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THE IMPACT OF TEAM PROCESSES ON PSYCHIATRIC CASE MANAGEMENT

ABSTRACT

Aims: To identify the structures and interactions within community mental health teams that facilitate or impede effective teamwork and psychiatric case management.

Background: Effective case management requires close collaboration between case managers or care coordinators and other members of the multidisciplinary mental health team, yet there has been little research into this relationship.

Methods: A multiple case study of seven UK community mental health teams was conducted between 1999 and 2001, using qualitative methods of participant observation, semi-structured interviews and document review.

Findings: Factors were identified that impacted on the ability of care co-ordinators to act effectively: ‘structure and procedures’; ‘disrespect and withdrawal’; ‘humour and undermining’; ‘safety and disclosure’. Care co-ordination was enhanced when team structures and policies were in place and where team interactions were respectful. Where members felt disrespected or undermined, communication, information sharing and collaboration were impaired, with a negative impact on the care provided to service users.

Conclusions: Teams require clear operating procedures alongside interprofessional trust and respect to ensure that there is open, safe, reflective participation. Further research is required to identify how best to bring about collaborative, effective teamwork in mental health care.

Keywords: community psychiatric nursing; community care; multiprofessional practice; qualitative approaches; teamwork; mental health

SUMMARY

What is already known about this topic:

- In psychiatric case management, an integrated package of monitoring, support and treatment is coordinated by a case manager or care coordinator.
- Effective discharge of case manager responsibilities requires a well-functioning multidisciplinary team, with high levels of communication and member participation in team meetings.
- In the UK, the effective deployment of case management has been undermined by the failure to address teamwork skills and underlying interprofessional and interpersonal tensions. Yet there has been little direct investigation of the impact of team processes on the psychiatric case manager role.

What this paper adds:

- This study identifies team processes that impact on the effective coordination of community mental health care for people with severe mental illness.
- Care co-ordination is enhanced when team structures and policies are in place and where respectful interactions in team meetings encourage participation.
- Where team members feel disrespected, undermined or ‘unsafe’, their psychological or physical withdrawal from team meetings impairs communication, information sharing and collaboration, with a negative and potentially risky impact on the provision and coordination of care.

INTRODUCTION

In psychiatric case management, people with severe mental illness should receive an integrated package of monitoring, support and therapeutic interventions (Mueser et al. 1998). Multidisciplinary input coordinated by a case manager is a key feature of most case management models (Simpson et al., 2003a). In the USA and Canada, health professionals and paraprofessionals undertake the case manager role (Newman et al. 1991; Liberman et al 2001; Forchuk et al 2002; Herrick & Bartlett, 2004). In Australia and New Zealand case managers are more likely to be mental health professionals (Muir-Cochrane, 2001). In the UK, psychiatric case management was introduced as the Care Programme Approach (CPA) and the case manager role was termed 'keyworker', then later 'care co-ordinator' (Simpson et al., 2003b). The role is most often held by Community Mental Health Nurses (CMHNs) (Schneider et al., 1999) and their work is now heavily focused on care co-ordination (Gournay 2005). However, there has been very little research into the care co-ordinator role in the UK (Ward & Stuart 2004).

BACKGROUND

Sullivan (1997) suggested the care co-ordinator role would enable CMHNs to act as a focal point for liaison, communication and facilitation within Community Mental Health Teams (CMHTs), but others were concerned that nurses lacked sufficient status, power and authority to co-ordinate the input of other team members (North, et al 1993; Gupta, 1995; May, 1996). From the outset, it was made clear that the effective discharge of individual CPA responsibilities could only be achieved in the context of a 'well-functioning team' (Shepherd, 1995), but the continued failure of different agencies and professionals to communicate and successfully deliver

coordinated care has been regularly highlighted in official reports and inquiries (Health Committee Report 1994; Department of Health 1995; Shepherd 1996). Subsequently, the CPA was re-launched with a re-statement of the centrality of teamwork and an insistence that care co-ordinators be endowed with necessary influence within teams to ensure care plans are adhered to (Department of Health, 1999).

In the USA, Liberman et al (2001) have stressed the importance of regular team meetings in ensuring effective team communication and functioning. A large survey of CMHTs in the UK reported an association between safe participation in team meetings (where disparate disciplinary contributions are valued and respected) and improved communication, effective teamwork and the positive mental health of the workforce (Borrill et al. 2000). But skills required to work effectively as part of a team have seldom been addressed (Sainsbury Centre for Mental Health, 1997). As a result, the CPA was introduced with the expectation that collaborative teamwork existed when this was not necessarily the case (Simpson 1999; Fakhoury & Wright 2000; Miller & Freeman, 2003). This has tended to exacerbate pre-existing personality clashes and interprofessional tensions over status and changing roles (Mistral & Velleman 1997; Cott, 1998; Norman & Peck, 1999; Brown et al., 2000). These difficulties need to be acknowledged and explored if they are to be resolved (Stark et al 2000; Burns 2004), especially as there is evidence that they can harm the delivery of patient care and contribute to eventual suicides and homicides (Royal College of Psychiatrists, 1996). In the USA, there has been considerable research conducted into collaborative team working and case management in medical settings (Wells, Johnson & Salyer, 1998), but there has been little research conducted

anywhere into the interactions between psychiatric case managers and their mental health team colleagues. This paper is the second of two reporting findings from a study that aimed to identify factors that impacted on the ability of CMHN care co-ordinators to meet service users' and carers' needs. The first focused on tensions with a therapeutic nursing role (Simpson 2005).

