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Thesis

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Abstract

This study narrates the organisation of mental health care via an ethnographic case study of a NHS Trust mental health directorate in England in the 1990s, during implementation of the Care Programme Approach (CPA). It seeks to understand how things are organised such that someone gets treated, by someone, in some way, and how far this mode of organisation commits people to courses of action and makes them accountable.

Various stories are told - in different ways, using different theoretical frameworks, and pitched at different levels of analysis. The thesis deploys two 'ontological themes' to do this: sense-making and authorising. Sense-making refers to the processes of how people understand and act; authorising refers to the limits and stabilisation of sense-making, the fixing and legitimisation of versions of the truth.

The systems story of organisation narrates a gap between what was anticipated by government policy by introducing the CPA, and what happened, with regard to systems of care and forms of responsibility and accountability.

The teamwork story narrates organising as accomplished through daily work practice. A ceremonial order in team meetings of *primus inter pares* results in different kinds of responsibility and accountability to that indicated in the CPA.

The patienthood story narrates how people are transformed into objects of mental health work. Becoming a psychiatric patient is more diffuse than much labelling theory presumes, and is the product of specific forms of organisation.

The thesis concludes by discussing the kind of organisation that allows for more or less authorised versions of what has been, and what should be, done. It suggests two ideal-typical forms of organisation, different kinds of 'structural context' within which organising may take place. The thesis produces two 'grand narratives' with regard to organisation: one, about the structure-process distinction; the other, about the evaluative nature of tales.

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PART ONE: Thesis Introduction

Chapter 1: Introduction

1.1 Introducing the topic

The organisation of community mental health care is a topical issue. A number of enquiries in the past 10 years, resulting from perceived failures of care in the aftermath of attacks on members of the public by psychiatric patients, has forced the issue of community mental health care further up the political agenda as well as making it a more prominent media issue (Muijen 1995). It is within this context that in the early and mid 1990s the (Conservative) government introduced a series of policies intended to provide systematic care for those diagnosed with mental illness¹.

These initially took the form of loose guidance but became increasingly prescriptive. introduced against a background of mounting public uncertainty over the impact of community care, the care that people were actually getting in the community, and about the dangers faced by the public. The policy directives covered: targeting of patients, through the categorisation of severe mental illness (SMI); a requirement on providers to establish systematic forms of assessment, coordination and review of care through application of the Care Programme Approach (CPA); this to include a formal assessment of, and plans for the management of, 'risk'; and an expectation that both health and social service agency providers would harmonise their practices to provide a seamless mental health service.

¹ These policies have been endorsed and extended by the current Labour Party government.

This thesis is about the organisation of mental health care against this situation of policy change and reformulation. The empirical data on which it is based were derived from a study of two sector teams² in one particular NHS Community Services Trust in England between 1996-1997. This took the form of an ethnographic study that included observation and interviews. This is discussed in detail in chapter 3.

There are a number of different ways to understand the organisation of mental health care in this policy context and with this research methodology. This thesis will explore those possibilities, and in so doing set out an approach for organisational study that is both processual and multi-faceted. By way of introduction to the various possibilities indicated, a sample of the observational data collected is presented below in order to identify the topics raised and consider the various 'ways in' to the thesis topic³.

² Sector teams refers to the organisation of services through 'joined up' health care teams spanning in-patient and out-patient secondary services, each team includes both a ward and a community mental health team (CMHT).

³ Please refer to Appendix One for a list of acronym definitions.

CPN1: [patient's name]. Following a CPA review I feel what's needed now is for someone to befriend this man, go to his home. I've identified three agencies who might help – MIND, [district name] social services, and Day Therapy at [name of the site within the Trust]. MIND say they would need to assess him first, I've got no joy with social services, and Day Therapy agree the patient needs something but are not able to provide the domiciliary service required for him. So none of these three are able to help now. Another review is planned for mid May. I'll approach [names team manager] fairly assertive rehab team. [Usually referred to by acronym ART. Much laughter from other team members at this form of designation].

CPN1: There'll be a crisis with this patient if things continue like this.

Several other team members at once: What's a crisis?

CPN1: He's psychotic and the crisis will emerge in the summer probably because he like to buy food and then leaves it to rot. He also likes to play with the electrics in his flat.

Other team members then suggest CPN1 gets the environmental health office involved.

CPN1 explains that the council's housing dept. have been 'in' - the flat has been referred for electrical repairs required because of previous tampering. But the subcontractors that the council use have visited and refused to do the work because they felt it was too unsafe. One of the housing officers also told CPN1 that the patient had 'nearly taken his head off'.

Discussion follows among the team about a possible section – how to assess? Admit him to the ward?

CP2 is for admission and section.

CP1 is against this course of action.

CPN1: The ideal is to get someone in at the patient's home for 2 hours a day.

CPN2 [also clinical supervisor to CPN1]: That's why ART is needed.

CPN1: ART won't get involved despite [name of ART CP] [formerly CP in Team A] being involved at the initial presentation.

CPN1 notes that in addition PAS and [name of one of Team A's hospital SWs] have been involved.

WM: This is a social thing – social services need to be involved.

CPN1 & CP2 respond that he's too ill for that. He needs someone to help him tidy the place up because he's delusional and needs input.

Discussion among the team returns to the idea of sectioning the patient.

CP1 [sounding annoyed]: We're trying to avoid admission and a section, which erodes someone's liberty! There's a serious issue here about individual rights versus community rights and providing proper care.

CPN2: The issue is about long term care and having the resources to develop that. It requires long term commitment, and that means ART.

CP1 [disagrees]: It's not intensive rehab that's needed. We need to provide from within the team. We need to free up [name of CPN1] to provide the service required.

CP1 then turns to CPN1 and advises him to go to social services and ask them why they won't provide what's been requested.

SW1: He needs a care manager.

TM with CPN1 and CP1 then agree that CPN1 should lean more heavily on social services. SW1 agrees to set up a meeting with the relevant district social services' team manager. CPN1 notes that the patient won't attend any of the meetings because he finds them too disturbing.

So this is what the data look like. At the most basic level, analysis of this data would identify the *dramatis personae* and that this sequence is about tasking – deciding who should do what with regard to whom. To unpack this a little further, we could focus upon a number of topics such as: the subjects of this exchange (the team players), the object of their discourse (the patient), or the issues implied by such discourse (policy directives and statutory rights and requirements).

Thinking about the subjects of the exchange indicates a consideration of teamwork and within this the realisation of occupational identities, inter-professional arrangements and relationships of power. Thinking about the objects of the exchange would require consideration of how the patient gets 'tasked' by the team. This would involve examination of the characterisation of patients and how they are made into suitable work for the team (or not). Thinking about the broader social and political contexts implied, points up the policy directives which community mental health teams are expected to follow by government. This would require a focus upon the main system for

organising mental health care introduced by government in the 1990s - the CPA together with an associated explicit formulation of mental health care by both politicians and the wider public in terms of the 'management of risk'.

It seemed to me that an examination of how mental health care was organised would be best enabled by addressing these various angles suggested by the data.

1.1.1 Sense-making and authorising

These various angles also suggest that the primary activity, both for participants and researcher alike, is one of trying to make sense. As the above data sample shows, participants are trying to make sense both of patients and each other as colleagues and team members. There are also senior managers and government officials who try to make sense of the situation of mental health care, and whose sense-making results in documents and procedures (such as the CPA): things that others in turn try to make sense of. There is, in addition, the sense-making undertaken by me, the researcher, in putting together this material in a way which will satisfy the requirements for a PhD thesis, demonstrating the use and interrogation of ideas from the academic disciplines, of medical sociology and organisation studies, by which it is located. Fundamentally, then, understanding the organisation of mental health care is one that engages explicitly with sense-making.

Weick's (1979; 1995) notion of 'enactment' is important here, focussing attention upon the (inter)subjective origin of organisations and the social construction of reality. For Weick, 'sensemaking' is the fundamental process in organised social life. Order and ordering emerge through response,

definition and interaction that create constraining and guiding subjective realities. So people in organisations do not so much act in response to a clearly defined and perceived environment, or respond to their environment and then develop a plan for action, which is then pursued. Instead, they try things out, discover what they are doing as they experience the outcome of their actions and then analyse these relationships to make sense of their experience. In this view it is action (including interaction) which produces organisational strategy or structure (rather than the other way round). And it is 'sensemaking' – the creation of reality as an ongoing accomplishment that takes form when people make retrospective sense of their situations – which shapes organisational structure and activities. The only ingredient I would add to Weick's definition is the role of both author and reader (researcher and examiners/other readers) in this process.

In this approach, the focus is upon 'organising' rather than 'organisation', that is, the topic is organisation in terms of process rather than outcomes. At first sight this might seem like a somewhat nebulous concept to get to grips with. And certainly for the reader at the start of this thesis it is useful to have some tangible 'things'⁴ upon which to hang the story beginning to be told. The notion of sense-making, as derived from Weick, helps perform this task. It is a task that occurs on several levels. There is the participant level, which includes various ways of making sense among those involved in the provision of mental health care in the case studied. There is also the

⁴ By 'things' I mean nouns to help grasp the verbs, or outcome-type objects that help map processes and intersubjective reality.

researcher level, which also includes more than one kind of sense-making, or ways of telling the story of organising mental health care. And there is, of course, also a reader level brought to bear on both of these two other levels.

Referring to these various levels of sense also indicates various kinds of authorship of the stories or senses made. Authorship does not just indicate who produces the text or is doing the sense-making, but also signals the *authority* of particular texts or sense-making. 'Author' and 'authority' share an etymology, both derived from the Latin 'auctor', 'to originate or promote' (Sykes 1976). Their shared etymology indicates the overlap between authorship as indicating the origin of something (including books, or events), and authority in the sense of settlement of some question or source of evidence or expertise. Authority also extends to the notion of the power or right to enforce compliance or agreement, to sanction something (documents, events, actions). 'Authorising' is the flip side of the sense-making coin. Here authorising refers both to the source of some version of sense-making together with the mandate or sanction for such sense-making to be followed. In other words, an authorised version limits sense-making, acting as a constraint upon the options available for warrantable sense-making.

In addition to this linguistic definition of authority, social theory and organisational studies have extended the definition with reference to ideas about legitimation and power. A key contribution is Weber's (Hatch 1997, p284) whose definition of bureaucracy included the notion of formal authority based on generalised rules and procedures - legalistic forms of control (Weber 1947). With new social forms came new forms of authority and control (e.g.

rational-legal bureaucracies as opposed to feudalism and aristocratic patronage). Thus, for something to be authorised, is to be deemed legitimate.

In addition, subsequent social and organisational theorists have gone on to define authority in relation to power and structures of accountability. In this definition authority is a source of power and is associated with hierarchy and a structural understanding of organisation: authority derives from one's structural position within an organisational hierarchy (Dalton 1959; Knights and Roberts 1982; Pfeffer 1981). The problem with many of these kinds of discussions is that the definitions become somewhat circular. Thus authority is power that has become legitimated within a setting; legitimation is something that is logically and/or lawfully proper, which occurs when something is authorised by those recognised to do so (in the hierarchy) in a particular setting (see, for example, discussion in Hatch 1997, pp283-4).

Circularity of logic aside, some of the authors in this field identify other qualities of authority of use to this study. First there is the view that authority occurs when perception of norms and expectations make the exercise of power accepted and expected (Hatch 1997; Pondy 1977). Here the distribution of power has crystallised into an authority structure produced by expectations about how those in authority will behave and how others will behave towards them. In other words authority is expressed in terms of expectations and obligations, and these are realised through structures of accountability.

