had made an explicit attempt to realise the macro-level requirement to ensure a single, clearly identified, care coordinator for all users of mental health services. These negotiations had resulted in the production of a local policy document addressing care coordination (or, as the Midtown CMHT called it, 'case management'), which sat alongside the team's operational policy as an example of successful interagency deal-making. As per the CMHT's negotiated case management policy, the CMHN who identified Jim as a possible participant in this study identified himself as fulfilling a care coordinator role. Data generation and analysis included a focus on this work.

Chapter 3 noted a shift in the structural context for mental health care towards the more vigorous management of the risk posed by people with mental health problems. This trend has, for example, brought closer a new legal framework for mental health services in England and Wales. At micro-level, typical responses to perceptions of elevated risk posed by mental health service users include consideration of the use of assessment and treatment sections of the Mental Health Act 1983. The micro-level operation of mental health legislation, as was revealed in Jim's case, has implications for occupational roles and responsibilities. A further area examined in this case study, then, has been decision-making in the context of applying for compulsory orders, and the shift this represents from the pursuit of strategies of negotiation to the use of strategies of coercion.

6.4 SIMON – MIDTOWN CASE STUDY SUBJECT 2

Simon, the second service user in Midtown to join the project as a case study subject, was suggested as a potential participant by a mental health social worker in the Midtown CMHT. Simon agreed to take part in the study in December 2000, and his network of care was explored from then until April 2001.

Simon was in his late 30s, and had used mental health services since his early 20s. He had been given a diagnosis of schizophrenia. During his participation in the study Simon lived in a residential home, The Oaks. This was funded by Midtown Local Authority, with qualified social work practitioners and care assistants providing round-the-clock services. Simon was also subject to 'supervised discharge' under section 25 of the amended Mental Health Act 1983. The employment of the snowball sampling approach in Simon's case led to interviews with: Simon himself; the Midtown CMHT MHSW who introduced me to Simon and who acted as his care coordinator and section 25 'social supervisor'; a residential social worker who had responsibility for Simon's day-to-day care whilst he lived at The Oaks; the social worker who managed the residential home; a consultant psychiatrist; Simon's GP; a local authority-employed day centre worker who had contact with Simon each week; Midtown NHS Trust's Mental Health Act administrator, who was instrumental in organising the review of Simon's section 25 status which took place during fieldwork; a hospital-based mental health nurse who had responsibility for aspects of Simon's prescribed medication regime; and a social worker employed by Midtown Local Authority whose work

encompassed the resettlement of people from institutional to community settings. Data generated during exploration of Simon's care also included audiorecordings of two care planning meetings, one to review his day-to-day care at The Oaks and the other at which the decision to renew Simon's section 25 status was made.

Simon was a priority user of Midtown's community mental health services, and coordination of his care plan was accomplished by a CMHT-based MHSW. Care coordination in his case was a major challenge, however. Contributions to care were made by workers located in highly dispersed settings: a residential home; a day centre; a psychiatric hospital; a CMHT; a local authority office; and a primary care team. Opportunities for face-to-face negotiation were limited, sometimes with implications for care provision. Moreover, even where opportunities existed – as at Simon's full section 25 care plan review meeting – negotiations over future options for meeting Simon's needs were not guaranteed to take place.

As in Jim's case, Simon's psychiatrist was physically based in Midtown psychiatric hospital rather than in the CMHT. This psychiatrist (who was not the same as Jim's) had additional responsibilities at meso-level as clinical director of Midtown NHS Trust's mental health services. His interpretation of his role was a particularly narrow one, and was limited to attempts to 'cure' the mental illness experienced by his patients. His enactment of the psychiatrist's role did not, therefore, extend to participation in protracted negotiations centred on the details of community care provision. Nonetheless, this

psychiatrist still viewed himself as leading Simon's care team. This was revealed, first, in his response to a unilateral, non-negotiated, decision by workers at The Oaks to change the way Simon managed his medication. This was also revealed in his decision to renew Simon's supervised discharge without first engaging in negotiation.

The work of meeting Simon's needs was largely undertaken by Simon's MHSW/care coordinator, a second qualified MHSW who was based at The Oaks, a local authority day centre worker who helped Simon develop his daily living skills, and by Simon himself. Becoming increasingly involved was the Midtown Local Authority's resettlement social worker, whose work centred on brokering arrangements for Simon's future home-for-life. Formal and informal opportunities for negotiation between these workers existed. For example, regular review meetings were convened by Simon's residential social worker at The Oaks. These events – one of which was observed during fieldwork – provided opportunities for face-to-face negotiation of Simon's care plan. However, these were only attended by residential home workers, Simon's care coordinator and Simon himself.

Historically Simon's trajectory had been a highly complex one. In the years prior to his joining the study he had experienced severe disruptions in his perceptions and thinking, and had behaved in ways which had given both his family and his care team cause for great concern. Simon had, for example, behaved in a violent manner as a hospital inpatient. Key events in Simon's trajectory also included multiple offences, including convictions for violence,

firearms possession, drug use and theft. His many hospital stays included compulsory admissions, including to a private psychiatric hospital specialising in the care of mentally disordered offenders.

Key events in Simon's trajectory focused on during data generation included, first, his placement in The Oaks following his last compulsory admission to hospital and the negotiation of plans to assist Simon in his transition to less supported accommodation elsewhere. The Oaks was not a 'home for life', and key workers were required to collaborate together to find an alternative long-term solution to Simon's housing and support needs. A second significant event in Simon's trajectory during fieldwork was decision-making related to the continued use (or not) of supervised discharge as a vehicle through which to organise his care. Significant interfaces were joined in the context of both key events, and threw into sharp relief the complex, and sometimes fraught, division of work between members of Simon's network of care. A third key event examined was the management of Simon's medication. In this area, non-negotiated decision-making had implications both for Simon's wellbeing and for interagency and interoccupational social relations.

The management of risk has emerged as a major theme in macro-level systems of work. In Simon's case, perceptions of risk and frameworks for risk management proved highly significant in patterning negotiations. Simon's status as a 'risky' service user clearly influenced workers' responses to his needs, and constrained the range of options considered by his care team. The attention paid at macro-level to the provision of services to high-risk mentally

disordered offenders was also reflected at micro-level by the significant resources devoted to Simon's care. Midtown lacked, at meso-level, a specialist NHS-provided inpatient service for offenders with severe mental health problems. Prior to his transfer to The Oaks Simon had been cared for, at considerable expense, in a private forensic psychiatric hospital. During fieldwork Simon's intensive, round-the-clock, care was provided by Midtown local authority, paid for in part by his receipt of housing benefit.

6.5 LENNY – MIDTOWN CASE STUDY SUBJECT 3

The final case study subject to participate in the Midtown area was Lenny. Lenny was suggested as a possible participant by Midtown CMHT's substance misuse social worker. Lenny agreed to participate in the study in January 2001, and his care was explored from then until May 2001.

In his early 20s, Lenny was the youngest of the six service users to participate in the study. His difficulties dated back to his early teens, with workers involved in his care describing problems with social anxiety, depression, violence towards family members and impulsive self-harming behaviour from then onwards. In addition, having once used street drugs, Lenny at the time of his participation in fieldwork had replaced this with heavy alcohol use. In response to his complex difficulties different diagnostic labels had been attached to Lenny over the years: depression; alcohol misuse; and personality disorder.

Investigating Lenny's network of care began with an interview-based exploration of the work of his MHSW/care coordinator. Other contributors to the task of meeting Lenny's needs who participated in interviews included: a second Midtown CMHT MHSW who assumed a care coordinator role when this first MHSW left his post; Lenny himself, along with his mother; a consultant psychiatrist; an assistant clinical psychologist based at Midtown Psychiatric Hospital who worked with Lenny on a sessional outpatient basis; a GP; an independent sector housing support worker whose work centred on promoting Lenny's independence from his parents; and a Midtown NHS Trust liaison mental health nurse based in Midtown General Hospital's Accident and Emergency Department who provided a service to Lenny during a psychosocial crisis.

Personal and family contingencies had a major part to play in complicating Lenny's trajectory. Particular problems were his substance use, family conflict and violence, and Lenny's erratic and sometimes high-risk behaviour. Organisational and worker-related contingencies had also had a bearing on the historical unfolding of Lenny's trajectory. Community mental health services often struggle to provide effective services to people with 'personality problems', and Lenny's repeated referrals, discharges and re-referrals to the Midtown CMHT are consistent with what is known about the experiences of people with difficulties of this type (Repper and Perkins, 1995). The Midtown CMHT MHSW and substance misuse specialist who acted as Lenny's first care coordinator during Lenny's participation in the study, for example,

described a long history of poorly integrated service provision and of therapeutic discontinuity.

Lenny's psychiatrist was the same consultant involved in the provision of care to Simon, the second of the three Midtown case study subjects. In both case studies, this practitioner enacted a narrow version of the psychiatrist's role. Central to the task of negotiating responses to Lenny's complex needs were social workers. Both of the MHSWs involved during fieldwork embraced face-to-face negotiations with other carers (both paid and unpaid) as key to their work. Prior to Lenny formally joining the study, his first MHSW had set about the task of negotiating an effective network of care to address his multiple problems. This had been attempted against the background of Midtown mental health services' collective failure, up to that point, to maintain a consistent approach to working with Lenny. This had been revealed by Lenny's repeated discharge from CMHT care, his frequent re-referral and his intermittent use of hospital and other services during periods of crisis. Brokering this new integrated response had involved negotiating a face-to-face meeting to discuss Lenny's needs and to agree a plan of action with clearly determined roles and responsibilities. This was the plan in place during Lenny's participation in this study, and was one drawing principally on CMHT-based social work and hospital-based clinical psychology services. Via the Midtown CMHT substance misuse MHSW/care coordinator, 'insight oriented' family therapy was provided to Lenny and his parents. Lenny also met this social worker individually for work centring on his substance misuse

difficulties. From the hospital-based psychologist Lenny received psychological interventions focusing on his social anxiety.

This negotiated attempt to proactively manage Lenny's unpredictable trajectory was vulnerable to system disturbance from a number of sources, however. First, the work of addressing Lenny's needs required contributions not only from paid practitioners but also from Lenny himself and his family. As participants in family and individual therapy, Lenny and his parents were expected to be major partners in his micro-level system of work. Hindering the execution of this part of his care plan was Lenny's erratic participation and his frequent missing of appointments. This echoed, perhaps, the erratic contribution to meeting his needs paid mental health workers had historically made. A further source of system disturbance, with a clear negative impact on attempts to more proactively manage Lenny's trajectory, was Midtown's lack of psychology resources and the loss during fieldwork of the MHSW who had brokered the initial deal to reorganise Lenny's care plan. Negotiating a clinical psychology service for Lenny was only possible when this service existed. No qualified psychology practitioners were in post during fieldwork, and the unsupervised assistant who worked face-to-face with Lenny left his position during Lenny's participation in the study.

The first key event focused on during data generation was the ongoing negotiation of consistent and effective therapeutic care for Lenny and his parents, and the division of therapeutic work between members of the care team. Workers contributing to the task of responding to Lenny and his family's

psychosocial needs included two CMHT-based MHSWs (the second replacing the first after the latter's departure from the team), a hospital-based assistant psychologist, a consultant psychiatrist, and Lenny himself and his family. The broad aims of this therapeutic work were the promotion of more effective personal problem-solving skills for Lenny, along with the enhancement of positive family relations. Working towards these goals involved complex negotiations over relative roles and responsibilities, and took place against the backdrop of limited resources and imminent micro-level organisational transition. These organisational contingencies were the second focus of data generation. This encompassed investigation into the impact on Lenny's trajectory of multiple personnel transitions, exemplified by the loss of one social worker and the arrival of another and the total loss of a psychology service.

As in the first two Midtown case studies, the macro and meso-level concerns with effective care coordination and the management of risk were played out at micro-level in Lenny's case. Whilst workers in the Midtown CMHT were oriented in their actions towards the enactment of locally agreed case management procedures, Lenny's case exemplified the additional challenge faced by services required to respond to need when key resources are lacking and when care coordinators leave their posts. The consequences of intra-occupational knowledge and skills differentials were also played out in Lenny's case. Whilst one social work care coordinator replaced another, the range of expertise held by both differed. Different ways of 'doing social work' thus had an impact on the provision of services to Lenny and his family.

Lenny's case also exemplifies the challenge of providing community-based mental health services to people prone to unanticipated crises. The construction of responses to manage the risk posed by Lenny's impulsive self-harming behaviour was a major component of the work of his two care coordinators.

6.6 MIRIAM – NORTHTOWN CASE STUDY SUBJECT 1

Fieldwork proper in the Northtown site commenced in June 2001. Miriam was suggested as a first potential service user participant by a Northtown CMHT community mental health nurse, and was also discussed as a possible case study subject with the CMHT's staff grade psychiatrist. Miriam agreed to take part in September of that year, and participated until April 2002.

Miriam was in her 60s, and had used mental health services since at least the early 1990s. At that time, according to her Northtown psychiatric records, she had been admitted to hospital in an emergency. The diagnosis Miriam had first received had been schizophrenia, though this had more recently been changed to a severe mood disorder. She was also an articulate user of mental health services, and met professional expectations of what it is to be a 'cooperative patient' (Strauss et al., 1985). This she demonstrated in her adherence to prescribed medications, her keeping of appointments and her general agreement with actions suggested by professionals in response to her fluctuating health contingencies. However, although well-supported in the community and in regular contact with health and social care workers, since

her first admission to hospital Miriam had experienced repeated crises in her mental health. These had sometimes culminated in serious disruptions to her thinking, and in self-harming attempts. Admissions to hospital, sometimes under compulsory orders of the Mental Health Act 1983, had often followed.

Exploring Miriam's network of care during fieldwork led to semi-structured interviews with: Miriam herself; the CMHN who had first suggested Miriam as a study participant; a Midtown CMHT MHSW who had negotiated a Social Services-funded care package for Miriam; a CMHT-based staff grade psychiatrist; a consultant psychiatrist who had responsibility for Miriam's care during periods that she was in her home; a consultant psychiatrist who assumed medical responsibility for the duration of Miriam's stay in a psychiatric ward in Northtown General Hospital; a physiotherapist attached to the Northtown CMHT who worked with Miriam; a hospital-based psychiatric nurse who acted as Miriam's primary nurse during the first of her two admissions to hospital; and Miriam's GP. At Miriam's specific request I did not pursue an interview with her closest friend and principal lay carer. In contrast to the three Midtown case studies, Miriam received ongoing services from both a mental health social worker and a community mental health nurse. Their relative roles and responsibilities were a first focus for data generation and analysis.

During fieldwork Miriam's was an eventful trajectory, which included two urgent admissions to different hospitals in the Northtown area – first to a psychiatric ward located in Northtown General, and later to a ward in

Northtown Psychiatric Hospital. These admissions to, and discharges from, hospital were the key events in her unfolding trajectory focused on during data generation. Part of Miriam's illness trajectory was her acute sensitivity to her environment, and precipitating both of the crises taking place during her fieldwork participation was her concern over the status of her tenancy. Whilst able to respond to her crises, her principal paid mental health workers were less able to negotiate a longer-term response to her housing concerns. Limited negotiations appeared to take place around this issue, with consequences for Miriam's continued mental ill health.

The work of Miriam's MHSW revealed considerable structural patterning. Unlike, for example, Lenny's social worker in Midtown, Miriam's MHSW enacted a relatively narrow version of the social work role. His work was largely confined to the management of Miriam's local authority-funded home care package (Hardiker and Baker, 1999), and, when this had been necessary in the past, the fulfilling of statutory approved social work duties (Evans et al., 2005) in relation to Miriam's compulsory admissions to hospital. Managing Miriam's social care package – for which she was not expected to make a financial contribution due to her former status as a patient detained under a treatment section of the Mental Health Act 1983 – was a time-consuming activity. Her MHSW, for example, described his work in this area as being bound up in considerable bureaucracy. In contrast, Miriam's CMHN's work was less clearly defined, and encompassed both practical and psychologically supportive activities aimed at sustaining Miriam in her own home and in

managing her transitions to and from hospital. Part of this CMHN's work had, historically, also been an attempt to maximise Miriam's entitlement to benefits.

At meso-level effective interagency relations in Northtown were less well-developed than in Midtown. Historically strained relations between health and social care agencies, and underinvestment in services, meant that considerable work had yet to be done to agree joint policies, including procedures for care coordination. This meso-level inability in Northtown to clarify the care coordinator role was played out in the context of Miriam's care. Neither her MHSW nor her CMHN identified themselves as formally fulfilling this role, although the CMHN identified herself as informal coordinator in recognition of the high degree of contact she had with Miriam. Lack of clarity over care coordination was matched by a lack of clarity over roles and responsibilities in other areas, including during Miriam's admissions to and discharges from hospital. Multiple psychiatrists were involved in these processes, with considerable consequences for micro-level system disturbance. The social organisation of psychiatry services in Northtown as this impinged on Miriam's care thus became a further focus for data generation, along with the impact of resource limitations in constraining the range of options open to members of Miriam's care team during her second crisis hospital admission.

The task of responding to Miriam's deteriorating mental health during fieldwork also fell to her CMHN, who during negotiations surrounding both Miriam's hospital admissions was required to work within the constraints

imposed by the organisation of hospital services in Northtown on multiple sites and by resource limitations. During the brokering of Miriam's second admission, for example, negotiations to secure admission to the inpatient ward in which Miriam was best known failed in the meso-level context of a lack of available beds. Protracted negotiations ensued between Miriam's CMHN, an on-call consultant psychiatrist and nursing staff at a second hospital site before Miriam's admission could be accomplished.

6.7 KERRY – NORTHTOWN CASE STUDY SUBJECT 2

Kerry was first suggested as a possible case study subject by the same Northtown CMHT CMHN who proposed Miriam. Kerry, too, was discussed as a potential participant with the CMHT's staff grade psychiatrist, and was independently proposed by the team's senior MHSW. The formal recruitment of Kerry to the study took time, however. Kerry was first identified as a service user to approach in July 2001, but did not give her agreement to participate until February 2002. The reasons for this delay were complex, and revealed information relating both to the pressures associated with working life in Northtown CMHT and to Kerry's particular needs. During fieldwork I engaged in multiple negotiations with CMHT practitioners to discuss Kerry's participation, and to secure access to her in order to invite her to join the study. Specific events to progress her recruitment were planned, but sometimes needed to be rearranged in response to team members' need to prioritise their work in the context of scarce resources. Physical illness also prevented Kerry from meeting with me. We finally met for the first time almost

six months after I had first been given information about her. Kerry formally participated in the study from February to July 2002.

Kerry was in her early 30s. Northtown CMHT held five volumes of notes relating to her care. These recorded a traumatic history of sexual abuse and serious self-harm, and a first contact with mental health services in 1990. An early CMHT record from that year indicated the plan for Kerry to receive a counselling-based intervention. By 1994, however, her care and treatment had expanded to include medication for a presumed severe mental illness characterised by, amongst other things, the experience of hearing voices. Medical interpretations of Kerry's difficulties had varied over the years. Depression, schizophrenia and schizoaffective disorder were all diagnoses which had been attached to her at one time or another and had been recorded in her CMHT casenotes. In her verbal account, Kerry's CMHN also expressed a view that Kerry had 'personality problems'. Complicating Kerry's trajectory, and of significance for all involved in her care, was her additional health problem of diabetes.

During the time of her participation in the study Kerry lived alone. Her son, to whom she had weekly access, was in voluntary foster care. Mapping Kerry's network of care led to the identification of a variety of workers, all of whom participated in interviews: Kerry herself; her Northtown CMHT CMHN; a further CMHN who joined the Northtown team and commenced work with Kerry following the departure from her post of Kerry's first CMHN; a senior Northtown CMHT social worker; a staff grade psychiatrist; the CMHT's nursing

assistant; Kerry's GP; a community pharmacist who dispensed medication to Kerry; and a non-statutory sector support worker who met weekly with Kerry to help her manage daily tasks such as cooking. In addition to interview data, data were also generated through the audiorecording of a care planning meeting.

In marked contrast to Miriam, Kerry was perceived by the CMHT workers who knew her as a challenging user of services. Kerry was articulate and, unique amongst the six case study subjects, was intimately aware of the fine-grained details of her health and social care. She was, for example, aware of her benefits entitlements, and that she was expected to make a financial contribution to the cost of her local authority-funded care (which included the provision of practical help in shopping and cooking). Kerry also actively drew her own clear distinctions between the roles she expected her paid carers to fulfil. She was, for example, clear that the person to discuss her personal difficulties with was her CMHN, and the person to discuss her son's foster care and her own social services provision with was her MHSW. However, Kerry's personal contribution to the work of responding to her needs was not always well-received by her paid carers. For example, having declared her suicidal intentions Kerry was observed during one fieldwork visit to actively resist her CMHN's request to relinquish her stored supplies of unused insulin, suggested as a practical means of reducing her risk of self-harm. Kerry had also defaulted on her payments to Northtown Local Authority for the cost of her social care.

As in Miriam's case, the meso-level lack of a clear care coordinator role in Northtown had consequences for the enactment of roles. Like her colleague working with Miriam, Kerry's MHSW fulfilled a relatively narrow function. This extended to negotiations with child protection social work colleagues with regard to the care of Kerry's son, and to the administrative management of Kerry's care management package. Kerry's CMHN – the same nurse who worked with Miriam – undertook a wider range of activities, which in her accounts encompassed the provision of psychological support along with practical help to sustain Kerry in the community and to maintain the fabric of her home. The work undertaken by Kerry's nurse and social worker was also influenced to considerable degree by Kerry's own differentiation of the relative role and responsibilities of each.

The lack of an agreed care coordinator and the lack of supporting meso-level procedures for the recording of interagency decisions and care plans meant that, for example, no clear lead was taken in the management of Kerry's face-to-face care review meeting. Record keeping was accomplished by Kerry's MHSW, and, in the absence of an identified meeting convenor and overall care coordinator, decisions were made in a relatively disorganised way.

Kerry was the first of the case study subjects presented thus far to have a high ongoing degree of contact with a psychiatrist during the time that she was living in the community. Psychiatry services in Northtown were organised differently than in Midtown, with both advantages and disadvantages for care delivery. In Kerry's case, the location of psychiatrists as full members of the

CMHT brought significant benefits and contributed to conditions in which responsive negotiations over care provision could be accomplished. Kerry's psychiatrist was also critical in the management of her crisis, taking a lead role in decision-making during the face-to-face care planning meeting and in making herself available for the provision of additional support.

Whilst all six service user case study subjects were registered with local primary health care teams, it was in Kerry's case in particular that the potentially strained relationship between mental health workers and GPs was best exemplified. Kerry was a heavy user of primary health care services, though attended relatively erratically and not, for example, in response to specific invitations to participate in diabetes management clinics. As Kerry's trajectory became more problematic in the light of her threatened risky behaviour, so it became increasingly necessary for her mental health workers to open negotiations with primary care colleagues. Information-sharing across the CMHT/primary care interface proved difficult, however. Opportunities for face-to-face interactions were not created, with negotiations instead being mediated through the use of technologies such as faxes.

Kerry was seen by her paid care workers as a high-risk service user. One key, evolving, event became a particular focus for data generation. This was Kerry's repeated plan that she would commit suicide during a time period specified in the future when she knew her son would be away on holiday. This was a constant source of concern to her carers, who, based on their knowledge of Kerry, perceived this as a very real threat. Kerry's use of insulin

in the management of her diabetes also meant that she had ready access to the means necessary to carry through her plans. As a consequence, negotiations between Kerry's carers became clearly oriented towards responding to this threat. Complicating this already complex trajectory were two significant organisational contingencies unfolding during fieldwork. First was the necessity for Northtown CMHT staff to manage the transition between the departure of Kerry's most significant paid carer, a CMHN, and the arrival of a replacement practitioner. Second, responses to Kerry's threats were required to take place in the context of scarce resources, a meso-level structural factor which served to constrain decision-making over the provision of additional services as a means of managing the anticipated crisis.

The management of risk has been a major feature of the macro and meso-level systems of mental health work. Kerry's care trajectory unfolded in this context, and roles and responsibilities were significantly patterned by the necessity of responding to the risk her threatened behaviour posed. Face-to-face negotiations were embraced by Kerry's principal workers as the best means of generating a shared plan of action, in consultation as far as possible with Kerry herself. Kerry's multidisciplinary care review meeting, which was observed and audiorecorded during fieldwork, was convened to fulfil this function.

6.8 JENNY – NORTHTOWN CASE STUDY SUBJECT 3

Jenny, the sixth and final case study subject, was identified as a possible participant by the staff grade psychiatrist based in the Northtown CMHT, who

also worked closely with Kerry. Negotiating access to Jenny took place in consultation with one of the Northtown CMHT's CMHNs, with my first meeting taking place in the CMHN's presence in February 2002. Following a second meeting Jenny agreed to participate in the study in March that year, and her care was mapped from then until the following July.

Jenny was in her early 40s, lived alone, and had been a user of mental health services since her late teens. Her difficulties over the years had included severe depression and anxiety, sometimes culminating in crises where Jenny had harmed herself. Jenny also heard voices, and over the years had been prescribed a variety of psychiatric medications. Exploring the system of work surrounding Jenny brought me into contact with these key informants: Jenny herself; the Northtown CMHT CMHN who had helped negotiate access to Jenny; a further CMHN who took over the first CMHN's work following this practitioner's temporary departure from the team; the CMHT's clinical psychologist who worked with Jenny on a sessional basis; the CMHT's sessional physiotherapist; a voluntary sector day centre worker; Northtown CMHT's staff grade psychiatrist; and the team's nursing assistant. There was one further significant worker involved in Jenny's network of care who proved difficult to make contact with, and who therefore did not participate in fieldwork: a support worker employed by the Northtown Voluntary Mental Health Services Organisation. All participating key informants were interviewed, with all except Jenny agreeing to these interviews being audiorecorded. In Jenny's case, detailed contemporaneous handwritten notes were produced instead.

Ongoing mental health care to Jenny was provided by a CMHN. In the absence of long-term care being provided by any other mental health practitioner, this nurse identified herself as fulfilling a care coordination role for Jenny. She also provided what she described as emotional care and support. The intra-CMHT referral from Jenny's psychiatrist to the team's clinical psychologist had triggered a micro-level adjustment to the division of labour. With the additional input of a psychologist, Jenny's CMHN withdrew from providing, as she had previously done, a cognitively based psychological therapy service.

Jenny had a limited social network, and used a local non-statutory day service. There she received a combination of practical and supportive care. As in Simon's case in Midtown, however, opportunities for the day centre worker who assisted Jenny with her daily living skills to interact with other members of her care team were limited. During fieldwork interactions between the Northtown Voluntary Mental Health Services worker who had once provided practical support to Jenny and other members of the care team were virtually non-existent. Exploring this worker's contribution face-to-face was not possible. Reports from other workers suggested, first, the existence of ideological differences underpinning the approaches taken by them and by the Voluntary Service Worker and, second, that this service had been closed to Jenny altogether because of resource constraints. This service withdrawal had implications for Jenny's trajectory, and placed additional resource

expectations on staff within the Northtown CMHT who were required to broker ways of filling the gaps.

Of the six caring trajectories explored in this study Jenny's was the most straightforward. Whilst Miriam had two hospital admissions during her participation in the project, and Kerry talked of suicide, no such crises were experienced by Jenny during the period that her care was followed. However, important negotiations took place around the delivery of psychological therapies, leading to micro-level modifications in the division of labour surrounding Jenny and her needs. Organisational contingencies also had an impact on the unfolding of Jenny's trajectory. These included, first, the loss of one CMHN and the arrival of another and, second, differences in therapeutic approach between CMHT workers and workers providing a service for Jenny through the Northtown Voluntary Mental Health Services Organisation. During fieldwork Jenny also lost this voluntary service contribution to her network of care altogether.

Access to psychological therapies has been identified at macro-level as a pressing area for meso-level service development (Department of Health, 2004b). The lack of clinical psychology services in Midtown, for example, was a resource issue with clear negative implications for the care of Lenny. In Northtown, meso-level organisational economies of scale contributed to the locality's multiple CMHTs being staffed by a wider range of practitioners. The Northtown CMHT, for example, included a clinical psychologist. His contribution included working with Jenny in the provision of CMHT-based

behaviourally oriented therapy. Jenny was, then, the only user participant in this study to receive services from a qualified psychologist.

6.9 CONCLUSION

Each of the six case study subjects had complex mental health and associated needs, and most had highly complicated care trajectories which were evolving in response to both individual and organisational contingencies. As has been demonstrated in the context of recovery from stroke, for example, organisational features (including 'system setbacks' and resource limitations) can exert a powerful influence on the health and illness experience (Hart, 2001; Allen et al., 2004b). Here, case study subjects' personal health-related contingencies included recent experience of mental health crisis (Jim), ongoing mental health crisis (Miriam) and threatened crisis (Kerry). Organisational contingencies impacting on care provision included high levels of turnover of paid workers, a lack of clear care coordination, the total loss of services, and the inability to provide services in the context of scarce resources at meso-level. The meso-level organisation of particular services, such as the location of psychiatrists in Midtown away from the CMHT base and the provision of inpatient care in Northtown on multiple sites, also had an impact on users' trajectories. Contingencies of this type were significant in all six cases. Sometimes, service user trajectories evolved in response to complex combinations of individual and organisational factors. An example was Miriam's second mental health crisis (a health-related contingency), which her CMHN responded to by negotiating an emergency admission to a

psychiatric hospital, albeit not to the ward where Miriam was best-known (an organisational contingency).

A full analysis of the consequences of individual and organisational contingencies, including the implications of these for case study subjects' caring trajectories, is presented in Chapter 9 below. The two Chapters preceding this, however, are devoted to cross-case analyses of the work of both paid and unpaid carers. The six micro-level systems of work explored during fieldwork drew on the combined contributions of an extensive range of workers: psychiatrists; nurses; social workers; clinical and assistant psychologists; occupational therapists; physiotherapists; pharmacists; health care assistants; support workers; unpaid lay carers; and service users themselves. Paid workers were employed by NHS trusts, local authorities, primary health care teams and non-statutory sector bodies.

In Chapter 7 the micro-level work of representatives of key mental health occupational groups is examined. This analysis reflects ecological thinking by casting the work of members of each group – psychiatrists, social workers, nurses, clinical psychologists and general medical practitioners – in the context of work undertaken in each micro-level negotiation context as a whole. This Chapter also includes analysis of the 'lines of impact' running between macro, meso and micro-levels. For example, consideration is given to the degree to which aspects of each micro-level negotiation context's overarching structural context exerted a 'patterning' effect on the work of representatives of each group, and helped frame division of labour negotiations.

Chapter 8 continues this analysis of work to encompass exploration of the contribution of marginalised professional groups (exemplified by community pharmacists), low status paid workers (health care assistants and social care support workers), and unpaid lay carers and service users themselves. As in Chapter 7, this analysis emphasises the ecological idea that individual contributions are best understood in the context of work undertaken as a whole. Also considered is the degree to which marginalised, low status and unpaid work reflects aspects of overarching structural contexts.

7 PROFESSIONAL WORK

7.1 INTRODUCTION

Case study data are drawn on in this and in the following Chapter to examine the work undertaken by paid and unpaid contributors to the six networks of care. Attention is paid to the negotiated and non-negotiated ways in which this work was divided up. Factors helping and hindering the overall provision of care at micro-level are considered. Reflecting negotiated order ideas, both Chapters also include analyses of the lines of impact between different organisational levels. In particular, the analysis includes consideration of the impact of macro and meso-level structural patterning on occupational roles and responsibilities. My analysis also addresses the degree to which occupational roles reflected the particularities of the specific workplaces in which these were enacted.

This Chapter focuses on the work of paid occupational groups principally encountered in the delivery of care to all six case study subjects.

Psychiatrists, social workers and mental health nurses were all prominent.

Meso-level resource limitations meant that psychologists were scarce in Midtown, but were represented in one case study in Northtown. All six service user case study subjects were registered for primary care services, and some had ongoing contact with general medical practitioners. As I explored in Chapter 3, these groups have all advanced specific jurisdictional claims to control areas of mental health work, with varying degrees of success. All present themselves in contemporary mental health systems as possessing

requisite bodies of abstract knowledge to underpin their claims to professional status, and all are core (as opposed to more peripheral) occupational groups typically encountered in local systems of mental health work.

7.2 THE WORK OF PSYCHIATRISTS

The profession of psychiatry occupies a powerful position in systems of mental health work, its jurisdictional success largely founded on its historic advancement of claims to the possession of biomedical understanding of the causes and treatment of mental illness. However, challenges have been mounted to psychiatric knowledge and practice, as I have previously observed. Aspirant professional groups such as nursing and social work have advanced claims to the independent control of areas of work. The fragmented character of systems of community care has also made it harder for psychiatric jurisdiction to be sustained beyond the walls of hospitals. Macro-level modernising policy is also beginning to challenge the working practices of psychiatrists, with one example being a formal review of roles and responsibilities in the context of interprofessional and interagency services (Royal College of Psychiatrists et al., 2005). However, whilst conditions for changes to the role of psychiatrists exist, it is still often assumed by practitioners, service users and carers that psychiatrists will fulfil leadership positions at a number of organisational levels (Peck and Norman, 1999). Psychiatrists, too, often assume that they will have leadership roles to play (Brimblecombe, 2005). At meso-level these assumptions are often underlined by the appointment of psychiatrists to clinical director posts; one of the two

consultants involved in service delivery to the three Midtown case study subjects, for example, held this position in Midtown NHS Trust.