THE STUDY

Aim

This paper aims to enhance understanding of the structures and interactions within CMHTs that facilitate or impede effective teamwork and case management.

Design

A multiple case study design was employed in which discrete CMHTs served as the 'case' and main unit of analysis (Stake, 1998). Following Bergen and While (2000), each individual participant (e.g. CMHN) was a 'subunit of analysis' and organisational factors and government policies were seen as contextual issues that interacted with and influenced the cases. Each team, its constituents, processes and interactions, was studied and compared with those of the other teams.

Sample/participants

All seven multidisciplinary CMHTs serving an urban population of approximately 280,000 agreed to take part in the study. All 24 CMHNs within the teams were invited to take part in an initial interview about the CPA, their nursing and care co-ordinator roles and teamwork and to provide caseload information. One refused. Using the caseload information provided, eight of the 23 CMHNs were excluded from the study

as their individual caseloads did not include service users on the enhanced level of the CPA, which was the focus of the study. Service users receiving enhanced CPA usually have severe mental illness and complex needs requiring *co-ordinated* interventions from different members of the multidisciplinary team. Consequently, 15 CMHNs took part in a longitudinal study of their work as care co-ordinators.

Data Collection

The author collected data between January 1999 and February 2001. Methods included non-participant observation, interviews, questionnaires and document review. Non-participant observation, in which the researcher observed but kept direct involvement in proceedings to a minimum, was conducted at over 70 meetings of the seven CMHTs and in team offices, at CPA review meetings and during CMHN-service user consultations. Tape-recorded semi-structured interviews were conducted with all 15 CMHNs and 15 service users on 'enhanced CPA' about their work as care co-ordinators, every three months for 15 months. The Camberwell Assessment of Need questionnaire (Slade et al 1996), which explores 22 domains of patient need (e.g. accommodation, self-care, psychotic symptoms, safety to self and others) was used during interviews to provide a semi-structured format about the areas of need being addressed but respondents also discussed wider issues and difficulties they faced as these emerged. The longitudinal and repeated nature of both the observations and interviews was designed to obtain a detailed and nuanced perspective of ongoing care co-ordination. All four CMHT managers, two psychiatrists, two social workers, two occupational therapists and six carers (total 16) were also interviewed. In total, five large books of detailed observation notes and over 200 interviews were

completed. Nursing files, care plans, local policies and audit reports relevant to the CPA were also reviewed.

Rigour

Rigour was provided through prolonged contact and engagement and discussion of emerging ideas and findings with participants (Davies & Dodd, 2002). The multiple data sources outlined above were employed to create a rich, detailed description of the phenomenon under study and allowed triangulation between methods (Murphy et al., 1998). Memo writing and progress reports included exploration of categories and concepts as part of a strategy aimed at enhancing the credibility, robustness and trustworthiness of emerging themes (Cutcliffe & McKenna, 1999; Long & Johnson, 2000). Constant critical reflection was conducted with supervisors on the choice of methods and the gathering and interpretation of data in order to challenge intuitive assumptions and values (Mackenzie, 1996).

Ethical Considerations

The Local Research Ethics Committee provided ethical approval. All participants were given written and verbal information and participation was voluntary. Participants gave written consent for recorded interviews and verbal consent for participant observation at meetings. Teams are referred to by colour-coded names and pseudonyms are used to maintain anonymity.

Data Analysis

Textual data were transcribed and imported into QSR NVivo software to aid analysis (Richards, 1999). Pattern analysis was employed, suitable in multiple case studies and

qualitative research (Robson 1993; Yin 1994; Thorne 2000). Pattern analysis requires the researcher to look for and describe patterns of behaviour or interactions in the case being studied. Where there are multiple cases, these patterns are then compared and contrasted with patterns identified in other similar or contrasting cases (i.e. teams). Central to this approach is the technique of 'constant comparative analysis', which involves the comparison of data (an interview, an observation, a theme) with other data in order to develop conceptualisations of possible relationships (Thorne, 2000). Emerging themes were used to organise and select further material in order to challenge, clarify and consolidate the conceptual explanations (Robson, 1993).

FINDINGS

Emergent themes that most impacted on team participation, communication, functioning and care co-ordination are described under the following headings: 'structure and procedures'; 'disrespect and withdrawal'; 'humour and undermining'; and 'safety and disclosure'.