Second, there is the kind of relationship between people implied by the above kind of conceptualisation: it is one that is defined by trust and

commitment. This is developed by Knights and Roberts in their definition of 'authoritative power':

Authority cannot be imposed or individually possessed, but always remains only a quality of the relationship between people, in which both are personally committed to, and see as legitimate, the reciprocal rights and obligations realized through their interaction.

Moreover:

It is this that makes authoritative power a moral relationship and a relationship of trust.
(1982)

Implied by the earlier definitions in terms of expectations and obligations between people, and made explicit here by Knights and Roberts, is the notion of authority deriving from commitments made by, and between, people in recognition of rights and responsibilities distributed among them. Further, this kind of relationship, invokes a moral dimension: that which is authorised (whether person(s), action or thing) is both true and good or proper.

Thus we have three dimensions to the definition of authorising. First, there is a linguistic sense, indicating a legitimate and reliable source. Second, there is a rational-legal sense, often indicating a legally binding contract, manifest through organisational structures of accountability. Third, and developing this notion of 'being bound', there is a relational sense, indicating the mutual rights and obligations between people as they recognise and accept, via expectations and commitments, certain things, situations or people as having authority or being authorised in relation to themselves.

In sum, the theme of sense-making refers to the process that occurs in organising mental health care, and the terms in which I describe what happens. The theme of authorisation refers to the limiting and fixing of possibilities for sense-making. Correspondingly, it follows that different forms of sense-making will enable or disable particular kinds of authorisation. These themes will be unpacked in more detail in successive Parts of the thesis: suffice to say for now, that they are of prime importance when we consider the organisation of mental health care. Right now I want to consider further the moral dimension introduced above and, in particular, to consider the specific spin this takes within the field of mental health care.

1.1.2 A moral terrain

The idea of sickness as a social-moral construct entailing rights and obligations is associated with Parsons (1951), who first conceptualised the notion of the 'sick role'. The sick role can be described as consisting of four components:

- ◆ an exemption from normal role obligations;
- ◆ a recognition of the patients' non-responsibility for illness and inability to get well without help;
- ◆ a requirement that the sick person sees the sickness as undesirable and display an orientation to getting well; and
- ◆ an obligation to seek out and cooperate with the relevant professional helpers

(Turner 1987, p38).

The ‘sick role’ conceptualisation indicates a notion of ‘deservingness’ (Griffiths and Hughes 1994) with regard to being a patient. Thus the mental health care policy directive from government for agencies to target ‘SMI’ adds a particular spin to the notion of just who is deserving of mental health care. It marks out patients or their sponsors (e.g. GP referrers to mental health care agencies) as needing to present in ways that indicate just such a categorisation. It marks out mental health professionals who work in such agencies as responsible for properly determining just who is so deserving of care, and in so doing assessing and managing risks posed.

Moreover, patients are deemed by virtue of their psychiatric illness as being unable to take responsibility for themselves to some, often disputed, degree. Instead, this responsibility is deemed to fall to the mental health professional involved in their care. And when some people are regarded as being responsible for the actions of others, then they are in jeopardy of being regarded as culpable for the actions of these others.

1.1.3 Responsibility and accountability

The above discussion points up the heightened moral quality that applies to the work of mental health care. It also points up mental health care as being construed in terms of responsibility and accountability. All of this takes place in an environment marked by great uncertainty: about what patients might do; about what colleagues and other agencies might do or not do; and about what is ‘the right thing to do’ (in, say, balancing respect for individual liberty with more directly protective and/or coercive measures).

Like any other kind of work, mental health work is organised and it is a constituent feature of this organisation that the objects of that work are construed in terms of ‘what must be done’, and by when and by whom: that is, they are configured in terms of organisational imperatives. However, as will be demonstrated in Parts Two to Four, the organisation of community mental health care is a ramshackle affair. This is work that goes on at the meeting point between different agencies and different occupational groups. There is always the potential for competing definitions of what the imperatives are: just what is ‘the organisation’ that is referred to. In this sense ‘the organisation’ in mental health care is not a stable category that either exists as a rational enterprise or can be read off from some wider political and economic structure. It is the product of negotiations and ritualised routines for interaction within the everyday life of mental health teams.

In so far as organisation members agree (or fail to agree) among themselves who should be doing what, for, or with regard to, whom, they are also laying the groundwork for potential claims about culpability in the face of later adverse events. Such imputations might be of two kinds: one to the effect that those who should have foreseen the risk did not do so; another that those who should have acted to prevent the adverse event failed to do so. Such imputations might be made at the corporate level; in terms of failings of the team; or at the individual level. Managing culpability in this way might be done explicitly, but it is more likely to be accomplished implicitly, and sometimes without members being aware that they are taking steps now which may, or may not, in the future provide resources for determining who or what was to blame. It is accomplished through the self-same tasks of configuring

problems and fabricating identities, i.e. ‘the problem/patient is such and such and this kind of problem/patient could be managed by this kind of expertise/agency/professional, which is best suited to this sort of problem/person’.

In these terms then, the production of an organisation in terms of agreements (or the absence of agreements) as to who should be doing what about whom and when, draws sets of cognitive and rhetorical resources regarding:

- ◆ the nature of mental illness, its management and remediation, including the risks of adverse events;
- ◆ the proper division of responsibility to be adopted for ‘cases like this’, including the division as between workers, and as between worker(s) and the client, and falling out of this;
- ◆ some prefiguring of an allocation of credit when things go right or blame when things go wrong.

How such matters are decided from time to time, or how they are left indeterminate *is* ‘the organisation of community mental health care’, or at least this listing defines its more salient features.

1.1.4 Research questions

When I started the research I was first aware of public documents and wider debates in the ‘trade’ or practitioner press about the Care Programme Approach. The CPA and associated guidance is a model of care promoted as the authorised version of care in the organisation of mental health services

since the 1990s. Implementing this model was not straightforward, as the controversy and confusion that beset the terrain of mental health care by the mid-1990s testified. I refer here to the failure to implement the CPA by many NHS Trusts by a series of deadlines over the first few years, different understandings about how to interpret and operationalise government guidance on the CPA, and contradictory views at local levels as to whether CPA was being followed or not (see Part Two for fuller and referenced discussion). It thus seemed timely to examine just how community mental health care was achieved following these policies and reformulation, and, as the research proceeded, to do so in light of the themes and issues identified in the discussion above. Thus the primary question that emerged was:

- ◆ How are things organised such that someone gets treated by someone in some way, and how far does this mode of organisation commit people to courses of action and make them accountable for following them?

As the research proceeded other questions emerged, questions that break down the primary question into several middle range questions, which are explored in the respective parts of the thesis as follows:

- ◆ Does this organisation result in the authorised, coordinated care envisaged by the CPA? (Part 2)
- ◆ How is the work defined and responsibilities determined among multi-disciplinary and multi-agency organisational members? (Part 3)

- ◆ How do members agree (or fail to agree) on patients and with what consequences? (Part 4)
- ◆ What are the consequences of such tasking processes for professional and patient identities? (Parts 3 and 4)

Finally much later in the project a concluding and second high level question was developed:

- ◆ What kind of organisation enables or disables the outcomes identified? (Part 4 and 5)

These questions helped chart a way into the topic, and in this sense are best understood as a 'medium' through which to gain a handle on the process of organising. Thus, this is not the kind of thesis that starts out from a deductive frame, with a series of hypothesis-testing questions. Rather, this is an inductively framed study, guided by a set of exploratory questions. The implications of this statement are taken up in the remainder of Part One.

1.2 Treatment of the topic: studying the organisation of mental health care

The prime research question and associated sub-questions for this thesis have now been identified. This raises the question of how to address them. To some extent an answer is provided by theoretical debates within organisational studies.

Several theorists on organisation have suggested a multiple perspectives approach in theorising organisations on the grounds of the complexity of organisation (see for example Burrell and Morgan 1979;

Czarniawska 1992; Hatch 1997). Many who adopt this approach also cite the Hindu parable of the blind man and the elephant to illustrate their reason for this strategy:

Six blind men met with an elephant The first said that an elephant was like a leaf. The second adamantly disagreed, claiming it was certainly like a wall. The third described the elephant as a mighty tree, the fourth a spear, the fifth a rope, and the last one thought it was really a snake. Each of them had gotten hold of a different part of the elephant and so had come away with remarkably different understandings of this creature. (Hatch 1997, p7)

And my point in re-telling this story is to highlight that students of organisation are a lot like those blind men, and the organisation they study is their elephant. While several authors have advanced a multiple perspectives approach to theorising organisation, far fewer have applied such an approach empirically (but see for example Allison 1971). This is how I intend to examine the organisation of mental health care in this thesis.

1.2.1 Anthropology of organisation

What is being proposed therefore is an approach which might best be characterised as ‘an anthropology of organisation’ (Czarniawska 1992). This is defined as “the study of meanings and artifacts ... a cumulative science, in which various elements ... contribute to a growing understanding of ... the complex organisation” (p186-187). For Czarniawska the ‘anthropology’ is created gradually, in the kind of intensive, ‘immersed studies’ conventionally associated with anthropology, through a number of partial studies, but I borrow from this to propose a series of studies through the various Parts of this thesis.

Following Czarniawska, then, the strategy is to:

Attempt a story (not a history) of a phenomenon. Try to tie together various versions, actors, situations and accounts so that they make sense even if they contradict each other. The result should be a multifaceted magnifying glass, showing a picture that is wholly visible but fuzzy from a distance, and that becomes sharp but incomplete when viewed through one of the facets. (Czarniawska 1992, p204).

The thesis takes this up as follows:

- Part two is a scene-setting story, with chapter 4 telling the tale of the CPA as a national policy initiative. Here I draw on government documents and 'trade' literature. Chapter 5 tells the story of attempts to implement the CPA in the NHS Trust studied. Here I draw particularly on an account I wrote as a 'management consultant' to the Trust, together with other studies of CPA implementation. Both these stories are written with a managerial voice and the image of organisation is one of structures and functions.
- ◆ Part Three looks at teamwork as it was practised by the teams I observed. Here the topic is organising, rather than organisation. The approach is ethnographic, though informed by ethnomethodology and by various conceptual tools drawn from Goffman and others influenced by him. Since these are *multidisciplinary* teams, the literature on this topic is reviewed, and the story is told as a contribution to debates about multidisciplinary and interdisciplinary relations.

- ◆ Part Four looks at the products of team deliberations described in Part Three. The products are the organisational personalities created for patients by teams as patients are transformed into objects of mental health work. Again, the approach is ethnographic. This is a field of study where ‘labelling theory’ has occupied a central space. The relevant literature is reviewed and this part of the thesis is told as a contribution to the critique of labelling theory.
- Part Five draws the other parts of the thesis together, and concludes with a retrospective methodological evaluation.

For the remainder of Part One, chapter 2 discusses the methodology that led to the selection and deployment of the methods used for the study. These are told in chapter 3 as the ‘story from the field’.

Chapter 2: Methodology

This chapter considers the methodology of the study – the broader theoretical and philosophical framework that underpins particular methods. Thus, the epistemological issues that frame qualitative research, and in particular ethnography, are considered. It forms the background for chapter 3, on method, which provides a narrative of how the research was conducted. An evaluation of the method is discussed in the concluding Part of the thesis.

2.1 Methodological issues

It is clear from the research questions outlined in chapter 1 that the focus for the study is upon how mental health care gets defined and practised. It was also suggested that ethnography was the most appropriate means to study such ‘accomplishment’ of organisation.