A key ecological insight is the observation that, notwithstanding the prevailing contours of systems of work at macro and meso-level, roles still have to be realised in specific, interactive, workplaces. What Strauss calls the 'lines of impact' (Strauss, 1978) running between different organisational levels are significant here, with both large-scale and local factors such as people and material resources often proving highly consequential for service delivery and receipt. For example, the shortage of psychiatrists in Wales (Wales Collaboration for Mental Health, 2005) was revealed, with potential consequences for micro-level case study subject care provision, in both research sites. Northtown CMHT's psychiatrist carrying consultant responsibility for all three case study subjects was a locum at the start of the project (but was later appointed, with no break in service continuity, to a substantive post). Meso-level spatial arrangements for the organisation of psychiatry in Midtown were also significant for care delivery, with both consultants involved in the provision of services to the three case study subjects being physically based in offices located in Midtown psychiatric hospital. This was consequential in two ways. First, opportunities for flexible negotiations and for the building up of strong working relations between psychiatrists and full CMHT members were constrained. Second, situating psychiatrists in the hospital setting was associated with the enactment of a relatively narrow version of psychiatric practice, characterised by a limited interest in the provision of services to users living in the community. For

example, the psychiatrist working with Jim, the first Midtown case study subject, clearly envisioned fulfilling a leadership role during particular phases of his patients' trajectories – specifically during periods of inpatient care – leading to a transfer of power and responsibility at the point of hospital discharge:

Consultant psychiatrist: [...] because of the way inpatient care works, the traditional ways and relationships and the roles, yes, it falls very much to myself as a consultant, the RMO [*Responsible Medical Officer*], to say, 'yes, we need to think about discharge', or 'we're not going to discharge', or 'discharge is today', or 'discharge is whenever', or how soon will it be. So yes, I guess that's one of my particular functions in the process, and in the community that has traditionally, that role is taken by the keyworker. The major contact, the major support worker in the community would take that role in terms of setting particular time points.

BH: So that sounds like there's some kind, there's almost a handover between your role in terms of overseeing Jim's care whilst he's in hospital but then letting some of that go as Jim's about to be discharged into the community so that the keyworker then begins to take lots of...

Psychiatrist: Yes.

(Interview, Psychiatrist, Midtown – 9: 196-211)

This same psychiatrist also exemplified the degree to which his profession remains a segmented (Bucher and Strauss, 1961) one, characterised by internal ideological and other divisions. Just as some of psychiatry's practitioners see community care as an opportunity to expand their jurisdictional authority into people's homes, others, like Jim's consultant, have both principled and practical objections to this aspiration. Jim's psychiatrist, for example, favoured a retracted role for community mental health services and

an expanded, 'normalising', role for primary care in the delivery of services to people with mental health problems living in their own homes.

The consultant psychiatrist involved in the care of Simon and Lenny, Midtown case study subjects 2 and 3, articulated and enacted his role in a narrowly defined, biomedically oriented, way. During my negotiations with this practitioner centring on securing research access to Simon and Lenny, he voiced his particular contribution to their care as one of treatment and 'cure', and not to the wider task of sustaining them in the community or helping tackle their substance misuse problems:

Consultant psychiatrist: These are all people for whom community care has failed. I can get rid of their psychosis – I can do that well – but I can't stop them taking drugs.

(Fieldnotes, Midtown – 34: 962-964)

A combination of locally specific and personal factors were highly significant in shaping the work of this psychiatrist and his social relations with other practitioners. Heavy work commitments (including as the Midtown NHS Trust's clinical director for mental health services), an interpretation of the role of the psychiatrist as centring largely on the physical treatment of mental illness, and his location in Midtown psychiatric hospital were all consequential for working relations and for overall micro-level care delivery. Also significant for social relations and care provision were this psychiatrist's personal, and limited, 'theories of negotiation'. Theories of negotiation, for Strauss, are an important negotiation subprocess (Strauss, 1978) with implications for the likelihood of negotiations (and non-negotiations) taking place. In this case,

Simon's and Lenny's psychiatrist's enacted theories of negotiation favoured unilateral, non-negotiated, decision-making on his part. This personal 'theory' was played out during at least one critical period of a service user case study subject's (Simon's) trajectory, with clear consequences for decision-making and interprofessional relations.

As with all interview-generated accounts of social relations, accounts of working life and interprofessional relations are contextually situated (Silverman, 2001). Accounts by workers with management responsibilities may reflect a desire to present services in a positive light. During a wide-ranging interview with the Midtown CMHT's senior social worker, for example, a description was generated of cordial and effective working relations between Simon's and Lenny's consultant and CMHT-based practitioners. In contrast, accounts from team members with practitioner rather than managerial responsibilities tended to be less positive. Simon's social worker, for example, was critical of what she saw as this psychiatrist's lack of interaction with team members and his general absence from important CMHT events such as the team's weekly clinical meetings.

A complex interaction of interoccupational power relations and disputed jurisdictional authority, spatial distance and negotiating styles were played out in Simon's case, with significant implications for the management of his trajectory. Despite his lack of day-to-day involvement in Simon's care and his enactment of a relatively narrow, illness-oriented, role, Simon's psychiatrist nonetheless operated the assumption that his position included the authority

to lead Simon's care team. This meant, first, that his expectation was that other members of Simon's micro-level care network would always negotiate with him prior to making important decisions and, second, that in his capacity as *de facto* care team leader he could legitimately make decisions unilaterally.

Reflecting the home's function as a stepping stone towards less supported accommodation, the ideology underpinning the provision of social care by staff at The Oaks was to encourage greater independence on the part of their residents. In the context of claiming jurisdiction over the work associated with social rehabilitation, staff assumed the authority to negotiate directly and unilaterally with residents to progress the self-management of prescribed medications. This claim reflected, in part, the social work occupational background of senior staff at The Oaks, including in the case of the worker there who had responsibility for Simon's day-to-day care. Encouraging residents to assume greater control in this area reflected wider social work concerns with the practicalities of independent community living. However, whilst the settlement between social work and psychiatry has given members of the former group the authority to undertake rehabilitative work, this jurisdiction is likely to be disputed where this work encroaches on the authority of psychiatrists to control physical treatments for mental illnesses.

The decision to negotiate directly with Simon over his medication management, but not to negotiate this part of his rehabilitative care with others in the care team, became a threat to the local enactment of psychiatric jurisdictional authority. For Simon's consultant psychiatrist, this amounted to a

challenge to his authority, albeit exercised at arm's length, to determine treatment regimes for his patients:

BH: Sticking with medication with Simon, I know that, and I'm thinking maybe it was around the same time that Simon had been in Midtown General and hadn't had his clozaril [*the medication Simon took for the treatment of his mental illness*], I know from speaking with The Oaks staff that they, off their own bat, decided to move towards Simon being self-medicating.

Consultant psychiatrist: Yes.

BH: Was that at the same time?

Psychiatrist: Yes. I think that was at the same time. And he was quite ill at that time when they decided to, you know, to self-medicate. And again it was not discussed. This is the difficulty, I think, in this case. I mean obviously they must have discussed in their meeting, but then there are things, which, I think, you know, that each discipline, in my view, they, if they stick to their own discipline it's much better.

BH: How do you think that could have been avoided, the decision, the situation where The Oaks decided unilaterally that they wanted to give Simon responsibility for his medication without discussing?

Psychiatrist: I think that those decisions should not be taken without a multi-disciplinary...

BH:...meeting.

(Interview, Psychiatrist, Midtown – 20: 151-172)

In addition to directly challenging psychiatric authority the unilateral decision to modify arrangements with respect to Simon's medicines also had significant consequences for Simon's illness trajectory, as is hinted at in the data extract above. Staff at The Oaks made their decisions at around the time that Simon was admitted to Midtown General Hospital for an appendectomy. During his inpatient stay Simon did not continue with his antipsychotic medicine, either because staff in Midtown General had been informed by staff at The Oaks that

Simon was now self-managing his medicines (but was not doing so), or because this part of his treatment was overlooked. Returning home, Simon either commenced or continued the responsibility to manage his tablets. His care coordinator recorded events of this time in her CMHT notes thus:

28/6/00: MDM [*multidisciplinary meeting*] at CMHT following concern about Simon's mental health. It would appear that when The Oaks staff stated that they had left Simon's medication at the general hospital, he was self-medicating. This had then continued at The Oaks on his discharge. There had been general concern from day care staff about his increased bizarre behaviour. Meeting attended by Dr Charles [*consultant psychiatrist*] who instructed hostel not to alter medication arrangements.

(Simon's Midtown CMHT case notes – 39: 100-105)

Simon's control over the administration of his medication was indeed reversed at this point. Whilst these events preceded Simon's formal entry into the study their reverberations were felt during fieldwork. During one of the two care planning meetings held for Simon which were observed during my participation in the field, members of his micro-level network of care had a further face-to-face opportunity to negotiate medication management issues. Negotiations there suggested that Simon's psychiatrist's earlier objection to the introduction of medication self-management related as much to the non-negotiated way in which this decision had been made, and the challenge which this represented to his jurisdiction, as it did to the inappropriateness of this action in the context of Simon's particular illness trajectory. At this formal face-to-face meeting, the psychiatrist used his authority to propose exactly the kind of medication self-management which staff at The Oaks had previously initiated. In so doing, jurisdictional authority was reasserted and new,

'legitimate' (Strauss, 1978), opportunities for negotiating a full programme of rehabilitation and recovery simultaneously opened up.

Negotiations over the management of medication were also significant in other case studies. Part of the work expected of service users living in the community, by both paid and unpaid carers, often includes adherence to prescribed medicines. Chapter 8 includes analysis of this in the context of a wider focus on the contributions of users and lay carers. With respect to the work of psychiatrists, a second key event in Simon's care was observed which exemplified both the local enactment of psychiatric jurisdiction and the negative consequences for interoccupational relations of exercising this in a non-negotiated manner.

Perceptions of risk exerted a powerful patterning effect on negotiations in Simon's case. Unique amongst the six case study subjects, Simon was subject to supervised discharge. Introduced as an amendment to England and Wales' Mental Health Act in 1995, supervised discharge extends the power of mental health professionals to specify where people previously treated in hospital under compulsory orders should live, and attend for the purposes of treatment, occupation or education (Holloway, 1996). This legal development represents a clear macro-level response to the problem of managing risk in mental health systems, although reflecting trends throughout the UK (Atkinson et al., 2002) this power was only rarely invoked in either Midtown or Northtown. However, community care had broken down in the past for Simon, and his discharge from forensic inpatient mental health care to his residency

at The Oaks in the year before fieldwork began had been carefully managed, with supervised discharge being put in place as an additional safeguard. This was explained to me by Simon's MHSW and care coordinator, who had a particular interest and legal responsibility in these matters in her additional capacity as Simon's 'social supervisor':

BH: What does that section 25 [*supervised discharge*] mean then [...] how does that work?

MHSW: [...] the 25 stipulates where he lives and that he has to attend for medical treatment, which doesn't seem a great deal but it seems to have worked for Simon. I mean he still could refuse medical treatment, he still could refuse to work with us, but that small amount of control for Simon seems to have worked. As far as we know anyway.

BH: In what way has it worked?

MHSW: In that he stayed at The Oaks. He's cooperated in a programme of sorts, although he does sort of push against us in that respect, and he complies with his medical treatment, he attends either weekly or fortnightly for the clozaril [*atypical antipsychotic medication*] clinic and that hasn't been a problem at all. So that, it seems to have worked with Simon, he seems to respond to that element.

BH: Would you say that, I suppose in some ways it's difficult to know without, because it's impossible to compare, but say Simon had been offered The Oaks, the same medication, the same care plan, but without the section 25, do you think that things would therefore be different?

MHSW: Not necessarily, because Simon is certainly much more well mentally than he has been for a long, long time. So, yes, and we could have come out on nothing and we still would have, you know, had him agree to all that he's doing, but I think it was a risk that people didn't want to take necessarily.

BH: Yes. Yes. So maybe things would have worked with Simon being placed at The Oaks having been discharged from the private hospital but certainly the feeling that things hadn't worked in the past, nobody wanting to take a risk that things would break down again, so a decision, the section 25 was most appropriate. Was that why he signed up to it, was there a consensus that that was the best course of action?

MHSW: Yes there was. I mean the private hospital, certainly in the meetings coming up to discharge, certainly felt that he needed some constraints on his behaviour and, yes, everybody was in agreement.

(Interview, MHSW, Midtown – 23: 182-220)

As this data extract infers, negotiated consensus had been achieved amongst all parties that the best way to manage Simon's initial transition to The Oaks had been through the use of a supervised discharge order. Having been renewed for a second six month period, Simon's section 25 was due to expire during the time that he was participating in this study. The decision thus had to be taken on whether or not to renew the section again. If renewed, the order could remain in place for up to a further full year. Negotiators with a particular interest in this critical event were Simon himself, his psychiatrist, his MHSW/social supervisor, his social work keyworker at The Oaks, and Midtown NHS Trust's Mental Health Act administrator who had the particular responsibility to make sure that a decision, one way or the other, was made.

As with events relating to the management of Simon's medicines, the physical location of these key players in different places hindered both formal and informal opportunities to engage in negotiation over section 25 decision-making. Simon's psychiatrist's theories of negotiation and his enactment of an assumed leadership role also contributed to the unfolding of events. In renewing the supervised discharge order on the first occasion, according to accounts given by Simon's MHSW, Simon's consultant had made his decision without first engaging in negotiations. This time, a face-to-face review and decision-making meeting had been brokered by Midtown NHS Trust's Mental Health Act administrator. This brief event (being the same meeting at which

Simon's medication management was discussed) was observed during fieldwork, and interactions between those present audiorecorded.

The decision to renew Simon's status as a supervised discharge patient was presented at a meeting which took place in the offices of the Midtown CMHT. This event was attended by Simon, his consultant psychiatrist, his social worker/social supervisor, a care worker from The Oaks, two medical students and me as an observer. During fieldwork, this was the only occasion at which I met this particular consultant in the premises of the Midtown CMHT. The stakes for all parties were high, not least for Simon and his appointed 'social supervisor', his social worker. An opportunity to actively and visibly negotiate interagency and interoccupational care for Simon existed at this event, but was largely missed. The decision to renew Simon's status as a supervised discharge patient was presented to Simon without obvious negotiation, and in a contradictory manner, as the following data extract reveals:

Consultant psychiatrist: So, Simon, you're section 25 and I'm going to renew it again, recommend, myself and Katie [*MHSW and social supervisor*] feel that we will renew it and continue to renew until you've settled in a group home because that is, at the moment you are, in fact you don't need section 25 because you are in a place where you have 24 hour care and that 25 would have been more appropriate if when you were in a group home, so we will continue to renew it until you've settled in a group home and then we will take the section 25 off, so we are renewing it today, it was going to expire today but we'll renew it today.

(Section 25/section 117 care planning meeting, Midtown – 21: 142-150)

Although not directly challenging the unfolding of events during this key meeting, Simon's MHSW later complained of the lack of negotiation between

her and her consultant colleague over this decision. She drew my attention, for example, to the way in which the section 25 renewal had been presented at the care planning meeting as a jointly agreed plan of action. Her perceptions of a general lack of collegiality were also underscored by the threat to her jurisdictional authority as 'social supervisor' which this unilateral, non-negotiated, decision-making represented.

Meso-level differences in the social organisation of psychiatry services were apparent across the two study sites. Relative to Midtown, Northtown's approach to the organisation of services brought both advantages and disadvantages for care provision at micro-level. The spatial organisation of psychiatrists in Northtown was largely helpful. As full members of the CMHT sharing office space with other mental health workers, psychiatrists were more visibly active in the day-to-day provision of services in the three case studies completed there, just as psychiatrists were in Strauss and his colleagues' original study of the division of work in 1950s US hospital care (Strauss et al., 1964). In addition, reflecting its status as a large team serving a relatively populous and needy area, the demand for psychiatry was such that the Northtown CMHT was able to operate an intra-occupational division of psychiatric work which the Midtown service had lacked the resources to achieve. For Northtown service users living in their own homes psychiatric services were overseen by one of two CMHT-based consultants, whose responsibilities usually extended to the provision of psychiatric care during periods of inpatient treatment as was necessary. However, day-to-day psychiatric services were the responsibility of a staff grade practitioner, whose

work was entirely community-oriented. This worker was perceived by her CMHT colleagues as highly accessible and competent, with whom helpful informal negotiations could be accomplished. For example, the CMHN working with both Miriam and Kerry (the first two case study subjects in Northtown) had this to say:

CMHN: I mean it can be, you know, it's very easy for me just to shout across the corridor, 'Tamsin' [*staff grade psychiatrist*], whereas trying to track a doctor down, maybe on the ward sometimes, phone calls, 'oh hang on, he's in', 'we'll get them to ring you back', whereas literally I can just scream across the corridor here.

(Interview, CMHN, Northtown – 66: 902-905)

The greater opportunity afforded for interprofessional negotiation by locating psychiatrists with other mental health workers in the Northtown CMHT was particularly significant in the care of Kerry. The team's staff grade psychiatrist knew Kerry well, and her availability as a full team member helped in the negotiation of responses to Kerry's ongoing threats of suicide. Lacking a commitment to the provision of services to users in hospital, this practitioner also had sufficient flexibility to be able to increase the frequency of her contacts with Kerry during the protracted period of crisis management.

During fieldwork a large care planning and review meeting for Kerry was held, chiefly to negotiate an agreed plan of action as a response to the increased risk which she posed. This important juncture was observed, and interactions audiorecorded. Whilst the provision of additional, short-term, services was agreed by all participants as being necessary, brokering the details of this plan was hindered by the intrusion of meso-level resource constraints. Kerry's

social worker, for example, entered into negotiations in the knowledge that her employing agency – represented by her budget-holding manager – was either unable or unwilling to devote additional funding to support the provision of enhanced social care for Kerry. This decision was made in the context of Kerry having already defaulted on her financial contribution to the provision of her routine social care. In the context of the work of psychiatrists, it was significant that the CMHT's staff grade practitioner was able to participate in negotiations at this care planning meeting with a high degree of autonomy, and with less overt concern for the meso-level resources implications of her contribution. Part of the negotiated response to the elevated risk in Kerry's case, then, involved this psychiatrist offering to increase the intensity and frequency of her work with Kerry. This was an offer which her social work colleagues had been constrained from similarly making, given significant resource-related meso-to-micro lines of impact.

Whilst the spatial organisation of psychiatry services in Northtown brought clear advantages by contributing to a local workplace context in which a full and flexible psychiatric contribution could be negotiated, a less helpful intra-psychiatry division of labour also existed there. In addition to the work undertaken by consultant and staff grade practitioners, a contribution to case study subject care was made by a representative of the profession who combined reduced clinical services with a commitment to research. Local relations between these two segments of the profession – the service-oriented and the academic-oriented – were tense. Fuelling this was the social organisation of academic psychiatry in Northtown, which saw research-

oriented workers confining their contributions to care only to the inpatient phases of service users' trajectories. This separation of community from hospital psychiatry services was a potential source of service discontinuity which was realised, with negative consequences, in Miriam's case. This is explored in detail in Chapter 9 in the context of a wider analysis of the impact of organisational contingencies on the unfolding of service user trajectories.

7.3 THE WORK OF SOCIAL WORKERS

In Chapter 3 I drew attention to the jurisdictional claims advanced by social workers with respect to the control of work associated with the care of people with mental health problems living in the community. These claims are underpinned by appeals to the possession of a social scientific knowledge base (Peck and Norman, 1999). Also observed earlier in this thesis is the way in which structural context changes have created clear expectations that social workers will fulfil specific responsibilities in a number of discrete areas. In mental health systems of work, reflecting their historic settlement with psychiatrists and prevailing macro-level legal frameworks, social workers are now expected to fulfil roles associated with the operation of mental health law (Evans et al., 2005). However, the numbers of social workers suitably prepared and available to undertake this work has dramatically declined in recent years (Huxley et al., 2005), placing pressure on those able to discharge legal responsibilities of this type. In addition, it is also typically social workers who are called on to act as community care assessors and care managers, with responsibility for the coordination and micro-level budgeting of social care provision (McCrae et al., 2004). In both Midtown and Northtown, these

structural factors had significant parts to play in patterning the contribution of social workers, with implications for micro-level service provision.

In addition to the patterning effects exerted by these specific macro-to-micro lines of impact, the differing characteristics of the two meso-level contexts also created the potential for locally specific patterning of social work roles. In Northtown relations between social workers and health workers had historically been strained. Meso-level informants also gave accounts of continued under-resourcing of local authority services. Both contributed to a perception on the part of many social workers that their relationship with health workers was an unequal one. Health agencies in Northtown, too, were able to use their organisational economies of scale to staff their integrated CMHTs with a particularly wide mix of occupational groups. Midtown, in contrast, was an area in which positive interagency and interprofessional relations had prevailed, and in which a strong culture of working together had developed within the locality's CMHT. The mix of occupations encountered in Midtown services was also a relatively narrow one, however, with consequences for micro-level care provision and the enactment of roles.

Social work contributions to micro-level networks of care were made in the cases of Miriam and Kerry in Northtown, and in the cases of all three service users in Midtown. The bundle of tasks associated with social work practice in Northtown was more limited than that associated with practice in Midtown. In Northtown, work undertaken reflected only those activities which social workers have secured a jurisdictional authority to perform in the legal sphere.

Enacted social work roles in Northtown thus revealed a more obvious macro-level patterning than was the case in Midtown. These differences in roles played out at micro-level can be partly understood by situating them in the context of the meso-level differences existing between the two sites. As Abbott observes, organisational features (including resource availabilities) are able to exert a powerful influence on professional roles, and can place pressure on the boundaries existing between different groups (Abbott, 1988). In Northtown CMHT, social workers worked alongside a large number and wide variety of other, NHS-employed, occupational groups. In an interagency and interprofessional service in which work was divided up amongst qualified social workers, nurses, psychiatrists, a psychologist, an occupational therapist and a physiotherapist, social work roles tended to be 'squeezed' to the fulfilling of statutory duties only. Stronger claims to the provision of personal therapeutic services, for example, could be advanced by members of other groups, such as by the CMHT's clinical psychologist and by members of the team's nursing contingent (some of whom had completed advanced clinically focused courses). In contrast, social workers in Midtown were members of a more depleted team, and in the absence of (for example) a clinical psychology service – and the subsequent creation of a 'jurisdictional vacancy' (Abbott, 1988) – had opportunities to expand their work to encompass the provision of face-to-face therapeutic services, as happened in Lenny's case.

A further consequential characteristic of the interagency meso-level context in Midtown was the relative speed with which NHS and local authority negotiators had been able to construct jointly agreed policies and procedures

relating to non-occupationally specific tasks such as micro-level care coordination. The principal CMHT-based care providers in Simon and Lenny's cases were both social workers, and both were clearly oriented in their work towards enacting the team's agreed 'case manager' role. In Northtown, in contrast, the challenge of coordinating complex plans of both health and social care was not attempted by social workers, reflecting the lack of success at meso-level in agreeing interagency procedures for this. At micro-level in Northtown, then, no clear frameworks to guide formal care coordination negotiations existed, leaving what Strauss (1978) calls the 'legitimacy boundaries' in this area unclear.

These observations regarding the work of social workers are exemplified in two contrasting case studies: Lenny's and Miriam's. Lenny had two Midtown social workers during the period of his participation in the study (the impact of the organisational contingency of his first social worker leaving and a second arriving are considered in Chapter 9 below). Lenny's first MHSW was nominally the team's substance misuse worker, and he rather than any other member of the team had become case manager because of Lenny's problems with alcohol. In his accounts, this MHSW was critical of the historic lack of a consistent response by workers to Lenny and his family's long-running difficulties. Embracing a full, rather than a narrow, range of tasks this practitioner brokered an interprofessional plan which clarified his own contribution and those of the assistant psychologist and psychiatrist who also provided care. His contribution was as overall care coordinator, and as provider of individual and family therapy. Alone amongst the CMHT-based

social workers in this study, then, this worker enacted a role which included the provision of direct face-to-face psychosocial therapeutic care. As he explained to me during an extended interview exploring his approach to his work, his provision of therapy reflected both his assessment of Lenny's needs (which had, he believed, to be seen in the context of his family) and his personal philosophy of 'doing social work':

BH: Lenny has told me as well that you meet with him individually, and you meet him and his family. When was it that you reflected on the fact that it was, 'Lenny with alcohol', 'Lenny with drugs', 'Lenny with college', 'Lenny with...', and took the decision to instead relocate your work so it's, 'Lenny within the context of his family', and who did you, or how did you work out that you were going to be the person doing that? Who did you come to speak with, or negotiate with?

MHSW: Yeah. Well I have to say that my way of working for personal reasons as well as professional is less mechanical than some of us and so therefore more, you'd classify more, organic, more evolving.

[...]

I think it was after the assessment, after Lenny found it difficult to access psychology, after I think a couple of overdoses and events in front of the family, so he'd taken an overdose in front of the family. I think, it was then that I began to realise that the assessment was pointing towards that.

(Interview, MHSW, Midtown – 13: 293-311)

A much more structurally patterned version of providing a social work service was provided to Miriam in Northtown. This stood in contrast to the social work role enacted in Lenny's case in Midtown, and in contrast to the less-obviously patterned role enacted by Northtown's staff grade psychiatrist. Unlike Lenny, Miriam received ongoing services from both a MHSW and a CMHN. Miriam's nurse maintained close contact with her, and was instrumental in negotiating organisational responses to fluctuations in Miriam's illness (see Chapter 9

below). The role played by Miriam's MHSW was limited to the carrying out of statutory tasks, areas over which this practitioner voiced strong jurisdictional claims. These tasks had historically included making an application for a compulsory admission to hospital, but were now confined to the assessment of Miriam's need for social care and managing the budgeted provision of services by local social care organisations. Having previously been compulsorily detained in hospital for treatment, Miriam was required to make no personal financial contribution to the cost of her local authority-funded care. For her MHSW, even during a period of relative instability in Miriam's mental health (exemplified by her two admissions to hospital during the six months of her participation in the study), his work was largely limited to meeting with, and nominally reassessing, Miriam in her home once each month, and suspending and restarting her domiciliary care package as she moved from home to hospital and back again. Other areas of work, such as assisting Miriam with form-filling in order to maximise her entitlements to benefits, were equally contributed to by either this social worker during his planned visits or by Miriam's CMHN. This limited enactment of a social work role had implications for Miriam's CMHN (see below), who was required to work particularly flexibly in order to provide a sufficiently responsive overall service to meet Miriam's complex and unpredictable needs.

7.4 THE WORK OF MENTAL HEALTH NURSES

Nurses are the largest of the occupational groups providing paid services to people with mental health problems living in the community (Department of Health, 2006a) and, as might be expected, were major contributors to the care

of the six case study subjects. Mental health nurses also featured in this study as providers of institutional care, and had significant parts to play in the management of case study subjects' transitions from hospital to home (see Chapter 9).

Reflecting their historic interoccupational settlement with psychiatrists, nurses often undertake work associated with the physical treatment of mental illness. This is exemplified by the continued association of mental health nursing with work relating to psychiatric medications (Gray et al., 2003). This orientation of nursing practice to medication-related issues was revealed in this project at case study level. However, as Chapter 3 illustrated, mental health nursing has in recent decades also advanced jurisdictional claims to control new areas of work independent from medicine. Community care has offered opportunities for nurses to advance their occupational status claims, underpinned by assertions to possess a necessary knowledge base derived from both the physical and social sciences. Often, contemporary nursing bases its jurisdictional claims to engage in mental health work on the strength of its practitioners' possession of particular human qualities and skills. Nurses frequently articulate the importance of drawing on these in developing and maintaining effective relationships with service users as key to their specific contribution (Barker et al., 1999; Peck and Norman, 1999). Whilst some evidence emerged in this study of nurses advancing jurisdictional claims based on their relationship-building skills, the micro-level contribution of nurses was most notable for its broadly based, flexible, 'working the system' quality (Allen, 2004b).

As in the case of psychiatrists and social workers, community mental health nurses in this study fulfilled roles which reflected the influence of macro-to-micro lines of impact, and the patterning effects of the particular workplaces in which they were located. CMHNs contributed as members of the micro-level systems of work surrounding Jim in Midtown, and all three service users in Northtown. A service was additionally provided to Simon in Midtown by a hospital-based nurse who ran a regular medication-monitoring and blood-taking clinic. Part of Simon's physical treatment was his prescription of clozapine, an atypical antipsychotic drug; this is the medicine which staff at The Oaks had earlier encouraged Simon to assume more direct control over. Use of this preparation has to be carefully monitored, however, as serious physical side-effects can occur. The nurse who saw Simon at Midtown Psychiatric Hospital on a monthly basis to take bloods as part of this monitoring fulfilled a very particular, closely circumscribed, role clearly reflecting nursing's historic association with the provision and monitoring of physical treatments.

Reflecting the existence of a negotiated, meso-level, interagency 'case management' framework, all service users of the Midtown CMHT were allocated a single care coordinator. This person would be either a nurse or a social worker. In the context of limited human resources, becoming a care coordinator in Midtown was likely to mean being the only professional community mental health worker to have ongoing service provision responsibilities. Ideally, the attachment of workers to service users will reflect

the particularities of a user's health and social care needs. Needs, for example, were associated with 'lead professional' allocation in the *Delivering health and social care* study from which this PhD has taken its design and methods (Allen et al., 2002). However, in Midtown, complex meso-level organisational contingencies exerted a powerful patterning effect on professional allocation. Social workers were allocated to Simon and Lenny, for example, not because both had predominantly 'social' rather than 'health' needs, but because of the existence of specific structural factors. Midtown Local Authority had assumed the agency responsibility to nominate one of its MHSWs as a dedicated substance misuse worker (explaining why a MHSW, rather than a CMHN, was allocated to Lenny). The Authority also undertook to allocate a social worker to 'out of area' service users, as it had done when Simon had been an inpatient in a private forensic psychiatric hospital.

In Jim's case, in the absence of meso-level structural factors exerting an impact on care coordinator allocation, interactive and other factors assumed greater significance in the identification of a lead professional. Jim experienced multiple mental and physical health problems. Arguably, his particular constellation of needs favoured his key professional being a nurse. Jim's care coordinator during fieldwork was indeed a CMHN, as had been his previous care coordinators. In his accounts of his work to me, Jim's CMHN advanced jurisdictional claims to the possession of a particularly 'nursing' body of knowledge and skills appropriate to his work with Jim, centred on medication management. He did not, however, explicitly extend his claims towards having a mandate to actively help meet Jim's physical health care

needs. Identifying the source of Jim's recent crisis as relating to his partial adherence to prescribed medication, this worker articulated the view that his occupationally specific understanding of psychiatric medications made him an ideally placed care coordinator:

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

CMHN: 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.

BH: And the thing that makes it specific to nursing is the medication?

CMHN: Yes, it's Jim's non-compliance really and lack of understanding of the medications and what they do and the reason for taking them which he often asks, you know, 'why am I taking them, what's it for?' Because in all fairness, a lot of the social workers know a great deal about the sort of medications that we use and the groups of meds that we use, but I think for the specifics Jim's been allocated a CPN from the start.

(Interview, CMHN, Midtown – 2: 374-389)

In this same interview this CMHN also advanced the jurisdictional claim that detecting the early signs of relapse (Coffey, 2003) was, first, an important task in Jim's case and that, second, this work could best be accomplished by a nurse drawing on occupationally specific clinical skills in mental health assessment. This practitioner also put forward the view that 'relationship work' was key to his approach to the provision of his distinctly 'nursing' care.

In Jim's case, the observed work of this CMHN reflected his prioritisation of medication-related issues. Finding ways of managing Jim's tablets became a

key component in the negotiations taking place between this CMHN, Jim himself and Jim's principal lay carer. Chapter 8 includes a detailed analysis of these interactions and the significance they had for Jim's ongoing care. Significantly, and in contrast to the claims advanced by this nurse to underpin his work with Jim, the MHSW who had contributed to Jim's care during the crisis phase of his trajectory upheld the view that a member of either occupational group (nursing or social work) would have been equally likely to have become Jim's CMHT worker and case manager. She saw nurses and social workers fulfilling broadly comparable day-to-day roles, and located the identification of workers to fulfil these positions as typically arising from face-to-face negotiations set in the context of managing overall workloads and responsibilities in the team.

The occupational background of Jim's case manager as a nurse had implications for his enactment of the care coordinator role, and for his interpretation of Jim's needs and the range of tasks which he undertook. As care coordinator, this CMHN sometimes engaged in activities which, in Northtown, only MHSWs involved themselves with. As in the case of social workers, then, enacted CMHN occupational roles in Midtown tended to encompass a fuller range of activities. For example, Jim's nurse opened negotiations with the social care agency which provided domiciliary care services shortly after Jim's return home from hospital. This was in order to effect a more frequent service. This same CMHN also engaged in other non-occupationally specific areas of work, such as using his care coordinator authority to mobilise additional resources to assist with Jim's care. For

example, he involved the team's untrained health care assistant to provide practical services to Jim, such as accompanying him to various primary care and outpatient appointments (see Chapter 8 below).

In Northtown, CMHNs were involved in the provision of care to all three case study subjects. Two case studies are drawn on to examine the enactment of nursing roles there: Kerry's and Jenny's. Exemplified in Kerry's case is, first, how occupational roles can reflect the expressed needs of recipients of services. Second, her case reveals the degree to which it is often nurses who expand the range of tasks they perform to fill the gaps in service provision which would otherwise be left unfilled, in order to accommodate unpredictable and complex service user needs (Allen et al., 2004a). Analytically interesting in Jenny's case is the related observation that nurses, having expanded their contribution to 'fill the gaps', will sometimes restrict the scope of their work when additional resources become available.

Kerry's CMHN (who also worked with Miriam) was a highly regarded practitioner in the team. Despite having completed a specialist post-qualifying course in evidence-based interventions for people with severe mental health problems, and shouldering a large and complex caseload, she occupied a relatively low-graded position. Whilst acknowledging the lack of meso-level progress in Northtown in formalising systems for care coordination, she nonetheless saw her high degree of face-to-face contact with Kerry as making her the most likely candidate to fulfil a *de facto* care coordinating role. A

distinctive characteristic of her work was her flexible approach. If work needed to be done, this CMHN was likely to do it, irrespective of role boundaries:

BH: What's your, given that there are all these other people around, who also work with Kerry, what's your particular role?