'Structure and procedures'

Communication within CMHTs mostly took place in weekly team meetings, which included discussions on referrals, assessments, discharging patients from hospital, allocation of care co-ordinator responsibilities, difficulties and general team business. 'Yellow team' alone operated to a clear structure that included use of regularly updated lists of patients in inpatient and hostel settings. This ensured the need for discharge planning was identified and agreed upon at an early stage and encouraged a multidisciplinary focus on the needs of patients compared with the other teams. A secretary took minutes at each 'Yellow team' meeting, which were referred to the

following week. Eventually, over the two-year period of the study, other teams developed similar systems and the benefits of such a process were clear. Teams not using a system to record decisions spent excessive time re-visiting issues that had been discussed and apparently agreed upon previously. Individuals forgot or avoided what they had agreed to do.

Where teams did not have agreed policies on the referrals they accepted, repeated discussion of the eligibility or otherwise of particular referrals to the team wasted many hours of valuable time. Team members went through arguments at numerous meetings trying to decide whether they should assess someone or refer them to another service. Frequently these arguments concerned issues discussed previously, such as people referred for alcohol dependency or relatively minor mental health problems. Once accepted by the team, service users had to be allocated a team member as their CPA care co-ordinator. Lack of capacity within teams caused by staff shortages created disputes over allocations, which were exacerbated by the lack of agreed policies over management of caseloads and workload.

> CMHN1: "Now these allocations…."
>
> CMHN2: "If they're not urgent we could discuss it in the [CPN] allocation meeting."
>
> Social Worker: "This one [takes file] no-one can see […]" [talks to team manager]
>
> OT: "Just give me one" [sounds irritated, gets up and takes a file]
>
> CMHN2: "I don't think that's the right way…."
>
> OT: "Oh, just take one, if you want one" [very annoyed]

CMHN2: "But they need to be discussed…."

OT: "They've been discussed several times now".

Team manager: [takes two files and looks at them] "These should have been allocated."

CMHN1: "I did my best".

[Observation notes from Orange Team meeting]

Team managers faced constant tensions trying to develop and establish team structures and policies whilst dealing with day-to-day demands and pressures. Lack of structures tended to create a vacuum, within which uncertainty and anxiety grew. In such situations, the consultant psychiatrists would frequently and understandably attempt to impose solutions to the perceived difficulties through their professional status or force of personality. Such actions tended to create resentment and resistance, rather than agreement and co-operation that are essential to the provision of co-ordinated care. When new procedures were established, they provided team members with a joint focus and prevented strong personalities from dominating proceedings.

"It took about six months really before people in [Red team] found their feet. I think what they didn't have was the structure for the meetings there. So if you now go back you can see that there is a very clear structure […] In terms of team processes, the agenda for the meetings were very clearly structured in terms of what is to come, times for this, etc. […] So the structure was there, so if people come in they are working towards that structure, whoever the professional is. […] So that helped the process I think. What the Red Team didn't have when I joined was that clear structure. And there was medical control basically. A very medical focused team meeting. So if you were to go

> back now you would see quite clearly the manager takes the chair for very obvious reasons. […] The personalities are still there, but they are working more together. The structure informs how the team relates." [Team Manager Interview]

'Disrespect and withdrawal'

Respect for team members and their professional input appeared to be an important component of an effectively functioning team. Interactions between members of the 'Yellow team' tended to be mutually respectful, with staff willing to offer information and seek advice and support. They also managed to praise one another on occasions, which was rarely witnessed elsewhere. Interprofessional respect was less apparent in other teams. In 'Orange team' for example, the consultant tended to talk at length about patients seen in an outpatients' clinic, whilst making no attempt to engage with their care co-ordinator. Team members explained that as the consultant frequently failed to consult with them they tended to feel unvalued and resentful. There was little or no recognition of the skills or contributions of others. One CMHN described how such attitudes had a negative effect on team morale and spoke of adopting a 'defensive posture' within meetings in response. She would sit quietly and contribute little in meetings or avoid attending meetings altogether. The team manager suggested that the consultant "failed to acknowledge that perhaps the care co-ordinator in the team might actually have more or a broader knowledge of the patient's needs".

Another CMHN, from 'Green team', also spoke of 'taking a defensive position' and 'withdrawing' from meetings, in response to the perceived lack of respect exhibited by the consultant psychiatrist. Following a number of incidents at hospital ward

rounds during which the CMHN felt her professional position had been undermined in front of staff and patients, she refused to attend ward rounds; “I used to sit with steam coming out of my ears”. To minimise the inconvenience and negative impact on the aftercare of patients, the CMHN regularly visited the ward and liaised with the patients and their primary nurse. CMHNs, occupational therapists and social workers stressed that it was important to feel that their professional views were sought, respected and considered. When this did not take place there was a tendency for resentments to grow and for some workers to withdraw cooperation. Such dynamics had a detrimental impact on their ability to operate as care co-ordinators, where a key part of that role involves communicating with members of community and inpatient teams.