Ethnography, at its most basic means writing (graphy) about peoples (ethno), and is frequently defined as “cultural description” (Hatch 1997, p221), as “the analytic description of a culture” (Van Maanen 1979), or with specific regard to organisation studies as “a method for studying organisational culture” (Rosen 1991, p1). This equation of ethnography with the study of culture has its roots in the development of anthropology and methods used to study different peoples during the 19th and early 20th century as this discipline evolved.

In the context of anthropology, the term ethnography was coined to denote “literally, an anthropologist’s ‘picture’ of the way of life of some interacting human group” (Wolcott, 1975, p112, quoted in Bryman 1988, p45). The implication is that ethnography does not simply refer to a set of techniques or research methods. It is also linked to methodology or matters of ontology and epistemology – different notions

about what there is to know and how we can know with regard to social reality and human nature. In this sense 'anthropology' is a discipline that invokes a set of ontological and epistemological notions about social research. This is not to suggest, however, that anthropology represents some sort of unitary, homogenous take on social research – the term refers to a discipline of study that incorporates various approaches. But what the discipline does offer broadly is a commitment to holism, interpretation, and direct, intensive and prolonged contact with the subject matter of study (Czarniawska 1992, p44). That ethnography has come to be identified in this sense as both method and methodology is nicely illustrated by Brewer's more recent definition of the term:

Ethnography is the study of people in naturally occurring settings or 'fields' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally. (Brewer 2000, p6).

The various aspects of methodology that this quote, and the above discussion, imply will be unpacked in more detail below.

2.1.1 Debates that frame qualitative/ethnographic enquiry

Debates that frame qualitative research/ethnography have in large part been pursued in paradigmatic terms, contrasting it especially with quantitative research. This has produced a debate framed largely in dichotomous terms. More recently, some qualitative researchers have taken issue with this, acknowledging the complexity of issues raised, which are not captured by an 'either/or' approach. Instead they argue for an instrumental approach to methodology which charts a 'middle-way' through the terrain (Hammersley 1992; Murphy, Dingwall, Greatbatch, Parker and Watson 1998; Silverman 1993).

2.1.1.1 Research philosophy

There are three key areas of research philosophy that frame attempts to define ethnography:

- ◆ critiques of realism;
- ◆ the logic of and place of theory in research and;
- ◆ the naturalistic stance.

Thinking about the relationship between reality and knowledge has been framed paradigmatically in terms of realism versus relativism or idealism (Hammersley 1992; Murphy *et al.*, 1998). This may be framed as debates within ethnography between natural science and humanistic models of enquiry and/or as antinomy between quantitative and qualitative approaches.

For the realist, there is an independent reality, that exists 'out there', that can be known and it is the job of the researcher to render this faithfully. Hence the trend in early anthropological and sociological research of the 1920s to 'get close' to the social phenomena studied, and the emergence of ethnography as the means to do so. In this frame there is a simple separation between researcher/observer and researched/observed. For the relativist, people construct the social world, both through their interpretations of it and through action based on such interpretations. Thus it is impossible to represent an independent reality: rather, there are multiple realities. In this frame there can be no simple separation of researcher/observer and researched/observed. Within this perspective there are stronger and weaker versions of such constructionism (Schwandt 1997). The stronger version, 'radical constructivism', argues it is only possible to have knowledge of phenomena through our own experience of it, or since it is only possible to have knowledge of phenomena through experience,

and everyone's experience is different, no one account of reality can be superior to any other. The weaker version, 'social constructionism', emphasises knowledge as intersubjectively, rather than individually constructed, so that knowledge of the world is an expression of the relationships among people.

The realist correspondence theory of knowledge/truth poses the problem of establishing any dependable grounds for truth claims, where in the face of challenge the result is one of infinite regress – evidence either goes on for ever or is circular (Hammersley 1992; Murphy *et al.*, 1998)⁵. The relativist approach can be seen as an answer to such problems. by side-stepping the correspondence theory of reality, so that knowledge is seen as context-bound. Then 'truth' becomes a superfluous term (Hammersley 1992; Murphy *et al.*, 1998). The result, however, is either the paradoxical one that ethnographers produce an 'objective' account of participants' social experiences, which in themselves are treated as incommensurable (unlike the ethnographer's account!) (Hammersley and Atkinson 1995). Or the ethnographer adopts a more radical reflexivity where the ethnographic account sits alongside participants' accounts, all equally incommensurable. However, the problem for research, then, is that it lacks any critical purchase on the various possible accounts (Schwandt 1997). Indeed one might wonder why researchers would then bother to pursue empirical enquiry.

⁵ Popperian falsification (Miller 1994) is often adopted as an escape route here, with the claim that while we can never be sure of what is true, we can be more, though still not entirely, certain as to what is false. On this basis the search for truth is conducted through the elimination of error. This approach is more characteristic of quantitative research, though there are, for example, elements of it in the strategies used by Becker and colleagues in their ethnographies of medical education, where they direct their search for evidence particularly towards that which would falsify their earlier assumptions (1977). However, it has been claimed that falsification is as problematic as verification (Hammersley 2002; Miller 1994, Chapter 2). The falsificationist programme might be said to represent a weak version of the idea of correspondence.

Of course, these two sets of ontological and epistemological positions are contrastive extremes, framed by a paradigmatic mentality. Hammersley has argued for a third position, which he terms ‘subtle realism’ (Hammersley 1992). This view is non-foundationalist in that the researcher concedes that it is impossible to have any certainty about knowledge claims, but retains the idea that some knowledge claims can be more true than others. Similarly, the researcher accepts the relational, mediated nature of knowledge. Reality can therefore be represented from a range of different perspectives. Research seeks knowledge about which we can be reasonably confident. Hammersley thus proposes a new construct of research validity, which extends beyond mere accuracy as ‘correspondence’. Instead the criteria that define validity are plausibility (whether any truth claim is likely to be true given our existing knowledge), and credibility (whether any truth claim is likely to be accurate given the nature of the phenomenon, the circumstances of the research, and the characteristics of the researcher)⁶. As Murphy *et al* note:

This opens up the possibility of multiple, non-competing, valid descriptions and explanations of the same phenomenon. However, it excludes the possibility of multiple, competing, valid descriptions or explanations of the same phenomena. (1998, p69). ⁷

And it is this position of ‘subtle realism’ that is adopted here.

The second philosophical aspect of qualitative/ethnographic enquiry that requires attention relates to the logic of, and place of, theory in research. Hammersley notes, in his discussion of ethnography, that qualitative research (including ethnography) is often characterised as adopting an inductive research strategy, in

⁶ Hammersley presented this subtle form of realism as equally appropriate for qualitative and quantitative social research.

⁷ Another way of coming at the idea of multiple *non-competing* valid definitions arises simply from the fact that any particular description or explanation is by necessity incomplete, and framed for some purpose/ in terms of some scheme of relevance.

contrast to quantitative research which is framed as deductive (Hammersley 1992). Indeed ethnography is often understood to be the inductive approach *par excellence*. This contrastive position owes much to qualitative-inspired methodological work in the 1960s by Glaser and Strauss (Glaser and Strauss 1967). Highly critical of what they saw as the obsession with theory testing in sociological research of the time, Glaser and Strauss argued that this emphasis had led to the neglect of the importance of theory generation. Instead they argued against the *a priori* imposition of theory upon data, making a case for the development of 'grounded theory', which because it is derived from the data, will fit and work. However, as Schwandt notes (1997), closer inspection of these methods indicates the use of both induction and deduction. The constant comparative method of theory generation and refinement advanced by Glaser and Strauss involves the continual movement between theory and data (Murphy *et al.*, 1998, p71). Several qualitative methodologists have argued that the qualitative data is simultaneously inductive and deductive (Bulmer 1979; Hammersley *et al.*, 1995; Lofland 1976; Murphy *et al.*, 1998). This combination is related to the process of qualitative research, where data analysis is not necessarily treated as a discrete stage of the research, but occurs *alongside data collection*. There is a movement between data and theory as the research proceeds. Given the subtle realist position outlined above, this aspect of the relationship of theory to data is not that surprising.⁸

It is this more qualified take on induction that is adopted here. As the discussion later in this chapter will demonstrate, certain theoretical ideas about innovation and change foreshadowed the substantive research undertaken. Further, while the primary

⁸ It is worth noting that discussion of inductivism and deductivism is rendered complicated by the fact that neither of these terms is used in the same way by all authors, and that any deductive thinking involves inductive moves, and vice versa (Hammersley 2002).

orientation during the empirical phase of the research was of an inductive nature, as data were collected these were progressively considered (albeit loosely) in relation to existing ideas about professional socialisation and multi-disciplinary teamwork. And this in turn shaped further data collection.

The third aspect of research philosophy that frames definitions of ethnography and qualitative research (in contrast to quantitative studies) is a naturalistic stance. The key aim from this position is to remain faithful to the phenomena studied and avoid imposing artificial structures upon it (as with experiments and structured interviews which determine categories in advance of study) (Bulmer 1979; Hammersley *et al.*, 1995; Lofland 1976; Murphy *et al.*, 1998; Silverman 1993).

However, the naturalistic stance is not straightforward. Several who recognise the importance of this aspect of ethnographic study also point up the distinction between artificial and natural settings as somewhat spurious (Hammersley *et al.*, 1995; Silverman 1993):

What happens in a school class or court of law, for example, is no more natural (or artificial) than what goes on in a social psychological laboratory. To treat classrooms or courtrooms as natural and experiments as artificial is to forget that social research is itself part of the social world, something that should not be forgotten.
(Hammersley 1992, p164).

As these authors argue, what distinguishes quantitative from qualitative/ethnographic enquiry is the degree to which the research situation is structured by the researcher. Whereas experimenters and survey researchers create special settings to conduct research and play a dominant role therein, ethnographers seek to study naturally occurring settings and adopt a more marginal, less intrusive role. What is at issue here is not the ontological status of a situation as 'natural' or not – all situations are 'natural' – but how far a situation studied can yield evidence about

unstudied situations. There must be serious doubts as to how far the situation of an experiment can serve as a proxy for non-experimental situations.

Hammersley notes that the argument in favour of a naturalistic stance is usually framed in terms of reducing the reactivity associated with quantitative methods of data collection (Hammersley 1992). Thus, rather than risk that research findings are the artifacts of the experiment, study of people in their everyday lives incorporates the social relationships and social context that affect the events and people studied and which continue to operate while the researcher observes. However, as Hammersley and Atkinson note, all researchers (of whatever type) are part of the social world they study (Hammersley *et al.*, 1995). Moreover, as passive and unobtrusive as they may be, the mere presence of researchers is likely to alter a setting in ways which may be significant (Hammersley 1992). Indeed it is perhaps more productive to treat such impact upon a setting as a resource rather than a liability. Hence the importance of the reflexivity (discussed earlier) within the subtle realist position.

The position adopted in this research was naturalistic in the sense of not seeking to structure the research situation and attempting to minimise intrusion through a more marginal role in the setting. However, it was never possible to be a ‘fly on the wall’. As I illustrate in chapter 3, there were many occasions when my presence in the fieldwork setting was a topic and/or a resource for the participants, which in turn I treated as both topic and resource for the research.

2.1.1.2 Research practice

Certain kinds of research practice follow from the kinds of philosophical positions defining ethnographic enquiry as discussed above. Just as those three areas of philosophy have been argued not to present neat dichotomous choices, so too the

aspects of practice discussed below, while orienting this study methodologically, are problematised and adapted.