CMHN: I don't know, I suppose I'm the one she comes to when anything goes wrong. I had a phone call on Friday, ten to five. 'Oh thank God you're there', she said, 'I've got a problem'. I was thinking, 'oh, ten to five', I said, 'what is it'? She said, 'I've bought a DVD and I can't plug it in'. So it's things like that. Or she'll ring me and...

BH: Very practical stuff, then?

CMHN: Yeah, it's very practical, so, or she'll ring me and she'll say, 'I'm suicidal', you know, 'come over', or she'll ring me and she'll say, you know, 'I've run out of medication', or you know 'I'm having problems with insulin' or whatever. So it's generally those, well it's broad, I can't really narrow it down with Kerry, you've got to be very sort of, I don't know, you've got to be everything with Kerry.

(Interview, CMHN, Northtown – 73: 153-169)

In addition to demonstrating a willingness to support Kerry during periods of crisis, and to fix her electrical equipment, this CMHN also undertook specific activities reflecting a clear orientation to nursing's historic concern with medication-related issues. For example, it was this nurse who, during a home visit at which I was present as an observer, opened negotiations with Kerry in an attempt to obtain unused supplies of insulin as a precaution against this being used in Kerry's threatened future suicide attempt.

Recipients of caring services are themselves part of a micro-level division of labour, and the work that users do can exert a significant patterning influence on the roles enacted by paid practitioners (Strauss et al., 1985). Helping to pattern the work which Kerry's CMHN undertook was Kerry's own relatively

sophisticated differentiation of the contribution which the practitioners involved in her care could, or should, make. Her social worker, for example, she clearly saw as fulfilling a specific role in relation to the assessment and management of her social care package, through which Kerry received practical help with household activities such as shopping and cooking. This MHSW was also the single CMHT practitioner with whom Kerry discussed the detail of the voluntary foster care of her son. At Kerry's request, this worker liaised with colleagues in Northtown Local Authority's Children and Family Social Services Department. In the case of her nurse, Kerry saw her role, first of all, as being related to her physical treatment for mental illness. Thus medication-related matters were, for her, a legitimate area in which to engage with her CMHN. Kerry also saw this nurse as fulfilling a broadly based supportive role, making her the person to look to for help with both emotional and practical matters.

Jenny, the service user who enjoyed the least problematic trajectory in this study, received ongoing care from a Northtown CMHT CMHN. Jenny also used the services of the team's sole clinical psychologist. This division of labour had been negotiated over a protracted period of time, with interactions involving Jenny herself, her nurse, the team's staff grade psychiatrist and the psychologist. Involving the team's clinical psychologist had implications for the micro-level bundle of tasks attached to particular occupational groups, and led to negotiated modifications in the work undertaken by Jenny's CMHN as she herself explained:

BH: [...] can you talk me through your involvement with Jenny?

CMHN: Well, I've been involved with Jenny over, about a year since I came here. The sort of involvement has, it's on a sort of, on the nursing side and I suppose in a sense it has changed a little bit because of the different involvement of other team members in, as we've had the case conference we've sort of clarified roles a little bit more. So initially my involvement with her was more on a sort of, proactive and trying to look at, sort of cognitive work, with her [...].

[...]

That role has slightly altered to more of a supportive role as she's now seeing the psychologist and he's looking more specifically at some of those issues. So my role has adapted to be more of a supportive role rather than sort of looking at specific sort of cognitive things [...].

(Interview, *CMHN*, Northtown – 75: 154-172)

Taken together, Kerry's and Jenny's CMHNs illustrate the ways in which nurses – more than the other occupational groups whose work was explored in this study – are liable to expand and retract the scope of their tasks reflecting the availability of other resources. This peculiarly nursing function, which is concerned with creatively 'working the system', acting as intermediary, and filling the gaps irrespective of rigid role boundaries, has been observed in previous studies of nursing work, but hitherto not in a specifically community mental health care context (for a review, see Allen, 2004b).

7.5 THE WORK OF CLINICAL PSYCHOLOGISTS

As an occupational group clinical psychologists have advanced strong claims to provide face-to-face therapies based on their knowledge of both normal and abnormal psychological functioning. Clinical psychologists are, however, a scarce resource, and vacancy rates throughout the UK continue to be high (Department of Health, 2004b). This was particularly revealed in Midtown,

where an unfilled psychology post existed within the CMHT. Hospital-based services in that locality were equally scarce. The qualified clinical psychologist who had worked with Lenny in the past, and who had then supervised the assistant psychologist who met with Lenny on an outpatient basis during part of Lenny's participation in the study, was on extended leave throughout the duration of fieldwork.

In Northtown a clinical psychology service did exist, however, and one case study subject – Jenny – received a service from the CMHT's psychology representative. Where, for example, nurses were required to fulfil flexible roles to meet fluctuating levels of need (as Kerry's CMHN did), this psychologist's work was closely defined and highly structured. In his view, no other occupational group combined the same theoretical knowledge base with the relative luxury of dedicated therapeutic time to provide the kind of service he did:

Clinical psychologist: [...] Jenny does have clear appointments, you know, which let's say are once a fortnight and they usually, in theory at least, can last up to about an hour. Most of the people here probably wouldn't normally offer sessions in quite that way. I mean the doctors, for example, would virtually never offer appointments that long, although they might well be scheduled in advance. The nurses might actually give as much time as that but they're probably not planned out quite so systematically in advance. So the combination of having quite a lot of time but on a very planned basis is probably something that's peculiar to, well probably peculiar, to me in this particular team, although not necessarily true of all CMHTs.

(Interview, Clinical psychologist, Northtown – 77: 556-566)

For Jenny, this combination of flexible care provision (from her CMHN), and highly structured therapeutic intervention (from her psychologist), was

described by members of her network of care as representing an effective strategy to meet her needs.

7.6 THE WORK OF GENERAL PRACTITIONERS

From their base in primary care, general medical practitioners occupy powerful positions in systems of health and social care work. The interface between mental health and primary care services, however, can be a problematic one. Relative roles and responsibilities are open to dispute. Workers in mental health settings will often launch critiques of the contribution of primary care colleagues, and *vice versa*. As I discussed in Chapter 3 above, recognition of the difficulties associated with the management of services across the mental health/primary care interface has led to a variety of strategies directed at tackling these. These include shared care registers, expanding the liaison and consultation role of mental health workers and better preparing primary care staff to provide direct face-to-face interventions to people with 'less severe' mental health problems.

The micro-level relationships between GPs and paid mental health workers in this study were patterned by the entry into each negotiation context of significant meso-level factors. As observed during fieldwork and described in Chapter 5 above, meso-level resource constraints in the Northtown CMHT, combined with high levels of mental health need experienced by the population living in the team's catchment area, meant that new referrals from primary care were always liable to be rejected. As Northtown's senior nurse with responsibility for community mental health care indicated, this had

historically been a source of considerable tension between CMHT and primary care staff. In Midtown, the view of many mental health workers was exemplified by the psychiatrist working with Jim. His position, described earlier in this Chapter, was that primary care workers could assume a far greater responsibility for the provision of services to people with mental health problems living in their own homes.

The contribution of GPs to mental health care varies considerably (Secker et al., 2000a), with most expressing a preference for care to be managed largely by mental health services (Kendrick et al., 1991). In this investigation, many of the case study subjects proved to be relatively frequent primary care attendees, reflecting patterns of service use observed elsewhere (Wear and Peveler, 1995). The application of the snowball sampling strategy revealed no primary care contribution to meeting case study subjects' needs other than that provided by GPs. Examples of actual micro-level negotiations, or reports of negotiations, to clarify relative roles and responsibilities across the mental health/primary care interface were limited. The routine work of GPs in the care of the case study subjects was largely limited to the provision of physical health care services (Beecroft et al., 2001) and the adjustment of prescribed psychiatric medications at the request of mental health workers. Less routine GP contributions were specific to phases of the case study subjects' trajectories. For example, just prior to Jim formally joining the study Jim's GP had fulfilled a specific role in relation to recommending a compulsory admission to hospital under a section of the Mental Health Act. As with the fulfilling of similar responsibilities by social workers, this stands as a good

example of micro-level work being directly patterned by role expectations established in statute at macro-level.

The relative lack of micro-level negotiations between GPs and mental health workers was associated with meso-level temporal, spatial and resource factors. Important junctures at which roles and responsibilities were negotiated – such as the face-to-face interoccupational and interagency care planning meetings observed for Simon and Kerry – took place at times when GPs were likely to be engaged in running their surgeries. Geographical distance inhibited the likelihood of helpful, responsive, informal interactions between mental health and primary care workers taking place. Heavy workloads on the part of all practitioners meant that space to negotiate face-to-face care delivery was rarely sought. These lack of interactive opportunities had potentially negative implications for care delivery. Jim, for example, was an older man with an illness trajectory made problematic by a combination of severe mental health and physical health problems. Lack of integrated service provision made for fragmented care, a problem partially solved by Jim's CMHN involving his health care assistant colleague to accompany Jim to his multiple primary care (and hospital outpatient) appointments (see Chapter 8).

Limited interprofessional negotiation did not mean, however, that GPs were not actively engaged in work with case study subjects. Rather, this work was largely invisible to CMHT and other mental health practitioners. Access to Jim's primary care records revealed that, for example, he had attended four appointments associated with the management of his physical ill health in the

three weeks prior to his notes being consulted. These notes were also, by far, the most complete set of historical documents found relating to Jim and his care. Details, of a type long since disappeared from his mental health records, were recorded of his first psychiatric hospital admission in the 1950s. More contemporaneously, these notes also revealed a steady flow of communication from CMHT members to Jim's primary care team: outpatient letters from Jim's consultant psychiatrist, letters from Jim's CMHN requesting medication changes, and so on. Multiple hospital discharge summaries were also found. In addition, Jim's primary care team appeared well-acquainted with the high degree of informal care Jim received, in a way which was not obviously appreciated by CMHT workers. The front cover of his notes, for example, contained contact details for his main lay carer (see Chapter 8). In an account given to me of his work during an interview held in his practice, Jim's GP demonstrated considerable knowledge of this extensive informal care network, which he drew on when seeking updates on Jim's state of health.

Negotiations can be face-to-face, but can also be mediated through the use of specific technologies. In her work, Miriam's and Kerry's CMHN and informal care coordinator conducted negotiations with GPs through the use of machines. In a way not characteristic of other workers in this study, she made particular use of her CMHT's fax. Using faxed handwritten notes to convey information or to request specific actions (typically medication changes), this CMHN maintained a working relationship with GPs which other mental health practitioners did not. In her account of her work, for example, Kerry's GP was

able to refer to this CMHN by name, and acknowledged that – whilst improvements in working together could be made – the flow of information from the CMHT was helpful:

BH: What are the means which you use and which they [CMHT workers] use to share information, to communicate? You mentioned the fax?

GP: It's usually the fax actually, because most of the time it's to do with short-term medication prescribing, or short-term crises. Effectively one of them will ring us, or they'll ring the receptionists, and Mo [CMHN] will ask if they can come and see us as an emergency, and then she'll come along sometimes with Kerry.

BH: Right. And does that work well, that system, and do you feel you are as aware as you'd like to be with respect to Kerry's mental health care and that the communication between you and the CMHT is good?

GP: It's not bad, it could be better though.

(Interview, GP, Northtown – 74: 80-92)

The transactional character of these technologically mediated negotiations was revealed in, for example, the context of managing Kerry's threats of suicide. Kerry's primary care records indicated that, in response to raised levels of concern over her risk of self-harm and her hoarding of medication, her GP had stopped issuing repeat prescriptions at the faxed request of CMHT practitioners.

Bearing out what is already known about the management of services across mental health/primary care interfaces, this study has generated further evidence of the often high levels of involvement GPs have in the provision of care to people with mental health problems, albeit carried out in ways which remain relatively invisible to mental health workers. Also significant is the

largely non-negotiated organisation of work across mental health and primary care organisational boundaries.

7.7 CONCLUSION

This Chapter has drawn on case study data to examine the work of representatives of five key occupational groups. All five groups are distinguished in contemporary systems of mental health work by having advanced knowledge-based claims to professional status. All featured strongly in the overall provision of services delivered to the six service users whose networks of care, and unfolding trajectories, were explored here.

Reflecting ecological ideas, I have assumed that the micro-level work of psychiatrists, social workers, nurses, psychologists and GPs is never self-evident. Rather, roles examined in this study were shaped by complex combinations of structural and people-related factors. I have given particular attention to an examination of what Strauss (1978) terms 'lines of impact', as a means of exploring the ways in which social relations and events unfolding at micro-level reflect macro and meso-level patterning. Specific examples given here include the ways in which the narrow range of tasks associated with CMHT-based social workers in Northtown reflected, first, their profession's macro-level jurisdictional success in controlling work associated with the operation of mental health law, and work related to the management of funded social care. I have also demonstrated how the enactment of social work roles in Northtown reflected meso-level lines of impact which served to constrain expansions to their work. In the contrasting Midtown meso-level

context, I have examined how social workers fulfilled both macro-level expectations regarding the content of their work but also had opportunities to expand their tasks into additional areas in the absence of other occupational groups able to advance stronger jurisdictional claims. With regard to this last example, in Chapter 9 I go on to show how opportunities taken to expand occupational jurisdiction can have both a positive, and a negative, effect on the delivery and receipt of services. This is exemplified by the case of a task-expanding social worker who left his post before completing his negotiated programme of psychosocial therapy, to be replaced by a worker who lacked the constellation of knowledge and skills necessary to continue with his predecessor's expanded contribution to overall service provision.

I have shown in this Chapter, then, how context-specific spatial, temporal, resource, organisational and personal factors all play important parts in influencing work. For example, the meso-level decision to locate psychiatrists out of the Midtown CMHT had clear implications for (non)negotiations, and was associated with the enactment of hospital-oriented, biomedically informed, psychiatrist roles. This was particularly exemplified in Simon's case, during (non)negotiations over the renewal of his supervised discharge order. The impact of ideological differences and role conflict were also revealed in the long-running matter of Simon's medication management. Significantly helping the negotiation of care was the location of psychiatrists in the Northtown CMHT, a meso-level feature with beneficial implications in, for example, Kerry's case.

Resources, and the relative lack of these, played an important part in patterning the work of professionals. Noted already is that the Midtown MHSW who engaged in individual and family therapy was able to do so partly because the team in which he worked lacked representatives of other occupational groups who might have advanced stronger claims in this area. As has been found in other studies, nurses demonstrated a particular willingness to work flexibly, and to cover gaps in care provision which would otherwise have been left unfilled. Jenny's CMHN, for example, expanded her work into the provision of cognitive therapy, only to retract the scope of her contribution in this area when her clinical psychologist colleague commenced work. Kerry's CMHN, her work shaped in part by the actions of Kerry herself as a particularly informed consumer of services, both demonstrated an orientation to medication-related work but also to the provision of more generalised emotional care and practical assistance. Clear meso-level resource constraints limited the options open to Kerry's MHSW during face-to-face negotiations intended to construct a plan of action in response to Kerry's threatened suicide.

Resource limitations in Midtown, coupled with meso-level success in agreeing procedures for care coordination, meant that ongoing care there was never provided by both a CMHN and a MHSW based in the same team. The occupational background of care coordinators was significant for care provision, where the identification of workers to fulfil this role was negotiated in the context of meso-level organisational contingencies, the necessity of balancing team members' workloads, and the importance of matching workers

to identified needs. For example, organisational contingencies meant that a MHSW rather than a CMHN became Simon's care coordinator. As a CMHN, Jim's care coordinator clearly demonstrated an orientation to medication-related work in a way which, possibly, a MHSW may not have.

Spatial, temporal and resource factors were also significant for the enacted roles of GPs. Few face-to-face negotiations across the mental health/primary care interface were observed or described. Alternative styles of negotiating were pursued in some instances. Examples included actions by Kerry and Miriam's CMHN in Northtown, who routinely engaged in technologically mediated negotiations to broker changes in Kerry's care, and by psychiatrists who routinely forwarded letters inviting care plan changes to primary colleagues following contact with service users.

The examination of work commenced in this Chapter continues in Chapter 8. There, roles fulfilled by three further types of worker are explored. The first category relates to the contribution of representatives of occupational groups which, whilst successful in advancing claims to professional status, are often thought of as fulfilling only marginal roles in systems of mental health care. The second category of paid worker whose contributions are examined includes those for whom no claims to professional status have been advanced. Finally, the Chapter which follows also examines the work of unpaid lay carers, and service users themselves. These, in particular, are groups whose caring contributions are typically not thought of as constituting 'work' at all (Strauss et al., 1985).

8 MARGINAL, NON-PROFESSIONAL, SERVICE USER AND LAY CARER WORK

8.1 INTRODUCTION

Sociologists have long recognised that contributions to health and social care provision are made by representatives of more than just established professional, and professionally aspirant, groups. Ecological insights urge a particular focus on overall patterns of work, including on the contributions made by peripheral, relatively invisible and less powerful groups. It is significant that, in recent years, health and social care policymakers in Wales and beyond have also turned their attention to the work of hitherto marginalised groups of this type. Under a 'whole systems' rubric, policymakers are recognising the importance of attending to the work of service users, carers, non-professionals and other groups traditionally thought of as being on the edges of service provision (see for example: Welsh Assembly Government, 2003b; Welsh Assembly Government, 2005a).

In this Chapter the micro-level work of relatively invisible professional groups is examined by focusing on the contribution of community pharmacists. The work of paid, but low status, workers is explored through a micro-level analysis of the role of health and social care assistants. Finally, the work of lay carers and service users is examined. As in the previous Chapter interpretation and presentation of data are theoretically guided. The impact of macro and meso-level structural patterning is again explored, as is the importance for roles of locally specific contextual factors.

8.2 THE WORK OF COMMUNITY PHARMACISTS

The constellation of macro-level structural factors with a bearing on the practice of community pharmacy differs markedly from those pertaining to the other occupational groups whose work is investigated in this thesis. As one of the two high street pharmacists interviewed during fieldwork pointed out, the employment status of pharmacists in privatised businesses is highly consequential for social relations with other health and social care workers and for patterns of care provision. As was found in the cases of Jim in Midtown and Kerry in Northtown, pharmacists are rarely considered by other practitioners to be part of an individual service user's network of care. Reflecting this, pharmacists are also often ignored in studies of interprofessional health and social care working (While et al., 2005). At worst, in the view of the pharmacist who most regularly dispensed medications to Kerry, efforts by pharmacists to become more involved in care negotiations are always liable to be misperceived by other practitioners as crude attempts to maximise profits:

Community pharmacist: They think we're shopkeepers, they still think we're shopkeepers. We do dispense prescriptions but basically we're shopkeepers who are in it to make money, it's just, and we haven't got a professional side.

(Interview, Community pharmacist, Northtown – 90: 420-423)

This relative marginalisation in Jim's and Kerry's cases sat at odds with the new macro-level interest in expanding the role of pharmacists (Department of Health, 2006c). It also sat at odds with the emphasis placed by members of

Jim's and Kerry's two micro-level care networks on the importance of adherence to medication regimes. Reflecting his nursing background, Jim's care coordinator, for example, made arrangements for the supervision of medication a priority in his negotiations with Jim's principal lay carer (see below). Erratic use of antipsychotic drugs, in his view, had been instrumental in contributing to the rapid deterioration in Jim's mental health leading up to his crisis admission to hospital prior to the commencement of fieldwork.

In Jim's case, pharmacy involvement in the preparation and dispensing of his medicines was ongoing and consistent, but was neither negotiated nor integrated with other elements of his care. Each week, the same high street pharmacist physically prepared Jim's drugs. Blister packs were used to divide up medicines into daily doses, in an attempt to promote concordance. After preparation, Jim's tablets were transported directly to his home, as part of a service provided to all regular users of this pharmacy whose disabilities made personal collection difficult. Giving an account of his work, the manager of this high street pharmacy described engaging in negotiations initiated by Jim's principal lay carer (in the past this carer had, for example, been the person to alert the pharmacist of Jim's return home from hospital and the consequent need to restart his home deliveries), but no negotiations with Midtown CMHT workers. Contact with members of Jim's primary care team did occur, but was limited to interactions with reception staff over the dispensing of repeat prescriptions. Independently, however – and unknown to this pharmacist who knew nothing of these arrangements – other members of Jim's care team were negotiating their own practical medication management strategies (see

below). It is possible that purposeful interactions between CMHT, primary care, pharmacy and lay workers (including Jim himself) may have led to a more effective and coordinated approach to the organisation of Jim's medicines.

A particular concern in Kerry's case was her ready access to stored supplies of insulin which, her paid mental health workers thought, could be used in a future suicide attempt. Technologically mediated interactions between Kerry's CMHN and her GP were directed at adjusting her prescription correspondingly. As with Jim in Midtown, however, negotiations between CMHT workers and the pharmacist who dispensed Kerry's medicines were limited. In her account, the pharmacist who usually dispensed to Kerry described her contact with CMHT staff as being limited to her initiating calls to the team's staff grade psychiatrist to request corrections to poorly prepared prescriptions. Kerry's first production of a prescription for insulin came as a surprise to this Northtown pharmacist, who had not been previously aware of Kerry's ongoing diabetes treatment; nor was she aware of CMHT workers' concerns over managing Kerry's suicide risk. Lines of impact were significant, with macro and meso-level features combining with Kerry's capacity (unlike Jim's) to physically collect her own prescriptions contributing to this situation. Kerry lived in a relatively urban area. According to the Northtown pharmacist who participated in this study, medication dispensing services had historically been provided by multiple high street pharmacies. In this market-based environment, with no obligation to consistently use one particular pharmacy Kerry had taken her prescriptions to more than one business. Whilst allowing

her a high degree of consumer choice, this action had nonetheless had negative implications for continuity of dispensing and for a consistent pharmacy involvement in her overall care.

8.3 THE WORK OF HEALTH AND SOCIAL CARE ASSISTANTS

Increasing numbers of CMHTs, as the Midtown and Northtown teams did, employ non-professionally prepared support workers and health care assistants (HCAs) (George, 1997), with service users reporting considerable satisfaction with the care provided by these groups (Meek, 1998). 'Non-aligned' workers also feature prominently in contemporary plans for the development of the mental health workforce (Department of Health, 2003b). Non-CMHT mental health services, in addition, are also often provided by workers who have not been prepared as members of the major mental health occupational groups.

Important meso-level structural factors influenced the roles fulfilled by NHS-employed health care assistants and local authority-funded social care workers. Both groups undertook practical, often time-consuming, tasks, and had high levels of face-to-face contact with service users. Health care assistants could be rapidly deployed to undertake delegated tasks, or to assist in the accommodation of service users' needs during critical phases of trajectories. In contrast – in Northtown in particular – the contribution of local authority-funded social care workers was more difficult to achieve, reflecting differential macro and meso-level arrangements for the funding of 'health care' and 'social care' resources.

In the immediate period following his return home from his most recent hospital stay Jim's care coordinator, a CMHN, maintained contact on a frequent, sometimes daily, basis. His work focused primarily on maximising Jim's medication adherence by negotiating strategies with Jim's main lay carer, and gathering observational and carer-reported data on Jim's mental health. However, maintaining Jim in his own home also meant brokering arrangements with meals-on-wheels and home care service providers, assisting Jim with correspondence, managing his finances, negotiating with housing association representatives over repairs to his home, and helping Jim to keep his multiple primary care and hospital outpatient appointments. Involving the Midtown CMHT's HCA to contribute to the practical work of accompanying Jim to his appointments and to complement the CMHN's face-to-face contact was readily accomplished, with no requirement for the costs of this additional support to be considered at meso-level. The content of the HCA's subsequent work was similar to the work initially undertaken by Jim's CMHN: visiting Jim in his home, interacting with his main lay carer, and accompanying Jim to appointments. Her account of her contribution was distinguished, however, by an absence of jurisdictional claims. For example, whilst claiming a shared role with Jim's CMHN in the assessment of Jim's response to antipsychotic medication she made no claims to the possession of a knowledge base to underpin an independent contribution in this area, and saw her role as primarily one of observing and reporting:

BH: What kind of work do you do with respect to monitoring side-effects of medication?

Health care assistant: Well, Jim reported to me that he was experiencing his tongue protruding, and although I'm a nursing assistant this is a new game for me because medication wasn't one of my key issues in my other role [*as a social care assistant*], so I came back, reported everything back to Colin [*CMHN*] after my visits and logged things down in his notes, and he explained then that it was a side-effect of his medication. So I asked Colin then would he just reinforce this to Jim when he went to visit him next, and just to reassure him really that it was a side-effect. So really listening to what the clients are telling me and just reporting back.

(Interview, Health care assistant, Midtown – 29: 98-109)

Involving the Northtown CMHT's HCA in Jenny's care was also accomplished in an unproblematic manner, although the reasons for her involvement contrasted with the reasons for a HCA beginning work with Jim in Midtown. Jenny had difficulties in using community facilities, and struggled with shopping for daily essentials. She had, previously, received a service from the Northtown Mental Health Voluntary Organisation, one of whose workers had provided specific practical help in this area. The loss of this service – for reasons which were unclear, but which appeared to be related to financial difficulties on the part of the Voluntary Organisation – left a gap in her overall care plan. Faced with the necessity of finding alternative means of accommodating Jenny's needs, Jenny's main paid carer (a CMHN) creatively 'worked the system' by securing the involvement of the CMHT's HCA. Practical work once undertaken by non-statutory support staff thus became part of the contribution made by a CMHT-employed health care assistant.

The devolving of social care budgets down to the level of the Northtown CMHT, where access to these was controlled by the team's principal social services officer, rendered the financial implications of involving local authority-

funded care workers more transparent than the financial implications of involving NHS-funded HCAs. This structural context feature directly entered into negotiations surrounding Kerry and her needs, and served to constrain the options open to Kerry's MHSW during the brokering of plans to manage Kerry's elevated risk. Thus, as I examined in Chapter 7 above, through its social work representative at Kerry's face-to-face care planning meeting Northtown Local Authority was unable to authorise additional funded social support because of the invoking of strictly held criteria for access to services. In addition, the day-to-day work of Kerry's local authority-funded social care support worker was significantly constrained by meso-level structural factors. Her involvement followed a CMHT MHSW's care management assessment, and payment for her and a colleague's services was partially made by Kerry herself. At the contractual level the boundaries of her work were tightly drawn. Excluded was any work associated with Kerry's mental health or the wellbeing of her son. Rather – possibly for the support worker's own protection, as a strategy to insulate her from the potentially overwhelming demands which Kerry might have placed on her – this worker was expected only to interact with Kerry in the undertaking of practical tasks such as shopping and cooking.

The work of Kerry's local authority-funded support worker, however, exemplifies the degree to which occupational roles are socially accomplished. Attempts to specify the content of her interactions with Kerry foundered in the face of the developing relationship between the two. This was revealed to me during a discussion with both, held in Kerry's home during one of their regular meetings:

Support worker: [...] my guidelines are very strict, you know, we mustn't discuss Kerry's son, we mustn't discuss, you know, my role was to come in and help Kerry with her shopping, and I was very hurt because, I mean, I've been seeing Kerry for over two years, even though she knows I'm a support worker, you do build up a friendship. You can't, I mean I'm not made of stone, at the end of the day.

[...]

Kerry: She [MHSW] told me as well. She said, 'oh, she's not there for your support, you know, not for support, for talk about, you know, anything, your problems and that', and also, 'you've got to be quiet. She's just there for shopping, cooking and that's about it'. So I had to try to put bricks up against myself not to speak about my problems.

BH: Right. Was that difficult for you?

Kerry: It was difficult, very difficult.

(Interview, Social care assistant and case study subject, Northtown – 81: 6-52)

A consequence of engaging in low-status work or in undertaking delegated tasks was the likelihood of being overlooked or devalued by representatives of higher-status occupational groups, as others have observed (Spilsbury and Meyer, 2004; Stacey, 2005), and being excluded from fora in which negotiations over care could take place. As with pharmacists, health and social care assistants and support workers were liable to become marginalised. This had consequences in Simon's case in Midtown, although, significantly, not for Kerry in Northtown where her support worker and the support worker's manager were involved as full participants in Kerry's care planning meeting. Part of Simon's routine, up to four times each week, was to participate in rehabilitative activities at a local authority day service in preparation for his move to more independent living. In the account of the day service worker who knew Simon best, this work was practically focused and

centred on developing skills crucial to everyday living in the community, including food shopping, cooking and budgeting. However, when it came to pooling information about Simon's progress and negotiating plans for his future, day centre staff were conspicuous by their absence at both the care planning meetings held for Simon which were observed during fieldwork. Important opportunities were thus missed to negotiate resettlement plans which encompassed full knowledge of Simon's daily living skills.

8.4 THE WORK OF LAY CARERS

From its inception, the system of community care has drawn on the efforts of unpaid, as well as paid, workers, with the contribution of lay carers in sustaining people with mental health problems in their own homes often proving critical (Perkins and Repper, 1996). However, it has long been recognised that family care of people with severe mental illnesses can be challenging, and can lead to mental health problems in carers (Brooker, 1990). Interest has thus grown in improving ways of supporting, and collaborating with, carers of people with mental illnesses. This trend also reflects the more general growth of interest, in policy, practice and research contexts, in the work of family carers and in the provision of care 'by', rather than just 'in', the community (Allen, 2002).

Micro-level lay carer involvement in this study exemplified contrasting modes of engagement with care provision. For example, Simon, who until a year before participating in the study had been a user of secure inpatient forensic mental health services, received no care from family members or other unpaid

workers. Faced with his increasingly challenging behaviour, his family had taken the decision to detach themselves from all involvement with him. During fieldwork his needs were thus met solely by workers employed by health and social care agencies. In contrast, Jim's network of care in Midtown exemplified the contribution that unpaid, and sometimes non-family, carers can make to the maintenance of people with mental health problems in community settings.

Jim was well-known in his locality, and was a man whose age and combination of physical and mental health problems marked him as being particularly vulnerable. Members of his local community played an essential part in sustaining Jim in his own home, with a key role being played by a neighbour who ran a shop a few doors away. Accounts from her and from Jim's CMHN indicated that her involvement in Jim's care had evolved over a seven year period. During fieldwork, contact between Jim and her was intense, with Jim's daily routine commencing with an early morning visit, as his CMHN indicated:

CMHN: I think she just befriended him [*Jim*] initially. When she moved to the current premises, which is two doors away, and he sort of popped in to say 'hello' to the new neighbour really, and then he sort of, what he does every morning, he goes in, he makes them, the two ladies there, Sarah [*principal carer*], and makes them a cup of coffee and takes them in and so they sort of just got to, well they got to befriend him really and sort of keeping an eye on him, plus the fact that where we were situated before in West House [*the CMHT's old base*] with wonderful gardens, Sarah used to, would have some foliage from sort of around, she'd had permission from the Trust and what have you, because she's got a flower shop.

BH: For the shop.

CMHN: So that's really how she came to know us, and how Jim was involved with us. It wasn't from a sort of knock on her door and saying, 'excuse me, do you know this guy down the road?', it was because she was coming to the grounds of where we were based that she sort of saw Jim there and then asked him and has just got involved in that way.

(Interview, CMHN, Midtown – 2: 124-141)

Over the years Jim's neighbour had expanded her work to encompass a wide range of tasks. Paid workers who were also a part of Jim's network of care consistently recognised this lay contribution. Both Jim's GP and his psychiatrist, for example, drew attention to the value of Jim's informal care network. For the former, this type of lay care exemplified the benefits of care 'by', rather than just 'in', the community. For the latter, Jim's neighbours' interventions made formal care less 'clumsy', with lay workers providing an important early warning system of imminent ill health and reducing Jim's likelihood of relapse by tolerating his presence in the community.

Jim's nurse, too, acknowledged that without the practical support of members of his community Jim would have needed significantly enhanced, paid-for, services. In his position as care coordinator he actively engaged in purposeful, work-oriented, negotiations with Jim's principal lay carer. These assumed particular significance in the context of managing Jim's transition home from his most recent period of hospital care. Jim's non-concordance with prescribed medication had been implicated in his compulsory admission. Part of the negotiated work of managing Jim's medicines on his return home involved an expanded role for his lay carers, with his neighbour assuming responsibility for storing, and supervising the taking of, his tablets. This was

an initiative which Jim's neighbour had taken the lead in brokering, initially as a response to the lack of information provided to Jim by staff at Midtown Psychiatric Hospital on returning home with his hospital-provided supply of medicines:

BH: So whose idea was it for you to have the tablets, for him to have them from you four times every day?

Carer: Well, I think, I think he came in, he came home this time, didn't he, with them all in a packet, all separated like that. Because I have to be fair, he'd go down the doctor's for his prescription and he come up with a bag full of bottles and what have you, he couldn't understand them. Some of them would say 'as directed', so I'd have to phone them to say what does 'as directed' mean? Then he'd have to put it in big black ink, one time a day, three times a day and all of that. So I think that wasn't helping him, it was too much for him to deal with that was. So this time now when he came in with the packet as they do, well I suggested then, I said, 'well, I can manage that', you know, and, 'if you let me have them here, all well and good, see'.

(Interview, Lay carer, Midtown – 3: 248-260)

Data relating to Jim's neighbour's role was also generated through observations. Fieldwork included accompanying Jim's CMHN on his home visits, and observing his interactions with Jim's neighbour. During one of these events, in addition to producing supplies of Jim's medicines and clarifying aspects of his treatment, Jim's carer also revealed experientially derived knowledge of the early warning signs associated with deteriorations in Jim's mental health. This knowledge proved significant in a critical phase of Jim's trajectory, in the period leading to his most recent hospital admission. However, the management of this phase also revealed limitations to the degree to which professionals were willing to permit lay knowledge to enter into Jim's negotiation context, or to influence the committing of statutory

resources. Whilst paid workers recognised the value of the *tasks* carried out by Jim's lay carers, they were arguably less willing to embrace the *social role* changes which this expansion of lay carer involvement potentially brought.