‘Humour and undermining’

Within some CMHTs, humour was used in a warm and inclusive way to connect with others, to gently tease others over their handling of situations or relieve anxieties associated with stressful and pressured work. In these situations, laughter was shared.

> Psychiatrist read out a referral.
>
> CMHN: "I used to see him."
>
> Psychiatrist: "Yes, he didn't like you." [General laughter]
>
> Social Worker: "Support from colleagues" [Jokey aside]
>
> Psychiatrist read out another referral.
>
> CMHN: "I used to see her too. Anything on me there? She likes me, doesn't she? She likes me too much."
>
> Psychiatrist: "She wants to see more of you."
>
> [Blue/Green Joint Team meeting observation notes]

‘Yellow team’ seemed to be particularly harmonious and this was evident in the gentle, warm humour that regularly pervaded their meetings. In one meeting, the team manager mentioned a patient and discussion led to agreement that allocating a keyworker would reduce the chances of her being re-admitted in a crisis.

> Junior psychiatrist: "She's doing my head in" [Laughter]
>
> Dr Yellow: "Don't say that *before* the allocation of a keyworker." [Laughter]
>
> [Yellow Team meeting observation notes]

However, in other teams there were times when humour was used to signal tension or annoyance or, in teams with higher levels of interprofessional or interpersonal difficulties, to belittle or undermine. During the early stages of the fieldwork, when new team managers were being appointed, there were a number of incidents that suggested underlying discomfort amongst the consultant psychiatrists who made jokes when the appointment of team managers was discussed. When a social work senior practitioner was appointed as team manager for two of the teams, the responses from within both teams contained humour that suggested an underlying dynamic. For example, at a ‘Green team’ meeting, one of the CMHNs smilingly introduced the new team manager to the consultant with, "He's your new boss." This was met with laughter around the team, perhaps revealing the difficulty members had in considering the idea of a non-medical practitioner managing a doctor. The social worker/team manager was obviously alert to this possibility and relieved the tension tactfully by saying, "So I don't want you late next Friday. And if you believe that you'll believe anything". This response is perhaps revealing – the social worker has to reassure the

consultant that he will not be telling him what to do. During interviews, all four team managers spoke of their awareness of having to manage teams whilst having limited power over consultants and the psychiatrists vigorously confirmed their resistance to being managed in later interviews.

> Researcher: You wouldn't like to see yourself being managed by the team manager?
>
> Dr Purple: Well obviously there would be several reasons not. But my first thing would be 'great' as long as the responsibility comes off my shoulders and I don't have the RMO responsibilities anymore, because there are a lot of responsibilities that rest with the consultant. I don't think you can have the consultant managed by somebody else who doesn't have those responsibilities really. Apart from the old culture of the fact that doctors wouldn't want to be managed by other professions. You've seen that with the other professions. Members of one profession don't like being managed by somebody from another profession. That's an awkward one.
>
> [Dr Purple Interview.]

In summary, humour could be used in a positive, inclusive way that served to unite team members or it reflected and allowed the expression of underlying tensions within teams. Those who felt relatively powerless used quips and asides, rather than address concerns directly. Those with more power used humour to belittle others who they feared might threaten their position. This tendency to belittle or undermine is now taken up in more detail and illustrates how it may have the effect of demoralising and disempowering the person holding the care co-ordinator role.

In ‘Red team’ meetings, the consultant psychiatrist frequently acted in a way that undermined team colleagues. For example, during a discussion about the issues discussed in team meetings, someone said they talked about their most difficult clients.

> Dr Red: “I never bring my worst problems. Some of the CPNs' worst problems are my easy ones.”
>
> [Observation notes from Red Team meeting]

When team members discussed their clinical work he would often interject with statements that would belittle the efforts being made. During one meeting, a CMHN discussed a patient who was causing him and others difficulties. The CMHN tried to enlist the help of team members to consider how best to work therapeutically and safely with a woman who self-harmed and made repeated suicide attempts. At the start of the discussion, the consultant said to the CMHN, “She's too clever for you.” Then, after a co-ordinated plan was established, the consultant said in a very dismissive manner, "You know she will just take an overdose as soon as you all agree something." Shortly after the team meeting, the CMHN spoke about his frustration and said that the discussions of clients at meetings "don’t get anywhere" and referred to the consultant’s comments that "undermine you and serve no constructive purpose". Such 'undermining’ served to counteract attempts to work effectively with some very challenging clients and diminished the chances of providing collaborative care.

'Safety and disclosure'

Team meetings at which difficult issues were discussed openly with little fear of derision provided a 'safe' environment in which members could explore difficulties they encountered and acknowledge the limits of their understanding. In such teams, information, support and encouragement were provided and members were empowered. Where care co-ordinators were more likely to experience disparaging or provocative remarks they were less likely to raise sensitive or challenging issues within meetings. There was also the suggestion that important information might be withheld from colleagues as a result of such actions, with potentially serious consequences.