In terms of research practice, Bryman's list is often cited, (as well as adapted and critiqued), as definitive of qualitative research/ethnography (Hammersley 1992; Murphy *et al.*, 1998; Silverman 1993). Bryman presents six features as characteristic of qualitative research (1988, pp61-69):

- ◆ 'Seeing through the eyes of' – taking the subject's perspective
- ◆ Describing the mundane detail of everyday settings
- ◆ Understanding actions and meanings in their social context - holism
- ◆ Emphasising time and process
- ◆ Flexible research designs
- ◆ Avoidance of theoretical frameworks and concepts at an early stage - inductive.

In a sense these various aspects of practice are 'recipes for conduct' that arise from the theoretical dimensions discussed above. They are worth considering with respect to the conduct of this research project.

2.1.1.2.1 'Seeing through the eyes of' – taking the subjects perspective

This statement attends to the focus upon participants' meanings. Much qualitative research is concerned with meaningful behaviour and this is often pursued through studies that seek to elicit the meanings that participants' ascribe to their actions and events in which they are involved. This aspect of research practice derives from certain anthropological attempts to produce an emic (insider's viewpoint) rather than an etic

perspective (imposed frame). I was keen to learn what participants believed were key issues around the implementation of the CPA and how mental health care organisation was constituted. This was a useful starting point for the research as well as being a readily meaningful position to participants. The common-sense understandings of participants served as a cue to 'how things worked'.

However, caution should be exercised in this regard. Understanding the meaning that underpins actions and events is problematic, especially with regard to reliance upon members'/participants' accounts of the meanings that underlie their actions and events they are involved in. Moreover, it is not possible to simply access and represent others' meaning. The products of research are not first order member accounts, but second order constructs of such accounts (Emerson 1983; Van Maanen 1979).

In this study, I was interested in members' talk with me as well as what they did, including how they talked with each other, during regular meetings and other work events. It will also become apparent that the data are presented via specific sociological frames of meaning (various 'second order constructs'). These indicate the range of 'interpretative procedures' adopted by myself in arriving at the explications of events and meanings discussed, and demonstrate the inextricability of 'methodology' and 'theory' in analysis.

Meaning is among the most problematic of philosophical terms and this in itself creates difficulties in deciding whether or not an ethnography has captured 'it'. Simplifying somewhat, we might say that there are two different approaches to meaning within qualitative sociology. A large percentage of qualitative researchers believe that their proper task is to produce faithful renditions of the diverse ways in which people experience their lives (Rock 1973). For this task scholars characteristically ask the question 'what was the meaning of the situation to this participant?', and answer it as if

the question were 'what must have been in his or her mind, that he or she said this or did that?'. Here the search for meaning entails using what is observable as a resource for constructing a model of the minds (motives, feelings, understandings) which lie behind the action (and, of course also using our assumptions of what such minds can be like as a resource for deciding what can be evidence of them). Much of traditional ethnography takes this line. For want of a better term it might be called an 'interactionist' approach (Shone and Atkinson 1983), although sometimes it is tagged with the term 'phenomenology' (Rock 1973).

The other approach to meaning derives much from the later Wittgenstein (1962) and shows itself most clearly, on the one hand, in pragmatic linguistics (Levinson 1983), and on the other in ethnomethodology, and particularly conversation analysis (CA) (Hutchby and Wooffitt 1998). Wittgenstein is well known for proposing that 'the meaning of a term are the rules for its use' and, in this vein, the search for meaning entails charting the way in which utterances of particular kinds are used as elements of 'language games'. 'Culture' then appears as a repertoire of language games (and of rule sets for other forms of communication). The idea of the 'meaning' of an utterance thus comes close to a specification of how these words can be used (within specified circumstances), without being incomprehensible (to specified audiences), and indicates the consequences of its use. The consequentiality of utterances (or other communicative behaviour) is of particular importance in pragmatic linguistics and ethnographic approaches influenced by them. Meaning does not apply to cognitive representation or experience, but to performance. The title of Austin's classic *How to do things with words* (1962) captures this nicely and shifts the notion of meaning away from what is going on in the mind of someone when they say something, and towards what happens

because they have said something. What mediates the performance and the consequence are shared understandings between speaker and listener.

This approach leads to close attention to small sequences of action ‘in context’ where ‘context’ refers first and foremost to immediate particularities, such as what immediately preceded the utterance of interest. An important characteristic of this, as against the more interactionist approach, is that the analyst needs to make fewer inferences about underlying mental states or cognitions. While it is doubtful as to whether anyone can experience the world as others experience it, there is at least some hope that we can learn to follow the rules of each other’s language games; or to use Garfinkel’s terms, to give an account of what members need to be able to do in order to pass as ‘competent members’ in some setting (Garfinkel 1967, chapter 5). For want of any better term I shall refer to this as an ethnomethodological approach.

There are many accounts where the contrast between these two approaches is handled paradigmatically, as if adopting elements of the one ruled out adopting elements of the other. This is particularly common where claims are made for the methodological purity of some genre of ethnomethodology ((for example Shone *et al.*, 1983). However, there are also many researchers who, from time to time, at least, adopt the fine-grained style of analysis characteristic of ethnomethodology, but would not call themselves ethnomethodologists. David Silverman and Phil Strong are cases in point (for example 1973; 1984; 1978; 1979b). It is notable that these authors are also strongly influenced by Goffman, particularly by Goffman’s focus on ‘situations’ as ‘ready-mades’ which, as it were, have a life of their own – their own ‘ceremonial order’ and into which diverse participants slot themselves appropriately or suffer the consequences of not so doing (Strong and Davis 1977). In Wittgensteinian terms such situations as ‘appointments interviews’ (Silverman), ‘medical consultations’ (Strong, Davis,

Silverman), or, for this current thesis, ‘team meetings’ are grand language games which have important consequences for participants, and where the consequences they have depend upon the ‘rules of the game’⁹. This observation leads to such situations being the important unit of analysis, and to the fine-grained study of large numbers of the same situation in order to chart the dimensions of their variation. As will be seen, much of this thesis reports the observation of large numbers of the same situation, such as team meetings, treating these situations as the contexts in which particular behaviours have meaning and in which organising gets done. The analysis is fine grained and tuned to what is accomplished using words, and in this sense the research was ‘ethnomethodologically informed’.

This allowed for study of how the organisation of mental health care was accomplished. In this way the research effort was geared towards what was observable rather than on uncovering participants’ cognition. If ‘seeing through the eyes of’ can mean providing an account of how members created situations that made sense to them, then, in so far as I accomplished this, the thesis qualifies as ‘ethnographic’ on the first of Bryman’s criteria.

2.1.1.2.2 Describing the mundane detail of everyday settings

Describing the mundane details of the research setting is important because the apparently superficial minutiae of everyday life can help in understanding what is happening in a particular setting. Moreover, this research, as with other ethnographic research, involved me in the study of a setting in which I had no previous first-hand

⁹ The game metaphor does not imply the constituent rules of a language game can be definitively and finally stated. Rather, as Wittgenstein makes clear ‘following a rule’ actually means behaving in such a way that one’s behaviour can be made out by others as consistent with a rule: the rule inheres in what is taken to be its following. Rather than language games being constituted by rules, rules are constituted (and re-constituted) in the playing of language games and are emergent rather than fixed phenomena (Kripke 1982; Weider 1974).

experience, and of which I anticipate readers may also lack detailed knowledge. So in addition to constituting a first stage to a more analytical rendering of the data, such detail allows both for the reality presented to be checked by members as well as to provide vicarious access for those for whom these settings will be unfamiliar.

However, given the discussion of research philosophy above, it is important to recognise that such description cannot be treated as a direct reproduction of reality. There is no 'pure description'. Moreover, rather than a description leading simply (or only) to 'member checks', mundane details may be precisely the elements of a highly familiar setting that are overlooked by members, but which are made 'recognisable', and possibly demonstrated as significant, through the research medium. This indeed was part of my experience of feeding back on the research to participants at the end of the fieldwork (see chapter 3 discussion of research process).

2.1.1.2.3 Understanding actions and meanings in their social context – holism

Holistic research practice refers to a concern to understand events and behaviour in the everyday contexts in which they occur. Such an approach is well-suited to understanding the processes by which such events and behaviours come about. The quality of holism is a particular strength of ethnographic research. In contrast to quantitative research which attempts to control the complexity of the social world by isolating 'confounding variables' (or the context from the items under study), ethnographic research places such complexity at the centre of the research. The focus is upon the interplay of elements in a particular social situation. As practices and interactions between participants were a central part of the study, then a holistic, contextual approach, attending to structural aspects of the setting as well as relationships, activities and perspectives, was required.

2.1.1.2.4 Emphasising time and process

An emphasis upon time and process acknowledges the view that life is a dynamic stream of interconnecting events, rather than a series of static, clearly defined situations. The preference with such an approach is for a longitudinal design that has the capacity to study how phenomena work, and possibly change, over time. At the outset of this research I was keen to study attempts to organise mental health care, especially as there were clear attempts by government to develop and refine existing systems. A processual, longitudinal research design enabled study of a policy implementation, occurring over a period of time, and facilitated attempts to understand everyday practice through prolonged contact with the setting.

2.1.1.2.5 Flexible research designs

The above practices indicate a need for a fairly unstructured, open-ended research strategy. Such a strategy allows room for participant understandings and respects context by allowing for a detailed understanding of the setting to emerge which may well involve revision of the topic and central research questions, or at least for the unexpected to be brought under scrutiny. My lack of familiarity with the research setting made me wary of imposing too much structure and definition at the outset. For these reasons a flexible, emergent design was adopted here as will be demonstrated in the next chapter.

2.1.1.2.6 Inductive

The last aspect of research practice indicates also a related wariness in terms of early imposition of a theoretical framework. Given the discussion of research philosophy and practice above, appropriate concepts and theories need to be determined in relation to the setting and thus decisions over theory will emerge alongside the fieldwork. Indeed in this study the notion of a non-paradigmatic take on organisational reality only

crystallised for me much later in the research process, as I tried to make sense and analyse (see chapter 3). The emphasis in this approach is upon discovery rather than testing initially, though what has been discovered needs to be tested sometime, if not by the discoverer, then by someone else.

Chapter 3: Methods: the tale from the field

Having outlined the general orientation of this research in terms of philosophy and practice, I shall now describe the process of the research. In light of the preceding discussion, it will be seen that this is a process marked by flexibility of design, a primarily inductive approach, attending to process and context, with an emphasis upon organisational behaviour in performative rather than cognitive terms. Further, while focusing upon the subjective and interactional nature of the setting, my aim has been to constitute the data reflexively.

As is usual in ethnographic accounts, I shall begin by indicating my starting point in terms of foreshadowed problems or areas of interest. Then I will outline the ‘who, what, where, when, how many’ type of information, plus noting particular methods used, that begins to set the scene of the study. This is then succeeded by a narrative describing the process of getting in, and staying in, the field. Finally, I consider the process of handling the data, indicating the emergence and development of analysis of the data. This chapter serves as much as a first take on ‘context’, as a means to assess research conduct with regard to the methodological discussion of chapter 2.

3.1 Foreshadowed problems

The topic of this research was to examine how mental health care was achieved following the introduction of the CPA, a model of care promoted as the government authorised version of care for mental health services in the 1990s. Initially, this topic was prompted by a mixture of personal interests, practical circumstances and prior academic research experiences.

By the mid 1990s the position of those with mental health problems in the community, and the adequacy of care made available to them, had forced them up the

political agenda as well as into greater public scrutiny. Inquiries into the death or serious injury of some patients, mental health employees and members of the public, added to and fuelled what had become a topic of popular debate expressed in the press and on television as the perceived failure of government to develop and implement effective community mental health care policy with the result that the public was exposed to serious risk from dangerous people (Muijen 1995). The CPA was introduced during a period marked by a number of high profile community mental health care disasters where the common theme emerging from successive enquiries was inadequate communication and coordination between agencies and professionals with the result that 'risk' was not properly assessed or managed.

