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NEW WAYS OF WORKING IN UK MENTAL HEALTH SERVICES: DEVELOPING DISTRIBUTED RESPONSIBILITY IN COMMUNITY MENTAL HEALTH TEAMS?

Abstract

Background   The paper examines the introduction and operation of a number of support roles in mental health services. This is done in the context of concerns about the effectiveness of CMHTs.

Aims   Three questions are addressed: the degree to which concern for the work of consultant psychiatrists informed the introduction of the new roles; what the reforms implied for the work of the psychiatrist and those in new roles; and the impact of any changes on the operation of CMHTs.

Method   Data were collected as part of a national-level evaluation. The main means of collection was the semi-structured interview.

Results   The study shows: that reform was underpinned by concerns about the workload of psychiatrists; and that while in principle the responsibilities of the psychiatrist were to be distributed across other team members, those in new roles felt themselves to be isolated.

Conclusions   Despite the intentions of policy, the creation of the new roles did little to extend the idea of distributed responsibility in CMHTs.

Declaration of interest   The research upon which this paper is based was funded by the UK Department of Health.

Introduction

A central concern of research into the operation of community mental health teams (CMHTs) has been to identify the factors that explain the continued difficulties they face. One thread running through the whole debate is the burdens placed on—and felt by—consultant psychiatrists. It is in this context that we need to understand the emergence of new ways of working in the mental health arena. This paper reports on a study of the introduction of a number of new 'support' roles. What our study shows is that although the development of new roles was strongly informed by concerns about the workloads of consultant psychiatrists, the teams themselves were characterised by an absence of a direct relationship between the consultants and the new support workers. The paper itself divides into five parts. Following this introduction we examine the literature on the operation of CMHTs. The paper's third part describes the research project from which the data for this paper are drawn, while the fourth presents our main findings. We conclude by bringing together our own findings with the earlier discussion.

Literature Review: CMHTs and the Consultant Psychiatrist

Community Mental Health Teams (CMHTs)

As long ago as 1994 Galvin and McCarthy (1994) talked about 'clinging to the wreckage' of CMHTs. Much of the literature takes the view that the failures are evident in the excessive workloads placed on the teams and, in part as a result of this, in the high levels of stress suffered by team members. Galvin and McCarthy (1994) argued that CMHTs were ill-equipped to deal with the complexity of tasks imposed upon them, while Onyett et al.'s (1997) survey, focussed on the stress experienced by team members, found high levels of employee 'burnout'. Onyett's (2011) return to these issues, over ten years later, found little evidence of the level of burnout having undergone a decline.

Some consideration has been given to the structuring of teams, particularly around the issue of how management responsibilities are distributed. As Onyett et al.'s (1994) study conceded, Ovretveit (1993) had made an attempt to identify some principles which might be applied to the organization of such multi-disciplinary teams, but the different types he identified were not so evident in practice (see also Carpenter et al., 2003). Onyett and Ford (1996) argue in this context that Galvin and McCarthy's (1994) 'wreckage' claims are overstated (see also Moss, 1994).

Rather than as teams *per se*, CMHTs are more often seen as the on-the-ground setting for inter-professional working (see Peck & Norman, 1999; Stark et al., 2002). Stark et al. (2002) refer in this context to how priority was given to the agendas of individual professions. Larkin and Callaghan (2005) found that despite what they described as the 'core structures' of teams being in place, these had little impact on team members' perceptions of inter-professional working. Brown et al. (2000) examined roles within teams, finding a range of views of views on the 'blurring' of professional boundaries. At the same time, if each group retained a strong identity, the role of the CMHT in professional decision-making was found to be rather limited (Norman & Peck, 1999). 'The team might be seen best as a resource for professional decision-making' said Norman and Peck (1999: 227). 'The professional will consult the team but ultimately must make his/her own decision'. There is in the literature some reference to the possibility that teams will give rise to the breakdown of professional boundaries and, with this, the creation of a new 'universal practitioner' (Stark et al., 2002) or 'generic worker' (Brown et al., 2000). There has, however, been little evidence of movement in this direction.