First to notice a worsening in Jim's mental health, Jim's unpaid carers acted on their concerns by attempting to alert CMHT workers. According to Jim's neighbour's account, these lay observations were received with initial doubt. Attempts to mobilise professional help were, at first, not heeded. Securing a professional response demanded a resourceful approach by members of the community, and a careful staging (Levy, 1982) of people and events prior to pursuing further negotiations with professionals:

BH: I was asking Colin [CMHN] this, what would happen if you weren't around, and he was saying you were having a huge impact on Jim and the care he receives and he was saying that he thought you were central.

Carer: Oh yeah. Because, and the girls from the other shop, to be fair as well, they do watch out as well because like when things go wrong now because we always seem to be talking about him, the lot of us, just saying about him, they'll always come in here and say, 'have you seen him yet today, is he alright?', and I'd say I'd phoned and then. The last time I had a lot of problems in actually getting them [*paid workers*] to realise he was ill, so one of the girls in the other shop then, I said, 'look, I've phoned them', I said, 'you phone up as well, so they'll not just think it was me, that's just being, you know, overreacting like'.

BH: Yes, they came to you, then you ring but then when nobody was taking notice that time you got them to ring as well, so you've got two different people ringing.

Carer: And then Eileen, then, who used to be Jim's home help, and she passes here every day because she lives at the back, and she called in here and I said, yeah, I said, 'Eileen, I have phoned', and she said, 'do you want me to phone?', I said, 'yeah', I said, 'because they'll think it's me', I said, 'just overreacting with him', and she phoned in as well then. See? So I think then it was a case of, well, let's get him sorted now.

BH: Yes, three people all giving their own reports that Jim's not very well, yes.

Carer: Yeah. See. 'Cause he's well liked, see?

BH: Yes. Yes.

Carer: 'Cause if he was an old cantankerous man, maybe people wouldn't be looking out for him, then if he was not so nice like, but because he's, you have a laugh with him and he's alright with the girls in the other shop as well and with Eileen and that, he's, you know, he's, got another woman see, Jim will tell you her name and she does all his washing.

(Interview, Lay carer, Midtown – 3: 89-125)

In addition to revealing the effort which lay workers devoted in order to secure a formal mental health services' response to Jim's deteriorating illness trajectory, and the depth of Jim's community support, the above extract also hints at an explanation for Jim's extensive lay carer network. A significant part of Jim's CMHN's account was his description of Jim as an atypical service user, characterised by having an informal care network far greater than that enjoyed by others on his caseload. Jim, as a n older, obviously vulnerable man – also blessed with a pleasant temperament – elicited considerable sympathy amongst members of his local community. Positive personal and social characteristics were thus a significant factor in influencing Jim's neighbours' decisions to assume active roles in his care. Assuming lay caring responsibilities was also allied to the knowledge that, unlike family carers, being a caring neighbour was unlikely to become a full-time job. Jim's principal carer undertook her caring work during her hours spent at her shop. As she indicated in the context of an interview held there, her work was thus relatively contained. Unlike a family member sharing a home with a cared-for

person, she was able to take time out from her caring role during time spent away from her paid employment.

As Strauss and his colleagues discovered in their original psychiatric hospital fieldwork, a characteristic of the system of mental health work is the variety of care and treatment approaches encountered within it, often reflecting different ideological positions on the part of practitioners (Strauss et al., 1964).

Insistence on the importance of physical treatments in Jim's case, for example, reflected the occupational background of his principal paid worker, a nurse. Whilst Jim's neighbours provided social support, were alert to signs of deteriorating mental health and negotiated enhanced roles in connection with medication management, their work was not embraced as an essential part of Jim's therapeutic care and treatment *per se*. Although Jim's professional carers uniformly linked his well-being to his adherence to prescribed medication, it was of no more than a practical benefit that these medicines were controlled by a lay worker. However, a very different type of unpaid lay carer work was exemplified in the case of Lenny in Midtown. In Lenny's case the work of family carers was embraced as a central, indispensable, part of his care and treatment. Lenny's principal paid worker prior to his departure from the Midtown CMHT was a MHSW, who – as I have discussed in Chapter 7 above – was able to expand his work to encompass the provision of face-to-face psychological therapies. Part of his explanation for Lenny's difficulties – which had attracted different labels, from depression to substance misuse to personality disorder – was to locate these within the context of Lenny's relationship with his parents. A therapeutic response to Lenny's psychosocial

problems, then, was to purposefully work with him and members of his family. This entailed expectations that both Lenny and his parents would become active collaborators in the work of family therapy.

In the event, this MHSW-brokered plan to engage Lenny's whole family in work foundered in the face of the organisational contingency triggered by this same social worker's decision to leave his post (see Chapter 9 below). However, in the view of Lenny's mother, expressed during an interview conducted in her home in the presence of her son, family therapy had been a particularly helpful response to the complex needs experienced by Lenny, her husband and her:

Mother: We've had problems since Lenny was fourteen, I mean I was getting so frustrated that I was hitting my head against a brick wall. Basically, 'well, he's your problem, you take him home and deal with it'.

BH: So nobody listening.

Mother: No. Exactly.

BH: And saying you've got to sort it out as a family.

Mother: This is it. 'Just do the best you can', like, 'you handle it'.

BH: Was there any particular part of what Keith [*outgoing MHSW*] did that was helpful, because you met with Keith individually didn't you, but then you had these family meetings as well?

Mother: Yeah, well I think it was a case, as I say, it was a case of people beginning to, my daughter, my husband, being able to say what they wanted to say [*recording indistinct*]

[...]

BH: Did Keith make it possible for that?

Mother: Yes.

BH: He did, right.

Mother: Yes.

[...]

BH: So when he was here, when you were all meeting with Keith they wouldn't be shouting, everybody had a chance to say...

Mother: Yes, whatever they wanted to say, yes.

BH: Did that kind of, did that hang over so that after Keith had gone, it had a longer lasting effect?

Mother: Oh yes. Everybody was a lot calmer, especially, as I say, Lenny. I don't know whether it's these new tablets he is on or what, but he is so much calmer than he were round here.

(Interview, Case study subject and mother, Midtown – 17: 369-424)

Family and community involvement in service provision thus exemplified very different ways of participating in care. Some family members withdrew entirely (as in Simon's case), whilst others committed themselves as active participants in formal therapies (as in Lenny's case). Jim's network of care, in particular, stands out as an (unusual) example of care 'by' members of a community, as opposed to just care 'in' the community.

8.5 THE WORK OF SERVICE USERS

The care work that service users themselves engage in is particularly vulnerable to being overlooked or devalued by representatives of paid occupational groups. As Strauss and his colleagues write in the context of hospital care:

Patients, however, are not employees of the hospital and have no status as health professionals or other kind of health workers, and so

they are not easily conceived by the personnel as actually working and certainly not as a literal part of the division of labor [...].

(Strauss et al., 1985, p191)

In participating in decision-making and in adhering (or not) to plans of care and treatment, recipients of formal services are, in reality, intimately bound up in the micro-level division of work. Moreover, in the years which have passed since Strauss and his collaborators made the observation reproduced above, users of services – including users of mental health services – have argued strongly for their particular contributions to be more readily acknowledged, and for paid workers to collaborate with them in more meaningful ways at macro, meso and micro-levels (Campbell, 2005). As I observed in Chapter 3, these claims, allied to notions of consumerism, have been felt at structural context level. Now, in contemporary systems of health and social care work at all organisational levels, more equal partnerships between professionals and users are expected.

Underpinning organised mental health service user advances in this area are jurisdictional claims that the experience of recovering from mental health problems is itself a source of expertise, of different but equal status to the knowledge claims made by professionals (Faulkner and Layzell, 2000).

Drawing on knowledge generated through experience, some have called for a greater appreciation by professionals of the value of user-determined (and often non-medical) micro-level strategies found to be helpful in coping with mental illness. In this way, users have collectively urged expansions to the range of activities accepted as legitimate components of the overall work of

recovering from mental illness. However, tension is always likely where the work of service users runs counter to the work expected of them by professionals. Not complying with professionally determined treatment plans, for example, is liable to result in negative evaluations by paid staff. Moreover, in stark contrast to other areas of health and social care, enshrined in macro-level statute are powers available to mental health professionals to compel people with mental health problems to comply with prescribed plans of care and treatment. Clear options to pursue strategies of non-negotiation are therefore open to paid workers.

The ways in which recipients of health and social services are evaluated by care providers is an area of longstanding sociological interest (Jeffery, 1979; Kelly and May, 1982; Griffiths, 1997; Griffiths, 2001; Shaw, 2004).

Categorisation is a complex process, related not only to the personal characteristics of service users and the content of their activities but also to the context in which their interactions with professionals take place (Kelly and May, 1982). As was demonstrated in the cases of Jim and Simon above, implicit categorisation is also undertaken by family members and other lay individuals, and has significance in informing decision-making on becoming involved in, or abstaining from, caring work.

In mental health settings, 'difficult' patients are often those perceived by staff as fulfilling roles which challenge professional control and competence (Breeze and Repper, 1998). The consequences of being identified as 'difficult' are significant. They can, for example, extend to the complete withdrawal of

services (Repper and Perkins, 1995), or the replacement by paid workers of strategies of negotiation by strategies of coercion (exemplified by the use of compulsory powers). Those rejected by services are often people with 'personality problems' (Repper and Perkins, 1995). Lenny, in Midtown, exemplified these processes. The two MHSWs who worked with him during fieldwork were determined to offer continuous therapeutic care. However, accounts by social workers and Lenny's family, and evidence from written CMHT records, indicated that Lenny's failure to comfortably fit into neat diagnostic boxes or to comply with treatment and to 'get better' had contributed to him receiving a very inconsistent mental health service in the past. His practitioner notes revealed, for example, repeated rejection through discharge by members of the Midtown CMHT and a general failure to formulate a consistent and ongoing plan of care.

Where case study subjects deviated from the work expected of them by professionals they were likely to be negatively evaluated. Conversely, positive evaluations were associated with the fulfilment of roles which centred on compliance with professionally determined treatment plans. The work of service users in relation to the maintenance of their prescribed medication regimes was seen by paid workers as being particularly important, with deviance from prescriptions likely to be perceived as representing a considerable challenge to practitioner authority. Two case study examples illustrate this.

Miriam, in Northtown, was independently described by her CMHN, her MHSW and her GP as being an unusually 'good patient'. These evaluations related not only to her personal disposition, but also to the role which she fulfilled in furtherance of her own care. Miriam's work included keeping her appointments, adhering to her prescribed medicines, and initiating and maintaining additional contact with her paid carers during problematic phases of her illness trajectory. Her interpretations of the nature of her ill health were also consistent with those held by her paid carers. Thus, even though Miriam's unfolding trajectory was one of the most complicated encountered during fieldwork (she had two episodes of acute illness, and was twice admitted to hospital), she was also perceived by paid workers as fulfilling the role expected of her, and was therefore not held responsible for her difficulties. As her GP put it:

GP: No, she's one of those patients who, quite honestly, the hospital clinics, outpatients, psychiatric clinics monitor very well, and when she is admitted she responds very quickly and she goes home able to cope. I would be concerned and I would become more involved if she came home and wasn't coping but she's a model patient in that point of view. She does respond to medication, she does take her medication. No, I don't think we can change very much for Miriam.

BH: Would that make her slightly untypical of people with mental health problems who are on your register?

GP: Oh, without a doubt. No problems with compliance with medication, attendance to outpatients, refusing help. No, Miriam's easy to handle.

(Interview, GP, Midtown – 67: 114-126)

Kerry, like Miriam, was articulate and well-aware of the minutiae of her care plan (part of which she was expected to make a financial contribution to).

Unlike Miriam, however, Kerry was perceived as one of the Northtown

CMHT's more challenging clients. Like Lenny in Midtown, she was described by her carers as having 'personality problems'. Thus Kerry's CMHN, whilst offering a full and flexible service to Kerry, also described her as:

CMHN: [...] very manipulative [...] there were, sort of, lots of suicide threats all the time and stuff like that.

[...]

you know the diagnosis is partly schizophrenia and partly borderline personality disorder, and it's because of that personality disorder, she's, you know, quite manipulative.

(Interview, CMHN, Northtown – 73: 80-85)

During fieldwork Kerry's network of carers were faced with the task of managing her declared threat of suicide. This, as the above data extract suggests, was familiar work to Kerry's carers. Reflecting her status as a challenging user of services, Kerry was not trusted by the professionals working with her as someone who could be safely left with supplies of medication. This led to attempts by Kerry's CMHN to use negotiation strategies aimed at attempting to secure unused supplies of insulin. As this fieldnote extract reveals, however, Kerry was capable of resisting professional exhortations to engage in work characteristic of 'good patients':

I accompany Mo [*CMHN*] on a home visit to Kerry's home. Mo says that the prime reason for this visit is to ask Kerry's permission to remove the quantity of insulin that she has stored, Mo fears in preparation for June [*the time at which Kerry had threatened to kill herself*].

Kerry invites us in. She has rearranged her front room. Kerry sits on a sofa, then Mo on a seat, then me next to Mo. Kerry looks flat, and gives only short responses to Mo's questions. Mo begins by asking what sort of weekend Kerry had:

Kerry: It was alright.

Mo then says:

Mo: The main reason I came round today was to ask if you would let me have the extra insulin that you've been storing.

Kerry: No.

Mo: I want to remove the insulin because we're worried about the extra risk.

Kerry: No.

Mo: Will you at least think about it?

Kerry: No.

Mo: In that case I'll have to write to your GP to tell them that you've stored insulin, and ask them to stop prescribing more.

Mo then asks what Kerry is planning for the rest of the day.

Kerry: Not much. Staying in the house.

Mo and Kerry confirm that they are meeting later in the week, to go out on a visit. Mo and I then leave.

Mo: You have to be able to read Kerry very closely. There's no point in staying for long when she's like that. I'll ring her later, and maybe ask for just half of her insulin.

(Fieldnotes, Northtown – 93: 917-953)

Of particular interest in this data extract is, first, Kerry's exercise of power in refusing to comply with a professionally initiated plan of action. Also of interest is the CMHN's articulated commitment, in the face of Kerry's refusal to play the 'good patient', to the continued pursuit of strategies of negotiation in preference to the use of, or threat of the use of, coercion. As this CMHN stated during this home visit, her strategy for managing Kerry's heightened

risk extended, following this encounter, to negotiating with Kerry's GP to reduce Kerry's access to prescribed insulin (see Chapter 7 above).

8.6 CONCLUSION

This Chapter has focused on the work of marginal professional groups (exemplified by the work of community pharmacists), and on the work of lay carers and service users. Despite the importance attached by mental health professionals to medication adherence, the actual and potential contribution of pharmacists was largely ignored by other paid workers. Lines of impact were important here, with macro and meso-level structural factors inhibiting more integrated working relationships from developing. The privatised character of high street pharmacy services contrasts sharply with the publicly funded character of other health and social services care providers. One pharmacist's view gained during fieldwork was that the employment status of members of her profession was negatively perceived by other workers, and acted as a significant barrier to more open and effective interactions. Inhibiting micro-level continuity of pharmacy services, in addition, was the freedom of service user case study subjects to take their prescriptions, in a marketised system, to any high street pharmacy. This was significant in Kerry's case in Northtown.

Significant micro-level work was undertaken by paid non-professional health and social care workers, with these practitioners enjoying high levels of face-to-face contact with case study subjects. As with the work of professional groups (see Chapter 7 above), macro and meso-level structural context factors were significant in shaping enacted roles. Health care assistants could

be mobilised quickly to undertake delegated tasks or to fill gaps in overall care provision left by the withdrawal of services elsewhere. The practical work of HCAs was of particular benefit in accommodating the needs of both Jenny in Northtown and Jim in Midtown. Mobilising a contribution from social care support workers was more problematic, however, reflecting the more obvious financial implications of drawing on local authority-funded services than on health service resources. Meso-level eligibility criteria, interpreted by a Northtown MHSW and purposefully entered into negotiations held for Kerry, thus prevented the provision of additional social support as a response to the management of Kerry's impending crisis. Interactionally, this careful MHSW intervention at this juncture stands as a further instance of the planned staging of negotiations (Levy, 1982), and as an enacted example of the manoeuvring of negotiations to ensure that one agency (an NHS Trust) assumed responsibility for funding additional care provision rather than another (a Local Authority). As played out in Kerry's case, the differences in financial arrangements for the resourcing of 'health care' and 'social care' thus created an unhelpful perverse incentive to meeting needs in a less-than-ideal way (Muijen and Ford, 1996; Allen et al., 2004a).

The use of contracts specifying the content of social care support work also exerted a patterning, 'lines of impact', effect on the work of Kerry's local authority-funded support worker. Her work also exemplified, however, the way in which roles are realised in particular contexts, with her face-to-face contribution growing as the relationship between her and Kerry evolved. Significantly, as low-status and relatively marginalised groups, the contribution

of care assistants (like that of pharmacists) was always liable to be overlooked during interprofessional and interagency decision-making. This was consequential in Simon's case in Midtown, where a notable absence from both of his observed care planning meetings was the day centre worker helping Simon to develop essential practical skills in preparation for his move to more independent living.

Community care has always relied on the contribution of unpaid lay carers, and different modes of caring involvement were exemplified by unpaid workers in this study. Jim was a highly unusual service user in that he benefited from an extensive network of informal care. Lay care involvement in his case had evolved over a period of years, and during fieldwork active strategies of negotiation were pursued by paid and informal workers during their frequent contacts. Jim's principal lay carer, a shop-owning neighbour, had come to fulfil a central role in sustaining Jim in his own home. She undertook practical tasks, notably supervising Jim's medicines, and with others in the locality took on the role of informal mental health assessor. However, limits to the contribution of lay carers were also revealed in Jim's case. Mobilising statutory services in response to a deterioration in Jim's state of health required considerable effort and resourcefulness on the part of key members of his informal care network, and revealed a professional unwillingness to accommodate changes in the social role of unpaid lay carers (Allen, 2000b). In a second case study, centred on Lenny and his care, a different mode of lay work was examined. For Lenny and his parents, participation in family therapy was seen as a key part of his care plan, in

contrast to the non-essential (though practically very helpful) role played by lay carers in Jim's case.

Finally, the work of service users – a contribution which is often not thought of as being 'work' at all – has been considered in this Chapter. The work expected of case study subjects by paid practitioners included adherence to professionally determined plans of care. Being a 'good patient' (exemplified by Miriam) was associated with medication compliance, keeping and participating in appointments, and alerting paid carers to significant events such as deteriorating mental health. Not all of the service user case study subjects were 'good patients' in this way, however. Kerry exerted power by challenging professional competence and control. She both threatened to engage in high-risk activities and then refused to fulfil the role of compliant service user by handing over stored supplies of medication. Like Lenny in Midtown (whose historical trajectory had included numerous rejections by members of the CMHT there), the suggestion by professionals that Kerry's difficulties were related to a disorder of her personality was associated with her being identified as being a particularly 'difficult' user. In Kerry's case strategies of negotiation were pursued by paid workers as a response to her refusal to hand over her medication. However, it is in circumstances such as these that mental health professionals will sometimes resort either to strategies of coercion (by, for example, using or threatening to use compulsory powers), or will reject service users altogether by discharging them from their care. This, for example, was what had happened to Lenny prior to fieldwork commencing.

Taken together, this and the previous Chapter have drawn on case study data to examine the work of the principal paid and unpaid workers contributing to service user care. Lines of impact running from macro to meso to micro-level have been explored, with the contributions of different groups of worker being clearly set in the particular contexts in which these were observed, reported or documented. Given the contested character of the mental health field, the wide range of dispersed workers with diverse contributions to make and the fluidity of occupational roles and responsibilities, these findings demonstrate the importance of negotiations as a means of ordering the work associated with micro-level care provision. In the final data-based Chapter which follows, my focus shifts from the investigation of worker roles and responsibilities to an examination of the management of significant events. Individual and organisational contingencies with implications for case study subjects caring trajectories are explored.

9 MANAGING TRANSITIONS

9.1 INTRODUCTION

Earlier Chapters in this thesis have demonstrated the degree to which systems of mental health work at macro and meso-levels are in transition. In this Chapter I return to the theme of transition, but this time in the context of the micro-level organisation and provision of services. This is an important area for investigation, with improving the management of transitions now identified as a priority area for mental health services development in Wales (Wales Collaboration for Mental Health, 2005). In contrast to the focus on *people* in Chapters 7 and 8, this Chapter achieves its aims by drawing on case study data to support an examination of *events* (such as entering hospital and returning home), and actions in response to these.

The Chapter is underpinned by Strauss and colleagues' concept of 'trajectory', initially introduced in this thesis in Chapter 2 above (Strauss et al., 1985).

'Trajectory' refers both to the unfolding over time of the experience of illness, and to the negotiated and non-negotiated organisation of work associated with this. Strauss and his associates introduced the term in the particular context of hospital-based care, and in *Social organization of medical work* they illustrate their concept with richly detailed descriptive accounts of individual trajectories unfolding. Whilst acknowledging the usefulness and novelty of the 'trajectory' idea – and particularly its value in focusing attention on the needs of recipients of care and the work involved in meeting these, rather than on the professions – Allen and colleagues have also attempted a

recent theoretical refinement, drawing on data generated in the study from which this PhD's design and methods were replicated (Allen et al., 2004b). Underpinning this has been Allen et al.'s intention to render the original 'trajectory' concept less of an illness-oriented, medicalised, one, and to increase its utility in underpinning analyses of combined health and social care provision across both hospital and community settings. Also driving this refinement has been an attempt to make clearer the complex relationships between trajectories and the organisational contexts within which these unfold. For the purposes of sustaining the analysis developed in this Chapter, however, I have elected to use the 'trajectory' concept without Allen and colleagues' theoretical additions. In order to illuminate the links between trajectories and the wider contexts in which they unfold I focus, as in earlier Chapters, on the significance of macro-to-meso-to-micro 'lines of impact'. I also extend the idea of trajectory to explicitly encompass analyses of work undertaken to meet both health and social care needs, and work undertaken across the hospital/community interface.

Whilst changes in the organisation of care can reflect predicted and unforeseen transitions in the health status of users, Strauss and his associates observe that individual trajectories are also sensitive to organisational contingencies not directly related to the health experience *per se*. System characteristics, such as the necessity of service users moving from one part of a system to another (for instance, from hospital to community care), and the existence of multiple occupational groups each with different cultures and working practices, can exert powerful influences on individual

trajectories. Previous studies have demonstrated, for example, the impact of 'system induced setbacks' on the experience of recovery from illness (Hart, 2001), and how the service user experience of care and recovery is intimately related to the micro-level organisation of services (Allen et al., 2004b). This Chapter builds on work of this type by examining, at micro-level, two types of critical event with implications for the unfolding of trajectories. First are events with their roots in the actual health and illness experience, exemplified by the recurrence of phases of ill health and subsequent actions taken by workers in response. Second are events unrelated to the experience of illness but having, instead, entirely organisational origins. Examples of trajectory-changing organisational contingencies of this type include the departure of key workers and the arrival of new staff. In events of both type, change can reverberate widely. Just as change in an individual's health status can trigger changes in the micro-level organisation of work, so too can organisational contingencies precipitate change – for better or worse – in health status.

Strauss and his associates observe that trajectories can be relatively straightforward or relatively problematic (Strauss et al., 1985). Trajectories of both types were encountered in this study. Jenny in Northtown, for example, enjoyed relative stability in her mental health throughout her participation in the study. In addition, no major organisational or personnel changes impacted on the unfolding of her trajectory. In contrast, at the point of his entry into the study Jim in Midtown was engaged in a transition back to his home following an admission to hospital negotiated as an organisational response to a sharp deterioration in his mental health. Particularly complex was Miriam's

trajectory. She had two mental health crises during her participation in fieldwork, and had two separate admissions to two different hospitals. I particularly focus in this Chapter on the unfolding of complex trajectories – including those of Miriam’s and Jim’s – with the aim of drawing general lessons for the management of significant micro-level transitions.

9.2 COMPLEX TRAJECTORIES AND HEALTH-RELATED CONTINGENCIES

9.2.1 Mental health crises: negotiating transitions from home to hospital

Many people with severe mental health problems experience periods of crisis, in which their usual capacity to cope is overwhelmed (Perkins and Repper, 1996). Different people experience crises differently, though often thoughts, emotions and behaviour are all affected. Miriam, in Northtown, was prone to severe fluctuations in her mood, and was vulnerable to acute, disabling, depression and associated auditory hallucinations. Miriam was particularly sensitive to external stressors, which were liable to place strain on her ability to cope effectively. A particular stressor for her was the status of her tenancy. As I observed in Chapter 6 above, whilst Miriam’s principal paid workers were able to respond to deteriorations in her mental health they were less able to negotiate a longer-term, proactive, strategy to alleviate her ongoing concern that she was at risk of losing her home.

During her six month participation in the study Miriam experienced two crises, the first happening in the weeks immediately following her inclusion in the project. In the course of an interview conducted in her home following its resolution, Miriam clearly identified her anxiety over her housing as the trigger for her breakdown and her subsequent overdose. Whilst housing concerns were an important precipitant of Miriam's worsening health, a focus on the study of trajectories and the unfolding of trajectory phases requires attention not only to the causes and experience of illness *per se* but also to the organisation of work associated with attempts to manage this.

The lines of impact running between macro, meso and micro-levels exert a powerful influence on attempts to manage, or 'articulate' (Strauss et al., 1985), problematic trajectories. For example, the options available to Miriam's paid workers as responses to her evolving crisis were clearly framed by meso-level structural factors. At meso-level the Northtown system of mental health work encompassed the provision of services through locality-based CMHTs, and the provision of inpatient mental health care provided in two separate hospitals. Whilst Northtown's health and social care agencies were piloting an extended hours CMHT, in order to better respond to service users' fluctuating needs, the Northtown CMHT operated a strict nine-to-five, five day a week, service (see Chapter 5). Although efforts to 'modernise' services were leading to the development of community-based alternatives to hospital admission, during fieldwork Northtown agencies had not yet established any crisis intervention and home treatment teams. Important meso-level differences in the division of psychiatric labour in the two Northtown psychiatric inpatient

services also existed. Psychiatric care in the wards located in Northtown General Hospital was provided by academic psychiatrists whose responsibilities did not extend to the provision of care to people in their own homes. As I observed in Chapter 7 above, this meso-level characteristic carried the potential for creating micro-level discontinuities in the provision of psychiatric services.

The task of negotiating responses to Miriam's deteriorating health fell to her CMHN. Her actions encompassed a first attempt to resolve Miriam's longstanding housing concerns by introducing Miriam to a solicitor able to clarify the details of her tenancy. This CMHN also drew on her practice knowledge and skills (she had completed a post-qualifying course in evidence-based interventions for people with severe mental health problems) to engage in a more active monitoring of Miriam's state of health, to negotiate urgent meetings with her staff grade psychiatrist colleague, and to assume a role as an informal prescriber of medication. These actions were recorded in her contemporaneous CMHT notes thus:

12-09-01: Home visit. Remains fairly stable. Increasing stress from uncertainty of housing issues causing M lack of sleep. Takes zimovane [*sleeping tablet*] on and off. Normalised situation.

Plan:

1. Weekly monitoring whilst under stress.
2. CAB for housing help.
3. Has solicitor – advised to contact, and let him worry as he's paid to do it.
4. Visit next week.

27-09-01: Home visit. M is getting increasingly wound up by housing issues. Is hearing the voice of the man upstairs – telling her "we'll get

you out". Slightly paranoid – has that stare which I feel is an EWS [early warning sign].

28-09-01: Took shopping to Asda. M still very worried about future – hearing voices of chap upstairs and this voice is becoming increasingly nasty.

Plan:

1. Appt with dr. next week.
2. Suggested increasing zimovane over next few days, as only 2/3 hours sleep each night.
3. See Monday first thing.

(Miriam's Northtown CMHT case notes – 94: 82-104)

Whilst working hard to accommodate Miriam's needs, in the event within existing resources this CMHN was unable to marshal a sufficient community-based response to manage Miriam's difficulties. Two days after making the last entry in her notes above – on a Sunday, when her usual network of carers was unavailable – Miriam took an overdose of her sleeping tablets. She then herself contacted an on-call CMHN (who she did not otherwise know), using an emergency on-call telephone number given to her by her regular CMHN. This on-call CMHN arranged for Miriam to be taken from her home to the Accident and Emergency Department at Northtown General Hospital, where staff, in turn, arranged for her to be transferred to the care of workers based in a specialist poisons inpatient service based in the grounds of the Trust's South City General Hospital.

On her return to work the following Monday morning, Miriam's CMHN made contact with the liaison mental health nurse based in the poisons service. Having determined that Miriam was at no physical risk from her overdose, negotiations between community nursing, hospital nursing and psychiatric

staff centred on effecting Miriam's cross-town transfer back to Northtown General Hospital for admission to the inpatient psychiatric unit located there. This was a ward Miriam was familiar with, having had hospital admissions there previously.

According to the account given by Miriam herself on her return home, and from the ward-based nurse who acted as Miriam's 'named nurse' during the period of her admission to this psychiatric ward, the management of this critical, hospital-based, phase in Miriam's trajectory was helped considerably by staff knowing Miriam and her particular needs, and by Miriam knowing them. However, even though the formal responsibility for caring for Miriam had now passed from the Northtown CMHT to colleagues in Northtown General Hospital, Miriam's main paid community-based carer (her CMHN) still had work to do to smooth Miriam's transition from home. Northtown CMHT notes record how this CMHN took on the responsibility to visit Miriam the day after her admission, and manage the practicalities associated with her sudden transition from home to hospital. This included obtaining Miriam's key, collecting clothes from her home, and arranging for her cat to be taken to a cattery.

Negotiating the transition from care in the community to hospital care is always a significant phase in any trajectory, demanding considerable individual and organisational responses. During this first admission for Miriam, the management of her transition was influenced by a number of factors. First, Miriam's CMHN accurately anticipated Miriam's likely need for additional

support. Ideally, Northtown's out-of-hours support services would have included the provision of extended community-based care for people in crisis (a service of this type has, since the completion of fieldwork, been introduced in the Northtown locality). However, during fieldwork Northtown agencies were able only to provide a minimal on-call CMHN service during weekends. The availability of this nonetheless proved critical for effecting Miriam's initial transfer to hospital. In response to Miriam's call to this service, a nurse (who did not otherwise know Miriam, and who in the absence of a system of electronic records would have known little of Miriam's past and recent trajectory) managed her admission to hospital. From her own account Miriam clearly benefited from being admitted, one day after her overdose, to a psychiatric ward in which she was well-known. Her transition was also helped by having a CMHN who was open to working in a flexible way, exemplified by her willingness to secure the care of Miriam's cat and to bring her fresh clothes to wear.

Having formally returned home after this first admission, Miriam was again admitted to hospital during the time that she participated in this study. Psychosocial stressors, again relating to housing, were implicated. In the time between these two crises, efforts were made to draw on additional, highly specialised, services to accommodate Miriam's complex needs. However, even the CMHN's efforts in enlisting the help of a solicitor (to fulfil a very particular function in the micro-level division of labour, namely to clarify the terms of Miriam's tenancy) proved insufficient to prevent this second crisis being reached. Believing, again, that Miriam's needs were too complex to be

met by community-based carers given existing meso-level patterns of service provision, her CMHN sought a psychiatrist's opinion of the appropriateness of Miriam being admitted to hospital. Again meso-level structural factors entered into the negotiation context; in Northtown, psychiatrists alone had the jurisdictional authority to gatekeep access to scarce inpatient beds. However, on this occasion, no CMHT-based psychiatrist was available to provide an urgent home-based assessment or to authorise the use of inpatient resources. The CMHN was therefore obliged to drive Miriam in her own car to Northtown Psychiatric Hospital's emergency clinic, where a daytime assessment service was provided.

Negotiating Miriam's admission to hospital as a response to this second deterioration in her mental health proved more problematic than had been the case previously. Meso-level resource constraints directly entered into the negotiation context, and limited the options open to Miriam's CMHN and to the on-call psychiatrist who met with Miriam in the emergency clinic and who agreed that her admission to hospital was warranted. Reflecting UK-wide patterns of heavy demand on inpatient psychiatric hospital facilities (Ford et al., 1998), no beds were available either on the ward in Northtown General to which Miriam had previously been admitted or the ward in Northtown Psychiatric Hospital which served the locality in which Miriam resided and with which the Northtown CMHT also linked. Miriam therefore needed to be admitted to a ward on which neither nursing nor medical staff knew her. As Miriam's CMHN indicated, admitting Miriam in these circumstances demanded considerable negotiation between her and inpatient nursing and medical

colleagues, and included enlisting the help of a hospital-based psychiatrist to take the 'flak' associated with seeking access to a scarce bed. Miriam's admission also triggered a significant, organisationally generated, change in the trajectory of another, unknown, inpatient:

CMHN: [...] before taking Miriam up, [...] I did ring Green ward [*the ward to which Miriam had previously been admitted*] to see if they had a bed, because I could have just taken her straight there, but they didn't. But they would have had her, so I thought, 'oh, I'll ring Yellow ward [*the ward in Northtown Psychiatric Hospital the Northtown CMHT also linked with*]', and they didn't have a bed, so hence I thought, 'well, just in case they say, the shift coordinator says, you know, 'no, this woman can't come in, we don't have a bed', she was suicidal, I'd get the doctor. Last time we had a doctor, make them take the flak, but it's a very nice doctor.

[...]