One of these incidents was almost on my own doorstep just prior to my starting the research, and the incident and subsequent inquiry coincided with a friend conducting research in the very same organisation. This research was focused on policy at a macro level, concerned with senior management and financial decision-making following the introduction of internal markets. So when we discussed what was coming up during their fieldwork, I found the questions raised for me during this period, heightened by media attention on the unit, could not be addressed by the kind of research and fieldwork they were conducting. I was curious about how different professionals and members of the unit's clinical team worked together and how patients and their care were understood, agreed upon and managed on a day to day level.

Coinciding with these more public disasters, one of my own relatives, who had been treated for a long term mental illness, committed suicide in circumstances which prompted expressed concern at the response of the local psychiatric service by the coroner and police involved. The subsequent internal hospital enquiry found senior health care staff to be negligent, resulting in disciplinary proceedings of a consultant

psychiatrist and nurse manager. The interest I had felt in those situations that had produced public inquiries, now began to bite in a much more personal way. Moreover, I had a first-hand sense of the confusion and lack of co-ordination between agencies involved in the care of those with serious mental illness.

At the same time as all this, I was also teaching a part time social science foundation Open University course to a group whose students included a number of nurses working locally, including one who was a CPN. As the group picked up on topical media items as well as bringing in examples from their own experiences as healthcare workers I began to learn about some of the frustrations and difficulties of mental health care nursing. Having shared my own developing interests in this area, the CPN contact was keen to see the service she was employed in, subject to further academic scrutiny and undertook to effect introductions to more senior personnel to help me establish access.

These practical circumstances and personal interests developed alongside certain academic concerns. I began reading about current government policy to address perceived shortfalls around community mental health care. I learnt there was something called the 'CPA' and also something called 'care management'. Some documents used the terms interchangeably and I was confused about their meaning and relationship to each other. This was not simply the confusion of a neophyte, however. Some of the government's own documents acknowledged problems about the introduction of two major measures in health and social services which purported to be distinct, but seemed to overlap significantly, without guidance on how they were to be implemented alongside each other in practice [(NHS Training Division 1995; North, Ritchie and Ward 1993). In addition there were struggles to understand the CPA itself and how to

operationalise the CPA directives within the context of existing service practice and resource constraints (Schneider 1993; Shepherd, King, Tilburu and Fowler 1995).

These confusions and concerted attempts to address them also resonated with my previous research interests drawing on actor-network theory (ANT) as a methodological and theoretical tool (Ormrod 1995). My earlier interests were in tracing the emergence of innovation, in particular tracing the emergence of something before it has been 'black-boxed'¹⁰.

Rather than taking 'facts' or artefacts as 'given' this approach is one that explores their accomplishment (Callon 1986; Latour 1988; Latour and Woolgar 1986; Law 1986). One postulate here is that processes (e.g. scientific facts), which are very much 'in the making' and the subject of debate, provide a way in for the researcher seeking to understand how it is such knowledge claims come about before they are stabilised and taken-for-granted as true. That is, before they are black-boxed. The controversy over implementation of the CPA, against a background of controversies over the delivery of community mental health care in several highly publicised instances, indicated this policy innovation to be a useful vehicle through which to explore the organisation of mental health care.

Moreover, in this approach ideas or things (e.g. the CPA, characterisations of patients) are not simply passed on between people ('transferred') but translated according to their frames of reference:

¹⁰ A simple way of thinking about black-boxing is as a way of putting something beyond question for most purposes. For example, a thermometer is a 'black box', which may be used for the purposes for which it is designed without users having to know anything about the physics of glass tubes or of mercury.

... the spread in time and space of anything - claims, orders, artefacts, goods - is in the hands of people: each of these people may act in many different ways, letting the token drop, or modifying it, or deflecting it, or betraying it, or adding to it, or appropriating it.
(Latour 1986, p267).

Thus the concept of 'translation' indicates two key aspects of the process - that this work is necessarily interpretative and that actors are inconstant. In this sense, agency and identity, innovation and organisation, are the products of particular constructs or associations of meaning and sense-making. So, my early orientation to this research was framed by these prior academic interests in terms both of theorising agency and identity, and proceeding methodologically.

In my previous research on gender and technology I had learnt the central significance of the making of meanings, including accounts or stories told, as the way to understand relations between people, how work gets done and the implications of this for (in that case gendered) identity. Moreover, classic texts in the mental illness field such as *Asylums* and *K is mentally ill* (Goffman 1961; Smith 1978) already pointed to the significance of stories and rhetorics in producing mental illness and 'mental patients'. I was therefore interested in the kinds of ways that groups of professionals, carrying responsibilities for mental health care, 'talked the work', so as to define who was eligible and in need of care, and with what (immediate) consequences, both for patients and professionals.

The topic in general is a not a new concern within health care study. There is a now well-established tradition in medical sociology of studying the social construction of care and/or patient identities via accounts, stories and talk in clinical encounters (see for example Atkinson 1981; Atkinson 1995; Atkinson and Heath 1981; Bloor, McKeganey and Fonkert 1988; Strong 1979a). To a lesser extent there are similar approaches within the study of psychiatric care (Barrett 1996; Baruch and Treacher 1978; Byrd 1981; Daniels 1970; Griffiths 1998; Mehan 1990; Prior 1993). However,

while many healthcare studies concentrate upon ‘doctor-patient’ encounters, few focus upon encounters between practitioners within such situations (Atkinson 1995; Byrd 1981; Griffiths 1997a; Griffiths 1998; Griffiths and Hughes 1993).

Moreover, in mental health care there are even fewer studies that take a focus upon practitioners’ talk (Griffiths 1997a; Griffiths 1998). Onyett has suggested that the fluid and negotiated membership qualities of community mental health care work have proved challenging to social research and this is why it has received such scant attention (1997). He argues for research on such work in terms of the processes by which the meaning of particular projects is negotiated among interdependent actors and commitments to action are achieved. The case is made for a social constructionist approach that attends to organisation and management as fundamentally processual and the outcome of interpretative work.

Aside from talk or interactions *per se*, there has developed in healthcare studies an interest in narrative as a methodological tool. Reporting and storytelling may be seen as general cultural forms that occur across a range of everyday and professional contexts (Labov and Waletzky 1967; Ochs and Taylor 1992; Polanyi 1989; Polkinghorne 1988; Ricoeur 1988). Davis notes that among narrative forms, stories are distinguished by their moral content: stories are ways to package experience with a message and/or moral content to which recipients are invited to respond (1988, p42). With reference to studies of illness and healthcare, and following the discussion of the sick role in Part One, the moral dimension to this form of expression is of particular interest here. Many studies have focused upon narrative forms as expressions of illness (see for example Davis 1988; Garro 1994; Kleinman 1988; Robinson 1990; Williams 1984). But, as with studies of talk, there is a similar asymmetry in this area also, with more attention paid to patient narratives, or the production of illness, rather than

practitioners' narratives, or the production of disease (Atkinson 1995. p96). One exception is Hunter (Hunter 1991, quoted in Atkinson, 1995) who provides an account of the function of doctors' narratives and the performance of such storytelling in the accomplishment of medical work. There is little of this kind of focus in social studies of psychiatry (but see Baruch *et al.*, 1978). But what is important here is the use to which such tales are put interactionally to persuade others of a particular course of action, such as designating someone as mentally ill, or not, and thus requiring a response/action accordingly.

This developing trend within medical sociology resonates with work within organisation studies that pursues a 'narrative take' in organisational research. These take various forms: tales from the field, tales of the field, and interpretative approaches that construct organisational life as story-making and organisational theory as story-reading (Czarniawska 1997; Weick 1995). Central to such approaches is a focus upon the creation of meanings and associations between actors, things and events to produce 'organisation'.

So to summarise on the academic concerns and interests which prefigured this research. I was keen to trace the particular associations of meaning, people and things that produced the organisation of mental health care. I wished to pursue an ethnomethodologically-informed ethnography, focused upon what people did, rather than meaning in the experiential sense of that term. I was especially interested in pursuing this through attending to interaction and practices, including the use to which stories were put in exchanges between participants, and with what consequences for agency and identity. I wished to do this theoretically and methodologically in ways that were symmetrical: not privileging any one set of actors, discourse or events over others.

3.2 Research setting and process

3.2.1 The setting

Fieldwork took place within the mental health directorate (MHD) of Westway Community Services NHS Trust¹¹ over the course of one year between late March 1996 and early April 1997. This work took the form of a mixture of observation at meetings as well as ‘hanging out’ in staff rooms/offices/wards, interviews with a range of staff and study of documents relating to the CPA implementation. Fieldwork concentrated on two of the three Sector Teams within the MHD.

Westway’s mental health directorate (MHD) was based in a mixed urban/rural environment in an English health authority. It was organised via a mixture of acute and rehabilitation services. These services were provided in the form of three sector teams (comprising ward and community services) and a separate rehabilitation service. A psychiatric hospital unit sited alongside the district general hospital in a suburb of the city provided 75 acute beds on three wards, and 46 beds were provided in five residential rehabilitation units in suburbs of the city. In addition there was community treatment from an assertive rehabilitation team (ART), and central crisis assessment facilities provided from a psychiatric advisory service (PAS) and emergency psychiatric service (EPS). Sectors were staffed by a multi-disciplinary team, spanning both health and social services with a number of different work bases. Sizes of the Sector teams varied a little given numbers of social service district offices/staff involved but ranged between 30-35 in total. Further details of the setting are given in section 5.4 and will emerge as the thesis proceeds.

¹¹ Pseudonym for purposes of anonymity.

3.2.2 Choice of setting

The selection of the research setting was, as is often the case in ethnographic research, driven by pragmatic considerations and opportunity. I had a contact who worked within a relevant setting, a mental health directorate, located reasonably close to me geographically. Further, there were a few well-placed individuals within the setting (the MHD Deputy and a couple of long-time senior nurses within two of the teams) who were positively disposed to social scientific research and especially so at that time, as the CPA was yet another policy directive to hit the service on the back of many changes which were felt to be overwhelming. In this situation research was seen as a potential resource (from various perspectives and levels of the organisational hierarchy) to harness (either to manage or express) complaint.

3.2.3 Emergent research design

The research design was a flexible one which shifted gradually from a general foreshadowed 'problem' to increasingly more specific or middle range research questions as the empirical work proceeded. Adopting an initial strategy of 'follow the CPA', I pursued meetings and documents and individuals holding special responsibilities for CPA implementation, as well as taking a broader look at how things worked through attendance at weekly team allocation meetings. This helped me to have some concrete base and focus during the early days of fieldwork when I had little idea of the organisation, such as what was happening and who was who. Initially I was interested in who was allocated for what kinds of work following the principles of the CPA. This is discussed in more detail from Part Two onwards, but essentially refers to the tasks of assessment, keyworker appointment, care planning and reviews. As I spent more time in the field and became more familiar with different personnel and settings and occasions within the organisation, including the haphazard nature of 'doing the CPA', I became less concerned with CPA 'markers' as such, and more interested in the

process of gatekeeping and allocating work within the teams. This covered how different team members negotiated with each other and formulated different kinds of work *vis a vis* the different agency members as well as how practitioners/team members constituted referrals as patients suitable for the team or not. It seemed this was the critical aspect to all work within the MHD and as such constituted 'the organisation of mental health care', including any attempts to introduce new systems to organise such care like the CPA.