Role of the Consultant Psychiatrist

What stands out as a thread running right through the work on CMHTs is the importance given to the role of the consultant psychiatrist. Peck and Norman (1999) asked groups of each profession involved in CMHTs to write their own account of how they saw themselves. While the psychiatrists saw themselves as being disproportionately burdened by working as part of a team, the nurses said that no-one had asked the psychiatrists to take on this degree of responsibility, and argued instead that that this power should be shared. Norman and Peck (1999) themselves concurred with this view, arguing that the psychiatrists needed to relinquish their 'illegitimate' power (based on 'traditional conceptions of medico-legal responsibility' (1999: 224)) in order for CMHTs to work effectively.

For Norman and Peck (1999) the failures of CMHTs were thus managerial in nature: the consultant psychiatrists had 'lost faith' (1999: 221) in the system in which they were working. In this account, psychiatrists had simply transferred to the new, community setting the responsibilities they had had in psychiatric hospitals. That they continued to have this responsibility was dismissed by Norman and Peck as a 'myth':

'There appears to be no basis in law or health policy for psychiatrists to shoulder the responsibilities they do' (Norman and Peck, 1999: 226).

Nonetheless, the feeling of the psychiatrists was that they were 'underwriting' the whole multi-disciplinary team structure, and this feeling was borne out in the studies that attempted to understand the impact of CMHTs. The centrality of the psychiatrist's role was captured by the concept of their being the 'responsible medical officer' (RMO), a status created by the Mental Health Act of 1983. As Kennedy and Griffiths (2002) argue, this encouraged the view that the psychiatrist had an almost direct, personal responsibility for all people in their area receiving mental health care. It is not too surprising, therefore, that Onyett et al.'s (1997) original survey found consultant psychiatrists to be experiencing significantly more emotional exhaustion than most other professions. Psychiatrists, argued Onyett et al. (1997: 64), 'often feel ultimately responsible for the overall welfare of large numbers of patients and sometimes the performance of the service as a whole'. The follow-up survey (Onyett, 2011) found this situation to have persisted. Onyett et al.'s (1994) earlier study highlighted the position psychiatrists saw themselves in, caught between, on the one hand, the feeling of responsibility, and, on the other, the failure for this to be recognised in the formal allocation of responsibility within the team.

Government Workforce Strategy

This concern for the workload of the consultant psychiatrist has been a key driver in the development of government workforce strategy. The most pertinent manifestation of this concern began in 2003, when the Royal College and NIMHE combined in order to encourage psychiatrists to examine their established working practices. Two major conferences on 'New Roles for Psychiatrists' were held, at which consultants pointed to the risks of high caseloads leading to increasing levels of career burnout and difficulties in recruitment and retention (National Working Group on New Roles for Psychiatrists, 2004). These conferences in turn gave impetus to the New Ways of Working initiative (NIMHE et al., 2004; DoH et al. 2005), itself a central part of the national mental health workforce strategy (NIMHE & MHCGWT, 2004).

While there appeared to be a high degree of consensus on what the main problem was being faced by CMHTs, it is less clear why a solution was sought in the development of new groups of support workers. Onyett et al.'s (1994) survey found support workers in over one-third of teams, with the average number of such workers

in a team being 0.65. Onyett et al. (1997) found support workers to be carrying caseloads which were small in comparison with those of other occupational groups, but which contained the greatest proportion of service users with severe and long-term conditions. While support workers were thus not only present in teams but also playing significant part in the teams' work, they had featured barely at all in the many attempts to understand and improve the performance of CMHTs.

Our review of this literature thus raises a number of questions that will be addressed in this paper:

- To what degree did the longstanding concern for the consultant psychiatrist inform the understanding of those charged with introducing new ways of working in mental health services?
- What did the reforms imply in practice for the work of the psychiatrist, for the new types of support worker, and for the relationship between them?
- In what way and to what degree have new ways of working impacted on the operation of the CMHT?

Context and Methods

The data presented and analysed here were collected as part of a national-level evaluation of a number of new roles in the mental health services workforce. The broader study, funded by the Department of Health (DoH) over the period 2006-09, was commissioned to look at seven roles that made up the New Ways of Working in Mental Health initiative (see DoH, 2007). The study was divided into three work packages, one of which involved a series of embedded trust-level case studies. We focus here on the most substantial of our five case study sites, 'Town & Country', where responsibility lay primarily with a large Mental Health Trust, employing over 7,000 people and covering a mixture of urban and rural locations. The choice to confine ourselves to Town & Country also arose from the fact that the three roles it allowed us to focus on were those most directly linked to the idea that issues with CMHTs could be addressed in terms of the burden on psychiatrists: Support, Time and Recovery (STR) Worker, a role designed to give support and time to mental health service users (DoH, 2003); Carer Support Workers (CSWs), whose role was designed to provide support to those caring for mental health service users (DoH,

2002a); and Gateway Workers, whose job it was to make it easier for people with urgent needs to access services (DoH, 2002b).