During observation of a home meeting between a 'Red team' CMHN and a service user, the user spoke in graphic and disturbing detail about visual hallucinations he experienced and the voices he heard. The CMHN worked skilfully to elicit and record more information whilst maintaining the client in a reasonably calm and safe state of mind. Towards the end of the session, the user said that he did not want the consultant psychiatrist to know what he had told the nurse, explaining that he did not trust the doctor and feared he would be compulsorily admitted to hospital, as on previous occasions. The CMHN explained that he worked as part of a team and would have to discuss matters with the psychiatrist. However, during a subsequent interview with the researcher the CMHN said that he shared the user's distrust of the consultant and felt frustrated that he did not feel "safe" within the team to openly discuss and consider alternative ways of working with the user, such as cognitive behavioural therapy, alongside the continued use of medication.

> "Some sort of trust needs to be built whereby [discussing his hallucinations] doesn't always equal admission and enforced treatment". [CMHN interview]

The CMHN outlined how the team meetings were not a safe place in which to discuss such matters and described previous situations where the consultant had undermined attempts to discuss patients, some of which had been observed during this study.

> "No, no, it's not [safe], I mean, it's not, because, you know, because of experiences it is a difficult place to disclose, there's not a great deal of space within that meeting to actually talk things through fully to come out with a rational conclusion to them. I mean I've had experiences where I will begin to talk about someone and [Dr Red] will cloud the rest of the team's judgement by his overall personal feelings about that person." [CMHN interview]

The CMHN made it clear that he was considering not reporting some of the content of the conversation with the client, as he did not trust the nature of the response by the consultant. He expressed his frustration that it was perhaps the lack of safety and containment within the team that prevented the CMHT being able to sufficiently support this man within his home.

> "I mean the team is so, so important, it's the core of everything. And maybe it's not necessarily down to resources. It's down to the strength, the strength of your team to be able to take stuff on board without panicking. Without having good solid reasons for that, you know. Good assessment of risk and good self-

> awareness and team awareness of what you offer as a unit. We offer this as a unit therefore we can absorb this chap, you know, within the community resources that we've got." [CMHN interview]

Care co-ordinators are less likely to apply their knowledge and skills to the welfare of their patients when they work in teams where they are disrespected or discouraged from openly discussing their uncertainties and the treatment options available. This makes them feel 'unsafe' and results in withdrawal and the taking of defensive positions. There is also the possibility that where team meetings are not perceived as safe places for open disclosure and discussion, important information may be played down or withheld by care co-ordinators with potentially serious consequences.

DISCUSSION

Processes and interactions within teams were identified that may facilitate or impede the ability of CMHNs and others to operate effectively as care co-ordinators and clinicians. First, teams worked more effectively and supported coordination of care when they employed clear structures and procedures. There is extensive literature extolling the importance of team structure, policies and procedures for the effective management of CMHTs (Onyett et al., 1995; 1997; Ovretveit 1997a; Liberman et al., 2001; Royal College of Psychiatrists 2005). Yet the majority of teams in this study were impaired by an absence of clear aims and policies regarding referrals, assessment and work allocation. These teams had been formed shortly before the start of the study and required time to develop team processes and norms (Drinka and Clark, 2000), but 18 months into the study, many of these were still not in place and it was evident that developing them whilst coping with the demands of day-to-day

operations was difficult. Such findings are important given the ongoing development of a range of new teams in mental health (Appleby, 2004).

Second, whilst interprofessional relationships were harmonious and productive in two of the CMHTs studied, interprofessional tensions continued to run through most teams, supporting suggestions that teamworking skills have not been addressed in the deployment of the CPA (Miller & Freeman, 2003). In particular, medical staff continued to occupy and sometimes exploit positions of power and superiority that are at odds with the need for effective interdisciplinary teamwork, mutual respect and consideration for alternative viewpoints and philosophies (Miller et al 2001). Occasionally, particular issues activated tensions between other disciplines, but it was teams in which consultant psychiatrists acted insensitively that appeared least able to function effectively; as this directly impacted on the quantity and content of information communicated within teams with negative and serious implications for patient care. Such antagonism also limited the tendency of CMHNs to work therapeutically with service users, as reported elsewhere (Warner et al., 2001). A large UK study of CMHTs reported a clear association between safe participation in team meetings and improved communication, effective teamwork and the mental health of the workforce (Borrill et al 2000). Staff are also significantly more likely to leave teams where senior psychiatrists overrule operational and clinical decisions of colleagues (Onyett et al 1994).