And there were no beds, there were no beds in the hospital and there were none in the county, so it went up to the consultant, who is Dr Eliot.

BH: On call consultant?

CMHN: On call consultant, and I think she kicked somebody off another ward and Miriam went in.

BH: Right. Right.

CMHN: So I said, 'thank you, Dr Eliot'!

(Interview, CMHN, Northtown – 69: 240-289)

This CMHN's appeal to a medical colleague to strengthen her claim, on behalf of Miriam, to access a scarce inpatient resource represents a further example of the careful staging of negotiations with the aim of securing a favoured outcome and accommodating need. However, these negotiations still led to a less-than-ideal conclusion, with Miriam's transition from home to a hospital setting which was unfamiliar to her and where she was not known to staff

proving a considerable hindrance to her care. Following her return home, she and I met for a further interview. In her account Miriam described some of her most basic needs not having been met during this time:

BH: [...] you've not been to that ward before, though?

Miriam: No, never.

BH: No. And you didn't know the nurses and the doctors there?

Miriam: No, I didn't, no, no.

[...]

BH: So Mo [CMHN] and you together went to hospital, met a doctor in the emergency clinic, there was no bed in the morning, but after Mo had returned from having her lunch, the doctor had found a bed but not on the ward that you normally...

Miriam: No.

BH: No, well not even in the same hospital that you normally go into? What happened when you were in hospital?

Miriam: I'm a veggie and they kept feeding me up meat. They said, 'the last veggie's just gone'. He wasn't a vegetarian, they, they were just having it, the patients, for devilment, so I wouldn't have it knowing I was vegetarian. That's what annoyed me.

BH: Presumably that's not happened when you've been at Green ward?

Miriam: No, not in Green ward.

BH: Because they know you there.

Miriam: I know. And they've had to do diabetics as well as being a vegetarian, you see. It's a very difficult thing to do.

BH: But they've always got that...

Miriam: They've always got it right there, always got it right. This last, twice I've been in Green ward, 'it's Miriam coming, veggie, diabetic', they put that down straight away and there's no problems.

BH: Because they know you.

Miriam: They know me.

BH: But that didn't happen on this occasion?

Miriam: Oh gosh, no, no.

BH: What about the fact that you didn't know any of the doctors or the nurses on the ward, what impact did that have?

Miriam: Nothing much, they hardly spoke to me there [...].

(Interview, Case study subject, Northtown – 72: 37-145)

Miriam's community consultant psychiatrist, too, was able to give an account of the disadvantages of Miriam being cared for as an inpatient in a non-locality ward. Her account suggested that Miriam was effectively lost to her usual network of carers during the first three weeks of this second admission, with neither hospital nor CMHT workers informing her of Miriam's crisis during this time. Only when Miriam was ready to return home in the opinion of the ward's junior doctor was this community-based consultant told of her admission.

9.2.2 Mental health crises: managing compulsory admissions to hospital

During fieldwork two other case study subjects also had admissions to hospital: Jim and Lenny, both in Midtown. Jim's transition to hospital is of particular analytic interest for two reasons. First, his admission exemplifies how, in complex micro-level systems of care, large numbers of paid and unpaid workers located in dispersed hospital and community settings may be required to work flexibly together over extended periods to negotiate responses to crises. Second, Jim's admission exemplifies a particular use of

power in mental health services, reflected in the transition by professionals from the pursuit of strategies of negotiation to strategies of coercion.

Jim joined the study after a compulsory admission to hospital, organised under a treatment section of the Mental Health Act 1983. A first fieldwork focus in Jim's case was the generation of retrospective accounts of the management of this transition, and the identification and analysis of written records produced at that time. As I made clear in Chapter 8 above, first to notice a deterioration in Jim's mental health was his main lay carer. She, however, needed to mobilise other members of the community to assist her in her negotiations with CMHT workers. Within Midtown CMHT, in the absence of Jim's care coordinator (a nurse), the responsibility to complete an urgent assessment of Jim's mental health fell to a social worker, who happened to be the team's duty approved social worker (ASW) that day, and a community mental health nurse colleague. The MHSW's retrospective, interview-generated, account of her work at that time revealed her orientation to the importance of medication compliance, with her explanation of Jim's deterioration – like that of Jim's CMHN – being linked to his reported erratic use of prescribed drugs.

Even at this early period in the management of Jim's crisis, two CMHT-based workers and a larger number of concerned members of the community had already become involved in influencing the course of Jim's trajectory. Following their home visit, which confirmed lay worker estimations of Jim's deteriorating wellbeing, the MHSW and CMHN together negotiated the

involvement of a third paid worker: Jim's hospital-based consultant psychiatrist. Here, lines of impact proved significant, with the meso-level characteristics of service organisation in Midtown serving to constrain the options open to CMHT staff. Not having psychiatrists based in the Midtown CMHT as full members of the team was associated with a hospital-centred approach to psychiatric practice (see Chapter 7 above). Rather than brokering a visit by a psychiatrist to Jim in his home, CMHT workers at this juncture were required instead to settle for an urgent clinic-based appointment. This Jim agreed to, and was driven later that day to Midtown Psychiatric Hospital by the MHSW, in her own car, with the CMHN accompanying.

Whilst strategies of negotiation had been pursued until this point, once in the hospital setting these were swiftly replaced by strategies of coercion. The retrospective, interview-based, character of data relating to this critical phase makes it impossible to recreate exactly the processes of decision-making which would have taken place. The account given by Jim's psychiatrist, however, suggests a brief period of negotiation between the three principal paid workers leading to a swift decision to use powers enshrined in statute at macro-level to compel Jim to enter hospital for treatment:

Consultant psychiatrist: [...] we discussed it, you know. I guess at one level I felt well, heck, this is breaking down, the chances of doing anything very much outside hospital are remote, he will have to come in. So we set up a, the process to assess him, I think, I'm sure he was detained [*under a section of the Mental Health Act 1983*].

BH: He was.

Psychiatrist: I just don't recall Jim ever having come into hospital voluntarily. So yes, that was the process. I mean there was a period of

breakdown with increasing concerns in the community, followed by a decision that we would have to admit him and set up an assessment and due process.

(Interview, Consultant psychiatrist, Midtown – 9: 97-107)

Interactions between members of different occupational groups can assume a particular character when these take place in the context of providing emergency services (Prowse and Allen, 2002). The necessity of safeguarding patient safety, and the need to act in time-constrained conditions, can have consequences for interprofessional negotiations. In the community mental health context, the decision to use a non-negotiable, coercive, strategy to compel a user of services experiencing a crisis to have treatment in hospital is a purposeful, interactive, event. It is also a process which is subject to particular checks-and-balances, in which representatives of key occupational groups are required to interact in highly patterned, temporally sequenced, ways.

In Jim's case, practitioner knowledge of his historical trajectory was an important factor entering into the negotiation context and influencing professional decision-making at this time; this is implied in the psychiatrist's comment reproduced above that Jim had never voluntarily entered hospital in the past. Meso-level features of the Midtown system of mental health work were also significant. It is conceivable that, for example – as with Miriam in Northtown – a different range of options available at meso-level, such as the provision of intensive home care and treatment services, may have influenced workers to embark on a different course of action at this point in order to accommodate Jim's needs.

Once professionals begin to negotiate, between themselves, a plan to pursue the use of compulsory powers a highly structured set of tasks typically follows. Reflecting their interoccupational jurisdictional settlement, particular actions in particular sequences are expected of both medical practitioners and social workers. In Jim's case, the decision to use coercive powers created an initial task for his psychiatrist, who immediately following his meeting with Jim completed the necessary legal document formalising his recommendation for Jim's admission to hospital for the purpose of treatment. On this first day, whilst this consultant completed his paperwork and drew in other professionals to help manage Jim's trajectory (by contacting nursing colleagues to secure a bed), the MHSW and CMHN together drove Jim back to his home to collect some of his personal effects. The MHSW was then required to open negotiations with a further professional, this time a GP, whose independent assessment and recommendation was also required before Jim could be formally admitted to hospital.

The social worker, one of her MHSW colleagues, hospital nurses, the consultant psychiatrist, a GP and Jim himself were all required to undertake work associated with this compulsory hospital admission during a second day of activity. This began with the MHSW who had, the day previously, been the Midtown team's duty ASW arriving with a social work colleague at Jim's home with the purpose of meeting with a GP. According to the ASW's retrospective account, this part of managing Jim's trajectory was complicated by the fact that the GP – whilst being a member of the primary health care team with

whom Jim was registered – did not personally know Jim. Nonetheless, it is GPs who have the particular jurisdictional authority to collaborate with psychiatrists and social workers in order to progress decisions on the use of sections of the Mental Health Act 1983, and this GP was reportedly sufficiently concerned by Jim's speech and actions, and sufficiently convinced by reports of Jim's past trajectory, to undertake the task of making his recommendation for Jim to be compulsorily treated.

Once all parts of the Mental Health Act admission application process had been completed by the psychiatrist, GP and MHSW, Jim – with his necessary personal belongings – had physically to be transported back to hospital. As a newly sectioned patient, Jim's status had changed sufficiently for the MHSW to no longer feel it appropriate for her to personally drive Jim to hospital in the way she had the day before. Negotiating transport by ambulance was less than straightforward, however. National blockades of petrol terminals by fuel protestors (a transient, but significant, macro-level contingency) delayed the arrival of an ambulance for two hours. Later on that second day, with Jim finally in hospital, the MHSW completed a further statutory task by calling Jim's stepson in his Mental Health Act-defined capacity as 'nearest relative'. He informed her that he no longer felt able to be involved in Jim's care. This social worker's final act to complete Jim's transition to hospital (still acting on a duty ASW basis) was to make telephone calls to negotiate the suspension of Jim's social care package, specifically his home care and meals-on-wheels.

This critical juncture in Jim's trajectory, beginning with his principal lay carer identifying a deterioration in his mental health and ending with a final key conversation between a MHSW and local social care providers, unfolded over a seven day period. One principal lay carer supported by an unknown number of others, one consultant psychiatrist, two MHSWs, one CMHN, one GP, one ambulance crew, one family member, an unknown number of hospital-based nurses and junior doctors, a manager who would have scrutinised the legal documents associated with the compulsory admission, and, of course, one service recipient, were all involved at various points throughout this process.

9.2.3 Negotiating transitions from hospital to home

Just as entering hospital is a significant and often complex, worker-intensive, phase in any trajectory, so too is preparation for, and accomplishing, the transition back home again. Common hindrances to effective management of this key juncture include inappropriately early or inappropriately delayed discharge, or discharge effected in the absence of adequate community resources (Glasby and Lester, 2005). In Miriam's case, preparation for her return home from her first admission was helped considerably by her CMHN maintaining contact with her and with hospital staff during her stay in Northtown General. During periods of leave, designed to bridge the transition between hospital and home, this CMHN also resumed contact with Miriam in a community setting. However, meso-level resource constraints directly entered into Miriam's micro-level negotiation context towards the very end of her inpatient stay, with negative consequences for her care. Six weeks after her entry into hospital a formal discharge planning meeting was arranged. This

should have provided the opportunity for final negotiations involving Miriam and her hospital and community workers, and for an effective face-to-face transfer of responsibilities. Pressure on inpatient resources, however, meant that this event did not occur as planned. Faced with 23 inpatients occupying 20 beds, with Miriam's 'leave' bed already having been allocated to another patient, I arrived to observe Miriam's meeting to hear from a member of nursing staff that she had been formally discharged the day before. This unplanned decision to discharge Miriam home had implications for the reestablishment of community services. Miriam's MHSW, for example, had requested notice before Miriam's discharge in order that her social care package could be restarted.

Management of Miriam's trajectory at the time of her transition home was also hindered by the meso-level organisation of services provided by psychiatrists. In Chapter 7 above I drew attention to the division of labour between academic-oriented and NHS-oriented psychiatrists in Northtown. Whilst in her own home Miriam received services from psychiatrists located in the Northtown CMHT. However, with her admission to a ward in Northtown General the responsibility for her psychiatric care shifted to an academic clinician. In his interview-generated account he was highly critical of the hindrance to the effective management of transitions from hospital to home posed by community-based psychiatrist colleagues failing to engage in negotiations. Whilst during this particular six week admission little in Miriam's care and treatment changed, during her previous admission to this ward major

adjustments to her medicines had been made. As the academic psychiatrist put it:

Hospital based consultant psychiatrist: [...] I'm leaving this job in despair about this, I have never managed to bring in one of my colleague consultants...

BH: From the community.

Psychiatrist: ...from the community to any of our meetings before discharge, even though we invite them, you know, religiously.

BH: Yes. Yes.

Psychiatrist: Because we feel that, you know, we have to hand over, and if they have some views about, you know, why we put people on some medication then that's the time to discuss it so that, you know, the changes are not introduced after that.

[...]

We understand that they have a heavy workload outside so, you know, we don't ask them to come all the time. CPNs come here on a weekly basis, OK, and we relay information through the CPN to the community team, but for the consultant, you know, we only want them to come once, at the end, hand over the medical thing. But it doesn't worked, hasn't worked so far.

(Interview, Hospital based consultant psychiatrist, Northtown – 62: 223-246)

For Miriam's CMHT-based consultant psychiatrist, the arrangement whereby service users admitted to Northtown General Hospital lost contact with their usual psychiatrist was also highly unsatisfactory. This she clearly linked to a combination of macro and meso-level structural factors. First was the requirement for research and teaching psychiatrists to be provided with opportunities to engage in clinical practice. Second was the high level of mental ill health experienced by members of the community which she and her Northtown CMHT colleagues served. Recognition of this at meso-level

had resulted in an additional linked ward being made available to serve the population living in the Northtown CMHT's catchment area. This was the ward to which Miriam had been admitted during her second hospital stay. Whilst the Northtown CMHT thus benefited from access to additional inpatient resources, the trade-off for this benefit was discontinuity of psychiatrist care.

In Jim's case in Midtown, his transition home following his compulsory admission to hospital exemplifies – as did his admission – how complex and resource-intensive the management of critical phases in trajectories can be. His discharge home also exemplifies the flexible role that hospital-based workers can fulfil in effectively bridging the gap between institution and home, and in accommodating users' changing needs. First, preparation for Jim's discharge was the single event in this study which drew on the contribution of an occupational therapist (OT). Her clearly focused task was to assess Jim's daily living skills, and particularly his ability to cook. This she did using both hospital OT facilities, and by accompanying Jim to his own home and observing his use of kitchen equipment.

This OT's report, along with other reports, were brought to Jim's ward-based discharge planning meeting. A number of key people were present at this event, which took place in the week prior to Jim agreeing to join the study: Jim himself; his CMHN/care coordinator; the ASW who had been involved in admitting Jim to hospital; and Jim's consultant psychiatrist. Once the formal decision had been made to effect Jim's transition back to his home, more micro-level negotiations were needed to make this a reality. Jim's community

nurse agreed to resume his role as care coordinator, and ward staff initiated, by telephone, the restarting of Jim's home care package. In Chapter 8 above I drew attention to the commitment to flexible working exemplified by nurses; this approach to nursing work was again demonstrated in the context of managing Jim's transition home. Considerable negotiation and flexible working was needed on the day of Jim's actual discharge, not least because his initial supply of medication had not been prepared by the hospital's pharmacy in time for Jim's departure. Flexible working by the ward-based nurse who had participated in negotiations around Jim's discharge made Jim's return home possible. Both she and Jim's CMHN indicated how she had physically taken Jim's medicines to his home on the day of his discharge after her shift had finished.

Trajectories, then, are liable to evolve in complex ways in response to health-related contingencies. Case study data drawn on here demonstrates, however, that the health and illness experience *per se* is only one factor implicated in shaping the course of a trajectory. The actions of workers in response to a service user's fluctuating state of health are also critical. The options to act open to workers, in turn, are framed by macro and meso-level structural factors entering into negotiation contexts. For example, faced with evidence of rapidly declining mental health in both Miriam's and Jim's cases, paid workers were obliged to negotiate access to the only services they had recourse to in these circumstances: hospital care. As in Miriam's case, health-related and organisational contingencies can combine together to make for particularly problematic trajectories. She, for example, entered hospital on the

second occasion as an organised response to evidence of her worsening health. Organisational contingencies – in this instance, a shortage of beds and the necessity for Miriam to be admitted to an unfamiliar ward – further complicated an already-complex trajectory.

The hospital admission and discharge events analysed here all shared their origins in case study subjects' experiences of ill health. Fieldwork in this study, however, also generated evidence of trajectory-altering contingencies entirely unrelated to the health experience. I turn now to an analysis of these.

9.3 COMPLEX TRAJECTORIES AND ORGANISATIONAL CONTINGENCIES

Strauss and his associates are clear that organisational, work-related and biographical contingencies have the potential to alter the course of trajectories, in addition to contingencies stemming from the health and illness experience (Strauss et al., 1985). Here I draw on case study data to examine the micro-level impact of organisational transitions where the origins of these do not lie in attempts to manage episodes of ill health. Key events analysed include the departure of significant members of micro-level networks of care, and the arrival of new staff as replacements. The implications of transitions of this type are analysed in the context of services provided to two people: Lenny in Midtown, and Kerry in Northtown.

Systems of mental health work are vulnerable to high levels of personnel transition. The loss of key staff, and a consequent absence of leadership, has

already been discussed as having been a major barrier to effective interagency working at meso-level, in Midtown in particular (see Chapter 5). Recruiting and retaining mental health practitioners continues to be a UK-wide challenge (Department of Health, 2001b; Wales Collaboration for Mental Health, 2005). Heavy workloads, coupled with the inherently stressful character of engaging in mental health work (Edwards et al., 2000), contribute to high levels of staff turnover. Where people are cared for by a large number of workers – as people with severe mental health problems, exemplified by the six case study subjects, often are – personnel changes within micro-level networks of care are likely to be encountered relatively frequently.

In Midtown, Lenny's first care coordinator was a MHSW, whose role involved working with people who, like Lenny, had substance misuse problems. The identification of a social work position dedicated to the provision of services to people with alcohol and drug-related difficulties was Midtown Local Authority's meso-level response to the needs of this growing population. In the particular Midtown context this MHSW was able to expand his work to encompass social care management and, unusually, the provision of face-to-face therapies (see Chapter 7 above). However, this same MHSW also planned to leave his post (and the profession of social work) during the period of Lenny's involvement in the study. During this period, the clinical psychology assistant working with Lenny also planned to leave his post at Midtown Psychiatric Hospital for promotion elsewhere.

The imminent loss of the two mental health workers who knew Lenny and his family best was a considerable source of micro-level system disturbance, with clear implications for the unfolding of Lenny's trajectory. The outgoing MHSW, for example, had brokered a plan of individual and family-oriented therapy which relied for its success on Lenny and his family's engagement with suitably prepared practitioners. In his interview-based account of his work and his planned departure from the team, Lenny's MHSW was clear that this therapeutic plan had not yet been carried out in its totality. Whilst a managed handover of Lenny's care might have helped maintain care coordinator and therapeutic continuity, lack of meso-level resources translated into the lack of an immediate replacement worker. Lenny's outgoing MHSW acknowledged the hindering effect of this for Lenny in an interview conducted in the offices of the Midtown CMHT on his last day in post:

MHSW: [...] when I reviewed the care plan last week I asked Lenny what he wanted and we, and the family, and it was agreed that not to carry on with a case manager would be detrimental because he tends to have a cycle of, of becoming, becoming more socially active, more confident and then having a sort of failure and just dipping again and we want to begin to get, although we're going to have ups and downs, we want to begin to get an upward curve. So I've put that down in the note as well, and really it's up to the team manager to reallocate. It's happened rather quickly. I suppose technically, you know, we could have, well, I mean ideally, it should have been planned and he should have been introduced to the next worker, and that hasn't happened, and that's sad, and that's to do with resources, you know, in terms of time, in terms of numbers of workers, in terms of numbers of clients and that is where, and this is where I find a lot of, on the edges, there's a lot of detrimental effects on the clients really, the under-resourcing.

(Interview, MHSW, Midtown – 13: 527-541)

As anticipated, the departure of Lenny's first MHSW and care coordinator had significant implications for Lenny's trajectory. A new worker could not be

allocated until an additional social worker had been appointed to the Midtown team. In the interim, Lenny and his family had access only to the team's duty system, which existed to provide interventions in urgent situations but which brought no care coordination or therapeutic continuity. It may be significant that, during this period of protracted care coordinator transition, Lenny took an overdose and was admitted briefly to hospital.

On his appointment to the Midtown CMHT, Lenny's new social work care coordinator voiced regret at the lack of opportunity to have met with his predecessor to gather information about Lenny's care in a face-to-face manner. Moreover, by his own account this new MHSW brought to his work a very different set of skills than had Lenny's previous social worker:

MHSW: Now what, 'cause what I, I'm aware that Keith [MHSW who had worked with Lenny and his family] did this family therapy. Now, that's not something I'm trained in, I am a qualified counsellor but I've never done any training in family therapy, and what I need to do is to think about what I feel competent to do in that area if required, and to discuss with Lenny in more, on a one to one basis, about how he sees his needs, and then try and work out what I can do, but I haven't really, you know, I haven't done that yet. That would be my next appointment when I will, when I will see him on his own. So I think that is the kind of important one, really, because this first meeting was just to look at all the bits and pieces and make sure that everything's ticking over and introduce myself to him and his family so they knew who I was and all that kind of stuff and, so the next meeting will be to actually kind of focus in on his actual mental health problem as such.

[...]

But you know family therapy is something I've never done before and, you know, I would have to make an assessment of whether it was something that I could usefully do.

(Interview, MHSW, Midtown – 24: 516-543)

The potential loss of a family therapy service for Lenny and his family – a part of the family's care plan which all had found particularly helpful – was a major hindrance. Whilst this first MHSW had expanded his work with Lenny in an attempt to more effectively accommodate his and his family's needs, his provision of a partially completed family therapy service also demonstrates the dangers inherent when workers expand their tasks into areas for which – should they leave their posts – finding functionally equivalent replacement practitioners might prove difficult.

This social worker loss was compounded by the departure of the assistant psychologist who had worked on a one-to-one basis with Lenny. Lenny, significantly, had formed a good working relationship with this practitioner:

BH: What do you think about Leon [*assistant psychologist*] leaving and...

Mother: ...well, I think that's where it started, because he seems to have got on with him better than with the other psychologist [*the qualified clinical psychologist who had previously worked with Lenny*] who was here, I mean, they seemed to have developed this sort of, well, he was somebody he could talk to, wasn't it.

BH: Yes, you were saying that, weren't you?

Mother: Yeah. He was on his wavelength. He was younger than the other psychologist, he would come down to his own level, you know.

BH: Yes, and you were able to speak to him, and had a good relationship?

Lenny: Yeah.

(Interview, Case study subject and mother, Midtown – 17: 348-362)

A significant meso-level feature in Midtown was the ongoing lack of clinical psychology resources. This made managing the micro-level transition from one psychologist to another impossible following the decision of the assistant psychologist to leave his post. On contacting the psychology team's administrator I was informed that no decision on providing Lenny with further services was likely to be made pending the return from extended leave of the qualified psychologist who had first worked with Lenny prior to the transfer of this work to her (now departed) unqualified colleague.

Staff transitions were also significant for Kerry in Northtown. There, in the middle of the management of the crisis posed by her threat to take her life at a predetermined date in the future, her CMHN and informal care coordinator successfully applied for a more senior community mental health nursing position elsewhere. The timing of this planned departure was critical, and the management of the transition from one worker to another had to be managed with considerable care. Kerry's outgoing CMHN was aware of the trajectory-changing potential her planned departure represented, and of the possibility of this imminent transition negatively contributing to Kerry's health status:

BH: Does Kerry know that you're leaving?

CMHN: No, not yet. I've got to give eight weeks notice. So it'll be a long time. It'll probably be just before she kills herself, so, and it's awful, it's going to be awful in a way because, I mean, that's a real predictor isn't it, suicide, you get used to like, key people, and when somebody gets very desperate or whatever and somebody's not there then that's another, so I don't know, but thankfully you know Sally's [*the Northtown CMHT MHSW who also worked with Kerry*] still involved

(Interview, CMHN, Northtown – 73: 744-751)

As was the case in the management of personnel transitions in Lenny's case in Midtown, effecting a smooth transition of care between Kerry's outgoing CMHN and her replacement proved difficult. The relatively large size of Northtown NHS Trust, and the large mental health nursing workforce it employed, was a significant meso-level factor. Kerry's eventual replacement CMHN was a practitioner already in post in another combined NHS Trust/Local Authority CMHT, who was transferred to work in Northtown CMHT to cover gaps left by departing staff. However, negotiating this arrangement took time, and – as happened in Lenny's case – there was a lack of opportunity for face-to-face interactions between Kerry's outgoing and her incoming CMHNs. This had consequences for the management of Kerry's trajectory. Whilst Kerry's new nurse praised her social work colleague for helping her to develop an understanding of Kerry's needs, it was also clear from my interview with her that in the absence of a protracted handover key information concerning Kerry's risk of self-harm had not been transferred.

Wider lessons can be drawn from the specific organisational and personnel transitions played out in the micro-level context of care provided to Lenny and Miriam. With the exception of self-help (Richards et al., 2003; den Boer et al., 2004), technologically delivered (Proudfoot et al., 2004) and pharmacological interventions (Gray et al., 2003), therapeutic work undertaken in mental health settings is invariably relationship-based. The aims and content of different styles of therapy vary, but the quality of the working relationship between recipient and provider is often held as key to overall service effectiveness (Howgego et al., 2003). High levels of turnover amongst providers of

therapeutic care, exemplified in this study by the loss of key workers in Lenny's and Kerry's cases, are major hindrances to the delivery and receipt of high-quality care. Whilst changes in personnel are to some degree inevitable, transitions of this type can be either well, or poorly, managed. Key respondents in Lenny's and Kerry's cases were clear in their accounts that the absence of periods of overlap between outgoing and incoming workers was a hindrance. Service discontinuity ensued, needs went unmet, and – in Kerry's case at least – critical information was not passed on. Promoting personnel, and therapeutic, stability are therefore important aims for mental health provider organisations.

Even when workers share occupational backgrounds, moreover, they may not share specific sets of knowledge and skill. In such circumstances, workers may not be able to fulfil functionally equivalent roles. This has the potential for disrupting trajectories, as it did in the case of Lenny. In ideal circumstances, the composition of teams, such as the Midtown CMHT, would contain a balance of practitioners collectively possessing the full range of knowledge and skills required to accommodate the needs of their populations served. In reality, where the recruitment of all types of worker is a challenge, this cannot always be achieved.

9.4 CONCLUSION

Here the concept of trajectory has been used to underpin a micro-level, data-based, analysis of transitions, where the origins of these lie in both health-related and organisational contingencies. Unlike in earlier Chapters, this

Chapter has focused on the management of critical events, rather than taking as an analytic starting point the work of representatives of particular groups.

Notwithstanding the emergence of alternatives to institutional care (such as the provision of intensive home treatment services), the psychiatric hospital retains a key place in meso-level systems of mental health work. As was exemplified in case studies completed in both Midtown and Northtown, as organisational responses to periods of mental health crisis workers will often look to hospitals as the most appropriate places within which needs might be best accommodated. Hindering the negotiation and delivery of care across hospital and community interfaces in the case studies completed here were, first, discontinuities in the provision of care by psychiatrists. Lack of opportunities for negotiation – notwithstanding attempts by CMHT workers, such as CMHNs, to bridge the hospital/community divide – made the transfer of responsibility between hospital and community-based psychiatric services an area ripe for improvement.

Resource pressures also directly hindered the provision of care during critical junctures in service users' trajectories. Over-occupancy of inpatient beds contributed to the decision to formally discharge home one service user case study subject before plans could be fully laid for her transition back to the community. Lack of beds for this person during a second admission also meant that she was admitted to a ward where, effectively, she was lost to her usual network of professional carers. Ward staff were unaware of this case study subject's particular needs or of arrangements for her usual care.

Evidence was also generated of factors helping the transition from home to hospital and back again. Lay carers were critical for one case study subject, both in alerting professional workers that action was needed and, as discussed in Chapter 8 above, in assuming an enlarged caring role on the service user's return home. Practitioners also often worked flexibly to bridge the gap between hospital and community services. Examples included transporting service users to and from inpatient settings, arranging for the care of pets during periods of admission and bringing clothes and other personal effects from home. Hospital workers helped effect smoother transitions home by delivering medication to discharged service users after their shifts had finished.

One possible policy and practice solution to the challenge of managing service user transitions across community and hospital interfaces is represented by the setting up of community-based alternatives to inpatient care. Crisis resolution and home treatment teams (Burns et al., 2001), for example, hold out the promise of effectively accommodating needs without triggering the kind of micro-level disruption associated with inpatient admission. However, teams of this type also magnify the number of organisational interfaces encountered in systems of mental health work, and raise considerable system-wide integration issues (Smyth, 2003; Onyett, 2004).

Jim's compulsory admission to hospital and his eventual transfer home exemplifies how complex micro-level systems of community mental health work can become. Lay carers, community and hospital nurses, social workers, a psychiatrist, a GP, ambulance staff and an occupational therapist were all involved in this process. His case also exemplifies the limits of negotiation, and the use by professionals of strategies of coercion. Where use is made of sections of the Mental Health Act 1983, as in Jim's case, sustained work needs to be engaged in – by social workers, particularly – to negotiate the completion of necessary assessments, make transport arrangements and liaise with family members. More than any other type of work observed or reported in this study, the medical and social work tasks associated with the use of compulsory powers revealed a clear orientation to structural constraints. Actions occurred in clear sequences, and drew on the contributions of specific workers in a highly patterned way. This, arguably, is exactly the kind of checks-and-balances approach intended in legislation of this type, which requires purposeful interaction between different constellations of key workers to occur before highly consequential decisions involving deprivation of liberty and compulsory treatment can be made.

Considerable staff turnover was observed during fieldwork. In all cases the transition of service user care from one professional to another could have been managed more effectively. During staff transitional periods in particular, the most knowledgeable person about a case study subject's plan of care was sometimes me, as researcher. Meso-level resource limitations, such as the inability of CMHTs to recruit replacement staff, significantly hindered transfer

of responsibility negotiations. Examples existed of vital information failing to be shared in these circumstances, including plans laid for crisis management. During a protracted handover of care, one case study subject and his lay carers were left with a skeleton service provided through a CMHT's duty worker system, along with the total loss of a psychology service. Longer-term implications for micro-level service provision also followed the departure of key paid workers. Differences in the expertise and practice interests of individual practitioners meant that, even where a worker from one occupational group was replaced by a worker sharing the same occupational background, continuity of therapeutic care could still be disrupted. One case study subject and his lay carers, for example, lost a family therapy service when their outgoing MHSW's replacement (also a social worker) declared himself unprepared for engaging in work of this type.

Whilst recognising that staff turnover is an unavoidable feature in any system of work, it is possible that the characteristics of systems of mental health work make staff retention a particular problem. Mental health work is stressful and poorly understood in the public domain (and indeed, by other health and social care workers). Measures suggested in recent years to improve retention, and thus reduce the meso and micro-level impact of staff transitions, include improving public representations of engaging in mental health work, making workloads more manageable, improving access to education and training, developing practice-based leadership, and improving the remuneration and conditions of staff (Department of Health, 2001b).

These, then, could be macro and meso-level aims for mental health care providing organisations.

10 CONCLUSION

10.1 SUMMARISING THE STUDY

The study reported in this thesis set out to investigate the organisation and delivery of interprofessional and interagency community care to people with severe mental health problems, and to explore factors helping and hindering this. Sociological theories of the division of labour have been used to underpin the study. These have included the ideas of work as interaction, of systems of work, of negotiations as a key (but not the only) way of 'getting things done', and of trajectories of health and social care.

Having established a theoretical framework for this investigation, Strauss' idea of 'structural context' (Strauss, 1978) was used to frame an analysis of community mental health care in its largest sense. This part of the thesis encompassed study of the emergence of a system of community mental health work over the last half century. This system was typified as being a particularly dynamic and complex one. The contours of mental health modernisation were also outlined here, and the implications of these for the mental health system examined.

Following an account of research process issues, including the research ethics and governance frameworks within which this study was undertaken, the two sites in which data were generated were introduced. Community mental health services in Midtown and Northtown were then analysed as two contrasting meso-level negotiation contexts. Key issues under negotiation

were discussed, and factors helping and hindering the planning and provision of services considered.

Following this, the six case studies completed as part of this investigation were introduced. Each was presented as a contextualised micro-level system of work. Key negotiators were introduced, and key issues actively under negotiation outlined. In the thematic Chapters which followed, case study data were first used to examine the contributions of paid and unpaid workers. The analysis presented here cast the micro-level work of representatives of each group in the context of work undertaken as a whole, and in the specific organisational context in which roles were enacted. Examples were given of the patterning of work, and the division of labour, by structural constraints directly entering into each case study negotiation context. The impact of health-related and organisational contingencies on the unfolding of case study subjects' trajectories was also examined. Throughout all five data-based Chapters, factors helping and hindering the provision of care were highlighted.

This closing Chapter distils the key lessons arising from the completion of this study and considers their implications for policy, practice and education in community mental health care. This Conclusion also highlights where this PhD's original contribution lies, and examines lines of enquiry for future research.

10.2 KEY LESSONS ARISING FROM THIS STUDY

Data generated during fieldwork in this study has clearly demonstrated that, at all levels from the macro through to the micro, significant change is a feature of contemporary systems of mental health work, and that change at one level has the potential to be felt at others. Without the benefit of a historical perspective macro-level change can sometimes be difficult to discern. A distinguishing characteristic of the system of mental health work in its largest sense in the UK, however, is the unusual speed with which it is currently developing (6 and Peck, 2004b). Macro-level developments in the structural context for mental health work have been keenly felt at meso-level, with Welsh public services modernisation (Jones et al., 2004) directly influencing work in multiple local settings. National initiatives have clearly created conditions of organisational instability at local level, with new agencies emerging, old agencies disappearing, and new frameworks for the organisation and delivery of services appearing.