The data on which this paper is based were collected through a combination of semi-structured interviewing and documentary data-gathering. All members of the research team had experience of carrying out qualitative research in a health services setting, and responsibility for carrying out the interviews was shared between them. In addition to the substantial amount of documentation issued by DoH (eg DoH 2002a, 2002b, 2003), use is made of interviews carried out with 10 key policy informants. Identified through initial contact with the office of the NIMHE Director of Workforce, the semi-structured interviews with these national-level managers were based on a topic guide which focussed on the managers' understanding of the policy initiative, their role in its implementation, and their assessment of its impact. Data collection within Town & Country itself took the form of two sets of semi-structured interviews: with, respectively, the new support workers and the managers responsible for implementation. A key management contact was used to generate an initial list of possible interviewees, and a process of 'snowball' sampling was thereby initiated. The voluntary nature of participation in the project was stressed in communication with potential interviewees. For the purposes of this paper, a total of 31 interviews are made use of, 15 of which were with managers. Interviews were carried out face-to-face and were based on topic guides which for those in the new roles covered their formal responsibilities and their day-to-day working experiences; and for managers, their understanding of national-level guidance and their own role in implementation. All interviews were audio-recorded and fully transcribed.

The process of data analysis consisted of two parts. In the first, our paper's first research question was addressed through an analysis of formal policy documentation and the interviews with national and local managers. The second part addressed the other two research questions. In line with standard practice aimed at developing theory on the basis of qualitative data, the interview transcripts of those in the new roles were subject initially to a process of open coding. The material was broken down into short extracts, and a code applied to each. These codes were then developed into a set of aggregated categories, which were, in turn, structured around a central organizing category. Sense could best be made of the data by using as categories the groups with which the support workers had relationships. These

categories were then centred around the idea of how integrated the support workers felt.

Findings

Implementation of Policy

In line with what we saw in our introduction, the structure of work that New Ways of Working was designed to replace was one centred on the consultant psychiatrist. The work of other mental health service workers was defined in terms of their relationship to the psychiatrist, described in one interview as 'the person who delegates the responsibilities to members of the team'.   The centrality of the consultant meant that the structure could be very wasteful in terms of service delivery: many patients simply did not require this level of expertise. The underlying motivation for change, however, was concern about what this way of working implied for the workload of the psychiatrists—a concern in part emanating from the psychiatrists themselves:

> I suppose the original idea … came … because psychiatrists were going off with stress, retiring, the job wasn't do-able anymore. They had massive case loads, they were suffering from burn out, so there was sort of this, 'We need to do something' … [national manager 2]

What New Ways of Working claimed to offer in place of this was a team 'where responsibility is distributed amongst team members rather than delegated by a single professional' (DoH, 2007: 14): the consultant psychiatrist has a certain expertise to offer, but was to do so as one component of the expertise offered by the team as a whole. An STR manager in Town & Country expressed this succinctly:

> … the clue is in the title, 'consultant', and you should be operating on a consultant basis. You are not about monitoring everything that goes on the team, you are about trusting other professionals to include you and bring you in when your expertise is required …

But what did this look like at local level? Evidence from local managers at Town & Country confirmed that they shared the policy-level concerns about consultants' workloads.   In this context, New Ways of Working can be seen as something which added force to changes that were already in train. 'I think our thinking,' said one manager, 'and the New Ways of Working sort of came together at some point', Those

responsible for the implementation at the local level emphasised the bottom-up nature of the changes and the degree of engagement of those directly involved.

What this give rise to was a structure of work very much in line with that envisaged at the national level:

> [responsibility] is distributed amongst the members of the team according to their skills, competency and experience ... So what that means … is that referrals are now made to the CMHT ... not to a main consultant psychiatrist. [local manager 8]

Under this model the consultant psychiatrist might not even act as nominal leader of the team. Indeed, there was an additional reconfiguration of their role. As well as responsibility being distributed across the team, reform in Town & Country saw a formal split between, on the one hand, acute or hospital-based care and, on the other, planned care based in the community. What had been in place was a system in which consultants took ultimate responsibility for a group of service-users across both of these areas.