3.2.4 Sampling issues

It is worth considering the 'caseness' or selection and sampling in this research and the implications of this thinking and approach for generalisation. The selection of the research setting, the MHD of Westway Community Services NHS Trust, may be seen as a naturalistic setting and as such seems to be a clearly bounded single case study.

Within this research setting however, various aspects of the setting having been examined and others ignored. It is never possible to study a 'setting' in its entirety .

Moreover within the setting the various aspects of work within the MHD that I chose to look at might be described as several cases within the setting that demonstrate some of its features. While the setting is specific and aspects studied within this are partial, it does share common features with other mental health care services in England - in terms of organisation through several teams which have community and ward responsibilities for particular geographical areas, staffed by a multi-disciplinary team encompassing health and social services agencies, and with multiple line management arrangements. I am not making claims to 'typicality' or representativeness (which would be complicated by various kinds of contextual features including organisational culture, demographics of the patient population and morbidity), but in terms of the nature of the work, of determining serious mental illness and allocating the work in a

MDT and multi-agency setting, analytic generalisations with some chance of being sound ones, are possible.

Sampling, or the choice of aspects and areas of focus, were largely opportunistic, especially at the outset: it was a matter of where I was most readily received as well as my choice of contexts most visibly engaged with the CPA. Thus there was a focus upon the sector teams and within these the CMHT aspect of their work, whose members were at the front-end of gatekeeping access to services. Here there were 'things happening' that could be observed and were talked about: a frequent throughput of patient referrals and the subsequent allocation of work. Team Managers of two of the three sector teams were more amenable to the research, and that informed the decision to only look at those two teams. These decisions emerged over the course of the fieldwork. At first I was unsure if I should attempt to study all three teams for a shorter time or just one in more depth. Not wishing to feel overwhelmed when so much seemed confusing in the early days, I opted to look at one team. Then it emerged that members of this team, as well as some from the other two teams, felt I had chosen the most troubled of the three teams. At this point I began to feel that I should look at one of the other two teams in addition. Partly this was because I worried that I had selected a most unusual case, partly also because I felt looking at another team might help me clarify key aspects of the processes of gatekeeping and allocation in this organisational setting, and partly because of my responsibilities to the participants. As a condition of my access (see below) I was required to produce a report for the MHD on their experiences and implementation of the CPA. I needed to ensure that the data on which I based my report was wide enough to do that job, as well as ensuring a large enough number of participants so that individual confidentiality for most members could be protected. At the same time I did not seek to make this an evaluative study of the

comparative performance of the teams, not least because this would have most likely compromised and limited the study to Westway's evaluation agenda and I was uncertain of the consequences for the teams and individual members if the study was framed in such terms.

As the fieldwork progressed, however, and with the qualifications mentioned above in mind, some theoretically-led sampling occurred. Following Hammersley and Atkinson, this was done along dimensions of time, people, and context (1995). In terms of time I sought to ensure that the fieldwork was sufficiently longitudinal so as to provide different times of the year for the regular team meetings – patterns of work and activity might be affected by holiday periods such as Xmas or summer or by the 6-monthly rotation of junior doctors to the teams. While team meetings occurred at the same time every week not all members were always present, so attending a number of meetings also allowed for a variety of times with different membership composition. I also attended other events of the teams at different times of the week. There were different kinds of relationships between the same members as well as activities in different aspects of the setting. So this was an attempt to sample a range of contexts for each team, and the MHD more broadly, within the setting. In terms of people, I sought to sample (via interviews) in terms of the range of different professions and agencies represented within the teams, as well as in terms of level of seniority (both length of service and grade). I also sought to sample in terms of specific patient cases, following across the range of meetings that might occur after acceptance and allocation at team meeting those cases that appeared to be most complex and requiring greater co-ordination of care (a prime reason for introduction of the CPA). In addition to these researcher-defined categories, member-defined categories also played a part, with members identifying certain events and individuals as worthy of attention, significant

either for a particular perspective or because of their role within the CPA implementation or their relations with other members or the team.

3.2.5 Data collection methods

As noted already, three methods of research were used: observation, interviews and informal conversation, and document collection, or in ethnographic parlance, 'hanging out, talking to people and reading the papers'. These are described below. (Details of samples and sources are set out in Appendix II.)

3.2.5.1 Observation

The main method pursued was observation at the weekly team meetings for two of the three sector teams between March 1996 and February 1997 (see Appendix II Table 2). I attended the once per week meeting in Team A for four months from April 1996-July 1996 and for just over four months during the period September 1996-February 1997. Team B had two weekly meetings covering the same tasks as Team A, and I attended these for four months between October 1996-February 1997. Thus I attended approximately 32 team meetings for each of the two teams.

In addition I spent time visiting other team activities and contexts (see Appendix II Table 2). Much of the work of the team was not readily observable, taking place through individual team member visits to patients at home or via telephone calls. I was therefore keen to identify those cases that would yield more public occasionings of the work. This was so for the more difficult and complex cases, which required the involvement of several team members and different agencies. During the first four months of visits to Team A meetings three patients appeared to most readily fit this category, with regular mentions during team meetings and informal conversations, together with the arrangement of multi-agency, multi-disciplinary reviews. I thus attended three CPA reviews for these three patient cases followed from Team A and

other ad hoc meetings that occurred. One of these cases proved most amenable to intensive study as the patient was admitted to hospital under detaining sections of the Mental Health Act 1983 during the last four months of the fieldwork. I thus attended a portion of the weekly ward rounds in which this patient was discussed. In addition to this targeted time on one ward, I also spent a few days visiting each teams' respective wards on different days of the week and weekend during March 1997. I spent most time hanging out in the ward staff room as this is where many staff spent their time, discussing patients and incidents, completing paperwork and other administration and 'handing over' to different shifts. This was driven mostly by the requirement for the Westway report on the CPA and a sense that I needed to get 'the ward-end of things' within the sectors.

In terms of MHD-wide observation, I also attended a number of one-off or occasional meetings between January 1996 - January 1997 – connected with the Directorate's implementation of the CPA, and profession-specific meetings for social workers and for CPNs.

Aside from these formal occasions, I was also invited by team members to more informal gatherings. Following the weekly team meeting, a sub-group of Team A members would often meet for a coffee and 'post-mortem' at the local supermarket coffee shop which was on the route back to the team base from the team meeting venue in the hospital. This 'backstage' scene was useful both in terms of developing relationships with participants as well as gaining some further insight on the meetings I observed. The first time I joined the group for a coffee one member acknowledged that:

It would still prove to be data collection for me and that was OK as they hoped I would gain a fuller understanding of how they experienced the work, just so long as I didn't quote them or tell the managers that they met for coffee like this!
(Fieldwork note 16/4/96).

There were also occasional social events (at the team meeting venue, or in pubs or restaurants) connected with the leaving of a team member, birthdays and Xmas and I was invited along with the rest of the team. In addition there were friendships between some members of Team A and B that led to the occasional 'cross-team' pub drink or meal out to which I was invited especially in the latter stages of the fieldwork when I had been around for a while. These more informal social occasions were also times for members to check out my understandings of the work and research findings as the research proceeded. I was mindful however to not feedback too fulsomely, though 'off-the-record' briefings and gossip that usually followed were helpful in developing my feel for the work and organisational culture.

3.2.5.2 Interviews

Interviews were conducted, totalling 61 in number across 43 individuals over the period December 1995 - March 1997. These were loosely structured, lasting between 45 minutes – 1.5 hours and largely geared to collecting understandings and experiences of the CPA as well as reflection upon team practices around allocation of work. Partly the interviews were driven by the requirement for the Westway CPA Report, but they were also an opportunity to explore my observations from team meetings. Thus the bulk of interviews were conducted between November 1996-February 1997. Those interviewed included a range of staff (covering the different professions/posts and agencies and levels of seniority) across the two sector teams studied, plus some others with Directorate-wide responsibilities (see Appendix II Table 1 for details of the sample). Some of the interviews, especially prior to November 1996 were geared to gaining access and general information about the MHD and the teams. Some interviews were geared to the three specific patient cases followed, and thus conducted with key team players involved.

While the interviews were loosely structured I was especially nervous, in the early days or later when interviewing staff with whom I had little contact, about conducting these exchanges in an easeful manner. I was mindful I had an agenda partly set by the Westway's CPA evaluation requirement of me and partly by my research on everyday practices. So I struggled with having 'things to cover' and asking about some things which are taken-for-granted and thus usually difficult to explain, requiring an analytical mode that may well be quite alien. Aiming also to conduct these meetings in a conversational way felt quite daunting. I became very aware of how odd the loosely structured interview situation is, combining the artifice of aiming to find out things while trying to follow the ebb and flow of everyday conversation.

3.2.5.3 Documentary research.

I also collected documents relating both to the MHD in general and the implementation of the CPA specifically. These took the form of previous research and audit reports on the MHD, operational policy and memos on practice, and CPA proformas (see Appendix II Table 3). Most of this was supplied by the MHD Deputy (later in the fieldwork he became Acting Director), though some items, notably memos, were passed on to me by individual team members. This material was mostly utilised in the production of the Westway CPA Report and Part Two here.

3.3 Fieldwork narrative

3.3.1 Establishing access

Access was established through a series of interviews and attendance at meetings to introduce me to a number of staff from across Westway's MHD, between December 1995 and January 1996. I interviewed my CPN contact to gather more information about the structure of the MHD, and 'snowballed' to other contacts identified from there. This included the MHD's Development Manager (a kind of deputy Director of

the MHD). Early on the Development Manager declared his interest in social science research, revealing that he was currently studying for a higher degree part time. He suggested that I attend the next couple of directorate-wide 'CPA Feedback meetings' in January and March 1996, first to get an idea of issues coming up and then to introduce me and the proposed research to as many as possible of the directorate's staff. From these initial meetings I learnt that key decisions on the work and the practice of the CPA, such as assessment and allocation of cases, was determined through each teams' weekly meeting and these events began to emerge as a significant focus for the research.

In addition I attended a couple of other one-off meetings. There was a CPA Steering Group of senior managers (clinicians and support functions) from across the MHD and the Development Manager also arranged for my invite there, both to learn more about the issues, as well as to introduce me to these staff and gain their approval in principle for the research. And I met individually with the senior social work manager from the steering group. At the steering group it was suggested that a condition of my access should be a report by me for the MHD on the implementation and experience of practising the CPA. Thus, these early interviews and meetings helped me to develop my proposal and negotiate access with participants.

While gaining approval for the research from the senior gatekeepers (the Development Manager and CPA Steering Group) I still needed to negotiate my entry at team level. Following the initial meetings, I arranged to visit each of the three sector teams' weekly team meetings for three consecutive visits during late March/early April 1996 to get an initial feel for the meetings and to talk about the research in more detail. During this time I drew up a fieldwork outline to take along that would enable me to develop access as flexibly as possible to begin with, so as to enable me to refine the research as I progressed.

During the initial visits to all three teams, it quickly became apparent that I was more readily welcome in two of the teams (Teams A and B). The Team manager for Team C expressed surprise on each occasion of the visits that we had arranged and while apologising for ‘forgetting’ seemed quite ill at ease with my presence. When I suggested on my third visit that I was considering starting out visiting only one team she was quick to say she hoped it would be one of the other two. I took all this as a strong cue to concentrate elsewhere, with a view to possibly returning later once I had become known about within the MHD and as the research design evolved.