In this study the mixture of structural and interactive, people-related, factors found to help the management of transitions taking place at the meso-level includes shared organisational boundaries, positive histories of interagency working, availability of adequate resources, good working relations between key negotiators, personnel stability and effective leadership. Conversely, historically strained interagency relations, high levels of turnover amongst key staff and resource inadequacies are all factors found to hinder meso-level transitions across agency and organisational boundaries. Combinations of helping and hindering factors were identified in each meso-level study site. In

Midtown, for example, relations between key interagency negotiators were better developed than in Northtown, and a more positive history of interagency relations was encountered. Northtown agencies benefited from greater organisational economies of scale, however, and were able to staff their services with more workers. In both locales lack of shared organisational boundaries and resource limitations were encountered.

These key findings are consistent with what is already known about effective working across meso-level organisational interfaces in mental health contexts. Peck and colleagues' evaluation of new models of commissioning and providing mental health services across NHS and local authority interfaces in Somerset, for example, also provides evidence of the complex relationships between, on the one hand, structural and organisational features and, on the other, interactive and occupationally related factors (Peck et al., 2001). Provan and Milward's US study, too, points to the importance for mental health service effectiveness of organisational stability and adequate resources (Provan and Milward, 1995).

Writing in the Silver Anniversary Issue of the journal *Sociology of Health and Illness*, Griffiths urges researchers to pay closer attention to the connections between macro, meso and micro-levels of organisation, and to include in their studies a focus on the interfaces between health care and social care provision (Griffiths, 2003). This challenge has been picked up by sociologically informed health and social care researchers, with examples of investigations into the links between macro, meso and micro-levels appearing in a recent

Sociology of Health and Illness-associated edited collection (Allen and Pilnick, 2006b). Connections of this type have also been made in this study, with explicit 'lines of impact' links being made between the macro-level structural context, the meso-level inhabited by local service planners and agency representatives, and the micro-level of actual service delivery. This study has also responded to Griffiths' challenge by explicitly encompassing analysis of work across health and social care interfaces.

Findings have exemplified the ecological idea that occupational roles are never a given. Clear evidence of macro-level role patterning has been found, and evidence, too, of the ways in which the work of psychiatrists, social workers, nurses, clinical psychologists, general medical practitioners, community pharmacists, health and social care assistants and unpaid workers is sensitive to the particularities of individual workplaces. Examples of macro-level features patterning roles enacted at micro-level include the case of social workers, whose work (in Northtown, in particular) demonstrated a clear orientation to the fulfilment of structurally patterned 'statutory duties' (Evans et al., 2005). Similarly, whilst the work of nurses typically included undertaking a range of tasks it also reflected a strong orientation to medication-related activities. This is an area which, moreover, nurses are being urged to further expand their skills and knowledge in (Gournay, 2001), including (despite some intra-professional and external resistance) into the area of prescribing (Department of Health, 2006c).

Enacted roles also reflected the meso-level characteristics of the contexts in which they were enacted. Meso-level differences with consequences for the work of particular groups have been shown to include: team composition and history; relative resource availabilities and arrangements for the funding of particular types of work; the agreement (or not) of formal localised policies and procedures relating to the carrying out of particular tasks, such as care coordination; spatial and temporal organisational factors; and the localised exercise of occupational jurisdictional authority. These differences, played out in the context of the micro-level delivery of services, all have consequences for the provision, and receipt, of care. In addition, uniquely micro-level personal factors have been shown to have consequences for the realisation of roles and the provision of services. Examples include: differentiations and non-differentiations of roles and responsibilities made by recipients of services; individual practitioners' levels of knowledge and skill; and the 'theories of negotiation' enacted by micro-level negotiators. These 'theories', as Strauss observes, can include ideas regarding who to negotiate with, and how (Strauss, 1978).

By focusing on an analysis of trajectories of care it has been possible in this study to examine, at micro-level, the recurring theme of transition. Clear examples exist of the ways in which service user trajectories are liable to become increasingly complex reflecting both health-related and organisational contingencies. This study has also demonstrated the ways in which workers' options to act in response to the unfolding of unpredictable trajectories are

constrained by the entry into negotiation contexts of significant macro and meso-level structural factors.

These lessons have implications for policy, practice and education. One objective for the study was to generate, and feed back to local stakeholders, findings of value for the future development of services in the sites in which data were generated. Two reports have been developed arising from this study. The first, produced in 2002, was delivered to key policymakers, managers and practitioners in the Midtown site. Two meetings were held to discuss emergent findings, one with senior workers in the Trust and local authority and one with Midtown CMHT staff (Appendix 8). A similar process is being managed in 2006 with representatives from the Northtown site (Appendix 9).

More generally, system-wide structural context change has been shown to create conditions of considerable meso and micro-level uncertainty, and is liable to trigger both intended and unintended consequences. Based on this observation, and on the analysis of data generated in the course of this investigation, I advance the idea here that a reflective pause by national policymakers may now be appropriate in order to better permit an examination of the system reverberations triggered by changes already introduced. In addition, at a time when functional specialist services (such as assertive outreach and crisis interventions and home treatment teams) are increasing in number (Welsh Assembly Government, 2005b), a case can be advanced for the maintenance and strengthening of locality community mental health

teams. As others have noted in comparable settings (Aggett and Goldberg, 2005), significant local knowledge was embodied in the Midtown and Northtown CMHTs, and the pooling of mental health expertise within single workplaces encouraged direct, helpful, face-to-face, interactions (Cook et al., 2001). The division of labour in community mental health systems of work is further fragmented by the emergence of multiple specialist teams. The more interfaces which exist, the more these need to be managed and the greater the potential for non-negotiation and service delivery discontinuity. Multiple specialist teams in single localities are also difficult to establish and sustain without expanded resources, including investment in the workforce.

Whilst CMHTs have occupied a central place in localised systems of work, other agencies and organisations also have important contributions to make. Two important interfaces are those between CMHTs and primary care services, and between CMHTs and psychiatric hospitals. Evidence consistently emerged in this study of limited negotiation across the mental health/primary care interface. Mental health workers were sometimes critical of what they saw as the limited contribution of their counterparts in primary care, and *vice versa*. In reality, workers in both specialist mental health and primary care services often had major parts to play in providing care, but undertook their work with little overt regard for how this integrated with the work provided by others. An important challenge for agencies and workers contributing to systems of mental health work is to find ways of promoting opportunities for negotiation across this boundary. It is significant that, for example, by the time I produced my report for staff in Midtown (Appendix 8) a

recent local service development had already led to the employment of two CMHT-based mental health nurses with the particular responsibility to improve liaison with, and services provided to, primary care. It is also significant that, in its most recent guidance to NHS trusts and local health boards, the Welsh Assembly Government has indicated that it expects 'gateway' workers to be appointed to sit at the interface between all Welsh primary care teams and mental health services by 2007 (Welsh Assembly Government, 2005c).

Hospital admission and discharge can be highly disruptive micro-level events (Jones and Bowles, 2005), as exemplified in this study in the case of Miriam. Resource limitations can be implicated here, with the problem of over-occupancy of beds leading to admission to wards not connected with care teams usually providing services. Attention could usefully be paid to improving the management of transitions of this type, and, further, to the development of meso-level alternatives to institutional care for people with severe mental health problems in crisis. Reflecting macro-level expectations of this type (Welsh Assembly Government, 2005b), since fieldwork Northtown agencies have commissioned and staffed a new crisis resolution and home treatment team. New services of this type, as I have indicated above, aim to provide effective and acceptable community-based interventions, but also represent a considerable source of system disturbance and magnify the potential for discontinuities in the provision of care.

Lack of human and material resources directly contribute to the experience of providing and receiving services. Loss of staff, and general difficulties in

recruitment and retention, are major hindrances. Finding and keeping dedicated mental health workers is a major challenge (Department of Health, 2001b; Welsh Assembly Government, 2005b), and is one which should be a priority for services at all levels. Improving the attractiveness of mental health careers, tackling excessive workloads and putting strategies in place to reduce and manage work-related stress are all actions which could usefully be considered. Similarly, lack of material resources and differences in the funding of 'health care' and 'social care' creates problems for service users, and places pressure on interprofessional and interagency relationships. An example from this study was observed in the case of Kerry in Northtown, whose need for enhanced support during a period of crisis was thwarted through the inability of social services gatekeepers to authorise additional funds as her needs failed to meet closely drawn eligibility criteria for access to services. Pooling health and social care budgets, as others have observed (Allen et al., 2004a), might help in this context. Changes of this type would, however, also trigger widespread system-wide change at a time when stability is needed.

The micro-level systems of work uncovered in this study were generally much larger and more complex than many key workers appeared to appreciate. This had major implications for the character of negotiations and for the delivery of integrated services. For example, when face-to-face care planning meetings were held not all those who contributed to the delivery of services were invited to participate. In one important care planning meeting observed, for example, a day centre worker who engaged in vital rehabilitative work with the service

user was not present. This was despite the fact that one of the items discussed at this event was preparation for the service user's eventual transition to less supported accommodation. Other relatively invisible groups existed, including community pharmacists. Although playing an important part in the dispensing of medication, pharmacists were largely excluded from negotiations. The part played by lay carers, whilst often appreciated by paid workers, was also sometimes discounted when critical decisions were being made. Attracting the attention of CMHT workers during a crisis period, for example, was a major undertaking for the carers of one service user, who had to supplement their efforts by enlisting the help of others in their community. Mental health care coordinators, then, should be urged on the basis of these findings to adopt a more inclusive approach to care planning and negotiation, and ensure that workers not traditionally included in negotiations have an opportunity to become more involved in decision-making and information-sharing.

Whilst face-to-face care planning meetings provide important opportunities for negotiations to take place, they do not guarantee that meaningful interactions will happen, or that service users and their informal carers (and indeed, all the paid workers contributing to an individual's care) will be fully involved in decision-making processes (Simpson, 1999; Webb et al., 2000). Important issues for service development and education include the leadership and management of meetings, and participation in decision-making processes. Representation and attendance at meetings is also important. Observed meetings in this study took place without primary care practitioner

representation, and in the absence of other key workers with important contributions to make. Where insurmountable problems prevent workers from participating in face-to-face negotiations over care provision, greater use of new technologies accessible to workers across agency and organisational boundaries (Blackburn, 2001) may help facilitate useful interactions.

These key lessons have implications for the education of student practitioners, across all health and social care occupational groups. This study has shown that making complex systems of mental health care 'work' demands high levels of social interaction, the undertaking of a wide range of practical, therapeutic and administrative tasks and a capacity and willingness to forge good working relationships across multiple occupational, agency, organisational, spatial and people-related interfaces. Given the interoccupational complexity of the micro-level networks of care uncovered in this investigation, it is striking how little opportunity there still is for student practitioners to interactively learn together across professional boundaries (Fowler et al., 2000) in order to develop these key interactive and 'working the system' skills. This, too, may be an area ripe for further development.

10.3 THE ORIGINAL CONTRIBUTION MADE BY THIS STUDY, AND LINES OF FUTURE ENQUIRY

The original contribution made by this study lies in a number of areas. There is originality demonstrated in the interpretation of mental health care as a complex and interrelated system of work, and in the way in which these ecological assumptions have been drawn on to underpin the type of empirical

investigation undertaken in the course of this study. The investigation reported here makes a distinct contribution by demonstrating how an ethnographic case study approach can be used as a means of mapping social relations and the unfolding of complex trajectories in the specific field of community mental health care. To the best of my knowledge, this type of data generation approach has not hitherto been attempted in this particular health and social care setting. The analyses advanced in this study also amount to an original contribution in examining 'lines of impact' in the mental health context, and in clearly linking macro, meso and micro-levels in the specific field of community mental health care. The attention to detail is a further strength of this study. Whilst it is recognised that continuity of care is a significant (and under-examined) area for mental health service development (Freeman et al., 2002), few studies demonstrate a focus on micro-level work and the service user experience in the way this study does. Attention to detail here has permitted a valuable examination into the micro-level outworkings of system of work structural features.

Whilst no claims are advanced here to have extended sociological theories of work, one area in which a theoretical refinement has been attempted is that relating to the concept of 'negotiation'. This I have expanded to include technologically mediated transactions of a type not obviously envisaged by Strauss and his colleagues during their various negotiated order deliberations (Strauss et al., 1963; Strauss et al., 1964; Strauss, 1978). Examples examined here include interactions via fax and telephone. Technological innovation has the capacity to further alter the content of health and social

care work, and the ways in which members of occupational groups interact together. Whilst not widespread, some evidence was generated in this study of, for example, the migration to paperless practitioner notes and the use of computer technology as a vehicle for supporting interoccupational interactions. Future research studies might usefully examine the system of work implications of developments of this type.

The study reported in this thesis is a self-contained one, but also represents the start of what is intended to become an ecologically informed programme of mental health research. Completion of this study has generated important future lines of enquiry, some of which it is my intention to develop as a post-doctoral researcher. Whilst it is known, for example, that crisis intervention and home treatment teams such as those now being established throughout Wales (Welsh Assembly Government, 2005b) offer advantages to service users over alternatives such as admission to hospital (Burns et al., 2001; Joy et al., 2004), the system-wide impact of setting up functional specialist teams of this type is poorly understood. Immediate post-doctoral research plans are in progress to investigate, in Northtown, the interfaces between a new crisis resolution and home treatment team and the other components of the system of work of which it is a part. It is proposed in this new study to explore the management of service user transitions across system-wide interfaces, including between locality CMHT and specialist crisis services. Other potentially important areas for research emerging from this study include examinations into the system-wide implications of the emergence of new roles in the mental health workforce, and into the impact of realigning the

relationships between occupational groups and their tasks. Future studies could, for example, explore the creation and implications of the planned approved mental health practitioner role intended to replace the existing approved social worker role (Department of Health, 2006e). Investigations could also progress into the consequences of introducing medication prescribing roles for mental health nurses (Department of Health, 2006c), and into the imminent arrival in Wales of 'gateway' workers sitting at the interface of mental health and primary care services (Welsh Assembly Government, 2005c).

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APPENDIX 1: ORGANISATION AND SEQUENCING OF WORK CULMINATING IN THESIS SUBMISSION

This Appendix summarises the phases of work leading to completion of this thesis, and serves as an 'audit trail'.

June 1999	Formal PhD registration
September 1999	Work as part-time PhD student commenced
September 1999	Commencement of reading to inform theoretical framework and analysis of structural context for community mental health care
September 1999	Negotiations opened with senior worker located in Central Health Authority with the aim of identifying two contrasting research sites
September 1999	Face-to-face access negotiations opened with senior nurse in Northtown NHS Trust
October 1999	First access letter sent to senior nurse in Midtown NHS Trust, requesting support for study to proceed
October 1999	Project presented to, and supported by, Northtown NHS Trust Nursing R&D Committee
November 1999	First application submitted for Central Health Authority Local Research Ethics Committee (LREC) approval
December 1999	Access negotiations opened with manager of the Northtown CMHT
January 2000	LREC refused permission for study to proceed
February 2000	First face-to-face access meeting with senior manager in Midtown NHS Trust, who gives permission in principle for study to proceed
March 2000	First meeting with consultant psychiatrist in Northtown CMHT, who agrees to support second application to LREC
April 2000	First face-to-face access meeting with members of the Midtown CMHT, including with consultant psychiatrist
April 2000	First face-to-face access meeting with members of the Northtown CMHT
April 2000	First access letter sent to senior manager in Northtown Local Authority Social Services Department
May 2000	Permission in principle for fieldwork to proceed given on behalf of workers in the Midtown CMHT by senior team member
May 2000	Permission in principle for study to proceed given by Director of Midtown Local Authority Social Services Department
May 2000	Written confirmation received from consultant

	psychiatrist in Midtown of support for the study to proceed and to include the involvement of service users with whom this practitioner worked
June 2000	Written confirmation received from consultant psychiatrist in Northtown CMHT of support for the study to proceed and to include the involvement of service users with whom this practitioner worked
July 2000	Permission in principle for study to proceed given by senior manager in Northtown Local Authority Social Services Department
July 2000	Second application submitted for LREC approval
July 2000	Smith and Nephew Foundation Nursing Research Fellowship awarded, to support fieldwork
August 2000	Written confirmation received from Central Health Authority LREC that the study, in the committee's view, does not require LREC approval
August 2000	Project registered with Northtown NHS Trust R&D Department
October 2000	Project registered with Midtown NHS Trust R&D Department
October 2000	Fieldwork commenced in Midtown
November 2000	'Jim' becomes first service user case study subject in Midtown
December 2000	'Simon' becomes second service user case study subject in Midtown
December 2000	Participated in Atlas.ti training day at Surrey University
January 2001	'Lenny' becomes third service user case study subject in Midtown
April 2001	Completion of data generation in Jim's case
April 2001	Completion of data generation in Simon's case
May 2001	Completion of data generation in Lenny's case
May 2001	Fieldwork concluded in Midtown
May 2001	Commencement of initial analysis and interpretation of data generated in Midtown
June 2001	Fieldwork commenced in Northtown
September 2001	'Miriam' becomes first service user case study subject in Northtown
September 2001	Conference event: Hannigan, B. 'Tales from the field: using ethnographic methods to investigate the provision of community mental health care', concurrent session presented at the 7 th International Network for Psychiatric Nursing Research Conference, Oxford
October 2001	Initial coding frame developed with Midtown data
February 2002	'Kerry' becomes second service user case study subject in Northtown
March 2002	'Jenny' becomes third service user case study subject in Northtown
April 2002	Completion of data generation in Miriam's case
July 2002	Completion of data generation in Kerry's case
July 2002	Completion of data generation in Jenny's case

Appendix 1: Organisation and sequencing of work

July 2002	Report for Midtown produced
August 2002	Fieldwork concluded in Northtown
September 2002	Commencement of analysis and interpretation of data generated in both Midtown and Northtown
September 2002	Conference event: Hannigan, B. 'Negotiating community mental health care: preliminary findings from a study of roles and responsibilities', concurrent session presented at the 8 th International Network for Psychiatric Nursing Research Conference, Oxford
February 2003	Conference event: Hannigan, B. 'Modernising mental health care in the UK: what does this mean, and what are the implications for nurses?', concurrent session presented at the 8 th European Mental Health Nursing Conference
April 2003	Conference event: Allen, D., Hannigan, B. and Lowes, L. 'Managing the practitioner/researcher interface in nursing research', symposium presented at the Royal College of Nursing Research Society Annual International Research Conference, Manchester
April 2003	Conference event: Procter, S., Kenkre, J., Clarke, C., Bolger, M., Hannigan, B., Allen, D. and Cochrane, W. 'Research governance: a bureaucratic nightmare or a driver for democratic change?', workshop held at the Royal College of Nursing Research Society Annual International Research Conference, Manchester
April 2003	Seminar event: Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', seminar facilitated at British Sociological Association Medical Sociology (Wales) Study Group, Cardiff
June 2003	Conference event: Hannigan, B. 'Joint working in community mental health care: key findings from a study of roles and responsibilities', invited plenary paper presented at the joint UWCM and Care Programme Approach Association conference, Cardiff
September 2003	Publication of: Hannigan, B. and Allen, D. (2003) 'A tale of two studies: research governance issues arising from two ethnographic investigations into the organisation of health and social care', <i>International Journal of Nursing Studies</i> , 40, 7, 685-695.
February 2004	Conference event: Hannigan, B. 'Understanding the complexities of community mental health care', concurrent session presented at the 9 th European Mental Health Nursing Conference, Dublin
March 2004	Final report submitted to the Smith and Nephew Foundation
March 2004	Publication of: Hannigan, B. (2004) 'Changes ahead for mental health workers?', <i>Mental Health Nursing</i> , 24, 2, 4-5.
July 2005	Completion of first draft of whole thesis

Appendix 1: Organisation and sequencing of work

- March 2006 Conference event: Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', poster presentation displayed at the Inaugural Annual Mental Health Nursing Awards for Wales, Cardiff
- May 2006 Invited seminar event: Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', invited presentation given in the Department of Mental Health and Learning Disability, St Bartholomew School of Nursing and Midwifery, City University, London
- May 2006 Report for Northtown produced
- May 2006 Final version of thesis produced and submitted for examination
- May 2006 Publication of: Allen, D. and Hannigan, B. (2006) 'Negotiating a proposal through gate-keeping committees', in Allen, D. and Lyne, P. (eds.), *The reality of nursing research: politics, practices and processes*, London, Routledge.
- May 2006 Publication of: Hannigan, B. (2006) 'Data generation', in Allen, D. and Lyne, P. (eds.), *The reality of nursing research: politics, practices and processes*, London, Routledge.
- August 2006 Publication of: Hannigan, B. and Allen, D. (2006) 'Complexity and change in the United Kingdom's system of mental health care'. *Social Theory & Health*, 4, 3, 244-263.

APPENDIX 2: PUBLICATIONS AND CONFERENCE

PRESENTATIONS

Work associated with this thesis has appeared in print or has been presented at conferences or seminars as follows:

JOURNAL PAPERS

Hannigan, B. (2004) 'Changes ahead for mental health workers?', *Mental Health Nursing*, 24, 2, 4-5.

Hannigan, B. and Allen, D. (2003) 'A tale of two studies: research governance issues arising from two ethnographic investigations into the organisation of health and social care', *International Journal of Nursing Studies*, 40, 7, 685-695.

Hannigan, B. and Allen, D. (2006) 'Complexity and change in the United Kingdom's system of mental health care'. *Social Theory & Health*, 4, 3, 244-263.

BOOK CHAPTERS

Allen, D. and Hannigan, B. (2006) 'Negotiating a proposal through gate-keeping committees', in Allen, D. and Lyne, P. (eds.), *The reality of nursing research: politics, practices and processes*, London, Routledge.

Hannigan, B. (2006) 'Data generation', in Allen, D. and Lyne, P. (eds.), *The reality of nursing research: politics, practices and processes*, London, Routledge.

CONFERENCE AND EXTERNAL SEMINAR PRESENTATIONS

Allen, D., Hannigan, B. and Lowes, L. 'Managing the practitioner/researcher interface in nursing research', symposium presented at the Royal College of Nursing Research Society Annual International Research Conference, Manchester, April 2003.

Hannigan, B. 'Tales from the field: using ethnographic methods to investigate the provision of community mental health care', concurrent session presented at the 7th International Network for Psychiatric Nursing Research Conference, Oxford, September 2001.

Hannigan, B. 'Negotiating community mental health care: preliminary findings from a study of roles and responsibilities', concurrent session presented at the

8th International Network for Psychiatric Nursing Research Conference, Oxford, September 2002.

Hannigan, B. 'Modernising mental health care in the UK: what does this mean, and what are the implications for nurses?', concurrent session presented at the 8th European Mental Health Nursing Conference, London, February 2003.

Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', seminar facilitated at British Sociological Association Medical Sociology (Wales) Study Group, Cardiff, April 2003.

Hannigan, B. 'Joint working in community mental health care: key findings from a study of roles and responsibilities', invited plenary paper presented at the joint UWCM and Care Programme Approach Association conference, Cardiff, June 2003.

Hannigan, B. 'Understanding the complexities of community mental health care', concurrent session presented at the 9th European Mental Health Nursing Conference, Dublin, February 2004.

Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', poster presentation displayed at the Inaugural Annual Mental Health Nursing Awards for Wales, Cardiff, March 2006.

Hannigan, B. 'Health and social care for people with severe mental health problems: an ethnographic study', invited presentation given in the Department of Mental Health and Learning Disability, St Bartholomew School of Nursing and Midwifery, City University, London, May 2006.

Hannigan, B. 'Exploring complex trajectories of mental health care', concurrent session presented at the 12th International Network for Psychiatric Nursing Research Conference, Oxford, September 2006.

Procter, S., Kenkre, J., Clarke, C., Bolger, M., Hannigan, B., Allen, D. and Cochrane, W. 'Research governance: a bureaucratic nightmare or a driver for democratic change?', workshop held at the Royal College of Nursing Research Society Annual International Research Conference, Manchester, April 2003.

APPENDIX 3: LITERATURE SEARCH STRATEGY

A systematic approach was adopted to the identification of data-based and other papers of possible relevance to this study. Specific databases were searched as follows, with retrieval of papers based on scrutiny of titles and abstracts, and limitation to English language:

SEARCH STRATEGY FOR PAPERS RELATING TO MENTAL HEALTH SERVICES

CINAHL: 1982 to July Week 4 2005

- Search term: 'community mental health services', mapped to subject heading and to keyword

MEDLINE: 1966 to July 29th 2005

- Search term: 'interagency', mapped to subject heading 'interinstitutional relations' and to keyword
- Search term: 'interprofessional', mapped to subject headings 'interprofessional relations', 'patient care team', 'interdisciplinary communication' and to keyword
- Search term: 'community mental health services', mapped to subject heading and to keyword
- Searches combined: 'community mental health services' AND 'interagency'; 'community mental health services' AND 'interprofessional'

AMED: 1985 – July 29th 2005

- Subject heading: 'community mental health services'

BNI: 1994 – July 2003

- Search term: 'community mental health services', mapped to three subject headings: 'mental health – services', 'mental health – community care', and 'multidisciplinary teams' and to keyword

BNI: July 2005

- Search term: 'community mental health services', mapped to two subject headings: 'psychiatric care in the community' and 'psychiatric services' and to keyword

ClinPsych: 1992 – June 2003

- Search term: 'community mental health services', mapped to subject heading 'community mental health services' and to keyword
- Subject heading: 'health care delivery'
- Combined 'community mental health services' AND 'health care delivery'

Embase: 1980 to July 29th 2005

- Search term: 'community mental health services', mapped to subject heading 'mental health service'
- Subject heading: 'Health care delivery'

- Combined 'Mental health service' as above AND 'health care delivery'

Health Management Information Consortium: July 29th 2005

- Search term: 'community mental health services', mapped to subject heading 'community mental health services' and to keyword
- Subject heading: 'health service provision'
- Combined 'community mental health services' and 'health service provision'

Social Sciences Citation Index: July 29th 2005

- Term entered for 'general search': 'community mental health services'

ASSIA: 1987 – July 29th 2005

- Thesaurus search: 'community mental health services'

Sociological Abstracts: July 29th 2005

- 'community mental health' searched as thesaurus term.

SEARCH STRATEGY FOR PAPERS RELATING TO THE NEGOTIATED ORDER

ASSIA and Sociological Abstracts

- Search term: 'negotiated order' [searched as 'exact phrase']

APPENDIX 4: INTERVIEW GUIDES

CASE STUDY-ORIENTED INTERVIEWS

Midtown

- What is your job title?
- How long have you worked in the team?
- Have you always worked in this capacity in this team?
- How long have you worked in a community setting?
- What professional and other qualifications do you have?
- How long have you been qualified in your profession?

- Why did you suggest X as a possible case study subject?
- Can you talk me through your involvement with X?
- What influences the work that you do with X?
[client need, professional training, personal interest, beliefs about mental health and illness, local policy, national policy, demands of manager/s, demands of other professionals]
- In what ways is your work with X similar to, or different from, the work that other health and social care professionals and carers do with X?
[do you have a distinct 'nursing' role with X? Could any mental health worker do what you do with X?]
- What implications do you think this has for the provision of X's care?
- What do other professionals and agencies inside and outside of the team do with/for X?
- What implications do you think this has for the provision of X's care?

- In what ways do you see the work you do with X overlapping with the work that other people do with X?
- What implications do you think this has for the provision of X's care?
- Have you ever done anything in your work with X that you think ought to have been carried out by another member of the team?
- What is the role of X's family/friends/carers in X's overall care?
- What implications do you think this has for the provision of X's care?
- How is X's care coordinated?
- What sort of problems do you encounter in your work with X?
- How are these resolved?
- How could X's care be improved?
- How typical is X of other clients you work with?

Northtown

- What is your job title?
- What professional and other qualifications do you have?
- How long have you been qualified in your profession?
- How long have you worked in a community setting?
- How long have you worked in the team?
- Have you always worked in this capacity in this team?
- What was the experience of joining the team like?
- In what ways is this team similar to, or different from, other teams that you have worked in?
- What does it mean to be 'in the team'? Who do you see as being members of the team?

[prompt: does it matter if 'team members' are not physically based here? Can only certain professions be 'in the team'? Are part-timers 'in the team'? etc.]

- Do you consider yourself to be a 'specialist', in terms of either working with a particular client group or in terms of working within a particular therapeutic approach? What are the implications of this?

- Why did you suggest X as a possible case study subject?

- Can you talk me through your involvement with X?

- What influences the work that you do with X?

[client need, professional training, personal interest, beliefs about mental health and illness, local policy, national policy, demands of manager/s, demands of other professionals]

- In what ways is your work with X similar to, or different from, the work that other health and social care professionals and carers do with X?

[do you have a distinct 'nursing' role with X? Could any mental health worker do what you do with X?]

- What implications do you think this has for the provision of X's care?

- In this team, in what ways is the work of members of your profession similar to, or different from, the work that other professionals do? What implications do you think this has?

- What is the contribution of other professionals in the team?

- How is it worked out who does what in the team?

[training? statute? personal interest? etc.]

- Specifically with regard to people newly referred to the team, how is it worked out 'who does what'?
- Why and how are these decisions about who does what made?
 - Is it because of professional training?
 - Is it because of personal interest/training?
 - Is it because of pragmatic reasons?
- What implications do you think this has?
- What are the mechanisms through which care is coordinated and delivered?

- Members of teams who provide care for people will often come and go. Has this happened in the care of X? If so, what implications do you think this has had for the provision of X's care?
- In a more general sense, what implications are there of team members coming and going?
[prompt: think about when other disciplines come and go. Has this had an impact on either care to clients, on the work of professionals, or on both?]
- What do other professionals and agencies inside and outside of the team do with/for X?
- How is the work of the team similar to, or different from, the work that other agencies and professionals outside of the team do?
[prompt: divisions of responsibility between team and primary care].
- What implications do you think this has for the provision of X's care?

- In what ways do you see the work you do with X overlapping with the work that other people do with X?
- What implications do you think this has for the provision of X's care?
- Have you ever done anything in your work with X that you think ought to have been carried out by another member of the team?
- What is the role of X's family/friends/carers in X's overall care?
- What implications do you think this has for the provision of X's care?
- How is X's care coordinated?
- What sort of problems do you encounter in your work with X?
- How are these resolved?
- How could X's care be improved?
- How typical is X of other clients you work with?

GENERAL INTERVIEWS

Midtown

- What is your job title?
- How long have you worked in the team?
- Have you always worked in this capacity in this team?
- How long have you worked in a community setting?
- What professional and other qualifications do you have?
- How long have you been qualified in your profession?

- Can you talk me through the work that you do in the team?
- Can you talk me through the organisation of the team?

- How is the team funded?
- What professionals are in the team?
- How is line management organised?
- How is supervision organised?
- How are policies/procedures made?
- In what ways is the work of the [*occupational group*] similar to, or different from, the work that other professionals do?
- What implications do you think this has?
- In what ways do you see the work of the CPNs overlapping with the work that other people do?
- What implications do you think this has?
- What is the contribution of other professionals in the team?
- How is it worked out who does what in the team?
 - How are case managers allocated?
 - How is it decided who does 'duty'?
- Why and how are these decisions about who does what made?
 - Is it because of professional training?
 - Is it because of personal interest/training?
 - Is it because of pragmatic reasons?
- What implications do you think this has?
- What are the mechanisms through which care is coordinated and delivered?
- What are the ways in which the team communicates with external agencies and professionals?
- What sort of problems do you encounter in your work?

- How are these resolved?
- How could the services the team provides be improved?

Northtown

- What is your job title?
- What professional and other qualifications do you have?
- How long have you been qualified in your profession?
- How long have you worked in a community setting?
- How long have you worked in the team?
- Have you always worked in this capacity in this team?
- What was the experience of joining the team like?
- In what ways is this team similar to, or different from, other teams that you have worked in?
- What does it mean to be 'in the team'? Who do you see as being members of the team?

[prompt: does it matter if 'team members' are not physically based here? Can only certain professions be 'in the team'? Are part-timers 'in the team'? etc.]
- Can you talk me through the work that you do in the team?
- Can you talk me through the organisation of the team?
 - How is the team funded?
 - What professionals are in the team?
 - How is line management organised?
 - How is supervision organised?

- How are policies/procedures made?

- In what ways is the work of [*occupational group*] similar to, or different from, the work that other professionals do?
- Are there 'specialists' in the team, in terms of either working with a particular client group or in terms of working within a particular therapeutic approach? What are the implications of this?
- What implications do you think this has?
- In what ways do you see the work of [*occupational groups*] overlapping with the work that other people do?
- What implications do you think this has?
- What is the contribution of other professionals in the team?
- How is it worked out who does what in the team?
 - How are case managers allocated?
 - How is it decided who does 'duty'?
 - [training? statute? personal interest? etc.]
- Specifically with regard to people newly referred to the team, how is it worked out 'who does what'?
- Why and how are these decisions about who does what made?
 - Is it because of professional training?
 - Is it because of personal interest/training?
 - Is it because of pragmatic reasons?
- What implications do you think this has?
- What are the mechanisms through which care is coordinated and delivered?