New Working Relationships

From the point of view of the national-level managers, it was not just a question of 'psychiatrists changing and expecting everybody else to change underneath them,' and this was recognised by the psychiatrists themselves, one of whom said, 'It's not about somebody taking on what I do to make my life easier.' This was also reflected in how other team members saw the psychiatrists. One referred to the psychiatrist in their team in the following terms: 'he is very much brought in as a consultant, as and when'.

In the absence of a direct relationship with a lead professional, therefore, how did our support workers define themselves and their role? From the point of view of local managers, the teams were beginning to operate on an integrated basis. The workers themselves, however, did not see things in this way, emphasizing the infrequency of contact and the isolated nature of their roles. '[We] kind of work autonomously and individually,' said one Gateway Worker; while according to one STR worker, 'We have ... a fortnightly team meeting where referrals and referral feedback is given'. A CSW reported on the difficulties they found in getting a more senior colleague to do an assessment of the carers they were dealing with, and CSWs

in general felt their concerns were not something shared by all team members. Indeed, there could be little contact even between workers in the same role.

For Gateway workers a key working relationship extended beyond the team. People with mental health problems were likely in the first instance to consult their General Practitioner (GP), for whom the Gateway Worker acted as an initial reference point in an area in which they did not have specialist expertise. In Town & Country each Gateway Worker was responsible for a number of GP practices:

> the post I took here was as a Gateway Worker working as triage for two GP practices … reviewing and assessing clients referred by their GPs and then onward, routing to other appropriate services if they weren't felt suitable for my skills, and some to be adopted for particular therapy work.

Discussion and Conclusions

In this final section of the paper, we return explicitly to the research questions raised by our literature review. In answer to the first of these questions, we have seen that workplace reform was to a substantial degree underpinned by concerns about the workload and responsibilities of the consultant psychiatrist. These findings can thus serve to confirm the continuation of the longstanding view in which CMHTs are regarded as being centred on this particular profession (Norman and Peck, 1999). There is no evidence of the teams' being seen as the site of a more egalitarian form of inter-professional working (Ovretveit, 1993), let alone of the emergence of a 'universal practitioner' (Stark et al., 2002) or 'generic worker' (Brown et al., 2000). The case study work presented in the present paper also allows us to say that there is evidence of these concerns being shared and acted upon at both national and local level.

In answer to our second question—what the reforms implied in practice for work--we can see that, at least in principle, the implication for the psychiatrists was that their responsibility was 'distributed' across the members of the CMHT. Like Onyett et al. (1994) and Carpenter et al. (2003) before us, however, we see little in the way of structured redistribution. In contrast to earlier studies (Onyett et al.1994; Onyett et al., 1997), what our analysis allows us to do is to look at this from the point of view of the newly introduced support workers. Amongst these workers there was certainly little feeling of their taking on distributed team responsibility. On the

contrary, they felt themselves to be isolated within the CMHT rather than an integrated part of it.

Looked at in terms of service delivery, we can see how it both shaped, and was shaped by, the introduction of the new roles. On the one hand, some part of the support workers' independent mode of working can be attributed to the changing nature of service delivery. As community-based services became more important, and, in this case, became less connected to hospital-based care, direct contact between workers tended to diminish. Moreover, a concern for greater integration with other health and social services meant that relationships were being developed with workers outside the team altogether. On the other hand, service delivery was itself changing with the new ways of working, as the introduction of new groups of support workers gave rise to a much greater emphasis on the direct relationship with individual service-users. For those in the new roles, this was a welcome and important part of their work.

What this meant for the teams was—in answer to our third question—that we have the apparently paradoxical situation that while concerns for the psychiatrist's workload within the team had motivated the workforce change and shaped it at a local level, and while the idea of distributed responsibility had been the way in which this concern manifested itself, the new roles created as part of the change took little part in this redistribution. The support workers took up new and different responsibilities—and developed new and different relationships—rather than taking over the responsibility and relationships of the psychiatrists.

The research presented here thus shows something of a disconnect between, on the one hand, the rationale for and the underpinnings of these new ways of working, and, on the other, the impact these new roles had in practice. Our own research design necessarily restricted the breadth of coverage, but at the same time generated the in-depth analysis that allowed us, in particular, to bring out the experiences of those directly involved in what was a new and fluid situation. Future research might build on these insights by trying to capture in a quantitative way the extent to which new roles add to, rather than substitute for, work that is already been done in the delivery of mental health services.

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