3.3.2 Maintaining relations

Although my presence in Westway MHD had taken a fair amount of negotiation, once access had been granted by the senior manager ‘sponsoring’ the research then, following initial introductions, my presence at various meetings was largely taken for granted. I always ensured I had sought permission from the chair in advance of attendance for the first time at any meeting group. Initial concerns largely hinged upon confidentiality, and I was careful to reassure participants that I would strive to ensure both anonymity and confidentiality for all. I noted that for those staff in positions or roles with only a single incumbent then that might limit this, but I did promise that a general guiding principle should be ‘that no harm should come to participants as a result of contributing to the research’. I had also agreed with the Development Manager that feedback on the CPA should follow a ‘bottom-up’ process with team staff who had been involved having first sight of and opportunity to comment on draft reports before the report was finalised and circulated to senior managers and throughout the MHD. Team staff were reassured by this approach. I was also at pains to emphasise that the focus of the research was upon how the team worked rather than individual performance, that feedback would take a thematic form and as far as possible be identified with groups/sub-groups of staff.

I explained at first meetings to members that I wanted to study how things worked so did not wish to intervene and alter that by participating, moreover as a non-clinician I would not wish to presume upon or to interrupt the usual flow of work. It was agreed that I would attend meetings as a silent observer and take hand-written notes to help me ensure I could keep an accurate record. So when, for instance, there were disputes or confusion in a team meeting over prior decisions (such as the allocation of a case) for which they did not have records I was careful not to speak up and supply the information to hand in my notebook. Of course, aside from intervening in the usual process of team events and possibly compromising relations with some team members, such an action would ignore the complexity around truth claims referred to earlier in this chapter. It was also notable that not all members talked in meetings, particularly in one of the teams, thus my silence was not too unusual *vis a vis* other members of the team. My key aim was to be as unobtrusive as possible.

It was not quite so simple however. I found as the research proceeded that different occasions required variations in my role and different degrees of participation during observation. Passing as a 'normal member' also seemed to be warranted for an unobtrusive presence. This meant that there were occasions when to not respond or react might have proved more disturbing or disruptive, and sometimes this meant there had to be a trade-off between maintaining purity of the research methodology and reasonable relations with fellow human beings. On one occasion having attended a series of ward rounds relating to one of the specific patient cases I tracked, the staff were struggling to work out their options with this patient because they did not understand the difference between Supervised Discharge and Guardianship, the former newly introduced along side the CPA by the Mental Health Act 1996. Initially the junior doctor responsible for leading the presentation under the watchful eye of the consultant

asked me if I could help them clarify things, and this appeal was swiftly supported by the consultant and other staff present. I explained my understanding of the matter. Everyone was appreciative of my contribution, including the SHO who made a point of thanking me privately later as she admitted to feeling 'on the spot'. I also offered to bring along a copy of a recently-published manual on the CPA (Open University, DoH and SSI 1996), which had been prepared by one of my supervisors, so that they could check this resource further to help them decide on definitions, as well as use for future reference. The consultant also noted this as being especially helpful. As I reflected on the appreciation expressed I felt it would have been unethical to have withheld information from the staff, and which I had been fortunate enough to acquire through my academic links, when they clearly had enough obstacles to contend with in the daily grind of acute mental health care.

More often, explicit appeals or directly including me, turned on humour. If during the course of meetings jokes or humorous exchanges occurred then I noticed that some team members would look at me and smile or laugh and not to join in would have seemed hostile. Anyhow these exchanges were usually funny - it was hard not to laugh - and at the expense of (absent) referrers or patients rather than other (present) members. On some occasions I was the explicit recipient of the joke. For example, when the Team Manager for Team A slipped up in introducing an item and then excused himself, noting my presence and that he was keen to 'get it right', a joke was made by the Consultant Psychiatrist who turned to me saying "Isn't that the Hawthorne effect?¹² What are you going to do about that then!". Indeed joking exchanges seemed to be a point at which

¹² The 'Hawthorne effect' refers to a classic social study of the US Hawthorne electrical plant in the 1920s and 30s which found a peculiar positive result after the early research experiments in the organisation, attributed to the (sympathetic) presence of the researchers.

members felt they could include me in the meeting and it felt like a friendly gesture of camaraderie, which I welcomed.

Linked to this, and already mentioned earlier, there were the various social events and informal contacts that required me to participate alongside everyone else, and which seemed to serve as *quid pro quo* in terms of maintenance of research relations.

Despite relative ease of access, and at times a quite enjoyable time spent in the field, this was sometimes complicated and difficult outside of the regular meetings I attended. This included more *ad hoc* meetings, meetings that occurred at short notice or on occasions when meetings had extraordinary agenda items and/or with a member who either struggled to grasp this kind of research or was openly hostile to the research.

Some *ad hoc* meetings were not formally constituted with a chairperson and were of uncertain membership - then it was difficult to agree my attendance in advance. I learnt this lesson rather sharply early on over a patient case I was keen to follow more intensively. This had been marked out during a Team A meeting as more complex and needing careful handling as well as members expressing annoyance that the case was being rather hastily transferred from Team C following the patient's change of address. On the back of an interview with the newly appointed keyworker (KW) for the case, a CPN from Team A, I was invited to attend a meeting to hand over the case, which would happen shortly after our meeting. He expected to meet with the previous KW from Team C, another CPN, and noted the possibility that one of his team's consultant psychiatrists might attend. The Team C KW arrived and readily agreed to my 'sitting in' on the meeting. No other staff arrived by the appointed meeting time and the two CPNs got started. However they were joined ten minutes later by a consultant psychiatrist from Team A (CP2) and the Team Manager from Team C. They both objected to my

presence, causing some embarrassment for the two junior staff, and I had to make a swift exit to prevent further trouble.

I continued to experience objections to my presence from this particular Team A consultant psychiatrist (CP2). This occurred on the more irregular occasions of my visits (e.g. *ad hoc* meetings as above, extraordinary agenda items dealing with staffing issues during weekly team or sector management meetings). Then, a few months into the research the Development Manager arranged for me to have an honorary contract with the Trust (essentially a formal confidentiality agreement). He explained that CP2 had protested about the research, after consensual agreement had been reached by the MHD and Team A. He had rejected her protests, noting that her objections would be covered by issuing me with an honorary contract. I suspected that the 'irregular occasions' created a kind of permissible opening for CP2 to revisit the decision to proceed with the research. I was left in no doubt that that this member was not agreeable to my presence. But this difficulty also pointed up the ethical dilemmas to gaining and maintaining agreements to conduct research with participants as a collective, achieved by group consensus. It may also have unwittingly added to tensions within this team between many members and CP2 that culminated in her sudden departure from Westway half-way through the research period.

No other participant was so explicitly against the research but one other participant, demonstrated a different style of response to the 'oddity' of a research presence. This was the Sector Manager of Team C, appointed a few months after my arrival, who objected to my silence in meetings. He repeatedly asked me for comments on discussions in the special CPA meetings he chaired. This usually occurred when other members had fallen silent. I would respond non-committally. When I finally established that my participation like this was not appropriate, he sought my services in

a secretarial capacity at subsequent meetings noting that if I was not going to speak I could make myself useful by being their secretary and taking minutes for them. This was issued in the form of an instruction rather than a request and appeared to be the condition for my further attendance at these meetings. I devised the minutes after the meetings drawing from my fieldwork notes. I felt I had no option but to comply, and while there had been other occasions during research when that kind of service had seemed like a fair *quid pro quo*, on this occasion, I felt bullied into it in a somewhat sexist manner. I was not alone in reading the behaviour this way: another (more junior and male) meeting group member who I knew from Team B privately apologised to me about his colleague's behaviour saying he was ashamed. I figured it was better to laugh this off rather than compromise the research by fuelling a complaint about sexism.

While some of these difficulties might be passed off as a problem of particular personalities, the incidents did serve to sensitise me to the pressures that research may place upon participants and that other participants may place upon each other through the vehicle of research.

Throughout the fieldwork I had periodic meetings with the Development Manager/Acting MHD Director. These were to review what I had been doing and any access issues that had arisen as well as to update me on MHD developments and movements of staff.

While it is always difficult to gauge 'researcher-effect' there is no doubt that for all my efforts to not intervene, there was no way to avoid this as part of managing my continuing access. However, I endeavoured to make my contributions as far as possible through sympathetic listening and curious questioning rather than advice.

3.4 Collecting and managing the data

Data recording methods took two forms – hand written notes, most of which were filled out in typing up later and tape recordings of interviews which were later transcribed.

Interviewees were asked immediately prior to the start of interview for permission to use a tape recorder. This was done following explanation about how the material would be used and protections regarding confidentiality and anonymity. In addition, I suggested I could stop the tape if they wished to say anything specific off tape, and showed interviewees how to switch off the recorder. No one refused the use of the tape recorder, but occasionally I was asked to switch the machine off for some moments. The interviews were transcribed partly by myself and partly by professional transcribers - OU secretarial staff who did such work on a freelance basis. I had plenty of experience from previous research of producing tape transcripts, and given the large number of tapes and their use primarily for background information for the Westway CPA Report it seemed reasonable to offload some of this. There were advantages and disadvantages to this. First, I gained valuable time, especially as a large number of these interviews were conducted over a short time period and were required quickly for examination in the drafting of the CPA report. However, as they were not present and thus could not use the memory cues of a remembered conversation some transcribers found it hard to hear all of what was said, so there were gaps in some tapes. In addition one transcriber had noted that she had not transcribed a large chunk at the start of one tape as it contained 'what seemed to be irrelevant material where the speakers discuss academic courses and ideas'. This referred to an interview where the interviewee had asked more about the research and how I came to do it at the start of the interview. As the conversation developed we discovered we shared some similar academic experiences and interests. For me such information is relevant because it alerts one to the immediate context of this interview and may indicate why certain kinds of questions

were asked in the way they were by me and ditto for the responses given by the interviewee.

Observational data and informal conversations were written up by hand as soon as possible, either during or later the same day after an event. Hand notes were taken contemporaneously in all meetings. As they were taken at the time and I was not usually involved in any other way in the meetings I could afford to take fairly full notes. At first it was difficult simply because I had not 'tuned in' to the meetings, not knowing most members or usual format and topics. As my familiarity increased it became easier to produce a fuller account of meetings. I found fuller notes helpful in the early stages as I was not sure how things worked and what was significant or of particular interest to me. Once I had become familiar with the setting and had begun to refine my own take on proceedings then I was more selective about what I recorded. I also had to be mindful that copious writing could prove somewhat distracting and/or disturbing to participants, especially as few members took notes themselves, or throughout, at regular weekly team meetings. Further, sometimes topics were flagged as particularly sensitive, or there would be a tense or difficult exchange between members and at those points I would endeavour to stop and then write up more fully during the next item. I could see from looks thrown in my direction that people felt more at ease if I was not scribing in these moments. It was useful also to have breaks from writing and to actually look around the room and watch proceedings rather than focusing on simply listening. It was at some of these moments that from the frowns and exchanged quizzical looks of others, I became aware of how I was not alone in struggling to hear what several members said in one team, where mumbling, or at least speaking in hushed tones, seemed to be part of projecting a therapeutic persona.