- **Members of teams often come and go. What implications are there of team members coming and going?**

[prompt: think about when other disciplines come and go. Has this had an impact on either care to clients, on the work of professionals, or on both?]
- **How is the work of the team similar to, or different from, the work that other agencies and professionals outside of the team do?**

[prompt: divisions of responsibility between specialist teams and primary care].
- **What are the ways in which the team communicates with external agencies and professionals?**
- **What sort of problems do you encounter in your work?**
- **How are these resolved?**
- **How could the services the team provides be improved?**

APPENDIX 5: CODE LIST

1 CENTRAL HEALTH AUTHORITY AREA
1 MIDTOWN CMHT
1 STUDY SITE - MIDTOWN
2 CITY CMHT
2 STUDY SITE - CITY
BOUNDARIES
BOUNDARIES - ASSIGNING RESPONSIBILITY (BLAMING)
BOUNDARIES - ASSIGNING RESPONSIBILITY (NEUTRAL)
BOUNDARIES - BEING FLEXIBLE
BOUNDARIES - BLURRING
BOUNDARIES - CHANGING ROLES
BOUNDARIES - CLAIMING EXPERTISE
BOUNDARIES - CLAIMING RESPONSIBILITY
BOUNDARIES - CONFLICT
BOUNDARIES - DISCLAIMING EXPERTISE
BOUNDARIES - DISCLAIMING RESPONSIBILITY
BOUNDARIES - EXPANDING ROLES
BOUNDARIES - LIMITS TO INFORMAL CARING
BOUNDARIES - LIMITS TO PROFESSIONAL WORK
BOUNDARIES - MAINTAINING
BOUNDARIES - MORAL RESPONSIBILITY
BOUNDARIES - NEGOTIATING
BOUNDARIES - NON-NEGOTIATING
BOUNDARIES - ROLE CLARIFICATION
BOUNDARIES - ROLE/RESPONSIBILITY - CLEAR
BOUNDARIES - ROLE/RESPONSIBILITY - UNCLEAR
BOUNDARIES - SHAPING
BOUNDARIES - STEREOTYPING
CASE STUDY SUBJECT - CCS1 [Miriam]
CASE STUDY SUBJECT - CCS2 [Kerry]
CASE STUDY SUBJECT - CCS3 [Jenny]
CASE STUDY SUBJECT - MCS1 [Jim]
CASE STUDY SUBJECT - MCS2 [Simon]
CASE STUDY SUBJECT - MCS3 [Lenny]
CASE STUDY SUBJECTS - NEEDS
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY INFORMAL
CARERS - NEGATIVE
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY INFORMAL
CARERS - POSITIVE
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY OTHER USERS -
NEGATIVE
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY STAFF -
ATYPICAL USER
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY STAFF -
COMPLEX NEEDS
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY STAFF -
NEGATIVE

CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY STAFF - POSITIVE
CASE STUDY SUBJECTS - PERCEPTIONS OF CSS BY STAFF - TYPICAL USER
CASE STUDY SUBJECTS - PERCEPTIONS OF STAFF BY CSS - NEGATIVE
CASE STUDY SUBJECTS - PERCEPTIONS OF STAFF BY CSS - POSITIVE
CASE STUDY SUBJECTS (USERS IN GENERAL) - PERCEPTIONS OF STAFF BY CSS - NEGATIVE
CASE STUDY TRAJECTORY
CASE STUDY TRAJECTORY - CARE PLANNING MEETING
CASE STUDY TRAJECTORY - DELAYED HOSPITAL DISCHARGE
CASE STUDY TRAJECTORY - GETTING WELL/DEVELOPING SKILLS
CASE STUDY TRAJECTORY - GETTING/REMAINING ILL
CASE STUDY TRAJECTORY - HOSPITAL ADMISSION (FORMAL)
CASE STUDY TRAJECTORY - HOSPITAL ADMISSION/ASSESSMENT (INFORMAL)
CASE STUDY TRAJECTORY - HOSPITAL DISCHARGE
CASE STUDY TRAJECTORY - HOSPITAL DISCHARGE (PREPARATION FOR)
CASE STUDY TRAJECTORY - HOSPITAL TRANSFER
CASE STUDY TRAJECTORY - LONG-TERM PLANS
CASE STUDY TRAJECTORY - MAINTAINING GOOD HEALTH
CASE STUDY TRAJECTORY - NEGATIVE SOCIAL EVENT
CASE STUDY TRAJECTORY - PERSONAL HISTORY [PRE-STUDY]
CASE STUDY TRAJECTORY - REFERRAL TO ADDITIONAL ORGANISATION/PROFESSIONAL
CASE STUDY TRAJECTORY - TRANSFER OF CARE COORDINATOR/KEY PROFESSIONAL
COMMUNICATION - CARE PLAN
COMMUNICATION - CARE PLANNING MEETING
COMMUNICATION - CASE NOTES
COMMUNICATION - CORRESPONDENCE
COMMUNICATION - ELECTRONIC
COMMUNICATION - FACE-TO-FACE
COMMUNICATION - FAILURE
COMMUNICATION - FAX
COMMUNICATION - MINUTES
COMMUNICATION - OPPORTUNISTIC
COMMUNICATION - PLANNED
COMMUNICATION - PROVIDING INFORMATION
COMMUNICATION - REPORT
COMMUNICATION - SUCCESS
COMMUNICATION - TELEPHONE
CONTEXT - CHALLENGING CLIENTELE
CONTEXT - CHANGING CLIENTELE
CONTEXT - COMMUNITY INTEGRATION
CONTEXT - COTERMINOSITY
CONTEXT - EQUITY ISSUES
CONTEXT - INFLUENCE OF MODELS OF MH

CONTEXT - INTERPERSONAL ISSUES - DIFFICULTIES
CONTEXT - INTERPERSONAL ISSUES - POSITIVE
CONTEXT - LOCAL KNOWLEDGE
CONTEXT - MORALE HIGH
CONTEXT - MORALE LOW
CONTEXT - NEW DEVELOPMENTS
CONTEXT - ORGANISATION SIZE - LARGE
CONTEXT - ORGANISATION SIZE - SMALL
CONTEXT - ORGANISATIONAL CHANGE
CONTEXT - ORGANISATIONAL STRUCTURE
CONTEXT - ORGANISING WORK BY GEOGRAPHICAL AREA
CONTEXT - ORGANISING WORK BY PHC BOUNDARIES
CONTEXT - RESOURCES LIMITED
CONTEXT - RESPONDING TO LEGAL OBLIGATIONS
CONTEXT - RESPONDING TO MODERNISATION (COLLABORATION)
CONTEXT - RESPONDING TO MODERNISATION (EFFICIENCY, EFFECTIVENESS)
CONTEXT - RESPONDING TO MODERNISATION (FINANCING)
CONTEXT - RESPONDING TO MODERNISATION (SCRUTINY)
CONTEXT - STABLE/UNSTABLE SERVICES
CONTEXT - STAFF ABSENCES
CONTEXT - TEAM CULTURE
CONTEXT - WORKING TOGETHER - DIFFICULT HISTORY
CONTEXT - WORKING TOGETHER - POSITIVE HISTORY
FINANCES - DISPUTED
FINANCES - FINANCING/COMMISSIONING SERVICES
HELPFUL FACTORS
HINDERING FACTORS
INTERFACES - INFORMAL CARER-INFORMAL CARER
INTERFACES - INTER-ORGANISATIONAL/INTER-AGENCY
INTERFACES - INTER-PROFESSIONAL
INTERFACES - INTRA-ORGANISATIONAL/INTRA-AGENCY
INTERFACES - INTRA-PROFESSIONAL
INTERFACES - PARAPROFESSIONAL-INFORMAL CARER
INTERFACES - PARAPROFESSIONAL-PARAPROFESSIONAL
INTERFACES - PARAPROFESSIONAL-USER
INTERFACES - PROFESSIONAL-INFORMAL CARER
INTERFACES - PROFESSIONAL-PARAPROFESSIONAL
INTERFACES - PROFESSIONAL-STUDENT PROFESSIONAL
INTERFACES - PROFESSIONAL-USER
INTERFACES - RESEARCHER-OTHER
INTERFACES - USER-CHILD
INTERFACES - USER-INFORMAL CARER
NEGOTIATING WORK - NEGOTIATION OBSERVED OR REPORTED
NEGOTIATING WORK - NO EVIDENCE OF NEGOTIATION
ORGANISATIONS - AMBULANCE SERVICE
ORGANISATIONS - CLINICAL PSYCHOLOGY DEPARTMENT
ORGANISATIONS - CMHT
ORGANISATIONS - HEALTH AUTHORITY
ORGANISATIONS - HOME CARE

ORGANISATIONS - HOSPITAL (GENERAL)
ORGANISATIONS - HOSPITAL (PRIVATE FORENSIC)
ORGANISATIONS - HOSPITAL (PSYCHIATRIC)
ORGANISATIONS - HOUSING ASSOCIATION
ORGANISATIONS - LHG
ORGANISATIONS - LOCAL AUTHORITY
ORGANISATIONS - MEALS ON WHEELS PROVIDERS
ORGANISATIONS - NAFW
ORGANISATIONS - NHS PRE-1990 ACT
ORGANISATIONS - NHS TRUST
ORGANISATIONS - OTHER
ORGANISATIONS - PHARMACY (COMMUNITY)
ORGANISATIONS - PHCT
ORGANISATIONS - SSD
ORGANISATIONS - SSD - CHILD CARE SERVICES
ORGANISATIONS - SSD DAY CENTRE
ORGANISATIONS - SSD RESETTLEMENT SERVICE
ORGANISATIONS - SSD RESIDENTIAL HOME
ORGANISATIONS - SUBSTANCE MISUSE SERVICE
ORGANISATIONS - VOLUNTARY
POLICY - LOCAL
POLICY - NATIONAL
POLICY - PROFESSIONAL
POLICY - STREET LEVEL
RESEARCH PROCESS - COMPARING SITES
RESEARCH PROCESS - ENDING RELATIONSHIPS
RESEARCH PROCESS - FAILED EVENT
RESEARCH PROCESS - FORMING RELATIONSHIPS
RESEARCH PROCESS - GENERATING DATA
RESEARCH PROCESS - NEGOTIATING ACCESS
RESEARCH PROCESS - PRACTITIONER/RESEARCHER INTERFACE
RESEARCH PROCESS - SCRUTINISING
RESEARCH PROCESS - SELECTING CASE STUDY SUBJECTS
ROLES - ADMINISTRATOR/SECRETARY
ROLES - CLINICAL PSYCHOLOGIST
ROLES - CLINICAL PSYCHOLOGY ASSISTANT
ROLES - COUNSELLOR
ROLES - DAY CENTRE WORKER
ROLES - DR - GP
ROLES - DR - PSYCHIATRIST
ROLES - DR - PSYCHIATRIST - CONSULTANT PSYCHIATRIST (CLINICAL DIRECTOR)
ROLES - DR - PSYCHIATRIST - CONSULTANT PSYCHIATRIST (FORENSIC)
ROLES - DR - PSYCHIATRIST - CONSULTANT PSYCHIATRIST (HOSPITAL)
ROLES - DR - PSYCHIATRIST - CONSULTANT PSYCHIATRIST (LOCALITY)
ROLES - DR - PSYCHIATRIST - JUNIOR PSYCHIATRIST
ROLES - DR - PSYCHIATRIST - STAFF GRADE

ROLES - DR - SPECIALIST PHYSICIAN
ROLES - HOME CARER
ROLES - INFORMAL CARER (FAMILY)
ROLES - INFORMAL CARER (NON-FAMILY)
ROLES - MANAGER - HA STRATEGIC MANAGER
ROLES - MANAGER - TRUST OPERATIONAL MANAGER
ROLES - MEALS-ON-WHEELS PROVIDER
ROLES - MENTAL HEALTH WORKER (NON-SPECIFIC)
ROLES - MHA ADMINISTRATOR
ROLES - NURSE - CMHN
ROLES - NURSE - CONSULTANT NURSE
ROLES - NURSE - DIABETES NURSE
ROLES - NURSE - HEAD OF MH NURSING
ROLES - NURSE - LIAISON MH NURSE
ROLES - NURSE - MHNS
ROLES - NURSE - NURSING ASSISTANT (COMMUNITY)
ROLES - NURSE - NURSING ASSISTANT (HOSPITAL)
ROLES - NURSE - PRACTICE NURSE
ROLES - NURSE - SENIOR CMHT NURSE
ROLES - NURSE - SENIOR NURSE FOR COMMUNITY
ROLES - NURSE - STUDENT NURSE
ROLES - NURSE - WARD NURSE
ROLES - NURSE - WARD NURSE - CLOZAPINE SPECIALIST
ROLES - OT (COMMUNITY)
ROLES - OT (HOSPITAL)
ROLES - PHARMACIST (COMMUNITY)
ROLES - PHYSIO
ROLES - RESEARCHER
ROLES - SECRETARY
ROLES - SERVICE USER
ROLES - SERVICE USER'S CHILD
ROLES - SOLICITOR
ROLES - SUPPORT WORKER
ROLES - SW - CHILD AND FAMILY SW
ROLES - SW - CHILD AND FAMILY SW ASSISTANT
ROLES - SW - MHSW
ROLES - SW - MHSW - UNQUALIFIED
ROLES - SW - MHSW AS ASW
ROLES - SW - PSSO
ROLES - SW - RESETTLEMENT SW
ROLES - SW - RESETTLEMENT SW MANAGER
ROLES - SW - RESIDENTIAL SOCIAL WORKER
ROLES - SW - RESIDENTIAL SOCIAL WORKER (UNQUALIFIED)
ROLES - SW - RESIDENTIAL SOCIAL WORKER MANAGER
ROLES - SW - SENIOR CMHT MHSW
ROLES - SW - SSD OPERATIONAL MANAGER
ROLES - SW - STUDENT
ROLES - VOLUNTARY SECTOR CARER
ROLES - VOLUNTARY SECTOR HOUSING SUPPORT
SUPERCODE: FACTORS HELPING INTERAGENCY WORKING

SUPERCODE: FACTORS HELPING INTRAGENCY WORKING
SUPERCODE: FACTORS HINDERING INTERAGENCY WORKING
SUPERCODE: FACTORS HINDERING INTRAGENCY WORKING
TRANSITIONS - HOSPITAL ADMISSION
TRANSITIONS - HOSPITAL DISCHARGE
TRANSITIONS - POLICY
TRANSITIONS - STAFF ARRIVALS AND DEPARTURES
WORK
WORK - 'DIRTY WORK'
WORK - ACCEPTING NEW CASES
WORK - ACCESSING LEISURE ACTIVITIES
WORK - ACCOMPANYING USER
WORK - ADMINISTRATION (NEGATIVE)
WORK - ADMINISTRATION (NEUTRAL)
WORK - ADVICE FOR USER
WORK - ADVOCACY FOR USER
WORK - ALLOCATING CASES
WORK - ASSESSING
WORK - ASSESSING CARERS' NEEDS/PROBLEMS
WORK - ASSESSING USERS' NEEDS/PROBLEMS (INITIAL)
WORK - ASSESSING USERS' NEEDS/PROBLEMS (ONGOING)
WORK - ASSESSING USERS' NEEDS/PROBLEMS (SPECIALIST
ASSESSMENT)
WORK - AUTONOMY
WORK - BEING A FRIEND
WORK - BEING BUSY
WORK - BEING DISENGAGED OR DISTANT
WORK - BEING ENGAGED
WORK - BEING ENGAGED/DISENGAGED (USER)
WORK - BENEFITS
WORK - BUDGETING
WORK - CARE AND SUPPORT
WORK - CARE MANAGEMENT (SSD)
WORK - CHILD PROTECTION/CHILD CARE
WORK - COORDINATING CARE (DAY-TO-DAY CARE)
WORK - COORDINATING CARE (LONG-TERM)
WORK - COMMUNITY CARE ACT RESPONSIBILITIES
WORK - COMMUNITY CARE ASSESSMENT
WORK - COMMUNITY CARE PLAN
WORK - COMMUNITY CARE REVIEW
WORK - CONTROLLING USER
WORK - CRISIS ASSESSMENT AND MANAGEMENT
WORK - DAILY LIVING SKILLS
WORK - DEVELOPING SKILLS AND KNOWLEDGE
WORK - DIAGNOSING
WORK - DISCHARGING CASES
WORK - DUTY WORK (ASW)
WORK - DUTY WORK (GENERAL)
WORK - EARLY WARNING SIGNS IDENTIFICATION
WORK - EDUCATION AND TRAINING

WORK - ELIGIBILITY FOR SERVICES - AGREEING
WORK - EMERGENCY RESIDENTIAL CARE
WORK - FACE-TO-FACE (GROUP)
WORK - FACE-TO-FACE (INDIVIDUAL)
WORK - FAMILY WORK
WORK - FINANCING CARE
WORK - FORMING RELATIONSHIPS
WORK - GOING THE EXTRA MILE
WORK - HANDING OVER CARE
WORK - HANDING OVER CARE (PREPARATION FOR)
WORK - HOME VISITS
WORK - HOSPITAL ADMISSION (FORMAL)
WORK - HOSPITAL ADMISSION (INFORMAL)
WORK - HOSPITAL DISCHARGE
WORK - HOSPITAL DISCHARGE (PREPARATION FOR)
WORK - HOUSING
WORK - INITIATING ACTION
WORK - INITIATING MH ASSESSMENT
WORK - INPATIENT ACUTE NURSING
WORK - INTERPROFESSIONAL ADVICE AND SUPPORT
WORK - LIAISING
WORK - MACRO LEVEL - PLANNING AND MANAGING SERVICES
WORK - MANAGING A CASELOAD
WORK - MANAGING A WARD
WORK - MANAGING AFFAIRS
WORK - MANAGING POTENTIAL FOR VIOLENCE
WORK - MANAGING SERVICES
WORK - MANAGING SERVICES - KNOWING YOUR PARTNERS
WORK - MANAGING SERVICES - STRATEGIC MANAGEMENT
WORK - MANAGING SERVICES - STRATEGIC MANAGEMENT - NEEDS
ASSESSMENT
WORK - MANAGING SERVICES - STRATEGIC MANAGEMENT -
PRIORITISING
WORK - MEDICATION
WORK - MEDICATION - ACCEPTING (USER'S PERSPECTIVE)
WORK - MEDICATION - ADMINISTERING
WORK - MEDICATION - DELIVERING PRESCRIPTIONS
WORK - MEDICATION - DISPENSING
WORK - MEDICATION - ENCOURAGING ADHERENCE
WORK - MEDICATION - MONITORING (GENERAL)
WORK - MEDICATION - MONITORING (SIDE-EFFECTS)
WORK - MEDICATION - MONITORING (SPECIFIC)
WORK - MEDICATION - PRESCRIBING
WORK - MHA 1983
WORK - MHA AFTERCARE
WORK - MHA ASSESSMENT/APPLICATION
WORK - MHA DISCHARGE FROM SECTION
WORK - MHA TRIBUNAL
WORK - NHS&CCACT
WORK - NOT TAKING DRUGS (USER'S PERSPECTIVE)

WORK - OUTPATIENTS OR CLINIC APPOINTMENTS
WORK - OVERSEEING CARE
WORK - PHYSICAL HEALTH
WORK - PHYSICAL REHAB
WORK - PLANNING CARE
WORK - POLICY - MAKING FORMAL POLICY
WORK - PRACTICAL ACTIVITIES
WORK - PRACTITIONERS - DEFINED BY POLICY, LAW OR PROFESSION-
SPECIFIC TRAINING
WORK - PRESENTING CASES
WORK - PSYCHOLOGICAL/PSYCHOSOCIAL INTERVENTIONS
WORK - REFERRAL ON
WORK - REHABILITATION
WORK - RESEARCH
WORK - RESPITE
WORK - REVIEWING CARE
WORK - RISK ASSESSMENT
WORK - RISK TAKING
WORK - SECTION 117
WORK - SECTION 25
WORK - SECTION 25 (LIMITATIONS)
WORK - SECTION 25 (PROCESS CLEAR/UNCLEAR)
WORK - SECTION 25 (SOCIAL SUPERVISOR)
WORK - SELF-CARE
WORK - STAFF SUPPORT
WORK - SUBSTANCE MISUSE
WORK - SUPERVISION OF STAFF
WORK - TEAM MEETINGS
WORK - VOLUNTARY WORK (SERVICE USER)



**University of Wales College of Medicine
School of Nursing and Midwifery Studies
Nursing, Health and Social Care Research Centre**

*Health and social care for people with severe
mental health problems: an ethnographic study*

APPENDIX 6: INFORMATION SHEET FOR PRACTITIONERS AND MANAGERS

Background

How community care is provided to people with severe and enduring mental health problems is a matter of significance to policy-makers, managers, practitioners and to individual service users and their carers. The overarching aim in this study is to examine the ways in which the different agencies and professionals involved in the provision of care to people with severe mental health problems negotiate their relative roles and responsibilities. What helps? What hinders? How can community mental health care be improved? This is an issue of significance and urgency.

Objectives

Objectives for this study include:

- mapping the network of care providers involved in the delivery of services to a series of case study subjects over a period of up to four months each;
- locating the findings within the broader policy context at both local and national level;
- undertaking detailed study of the ways in which carers manage their respective roles and responsibilities in the delivery of health and social services;
- identifying the range of factors related to interagency collaboration which, in the opinion of local stakeholders, contribute to or detract from the effectiveness and quality of service provision in the study settings;
- feeding back the findings to the study settings, enabling critical reflection on the delivery of care and assisting in future service planning;
- using these findings to make recommendations concerning the development of roles and responsibilities in the provision of community mental health care;
- sharing and disseminating the research findings to a multidisciplinary audience.

Research design

Access has been sought to two contrasting study sites within the Central Health Authority area. In each site, as full a picture as possible will be sought of the community care provided to up to four individuals identified as suffering from severe mental health problems. Established ethnographic case study methods will be employed. In each case study, the network of care provided will be mapped, in detail, for a period of up to four months. These networks will be explored using a range of methods: semi-structured interviews with health and social care providers, informal carers and clients, and key policy makers and service managers; observation of critical meetings; and analysis of case notes and key local and national policy documents. Where possible, interviews and observations will be tape-recorded.

Ethical and access considerations

The approval of the Central Health Authority Research Ethics Committee to undertake this project has been obtained. Potential participants in this study will have the freedom to make an informed decision on whether or not they wish to take part. All participants will, in addition, be assured of their right to withdraw at any point, without this in any way affecting their care and treatment. Pseudonyms will be used for the electronic and paper storage of data. The anonymity of individuals and study sites will be preserved, as far as possible, in the writing up and wider dissemination of findings from the study.

Access to case study subjects will be sought via the hospital and/or community settings. Subjects will be purposively selected. Access will particularly be sought to individuals the complexities of whose needs determine that a wide range of professionals and agencies are involved in their care.

What the study would involve for health, social services and other personnel

In seeking your support for this study I am asking for:

- permission to approach clients who have been identified as experiencing severe and enduring mental health problems to participate in the study;
- permission to observe, and if possible tape record, key events related to the care of the case study subjects (for example, ward rounds, care planning meetings taking place in the community, admission and discharge procedures);
- access to the client/patient records kept by different professionals relating to each case study subject;
- permission to carry out tape recorded interviews, for approximately one hour each, with the health, social and other workers involved in the provision of care to each case study subject.

Practical benefits

Against the background of complex and shifting health and social policy frameworks, this study will generate new understanding into the ways in which the different professionals and agencies involved in the provision of community mental health care negotiate their respective roles and responsibilities. In particular, insights will be developed into the range of factors which facilitate, and detract from, the delivery of high quality, effective community mental health services. The feeding back of findings to the study sites will enable critical reflection on the delivery of care, and assist in future service planning. Findings will also be used, where appropriate, to make recommendations concerning the future development of roles and responsibilities in the provision of community mental health care. Finally, this study will generate starting points for further investigations into the delivery of multiagency and multidisciplinary care.

The research team

The principal researcher, Ben Hannigan, has a background in community mental health nursing. Since Autumn 1997 he has worked as a Lecturer in the School of Nursing and Midwifery Studies, UWCM, teaching and researching in the field of community mental health. Research supervision is being provided by Dr Davina Allen and Professor Philip Burnard, both also of the School of Nursing and Midwifery Studies, UWCM. Dr Allen is a skilled ethnographer, whose research interests have focused on changing roles in the health service. She was also a principal researcher on a project funded by the Welsh Office of Research and Development for Health and Social Care which used ethnographic case study methods to investigate the complexities of providing care to people recovering from neurological conditions. Professor Burnard has extensive experience in undertaking and supervising qualitative research, and has written and researched widely in the mental health field.

External support

This study is being supported through the award of a Smith and Nephew Foundation Nursing Research Fellowship.

Further details

For further information, please contact: Ben Hannigan, Nursing, Health and Social Care Research Centre, School of Nursing and Midwifery Studies, University of Wales College of Medicine, Caerleon Education Centre, St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XR. Telephone: 01633 436 136. Email: hanniganb@cardiff.ac.uk



University of Wales College of Medicine
School of Nursing and Midwifery Studies
Nursing, Health and Social Care Research Centre

APPENDIX 7: INFORMATION SHEET FOR SERVICE USERS AND CARERS

Please will you help me with my research?

I am undertaking a research project in the Nursing, Health and Social Care Research Centre at the School of Nursing and Midwifery Studies, University of Wales College of Medicine.

Aims: The aim of the project is to find out how those who provide community care to people with mental health problems work together to meet clients' needs, and what can be done to improve services.

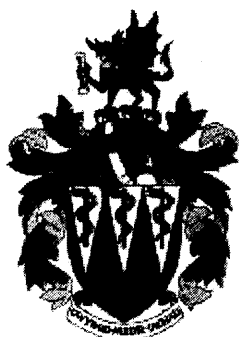
How can you help? In seeking your support for this research, I am asking if you and your family and friends will:

- allow me to follow your progress for up to four months;
- talk to me about your care and experiences and allow this conversation to be tape recorded;
- allow me to observe and tape record events in which aspects of your care are discussed. For example, hospital discharge meetings and care planning meetings taking place in the community;
- allow me to read and record information written about you by the different members of staff who provide care for you;
- allow me to interview the staff who provide care for you.

Confidentiality: All information will be treated in the strictest confidence. I will record information in a notebook or on a tape recorder. Information will be transferred to a computerised database, in order that it can be analysed as the study progresses. All information will be recorded, stored and reported so as to protect the identity of all participants in the study.

Participation: There is no obligation for you to take part in this study. Any decision you make will not affect your care in any way. If you do chose to participate, you are free to change your mind and withdraw at any time.

Further details: For more information, please contact the researcher: Ben Hannigan, School of Nursing and Midwifery Studies, University of Wales College of Medicine, Caerleon Education Centre, St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XR. Telephone: 01633 436 136.



**University of Wales College of Medicine
School of Nursing and Midwifery Studies**

Nursing, Health and Social Care Research Centre

**Health and social care for people with severe mental health problems:
an ethnographic study**

APPENDIX 8: REPORT FOR MIDTOWN

July 2002

Ben Hannigan
Nursing, Health and Social Care Research Centre
School of Nursing and Midwifery Studies
University of Wales College of Medicine
Caerleon Education Centre
Grounds of St Cadoc's Hospital
Caerleon
Newport
NP18 3XR

(01633) 436136
hanniganb@cardiff.ac.uk

INTRODUCTION TO THE REPORT

The PhD study from which this document is drawn is an investigation into the ways in which the different professionals and agencies involved in the provision of community mental health care negotiate their respective roles and responsibilities. It is being supervised by Dr Davina Allen, Senior Lecturer in Qualitative Research in the School of Nursing and Midwifery Studies, and Professor Philip Burnard, Vice Dean in the School. The study is part of a University of Wales College of Medicine School of Nursing and Midwifery Studies research programme titled The ecology of health and social care work. Studies in this programme share a concern with the exploration of the division of labour in health and social care, and of the organisation and delivery of services.

This study replicates the research design and aims and objectives of an earlier project, titled Delivering health and social care: changing roles, responsibilities and relationships (Allen et al. 2000, 2002). The study from which this report arises commenced in Autumn 1999, and is ongoing. This document reports on the period of data generation which took place in the Midtown area between October 2000 and May 2001. Since May 2001, data generated during this time have been subjected to preliminary analysis. Data generation has also commenced in a second study site. It is anticipated that further analysis of the total body of data generated in both Midtown and in the second study site will continue through into 2003.

This preliminary report has been produced for health and social care practitioners and managers in the Midtown area. The style of the report is largely descriptive, and is not intended to be read as a definitive account of the study and its associated findings. The report is, however, intended as a vehicle for sharing emerging themes and issues, including those related to the effective and efficient delivery of care and the factors both helping and hindering this. At the end of the report is a summary of key issues identified, along with a series of questions for service planners and providers. The overall report, and this summary in particular, is intended to stimulate reflection and discussion related to the provision of care to people with ongoing mental health problems.

Further items of output will include a completed PhD thesis, conference presentations and papers prepared for publication. Care will be taken to preserve, as far as possible, the anonymity of individuals and study sites in the writing up and dissemination of findings. Copies of papers accepted for publication will be forwarded to practitioners and managers in both sites.

Thanks are extended to the practitioners and managers in Midtown who permitted research access during the period of data generation. Particular thanks are also extended to the individual service users and their carers who agreed to participate in the project during this same period.

INTRODUCTION TO THE STUDY

Care for people with severe mental health problems is provided in a complex environment. The responsibility for organising and delivering services is

shared between a wide range of agencies and professions. Contributions are made by National Health Service (NHS) trusts, local health groups, local authority social services departments, primary health care teams, and a variety of other statutory and non-statutory sector organisations. Occupational groups participating in the provision of mental health care include branches of the medical profession (psychiatry and general practice in particular), nursing, social work, occupational therapy, clinical psychology and unqualified health and social care workers. Informal care is also provided by family members, friends and members of local communities.

Through an examination of the ways in which different agencies, professionals and lay carers work together, the study aims to generate new knowledge relating to the range of factors that help and hinder the effective delivery of services. Key questions include: what are the organisational factors that influence the effectiveness of care? How do professionals and agencies negotiate their relative roles and responsibilities? How can community mental health care be improved? These are issues of significance to policy-makers, managers, practitioners and to individual service users and their carers.

OBJECTIVES

Objectives for this study have included:

- mapping the network of care providers involved in the delivery of services to a series of case study subjects for a period of four to five months each;
- locating the findings within the broader policy context at both local and national level;
- undertaking detailed study of the ways in which carers manage their respective roles and responsibilities in the delivery of health and social services;
- identifying the range of factors related to interagency collaboration which, in the opinion of local stakeholders, contribute to or detract from the effectiveness and quality of service provision in the study settings;
- feeding back the findings to the study settings, enabling critical reflection on the delivery of care and assisting in future service planning;
- using these findings to make recommendations concerning the development of roles and responsibilities in the provision of community mental health care;
- sharing and disseminating the research findings to a multidisciplinary audience.

RESEARCH DESIGN AND METHODS

This project has used a cross-site, multiple case study design. Research access was negotiated to two contrasting study sites within the Central Health Authority area, each of which was served by a different NHS trust and a different local authority social services department. Midtown was the first of these two sites. The research base in each area was a community mental health team (CMHT), which in this site was the Midtown CMHT. Access to case study subjects was initially negotiated with CMHT practitioners. Prior to

the commencement of data generation, approval for the study was obtained from the Central Health Authority Local Research Ethics Committee (LREC).

In each site, as full a picture as possible was sought of the community care provided to three individuals identified by CMHT practitioners as suffering from severe mental health problems. Snowball sampling was used to identify the range of individuals involved in providing care to each case study subject. The mapping of each care network commenced with initial contact being made with a key informant, such as a community mental health nurse or a mental health social worker. Each informant was then asked to identify further individuals involved in providing care. In each case study, this process continued until all those providing care were located.

Data were generated using ethnographic methods. In each case study, the network of care provided was mapped, in detail, for a period of four to five months. Networks were explored using a range of methods: semi-structured interviews with health and social care providers, informal carers and clients, and key policy makers and service managers; observation of critical meetings; and analysis of case notes and key local and national policy documents. Where possible, interviews and observations were tape-recorded.

THE MIDTOWN AREA

Midtown is characterised by high levels of deprivation and ill health. The borough has a population of 57,600, included in which is the highest proportion of under-18s in Wales. Two-thirds of households have annual incomes of less than £10,000, over a fifth of households are in receipt of income support, and over a quarter receive housing benefit. In the five years to 1997, the mortality rate for under-75s in the area was 30% higher than the average across Wales. Over a fifth of people have a limiting long-term illness or disability. High levels of mental ill health are also reported (National Assembly for Wales 2000).

DATA GENERATION AND MANAGEMENT

Ongoing fieldnotes were maintained throughout the period of data generation in the Midtown area. Fieldnotes included records of informal interviews and observations. A total of 35 recorded interviews took place. These ranged from under ten minutes in length to over an hour. Multiple sets of case notes for each case study subject were located and analysed. Local and national policy documents were obtained and read.

Interviews were transcribed in full, anonymised, and entered into version 4.2 of the computer aided qualitative data analysis software program, Atlas.ti (Scientific Software Development/Scolari 1997). Fieldnotes and case notes were also entered into the software program.

DATA ANALYSIS

Using the Atlas.ti program, codes were attached to extracts of the data. This initial coding framework reflected a wide range of analytic, practical and research process concerns. For example, codes were used to identify instances of interprofessional negotiation, and of key interfaces (such as the

interface between hospital and community). The initial framework also included codes relating to the process of negotiating access to people and places in the Midtown area. This initial coding framework was developed and refined, and used to inform the construction of the themes which are used in this preliminary report to organise the presentation of findings.

PRELIMINARY FINDINGS

This study has generated evidence of transitions. These have come in a number of different forms, and in different contexts, and this report uses these as a way of organising findings. Transitions identified are:

- 'Modernising' care: transitions in the mental health policy context;
- Transitions in the delivery of care I: roles, responsibilities and relationships within the specialist mental health services;
- Transitions in the delivery of care II: roles, responsibilities and relationships in the overall provision of community mental health services;
- Service user transitions: negotiating 'critical events'.