The CMHT managers in this study did not manage the psychiatrists, despite arguments that a unified managerial structure in teams is preferable (Onyett 1997; Ovretveit 1997b). However, there is no guarantee that such arrangements would have resolved problems. CMHT managers reportedly often fail to acknowledge the

legitimate power differences within teams or address and challenge illegitimate power employed by some team members (Norman and Peck 1999). The use of humour within teams revealed anxieties that the imposition of team managers threatened to weaken the psychiatrists' hold on power and belied attempts to gently subvert and undermine the new team leaders. Humour is often used in an attempt to resist or attenuate instructions from those with power, but is also used in an attempt to gain or retain control (Hatch & Ehrlich, 1993; Griffiths, 1998).

Studies of doctor-nurse interactions in other settings have reported improvements in relationships, which have been attributed to changes in the education, skills, status and assertiveness of nurses (Allen, 1997; Wicks, 1998). Nurses are able to challenge doctors and negotiate their work relationships on a more equitable basis. It would appear that the doctor-nurse relationship in psychiatry has some way to go in comparison and there may be explanations for this. Psychiatrists perceive their power and status to be under attack from various directions (Mackay et al., 1995) and can feel "as stigmatised as their patients" (Deahl et al., 2000: p.207). Consequently, many psychiatrists believe that whilst 'the buck still stops with them' they have less say and control over services (Kennedy & Griffiths, 2000). In such an atmosphere, it is understandable that psychiatrists respond defensively. Yet some are able to re-negotiate interprofessional relationships in a manner that allows them continuing status and influence albeit from a less domineering position (Baker et al,. 1997; Cox 2000). Others, as found in this study, attempt to undermine and destabilise those they see as a threat, in line with Strauss' (1978) negotiated order theory, in which covert, subtle and even underhand methods are employed to 'negotiate' positions of interest and unsettle others. Indeed, the attempt to publish the findings from this study led to

critical and arguably defensive responses that included the suggestion that the paper was 'more suited to a journal of nursing' than for a wider readership, which highlights the challenge faced in bringing about more constructive relations.

Psychiatrists are often seen as barriers to change (Warner et al., 2001), but the constructive involvement of doctors in multidisciplinary teams is important. In studies of collaborative working in USA medical settings, perceived physician involvement appears to play an important role in increasing collaboration among other team members (Wells, Johnson & Salyer 1998). The development of effective mental health services will continue to be damaged unless attempts to develop effective teamworking do not continue to be undermined by reluctant medical staff and managers (Reeves et al, 2006). International implications may be limited by wide variations in the organisation and delivery of psychiatric case management and cultural differences around professional status and hierarchy in team environments (Smith 2000; Burns et al 2001; Herrman et al 2002). However, services need to step back from the rhetoric of teamwork and help establish the structures and processes necessary to provide safe, respectful team environments that enable communication, collaboration and co-ordination.

STUDY LIMITATIONS

This study involved intensive, prolonged fieldwork that has produced sturdy and reliable findings, but these are derived from a relatively small sample so some caution must be taken before drawing any transferable conclusions. The data was collected just over five years ago and analysed and written up as part of a larger PhD study. Preparation and submission of several papers alongside other work commitments has led to some delay in this paper reaching publication. However, through presentation and discussion of the findings at a number of international conferences and in 2006 at a pan-London meeting of CMHT managers, it was made clear that the findings resonate and remain topical. The recommendations for improving teamwork and case management are applicable to managers and staff working in CMHTs and the array of assertive outreach, crisis response, home treatment and early intervention teams that now form part of modern community mental health services (Appleby 2004). Additionally, the CPA is once again under review in England (Department of Health 2006).

CONCLUSIONS

Teams require effective structures and mutual interprofessional trust and respect to ensure participative safety within teams that encourages open, reflective discussion. Where teams are characterised by unsupportive procedures and obstructive interactions, care co-ordinators will remain limited in their ability to work effectively and to constructively influence the provision of care and treatment for people with severe mental illness. Further research is required to identify how best to bring about collaborative, effective teamwork in mental health care.

REFERENCES

Allen, D. (1997). The nursing-medical boundary: a negotiated order? *Sociology of Health and Illness, 19*(4), 498-520.

Appleby, L. (2004). *The National Service Framework for Mental Health - Five Years On.* London: Department of Health.

Baker, P., Coleman, R., & Thomas, P. (1997). From victims to allies. *Nursing Times, 93*(27), 40-42.

Bergen, A. & While, A. (2000). A case for case studies: exploring the use of case study design in community nursing research. *Journal of Advanced Nursing, 31*(4), 926-934.

Borrill, C., West, M., Shapiro, D., & Rees, A. (2000). Team working and effectiveness in health care. *British Journal of Health Care Management, 6*(8), 354-371.

Brown, B., Crawford, P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health and Social Care in the Community, 8*(6), 425-435.

Burns, T. (2004). *Community mental health teams: A guide to current practices.* Oxford: Oxford University Press.

Burns, T., Fioritti, A., Holloway, F., Malm, U., & Rossler, W. (2001). Case management and assertive community treatment in Europe. *Psychiatric Services, 52*(5), 631-6.

Cott, C. (1998). Structure and meaning in multidisciplinary teamwork. *Sociology of Health and Illness, 20*(6), 848-873.

Cox, J. (2000). Person-power: reflections on the mental health National Service Framework for adults of working age. *Psychiatric Bulletin, 24*(6), 201-202.

Cutcliffe, J. R., & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing, 30*(2), 374-380.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*(2), 279-289.

Deahl, M., Douglas, B., & Turner, T. (2000). Full metal jacket or the emperor's new clothes? The National Service Framework for Mental Health. *Psychiatric Bulletin, 24*(6), 207-210.

Department of Health. (1999). *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. A Policy Booklet.* London: HMSO.

Department of Health (2006) Reviewing the Care Programme Approach 2006: A Consultation Document. London: Department of Health.

Drinka, T. J. K., & Clark, P. G. (2000). *Health Care Teamwork: Interdisciplinary Practice and Teaching.* London: Auburn House.

Fakhoury, W. & Wright, D. (2000). Communication and information needs of a random sample of community psychiatric nurses in the United Kingdom. *Journal of Advanced Nursing, 32*(4), 871-880.

Forchuk, C., Ouwerkerk, A., Yamashita, M. & Martin, M-L. (2002) Mental health case management in Canada: Job description analyses. *Issues in Mental Health Nursing, 23*, 477-496.

Gournay, K. (2005) The changing face of psychiatric nursing. *Advances in Psychiatric Treatment, 11*(1), 6-11.

Griffiths, L. (1998). Humour as resistance to professional dominance in community mental health teams. *Sociology of Health and Illness, 20*(6), 874-895.

Gupta, N. (1995). Keyworkers and the care programme approach: The role and responsibilities of community workers. *Psychiatric Care, 1*(6), 239-242.

Hatch, M. J., & Ehrlich, S. B. (1993). Spontaneous humour as an indicator of paradox and ambiguity in organisations. *Organisation Studies, 14*(4), 505-526.

Herrick, C.A. & Bartlett, R. (2004) Psychiatric nursing case management: past, present and future. *Issues in Mental Health Nursing, 25*, 589-602.

Herrman, H., Trauer, T., Warnock, J., & Professional Liaison Committee (Australia) Project Team. (2002). The roles and relationships of psychiatrists and other service

providers in mental health services. *Australian and New Zealand Journal of Psychiatry, 36*(1), 75-80.

Kennedy, P., & Griffiths, H. (2000). *Discussion Paper: An analysis of the concerns of Consultant General Psychiatrists about their jobs, and of the changing practices that may point towards solutions.* Durham: Northern Centre for Mental Health.

Liberman, R. P., Hilty, D. M., Drake, R. E., & Tsang, H. W. H. (2001). Requirements for Multidisciplinary Teamwork in Psychiatric Rehabilitation. *Psychiatric Services, 52*(10), 1331-1342.

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing, 4*, 30-37.

Mackay, L., Soothill, K., & Webb, C. (1995). Troubled times: The context for interprofessional collaboration? In K. Soothill, L. Mackay, & C. Webb (Eds), *Interprofessional Relations in Health Care* (pp. 5-10). London Edward Arnold.

Mackenzie, J. E. (1996). Problems of the researching person: doing insider research with your peer group. *Journal of Psychiatric and Mental Health Nursing, 3*, 267.

May, P. (1996). Joint training for mental health key workers: Part 1. *Nursing Standard, 10*(43), 39-42.

Miller, C., & Freeman, M. (2003). Clinical Teamwork: the impact of policy on collaborative practice. In A. Leathard (Ed), *Interprofessional Collaboration: From Policy to Practice in Health and Social Care* (pp. 121-132). London: Routledge.

Miller, C., Freeman, M., & Ross, N. (2001). *Interprofessional Practice in Health and Social Care: Challenging the shared learning agenda*. London: Arnold.

Mistral, W., & Velleman, R. (1997). CMHTs: the professionals' choice? *Journal of Mental Health, 6*(2), 125-140.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin, 24*(1), 37-74.

Muir-Cochrane, E. (2001). The case management practices of community mental health nurses: 'Doing the best we can'. *Australian and New Zealand Journal of Mental Health Nursing, 10*, 210-220.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). Qualitative research methods in health technology assessment: a review of the literature. *Health Technology Assessment, 2*(16).

Newman M., Lamb G.S. & Michaels C. (1991) Nurse case management: the coming together of theory and practice. *Nursing and Health Care 12*(8), 404–408.

Norman, I. J., & Peck, E. (1999). Working together in adult community mental health services: An inter-professional dialogue. *Journal of Mental Health, 8*(3), 217-230.

North, C., Ritchie, J., & Ward, K. (1993). *Factors Influencing the Implementation of The Care Programme Approach.* London: HMSO.

Onyett, S. (1997). Collaboration and the community mental health team. *Journal of Interprofessional Care, 11*(3), 257-267.