'MODERNISING' CARE: TRANSITIONS IN THE MENTAL HEALTH POLICY CONTEXT

Mental health care throughout Wales and the UK is in a state of change. During the time that this study has been taking place, important new mental health policy frameworks have emerged (see for example: National Assembly for Wales 2001, 2002). Changes in the organisation, delivery and monitoring of care have also been brought forward by the implementation of general policy initiatives (see for example: Welsh Office 1998). In this section, the impact of these changes in the Midtown area is analysed. These findings provide a backdrop for the analysis of roles, responsibilities and relationships at case study level.

Policy-driven changes in health and social services mean that the responsibility for planning and delivering mental health care in Midtown is shared between a range of organisations: Midtown NHS trust, Midtown County Borough Council, Midtown Local Health Group, primary health care teams and a range of other statutory and non-statutory sector bodies.

Contemporary policy emphasises the importance of effective interagency partnership. Managers and practitioners recognised the importance of collaboration, but also described the challenges posed by this. For example, the appearance of new organisations presented a challenge to representatives of more established bodies. The Local Health Group, set up in April 1999 (Welsh Office 1998), was a new partner for both the trust and the local authority. One local authority worker spoke of the good sense of amalgamating the unitary authority's social care plan with the local health group's plan, but also described how the product of this collaboration was a compromise document that "became less concerned with annual objectives", and instead "became a bit more overarching" and "not sufficiently focused".

Interagency collaboration was hindered by the lack of coterminous boundaries. As a consequence, some senior managers were obliged to work with representatives of multiple partner organisations. These difficulties were compounded during periods of high turnover in key personnel. As one senior manager put it: "So how can you actually even attempt to get joint working and joint planning when you really can't even work your way around the system to find out who's who?"

Health and social policy initiatives in recent years have introduced new mechanisms for scrutinising the quality of services provided, and for monitoring the use of public resources. Two external reviews took place during this data generation period: a Joint Review of Midtown social services undertaken on behalf of the National Assembly for Wales and the Audit Commission (National Assembly for Wales/Audit Commission 2001); and a clinical governance review of Midtown NHS Trust completed by the Commission for Health Improvement (Commission for Health Improvement 2001).

Responding to the demands of external reviews had implications for both managers and practitioners. Senior staff recognised the importance of external scrutiny, but also said how preparing for and participating in reviews took them away from other important areas of work. The reports arising from external reviews were perceived as important documents, which, for some, could have included more critical comments than they did. As one senior member of staff said: "I wish in some ways they had sort of criticised us a little bit more on a few things because I think there were still things that they didn't unearth and it wasn't from the lack of people telling them." Reports highlighting shortcomings were seen as a vehicle for driving forward change, with recommendations from external bodies being seen as carrying more weight than recommendations originating from within an organisation.

NEGOTIATING TRANSITIONS IN THE DELIVERY OF CARE I: ROLES, RESPONSIBILITIES AND RELATIONSHIPS WITHIN THE SPECIALIST MENTAL HEALTH SERVICES

Specialist mental health professionals and paraprofessionals, and the organisations in which they work, have a particular responsibility to provide and coordinate community care to people with severe mental health problems. At the 'everyday practice' level, increasing emphasis is now being placed on, for example: effective collaboration across professional groups and agencies; the dismantling of 'traditional' boundaries; partnership with users of services; the delivery of effective and value-for-money interventions; and the management of risk.

During the period of data generation a variety of health and social services staff worked in or with the Midtown CMHT: community mental health nurses (CMHNs); psychiatrists; mental health social workers (MHSWs); unqualified health and social care workers; and administrative staff. A vacancy existed for a clinical psychologist. Management of the team was shared between a senior MHSW and a senior CMHN.

Senior and long-standing members attached considerable significance to the team's history, as did senior managers in both the trust and the local authority. Some expressed the view that the long history of the CMHT had encouraged a form of 'seepage', in which sharp interprofessional differences had eroded over time.

'Joint working' was a phrase that was often used by CMHT professionals and service managers. 'Joint working' had a number of different meanings:

- agreeing shared policies and procedures (for example, agreeing a multiagency operational policy);
- blurring of professional boundaries, particularly in relation to the activities of nurses and social workers (for example, both professional groups taking on the 'case manager' role in an interchangeable fashion); and
- working in a supportive, collegial manner (for example, team members taking on extra work and helping out when colleagues went on sick leave).

However, 'joint working' – particularly 'joint working' which referred to the blurring of professional roles – had its limits. For example, one senior manager expressed the view that the CMHT was a 'parallel', rather than a 'joint' service. Whilst CMHNs and MHSWs shared a number of responsibilities (such as acting as case managers and carrying out 'duty assessments'), long-acting depot medication administration was the sole preserve of CMHNs, and making applications under sections of the Mental Health Act (MHA) (1983) was a responsibility only for MHSWs. Discipline-specific roles and responsibilities such as these were typically related to professional training (nurses are trained in medication administration, social workers are not), or to activities defined by statute (only 'approved' social workers are able to make applications for the use of sections of the Act).

Not all CMHT members felt that blurring professional boundaries was either possible or desirable. For example, one social worker said: "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 knowledge is more towards holism and not pathologising but looking at systems. I think nursing is moving that way but I don't think that nurses on the ground necessarily have the equipment to do it ... and then technically there are barriers to other agencies providing that case management anyway."

Different perspectives to working with people with mental health problems, whether real or perceived, also helped to sustain professional boundaries within the team. For example, one social worker expressed the view that: "I feel that a lot of people in the team, and perhaps this is more the nurses, if something can't be fixed with medication they tend to feel it can't be fixed period." For some nurses, this focus on medication was an important part of their core work, and one that only they were fully equipped for. One nurse

said: "I don't know, I suppose a social worker could do it in effect [monitoring a client's medication use] but I think the nursing skills have been identified as being far more suitable ... than perhaps a social worker."

Not all the specialist community mental health workers in Midtown were physically located in the CMHT. For example, both consultant psychiatrists in the team worked from a base at Midtown Psychiatric hospital. As one acknowledged, this made him relatively inaccessible, and meant that much of the day-to-day community mental health work was achieved without the input of senior medical staff. Other mental health practitioners employed by the trust were also based outside of the CMHT, as were a number of social care workers. For example, the local authority funded a specialist rehabilitation service, with which CMHT workers liaised, and also provided supported residential and day care services. Many practitioners described having good face-to-face working relationships with colleagues as being very important, and staff being physically based in the same location increased the opportunities for both planned and unplanned liaison. Often, geographical distance was no barrier to effective collaboration between specialist mental health workers. However, when breakdowns did occur, these often involved workers located in geographically distinct settings.

Care for the three service users studied in this project involved contributions from both CMHT and non-CMHT specialist mental health workers. In each case, the role of 'case manager' for each service user was fulfilled by either a CMHN or a MHSW. Reflecting contemporary policy expectations, the responsibilities of case managers included overseeing case study subjects' plans of care, and ensuring that care plan reviews took place as needed.

Interviews and observations generated evidence of effective interprofessional and interagency working, but also evidence of some difficulties and tensions. In relation to the care of one of the case study subjects, staff described the advantages of convening a face-to-face meeting in order to resolve difficulties in relation to professional roles and responsibilities. Part of this person's care plan included family work, which after discussion between members of the care team fell to a MHSW to deliver. Before this agreement had been made, however, another professional in the team described the dangers of 'therapeutic overlap': "I think essentially if you've got two people dealing with the same issues then things are just going to get confused from whatever sort of theoretical perspective that may be".

Long-running tensions existed in the care of one of the three case study subjects in relation to arrangements for the administration and supervision of medication. A decision by some workers to encourage this service user to assume more responsibility for their treatment was challenged by other members of the care team. This objection was based on the grounds that this decision had not been taken in the context of a wider team discussion, and had, particularly, not involved medical staff. Another interprofessional tension in the care of one of the case study subjects centred on the use of a section of the Mental Health Act. In this example, some key members of the care team

described having only limited opportunities to contribute to discussions around the appropriateness, or not, of using this.

NEGOTIATING TRANSITIONS IN THE DELIVERY OF CARE II: ROLES, RESPONSIBILITIES AND RELATIONSHIPS IN THE OVERALL PROVISION OF COMMUNITY MENTAL HEALTH SERVICES

Whilst CMHTs and the workers based within them have a particular responsibility to provide and coordinate community care to people with severe mental health problems, the overall provision of care is shared amongst a much wider range of individuals and organisations: health and social care professionals who are not mental health specialists; voluntary sector workers; lay carers; etc. In this section, the focus is on two key interfaces: the interface between specialist mental health services/workers and primary care, and the interface between specialist mental health services/workers and lay carers.

Current policy frameworks place a considerable emphasis on effective, 'joined up' working between primary care and specialist services (see for example: National Assembly for Wales 2001, chapter 7). However, in the care of each of the three case study subjects, there was little evidence of ongoing collaboration between primary care and specialist mental health workers. Mental health professionals and GPs appeared to work closely together only when the Mental Health Act was used. This absence of active collaboration meant that planning to meet the mental health needs of each of the case study subjects was carried out solely by mental health professionals. This lack of ongoing primary care - mental health collaboration revealed itself in a number of ways. GPs, for example, did not always know who case managers were, or sometimes (incorrectly) made the assumption that this person must be the social worker who had most recently applied for a case study subject to be compulsorily admitted to hospital.

Tensions existed at the specialist mental health-primary care interface. For example, the GP of one of the case study subjects expressed the view that the CMHT did not provide updates regarding the case study subject's care plan. One senior mental health practitioner, however, suggested that information sent by mental health workers to primary care staff was unlikely ever to be read in detail. Confusions and disagreements over the prescription of medication were also reported. For example, one mental health worker described how a GP refused to prescribe a medication suggested by the service user's psychiatrist.

Whilst mental health workers were critical of the lack of primary care involvement in their clients' care, some also recognised the problems faced by GPs in particular in making time to achieve this. The dangers of delivering mental health care largely through secondary services were raised by one senior mental health practitioner, who spoke of a concern that this served to increase the stigma and exclusion that people with mental illnesses experience.

It is often assumed that, alongside the provision of services by professionals, family members and other informal carers will also provide a large, or even

the largest part, of the overall care that people with complex health and social needs living in the community receive. However, in the overall care of the three case study subjects, the work of lay carers varied considerably. In one of these cases, the care provided by members of the local community was a crucial part of the overall care plan. With the service user's agreement, neighbours supervised medication, and provided a vital link to the professional care team. Typically, it was the lay carers in this case who were the first to notice changes in the service user's routine, which from experience they were able to identify as the early signs of deteriorating mental health. The view of most of the professionals working with this case study subject was that the work of lay carers was an essential component in the person's overall care plan. For example, it was the case manager's view that the absence of informal care for this service user would have considerable implications for statutory services, who would then need to provide "a full package of care", including both qualified and unqualified social workers.

SERVICE USER TRANSITIONS: NEGOTIATING 'CRITICAL EVENTS'

This section focuses on the management of key transitions, or 'critical events', in the care of each of the case study subjects. Two key junctures are addressed: the management of hospital-community interfaces, and transfers of care between practitioners.

Admission to hospital and discharge home are significant, and complex, events, and this study has generated evidence of the difficulties liable to be associated with these. Admission to hospital involving people with mental health problems can be particularly difficult when this involves use of sections of the Mental Health Act. One of the case study subjects had just returned home from a compulsory admission to hospital at the point of joining the study. The complete process of organising admission spanned a number of days, and involved a large number of mental health, primary care, emergency services workers, and lay carers. Negotiating admission had involved formal assessments by an approved MHSW in the CMHT (who had not been involved in this person's care up to that point), a GP (who also did not know the service user), and a psychiatrist (who was familiar with the person). In the days and weeks prior to these formal assessments, however, the case study subject's informal carers, the case manager (a CMHN) and other members of the CMHT played significant parts in alerting medical and social work staff to the person's deteriorating mental health. However, this service user's most significant lay carer expressed the view that persuading mental health professionals of the person's increasing ill health prior to admission had been a difficult task, involving representation from three concerned members of the local community. On the day of admission, a psychiatrist needed to free up a bed in an acute admissions ward, and an ambulance was needed to physically convey the person from home to hospital. For the approved social worker, involvement in this admission continued long after the case study subject had arrived on the ward. Action was needed to attempt to make contact with relatives, and to offer to secure the person's home whilst they remained an in-patient.

Discharge from hospital is also a significant event. The case of the service user discussed above illustrates the complexity of this process, and the factors helping and hindering this transition. During admission, preparation for discharge included an occupational therapy assessment, conducted at home, of the person's ability to use domestic equipment such as a gas cooker. Periods of leave were also organised, arranged in collaboration with the case manager. Key informants described regular ward-based planning meetings, and, immediately prior to discharge, a multidisciplinary meeting to finalise arrangements for the return home. Hospital nurses, both qualified and unqualified, were involved in re-establishing home supports (such as meals-on-wheels and home care), and in arranging for new prescriptions to be ordered from the hospital pharmacy. Neither hospital nor community staff informed the community pharmacist of this case study subject's discharge home, however; this work was completed by the person's lay carers. On the day of actual discharge, a number of staff needed to display considerable flexibility in order to make sure that the person safely returned home. Physically transporting the service user from hospital to home was achieved by the CMHN/case manager using his own car. At the time of departure, the person's two-week supply of medication was still in the hospital pharmacy, and it fell to a ward nurse to drop these at the person's home after her shift had finished.

Other key transitional events observed included the departure and arrival of key professionals. One of the case study subjects experienced a changeover in case manager during their participation in the study. Resource constraints meant that the original case manager (a MHSW) had left before a new case manager could be found. This meant that a face-to-face handover of care could not be achieved. For the service user, the imminent departure of one key person and the arrival of another was anxiety-provoking, and for both this person and their family the period in between case managers meant that access to CMHT care could only be via the team's duty system.

SUMMARY AND QUESTIONS

This preliminary report has focused on four key, and complex, areas: the impact of a changing mental health policy context; roles and responsibilities in specialist mental health services; roles and responsibilities in the overall delivery of community mental health care; and the negotiation of critical events. All four areas have been characterised by transition, of one form or another.

Key questions posed by this report, which are offered here with the intention of stimulating critical reflection and discussion on the organisation and delivery of community mental health services in Midtown, are:

1. At a strategic level, effective collaboration was hindered by a lack of shared boundaries, and by the emergence of new health and social care partner organisations and the turnover of key staff. Structural changes of this sort are expected in the future. **Given that the systems in which staff work are subject to continuous change, how can the organisations and individuals with a responsibility**

for mental health care accomplish a more 'seamless' approach to the planning and delivery of services?

2. One view expressed during the course of this study was that the findings arising from organisations engaged in external scrutiny were an important tool in helping to develop services. **Why are external reports perceived as being particularly important in shaping services in Midtown, and how can change be initiated and sustained 'from within'?**
3. At the 'everyday practice' level, mental health workers displayed a considerable commitment to 'joint working', a phrase which had a number of different meanings. However, one view was that limitations existed to some versions of 'joint working'. Another was that not all aspects of 'joint working' were necessarily desirable. **What do the organisations and individuals in Midtown understand by the term 'joint working', and what aspects of this are they committed to consolidating and what aspects are they not?**
4. 'Case management' was a role fulfilled by a number of different professional groups. A view expressed in this study was that different professional groups bring different skills and perspectives to case management. **What are the 'core' skills and perspectives required of case managers, and what needs to be done to ensure that all mental health workers possess these?**
5. Effective interprofessional and interagency collaboration was hindered when staff were required to collaborate across physical boundaries. **What can be done to address this problem?**
6. Examples were found in this study of service user-related decisions being taken by practitioners without reference to the views and experiences of members of the wider care team. **Can the organisations and professional groups in Midtown agree on the types of issues that require multidisciplinary consultation, and what do not?**
7. The role of primary health care workers in the care of people with mental health problems appears limited. **What can be done to strengthen mental health - primary care collaboration? Or, what alternative arrangements might be put in place of this (for example, extended roles for other practitioners if GPs and other primary care workers cannot take on additional mental health work)?**
8. The part played by lay carers in the care of people with mental health problems varies. **What are the implications of this, and what factors influence the decision of family members and members of local communities to either become involved, or not become involved, in providing care? How can professionals increase the involvement of lay carers, and increase the support they provide to them?**
9. Hospital admission and discharge are critical junctures in the care of people with mental health problems. This study has shown that both professionals and lay carers are often involved, and that successful negotiation of these events often involves considerable flexibility in working practices. **What can be done to maximise the chances that**

admission to hospital and discharge home happen in an organised and efficient manner, and to the satisfaction of service users, lay carers and professionals?

10. The departure and arrival of key professionals are also critical junctures in the care of people with mental health problems. **What can be done to maximise the chances that professional transitions of this sort happen in as least a disruptive a manner as possible?**

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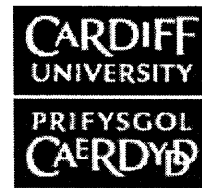
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Cardiff University
School of Nursing and Midwifery Studies

Nursing, Health and Social Care Research Centre



**Health and social care for people with severe mental health problems:
an ethnographic study**

APPENDIX 9: REPORT FOR NORTHTOWN

May 2006

Ben Hannigan
Nursing, Health and Social Care Research Centre
School of Nursing and Midwifery Studies
Eastgate House
35-43 Newport Road
Cardiff
CF24 0AB
UK

(029) 20917726
hanniganb@cardiff.ac.uk

coleg meddygaeth
wales
college of medicine
cymru

INTRODUCTION TO THE REPORT

The PhD study from which this document is drawn has been an investigation into the ways in which the different professionals and agencies involved in community mental health care negotiate their respective roles and responsibilities, and the impact of this on service provision and receipt. It has been supervised by Professors Davina Allen and Philip Burnard, and is part of a Cardiff University School of Nursing and Midwifery Studies research programme concerned with the investigation of health and social care interfaces.

This study replicated the research design and methods of an earlier project, titled *Delivering health and social care: changing roles, responsibilities and relationships* (Allen et al., 2002; Allen et al., 2004a; Allen et al., 2004b). The study from which this report arises commenced in Autumn 1999, and is now close to completion. This document reports on the period of data generation which took place in Northtown between April 2001 and July 2002. Since the completion of fieldwork all data generated in the two sites in which this study took place, including Northtown, have been subjected to analysis. A PhD thesis has been produced.

This report has been produced for health and social care practitioners and managers in the Northtown area. The report is intended as a vehicle for sharing emerging themes and issues, including those related to the effective and efficient delivery of care and the factors both helping and hindering this. At the end of the report is a summary of key issues identified, along with a series of questions for service planners and providers. This report is intended to stimulate reflection and discussion related to the provision of care to people with ongoing mental health problems.

Further items of output will include conference presentations and papers prepared for publication. Care will be taken to preserve, as far as possible, the anonymity of individuals and locations in the writing up and dissemination of findings, including in the final PhD thesis. Copies of data-based papers accepted for publication will be forwarded to practitioners and managers in both sites.

Thanks are extended to the practitioners and managers in Northtown who permitted research access during the period of data generation. Particular thanks are also extended to the individual service users and their carers who agreed to participate in the project during this same period.

INTRODUCTION TO THE STUDY

Care for people with severe mental health problems is provided in a complex environment. The responsibility for organising and delivering services is shared between a wide range of agencies and professions. Contributions are made by National Health Service (NHS) trusts, local health boards, local authority social services departments, primary health care teams, and a variety of other statutory and non-statutory sector organisations. Occupational groups participating in the provision of mental health care include branches of the medical profession (psychiatry and general practice in particular), nursing,

social work, occupational therapy, clinical psychology and unqualified health and social care workers. Informal care is also provided by family members, friends and members of local communities.

Through an examination of the ways in which different agencies, professionals and lay carers work together, this study has aimed to generate new knowledge relating to the range of factors that help and hinder the effective delivery of services. Key questions have included: what are the organisational factors that influence the effectiveness of care? How do professionals and agencies negotiate their relative roles and responsibilities? How can community mental health care be improved? These are issues of significance to policy-makers, managers, practitioners and to individual service users and their carers.

OBJECTIVES

Objectives for this study included:

- mapping the network of care providers involved in the delivery of services to a series of case study subjects for a period of four to five months each;
- locating the findings within the broader policy context at both local and national level;
- undertaking detailed study of the ways in which carers manage their respective roles and responsibilities in the delivery of health and social services;
- identifying the range of factors related to interagency collaboration which, in the opinion of local stakeholders, contribute to or detract from the effectiveness and quality of service provision in the study settings;
- feeding back the findings to the study settings, enabling critical reflection on the delivery of care and assisting in future service planning;
- using these findings to make recommendations concerning the development of roles and responsibilities in the provision of community mental health care;
- sharing and disseminating the research findings to a multidisciplinary audience.

RESEARCH DESIGN AND METHODS

This project used a cross-site, multiple case study design. Research access was negotiated to two contrasting study sites within what was then the Central Health Authority area, each of which was served by a different NHS trust and a different local authority social services department. Northtown was one of these two sites. The research base in each area was a community mental health team (CMHT), which in this site was the Northtown CMHT. Access to case study subjects was initially negotiated with CMHT practitioners. Prior to the commencement of data generation the study was scrutinised by the Central Health Authority Local Research Ethics Committee.

Interview, observational and documentary data were generated relating to the general organisation of community mental health services in each site. In addition, in each locale as complete a picture as possible was sought of the community care provided to three individuals identified by CMHT practitioners

as having severe mental health problems. Contact was made with the full range of paid and unpaid workers providing care to each case study subject. The mapping of each care network commenced with initial contact being made with a key informant, such as a community mental health nurse or a mental health social worker. Each informant was then asked to identify further individuals involved in care provision. In each case study, this process continued until all those providing services were located.

In each case study, the network of care provided was mapped, in detail, for a period of four to five months. Networks were explored using a range of methods: semi-structured interviews with health and social care providers, informal carers and service users; observation of critical meetings; and analysis of case notes. Where possible, interviews and observations were tape-recorded.

DATA GENERATION AND MANAGEMENT

Ongoing fieldnotes were maintained throughout the period of data generation in the Northtown area. Fieldnotes included records of informal interviews and observations. A total of 34 recorded interviews took place. These ranged from under fifteen minutes in length to over an hour. Multiple sets of case notes for each case study subject were located and analysed. Local and national policy documents were obtained and read.

Interviews were transcribed in full, anonymised, and entered into version 4.2 of the computer aided qualitative data analysis software program, Atlas.ti (Scientific Software Development/Scolari, 1997). Anonymised fieldnotes and case notes were also entered into this software program.

DATA ANALYSIS

Using the Atlas.ti program, codes were attached to extracts of the data. This initial coding framework reflected a wide range of analytic, practical and research process concerns. For example, codes were used to identify instances of interprofessional negotiation, and of key interfaces (such as the interface between hospital and community). The initial framework also included codes relating to the process of negotiating access to people and places in the Northtown area. This initial coding framework was developed and refined, and used to inform the construction of the themes which are used in this report to organise the presentation of findings.

FINDINGS

Findings are presented here in two parts. The first relates to the negotiation of services at 'meso' level. The second relates to the provision of care to the three service users who each became the starting point for an in-depth case study.

INTERAGENCY AND INTERPROFESSIONAL RELATIONS AT THE MESO-LEVEL

The policy context

Mental health care throughout Wales and the UK is in a state of change. During the time that this study has been taking place, important new mental

health policy frameworks have emerged (see for example: National Assembly for Wales, 2001; Welsh Assembly Government, 2003; Welsh Assembly Government, 2005a). Changes in the organisation, delivery and monitoring of care have also been brought forward by the implementation of general policy initiatives (see for example: Welsh Assembly Government, 2005b)

Interagency working

During the period of data generation the responsibility for planning and delivering mental health care in Northtown was shared between a range of organisations: Northtown NHS Trust, Northtown Council, Northtown Local Health Group (now expanded and renamed as Northtown Local Health Board), Central Health Authority (a body which no longer exists), primary health care teams and a range of other statutory and non-statutory sector bodies.

Contemporary policy emphasises the importance of effective interagency partnership. Managers and practitioners recognised the importance of collaboration, but also described the challenges posed by this. For example, at a number of organisational levels key informants described historically strained health service/local authority interagency relations. One senior Local Authority interviewee described their agency as having been a 'poor relation' to its NHS partner, and spoke of the historic difficulties faced in forging a more equal partnership. This challenge was seen as having been compounded by a relative lack of Local Authority investment in mental health services:

The community mental health teams in the Northtown area came about, I suppose, in the late eighties when we centralised, and discussions with health about joint teams etc. I suppose it's fair to say that that relationship has always been a rocky one [...]. The Social Services' perspective is that, you know, they've always been seen as the Cinderella service.

[...]

I think the other thing to say is that the Northtown area has significantly under-invested over the years in mental health, and in that sense it is a very Cinderella service.

One of the consequences of the greater investment made in mental health services by the Trust and its predecessor bodies was a general assumption of this organisation's automatic right to assume lead agency responsibility in the provision of mental health services for working age adults. For some senior Local Authority workers this was accepted as a logical consequence of what they saw as their agency's failure to prioritise mental health care, and was a situation likely to be encountered in many areas throughout the UK.

Interagency collaboration was hindered by the lack of coterminous boundaries. As a consequence, some senior managers were obliged to work with representatives of multiple partner organisations. A senior Trust

manager, for example, described the challenge of working with two local authorities, in which organisational structures differed:

One issue that you need to bear in mind is that the Trust serves two local authorities. Now the make up of the social services departments and their job descriptions, their titles, are different within the two areas. So for instance, if we say in the Operational Policy something like 'The Senior Practitioner or PSSO would be responsible for this', well, they haven't got PSSOs in the other local authority, so that causes problems [...].

Working in the CMHT

During fieldwork the day-to-day management and coordination of the CMHT's activities was undertaken by a senior nurse, who also had responsibility for a second team. The CMHT benefited from being staffed by a large number of workers drawn from a wide range of occupational groups: psychiatry, nursing, clinical psychology, social work and occupational therapy. The team also employed an administrator, support workers, and received sessional physiotherapy input. Offices were peopled by health and social services staff together, with other rooms being used for the purposes of client work, storage of service user case notes, and for business and clinical meetings.

CMHT members described a fractured and conflictual interprofessional and interagency team history. However, the imperative of bringing health and social care workers together in integrated teams along with the gradual reconstitution of the workforce meant that this early, serious, breakdown of relations had passed by the time fieldwork commenced. Whilst everyday interactions between workers were cordial and positive, some team members described a degree of confusion over occupational roles and responsibilities. One worker, for example, pointed to both the strengths and weaknesses of the team's rich mix of workers:

[...] obviously there's advantages that you've got a wider sort of skill mix and knowledge base, although I don't think it's always clear what the individual roles are. There are benefits of having lots of different people to refer to but it becomes more, it can become more of a melting pot.

Others pointed to the practical benefits associated with bringing together health and social care practitioners from all the major mental health occupational groups within a single workplace:

I mean it can be, you know, it's very easy for me just to shout across the corridor... whereas trying to track a doctor down, maybe on the ward sometimes, phone calls, 'Oh hang on, he's in', 'We'll get them to ring you back', whereas literally I can just scream across the corridor here.

[...]

...we've got OTs and psychologists and, you know, we've got everybody on site which is really good. You don't have to go careering round, at least if somebody's out on a visit we, you know, you know their mobile phone number and nobody really gets annoyed if you ring them, you know, so that's good.

Care coordination

An important ingredient in the organisation of community care for people with severe mental health problems is effective care coordination (Welsh Assembly Government, 2003). Evidence generated in this study suggested that this was an area in which considerable confusion existed. Multiple team members described a lack of clarity over care coordination, and senior staff expressed doubt that it would be possible to identify each service user's lead professional. One worker put it thus:

To be honest, I really haven't got a clue about keyworking, I haven't got a clue. Nobody ever told me and now I'm too long in the tooth to ask.

NEGOTIATING SERVICE USER CARE

Professional roles in the CMHT

The three service users participating in this study benefited from care provided by a rich mix of CMHT-based practitioners. In their accounts all three expressed general satisfaction with the services they were receiving.

Reflecting their physical location in the team, psychiatrists were both active and visible in service delivery. The ready availability and contribution of psychiatrists was particularly helpful in the care of two of the service users, for whom close working was necessary during the management of periods of crisis. In the context of an interprofessional care planning meeting convened to review the provision of services to one of these two users, for example, a CMHT-based psychiatrist was able to play a prominent and helpful part in negotiating an enhanced package of care which included increased psychiatrist input.

Nurses and social workers had significant parts to play in care delivery. Social work roles were clearly focused on the important tasks of fulfilling statutory Mental Health Act responsibilities, and assessing the need for, and managing, funded social care packages. Whilst managing funded care packages brought a considerable administrative responsibility, service users benefited by receiving practical support critical to sustaining them in the community. Nurses undertook a wide range of tasks, including engaging in helpful face-to-face supportive and therapeutic activities. During critical phases of service users' trajectories – including during periods of mental health crisis – nurses undertook tasks associated with the management of organisational responses. For example, for one service user who had two admissions to hospital during the time that she participated in this study her community mental health nurse offered a responsive service which included negotiating admissions to hospital and assisting with the transition from home to institutional care.

Contributions to service user case study subject care were also made by the CMHT's clinical psychologist and health care support worker, and by the team's sessional physiotherapist. Clinical psychology and physiotherapy input benefited from being both clearly structured and closely bounded. Securing the additional contribution of the team's health care assistant was particularly helpful for one case study subject, who benefited from additional practical support during a period of impending crisis.

Working across the mental health/primary care interface

The interface between community mental health and primary care services is a complex one. Whilst primary care practitioners were often closely involved in working with service user case study subjects, active collaboration across the CMHT/primary care boundary was limited. Temporal and spatial factors were significant here. GPs, for example, were physically located in different buildings from those housing mental health practitioners. Primary care commitments made attending and participating in care planning meetings difficult. Nonetheless, evidence was found of considerable information exchange. One service user's primary care notes, for example, contained multiple items of correspondence from mental health workers, including numerous faxes from her community mental health nurse providing updates on care and requesting medication changes. This non face-to-face way of negotiating services had some successes. This same service user's records indicated that, for example, in response to raised levels of concern over her risk of self-harm and her hoarding of medication her primary care team had stopped issuing repeat prescriptions at the request of CMHT practitioners.

One GP saw the division of work over the prescription of medication as a hindrance to the delivery of effective care:

...faxes will come if it's something acute that's happened to [*name of service user*], but letters take a long time to come through for her sort of chronic management, if you like, and I guess also what makes it difficult is that we prescribe for [*name*] whereas it would be far better for the CMHT to prescribe for her.

Managing transitions across the community/hospital interface

During her six month participation in the study one service user was twice admitted to inpatient psychiatric hospital care. Whilst discharge plans were made early in the first admission, a final care planning and transfer of responsibilities meeting was not held due to pressure on beds and the need to make room on the ward for a new admission. This had implications for the reestablishment of social care services. A more significant hindrance to continuity of care was associated with the local organisation of psychiatry services. Whilst in her own home this service user received care from psychiatrists located in the CMHT. Admission to hospital brought a shift in responsibilities, with care there being overseen by an academic psychiatrist whose clinical work was entirely hospital-focused. This intra-psychiatry division of labour – whilst enabling academic clinicians to engage in practice – made the management of the hospital/community transition particularly problematic.

Having returned home after this first admission this same person was again admitted to hospital during the time that she participated in this study. On this second occasion no beds were available on either of the CMHT's link wards. The transition from home to a hospital setting which was unfamiliar had considerable negative implications for continuity of care, and led to some basic needs not being met. Management of this person's transition home was also hindered by her admission to a non-locality ward, with a communication breakdown meaning that her CMHT-based psychiatrist was not informed of this second hospital stay.

Managing staff transitions

Staff transitions were a significant source of discontinuity for one service user, whose community mental health nurse and informal care coordinator left during a period in which the care team were managing a prolonged crisis. Putting into action a plan to effect a smooth transition proved difficult. Lack of CMHT resources meant that no overlap in practitioners was possible, with a replacement worker only forthcoming once a worker already in post in another CMHT could be transferred. In the absence of a protracted, negotiated, handover key information was only partially transferred. In this same case the provision of additional support during a crisis period was hindered by the application of tightly drawn eligibility criteria for access to Local Authority-funded services.

QUESTIONS

This report has focused on data generated at two linked levels: the meso-level at which services are planned and organised and the micro-level at which care is provided.

Key questions posed by this report, which are offered here with the intention of stimulating critical reflection and discussion on the organisation and delivery of community mental health services in Northtown are:

1. Given reports by key respondents of a history of strained interagency relations and of relative underinvestment in services, **what needs to be done to sustain and enhance progress already achieved in making NHS/local authority relations more equal, collaborative and effective?**
2. Significant benefits flowed from bringing together practitioners from all the major mental health occupational groups in a single CMHT. However, some respondents reported a lack of certainty over relative roles and responsibilities. This uncertainty is likely to be compounded by changes in occupational roles precipitated by aspects of current health and social policy. **What are the local implications of changes in occupational roles and responsibilities, and how can these be best managed?**
3. Evidence was generated of good practice in communicating across organisational interfaces. The coordination of overall plans of health and social care, however, worked in an *ad hoc* rather than in a formalised way. The recent introduction of the care programme approach throughout Wales requires a more structured style of care coordination. **What needs to be done to develop existing mechanisms for the coordination of**

health and social care, in order that integrated services can be effectively provided across multiple agency, organisational and occupational interfaces?

4. **What can be done to strengthen collaborative working across the mental health/primary care interface?**
5. Hospital admission and discharge are critical junctures in the care of people with mental health problems. CMHT and hospital-based staff worked hard to manage these transitions, but organisational factors sometimes hindered efforts to secure continuity of care. **What can be done to maximise the chances that admission to hospital and discharge home happen in an organised and efficient manner, and to the satisfaction of service users, lay carers and professionals?**
6. Given the relationship-based nature of mental health work, the departure and arrival of key professionals are also critical junctures in the care of people with mental health problems. **What can be done to minimise the disruption caused by professional transitions of this sort?**

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