Onyett, S., Hepplestone, T. & Bushnell, D. (1994) A national survey of community mental health teams: Team structure and process. *Journal of Mental Health, 3,* 175-194.

Onyett, S., Pillinger, T., & Muijen, M. (1995). *Making community mental health teams work.* London: Sainsbury Centre for Mental Health.

Onyett, S., Standen, R., & Peck, E. (1997). The challenge of managing community mental health teams. *Health and Social Care in the Community, 5*(1), 40-47.

Ovretveit, J. (1997b). Leadership in multiprofessional teams. *Health and Social Care in the Community, 5*(4), 276-283.

Ovretveit, J. (1997a). Planning and managing teams. *Health and Social Care in the Community, 5*(4), 269-276.

Reeves, S., Freeth, D., Glen, S., Leiba, T., Berridge, E-J. & Herxberg, J. (2006) Delivering practice-based interprofessional education to community mental health teams: Understanding some key lessons. *Nurse Education in Practice, 6,* 246-253.

Richards, L. (1999). Data Alive! The thinking behind NVivo. Qualitative Health Research, 9(3), 412-428.

Robson, C. (1993). Real World Research: A resource for Social Scientists and Practitioner-Researchers. Oxford: Blackwell.

Royal College of Psychiatrists. (2005). *Community Mental Health Care: College*

Report CR124. London: Royal College of Psychiatrists.

Royal College of Psychiatrists. (1996). *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People*. London: Royal College of Psychiatrists.

Sainsbury Centre for Mental Health. (1997). *Pulling Together: the training needs of mental health workers.* London: Sainsbury Centre for Mental Health.

Schneider, J., Carpenter, J., & Brandon, T. (1999). Operation and organisation of services for people with severe mental illness in the UK: A survey of the Care Programme Approach. *British Journal of Psychiatry, 175,* 422-425.

Shepherd, D. (1996). *Learning the lessons - mental health inquiry reports published in England and Wales between 1969 and 1996 and their recommendations for improving practice. (2nd Edition)*. London: Zito Trust.

Shepherd, G. (1995). Multi-disciplinary team-working: The essential background to the Care Programme Approach. In NHS Training Division: *Building on Strengths: Developing the Care Programme Approach.* Bristol: NHS Executive.

Simpson, A. (2005). Community Psychiatric Nurses and the Care Co-ordinator Role: Squeezed to provide 'limited nursing'. *Journal of Advanced Nursing, 52*(6), 689-699.

Simpson, A. (1999). Focus on training. *Nursing Times, 95*(47), 67-68.

Simpson, A., Miller, C., & Bowers, L. (2003a). Case management models and the care programme approach: how to make the CPA effective and credible. *Journal of Psychiatric and Mental Health Nursing, 10*, 472-483.

Simpson, A., Miller, C., & Bowers, L. (2003b). The history of the Care Programme Approach in England: where did it go wrong? *Journal of Mental Health, 12*(5), 489-504.

Slade, M., Phelan, M., Thornicroft, G., & Parkman, S. (1996). The Camberwell Assessment of Need (CAN): comparison of assessments by staff and patients of the needs of the severely mentally ill. *Social Psychiatry Psychiatric Epidemiology, 31*, 109-113.

Smith, D. J. (2000). Multi-professional training in psychiatry. *Psychiatric Bulletin, 24*(9), 354b.

Stake, R. E. (1998). Case Studies. In N. K. Denzin, & Y. S. Lincoln (Eds), *Strategies of Qualitative Inquiry.* (pp. 86-109). Sage: London.

Stark, S., Stronach, I. & Warne, T. (2002) Teamwork in mental health: rhetoric and reality. *Journal of Psychiatric and Mental Health Nursing, 9*, 411-418.

Strauss, A. (1978). *Negotiations: Varieties, contexts, processes, and social order.* San Francisco: Jossey-Bass.

Sullivan, P. (1997). The care programme approach: a nursing perspective. *British Journal of Nursing, 6*(4), 208-214.

Thorne, S. (2000). Data analysis in qualitative research. *EBN Notebook, 3*(3rd July),

68-70.

Ward, M. & Stuart, G.W. (2004) Case management: perspectives of the UK and US systems. In Harrison, M., Howard, D. & Mitchell, D. (Eds) *Acute mental health nursing: From acute concerns to the capable practitioner.* London, Sage. pp90-110.

Warner, L., Hoadley, A., & Ford, R. (2001). Obstacle course. *Health Service Journal, 111*(5775), 28-29.

Wells, N.D., Johnson, R. & Salyer, S. (1998) Interdisciplinary Collaboration. *Clinical Nurse Specialist, 12*(4), 161-168.

Wicks, D. (1998). *Nurses and Doctors at Work: Rethinking professional boundaries*. Buckingham: Open University Press.

Yin, R. K. (1994). *Case Study: design and methods (Second Edition).* London: Sage.