The format adopted for records of meetings, which evolved over the first few weeks, was to list all members present, their roles, including any formal ones in the meeting such as chair or minute-taker and agency affiliation (over time initials were sufficient as I knew who was who and their agency affiliation). I then noted all agenda items in order of the sequence followed, including the 'leaps' around the agenda that did occur. The notes were a mixture of description, paraphrase and short verbatim sections around items that appeared to be especially 'juicy'. I aimed to make my descriptions full, of the 's/he said/then s/he said' kind, rather than summarised so as to capture what was happening and not rush in to judge while also trying to observe. Given the declared intention in the earlier part of this chapter towards interpretations in terms of practice rather than cognition, then it would seem that treatment of language more in terms of linguistic moves than in thematic terms might best be done via taped material. However, while tape recordings would indeed provide the fullest speech account of meetings, this was not an exercise in conversation analysis. Moreover my use of language has been pragmatic, understanding the use of language by members in meetings, rather than semantic. Thus my approach has been to record 'illocutionary chunks'. There is, moreover, a tendency to forget the problems produced by transcripts of taped material. It is easy to think the tape captures all but there are numerous shortcomings. Aside from the practical issue of clearly capturing and distinguishing the various contributions in a meeting of 16+ people, there is the matter of how people are reacting visibly around a room, of people not being distracted or threatened from usual participation by the presence of a tape recorder. Moreover transcripts produce language which is frozen: it is possible to make more of it and claim it is true because all the words are there.

My definition of the criterion 'juicy' was initially more theoretically-informed, deriving from other readings in medical sociology and geared to listening out for

‘atrocities stories’, jokes, and any kind of dispute that seemed to invoke a ‘it’s (not) how we do things around here’ line. Generally what these kinds of things can illustrate is usual practice and the taken-for-grantedness of relationships between members that are not usually remarkable but might become more visible and remarked upon via the unusual or an interruption of the agenda. Given my initial framing of the research topic, I was also listening out for anything that used the CPA language, though that proved to be much rarer (see Part Two). Much later, I was listening out for examples of exchanges that would confirm or disconfirm my ideas about due procedure and trouble in teamwork and about the disposal of patients (see Parts 3 and 4).

At this point collecting data clearly begins to blend with analysing data. In the latter stages of the fieldwork I was not trying to record as much as possible indiscriminately, but being far more selective, geared to the research design that had emerged.

Fuller analysis did occur, however, once fieldwork had completed. As many others have noted, qualitative research has no ‘one textbook method’ but rather the term ‘analysis’ indicates a range of different procedures that may be adopted (Murphy *et al.*, 1998, p131-2). Here, analysis combined elements from more conventional ethnography with elements usually located within ethnomethodology. This meant analysis geared to produce an accurate description of the organisation studied, combined with theoretical commentary on everyday practices deriving from a linguistic treatment of interactions. Thus data were scrutinised to establish themes in the description of patients, that led to the development of a set of categories to organise examples in the data, and this was combined with a focus upon the situated use of such descriptions/stories in the accomplishment of the allocation of work (see Part Four).

The analysis also included elements usually identified with analytic induction, though in no sense was this research an attempt to produce a thorough-going example of such an approach. Thus team meeting data were scrutinised to establish the different kinds of disposal actions for cases referred to the teams. The data were also examined to see if any particular team members were identified with specific parts of this process and types of action. These exercises were used to generate an algorithm for team moves (see Part Three) that was then used to check against further data. In addition, the use of deviant or negative examples was pursued in order to clarify the everyday organisation of mental health care.

It is worth saying something also here about the status of the different kinds of data *vis a vis* each other. No one method is privileged in the approach adopted, though some kinds of data have been focused upon more than others in different parts of this thesis, with interview and documentary materials more in Part Two, observation of meetings in Parts Three and Four. Moreover, all accounts are grounded in the circumstances of their production and caution is required with regard to both interview and observation material. Thus observation notes have already filtered the reality of team meetings by my interests and concerns and possible biases. And interview material, while yielding important details about participant perspectives, does not provide any simple report on an external reality of practices occurring beyond the interview. If anything it is most accurate only with regard to the interaction between the participants in the interview. What I hope, however, is that the description of the research process given here will allow those matters to be adequately judged when reading the following parts of the thesis. Further comments are made on the methods in the form of a retrospective evaluation at the end of the thesis.

Conclusion to Part One

The last two chapters have discussed the approach taken to the research presented in this thesis. In common with much ethnographic research I have described the process of the research as a means to indicate the kinds of procedures employed and relationships forged in the conduct of the fieldwork undertaken. This has been set within the broader academic context of methodological debates on qualitative research and ethnographic study. The position taken on these areas of philosophy and practice has emphasised a processual, responsive and reflexive approach. It is argued that the ‘anthropology of organisation’ proposed in chapter 1 and worked through further in chapters 2 and 3, demonstrates how these methodological matters have informed and shaped the research. Moreover it is also argued that this approach has begun to indicate in more detail the project advanced in chapter one, to narrate organisation, here demonstrating construction of the field, the relationship between me and the particular research setting. Thus, following Czarniawska, (1997, p26) there is a tale from the field, the organisation told about in a story-like way (the stuff of conventional ethnography); tales of the field, stories collected from participants; and tales in the field, research that conceives of “organisational life as story-making and organisational theory as story reading” (p26). In this thesis the tale from the field is the tale that constructs the organisation as the site of the ethnographer’s journey, used to demonstrate research practice in the field. Tales of the field, stories collected from participants, inform the rest of the thesis but rather than any simple kind of reality waiting to be collected and revealed these tales highlight the perpetual making of sense in organising. This is made explicit and constituted reflexively with regard to the third aspect of tales - about ‘story-making’ and ‘story-reading’ - which indicates the fundamentally interpretative work conducted both by participants and researcher in the making/telling of organisation. The first of those tales has principally been told about here. It is to the other two kinds of tales that I now turn.

PART TWO: Scenes and systems

Chapter 4: Introduction to Part 2 – the CPA

Part Two performs two main tasks for this thesis. First, it sets the scene for this thesis, both in terms of introducing central government policy initiatives relevant to the implementation of the CPA, and in terms of introducing the local research site. In this sense it represents a way in for the reader, a point from which to negotiate successive interpretations. Likewise, learning about the authorised version of care according to the Department of Health was a way in for me at the start of the research. If I was to get to grips with the organisation of mental health care then it seemed the first step was to understand something of the authorised form of care in theory (national level policy) and practice (local research site implementation).

Second, by doing the first task, Part Two presents a 'systems perspective' for understanding the organisation of mental health care. In saying this I wish to alert the reader to the dual nature of the material presented here – in that it is both resource and data. In this sense the indexical take on the material presented is counter-pointed by a reflexive one. And in doing this, the chapters in Part two demonstrate the social constructionist methodology adopted and discussed in Part One.

4.1 The CPA - national scene

4.1.1 Introducing the Care Programme Approach

During the first half of the 1990s the government introduced a number of policy guidelines and acts of parliament in the specific area of mental health provision for both purchasers and service providers. These policies were introduced at various times against a background of public concern over the impact of community care following a government commitment to close many psychiatric hospitals, concern about the care that people were actually getting in the community, and about the dangers faced by the public as manifested in various high profile incidents - Christopher Clunis killing

Jonathan Zito on a London Underground station, in 1992 (Ritchie, Dick and Lingham 1994); Ben Silcock climbing in to the lions' den at London Zoo, in 1993 (Anon 1993; Silcock 1993); and Andrew Robinson killing an occupational therapist in Devon, (Blom-Cooper, Hally and Murphy 1995). Subsequent inquiries on such critical incidents repeatedly came to similar conclusions of failures in communication and liaison and inadequate information systems. Overall the message was one which indicated a signal lack of accountability among those charged with the care of severely mentally ill patients. This is not to suggest, however, that the introduction of the CPA was simply a knee-jerk response in the face of mounting public concern. Indeed publications and policy guidance indicate a concerted approach by government well before the high profile disasters of the early 1990s to establish adequate, systematic forms of care (see for example Spokes Report of 1988 DHSS , the recommendations of which were consolidated by 1991 into the CPA).

Since 1991, English mental health policy guidelines have been explicit in recommending inter-professional working, involvement of patients and carers, harmonisation between health and social services and targeting at people with severe mental illness (SMI). According to *Building Bridges* (DoH 1995) the Care Programme Approach (CPA) was "the cornerstone" of mental health care in England for people with severe mental illness. The CPA for people referred to specialist psychiatric services was introduced in 1991 (DoH 1990b). This required providers to establish systems of assessment and review for deciding on the treatment of individual patients.

The policy was expressed through four key requirements:

- ◆ comprehensive assessment of mental health and social care needs
- ◆ formulation of a care plan
- ◆ appointment of a keyworker to coordinate care, and implement and monitor the care plan
- ◆ periodic reviews of the care plan

(DoH 1990a).

In addition, the injunction to implement a CPA was accompanied by another - to prioritise 'the most severe mentally ill' (SMI). In turn, this focus upon those judged most vulnerable was set out alongside advice to ensure explicit mechanisms for assessing and managing the risks associated with such patients (DoH 1994c). This emphasis on SMI and systematic risk assessment was consolidated soon after in the form of further measures: by the introduction of supervision registers from April 1994 (NHS Management Executive 1994) and supervised discharge from April 1996 (DoH and Welsh Office 1996).

The aim was to provide a "network of care in the community" (NHS Training Division 1995, p7). Within the context of budgetary restraints, providers were expected to make individual needs central to the care plan and appoint keyworkers to develop and monitor the care plans. The keyworker, therefore, was required to liaise with a number of professionals to draw up individual care plans. The essential rationale for the government in introducing the CPA was to ensure that patients were properly assessed, either in the community or prior to discharge, and thereafter effectively monitored and supported. Thus named staff were to be made responsible for each patient's care and,

where more complex packages of care were required, they were to be responsible for co-ordinating across different professionals and agencies involved.

Though health-led, the CPA through Circular HC (90)23 was addressed to both health and social services authorities. Since 1993 the CPA has also been linked with a social services-based system - Care Management (DoH and SSI 1991a). Care management applied to a wider range of client group beyond individuals with mental health needs. Its significance for the CPA and mental health services was that care management involved purchasing responsibilities. Thus care managers in social services held the budget for purchasing social care identified by CPA keyworkers.

However, the introduction of these two major health and social service measures, in particular the nature of overlap and relationships between them, generated a good deal of confusion and concern, with evidence of duplication, and inefficient use of resources, problems acknowledged even in the government's own guidance documents (NHS Training Division 1995, p25; North *et al.*, 1993; Schneider 1993; Schneider, Hayes, Beecham and Knapp 1993; Thornicroft, Ward and James 1993). There were struggles to understand the CPA itself and how to operationalise the policy guidance within the context of existing service practice and resource constraints (Schneider 1993; Shepherd *et al.*, 1995). Hence there was a range of documentation explaining and expanding on the original guidance issued between 1991 and 1995 resulting in *Building Bridges* as an attempt by the government to provide fresh guidance on the CPA in order to address the confusion both within health and with regard to relationships between health and social services (DoH 1990a; DoH 1990b; DoH 1993; DoH 1994c; DoH 1995; DoH *et al.*, 1991a; DoH and SSI 1991b; DoH and SSI 1991c; NHS Executive 1994; NHS Management Executive 1994; NHS Training Division 1995). In this context it was hardly surprising that by the start of December 1995 many

health authorities had missed the, already revised, deadline for implementation of the CPA (Community Care 1995; Whiteley 1996).

Indeed this trend of expressed confusion, slow implementation, and variations in practice followed by further government guidance and endorsements of the CPA continued for some time beyond the mid '90s. Thus at the end of the '90s, and with a new Labour government, came further refinements of the CPA couched within more general policies to modernise and set national standards for mental health services (DoH 1998; DoH 1999; SSI 1999). This was followed with the publication in 2000 of a 36-page booklet designed to "clarify the role and purpose of the CPA in the context of the provision of modern mental health care" (DoH 2000, p3). Each successive set of guidance has decreased the amount of discretion available to local services in terms of interpretation and implementation. Thus, the latest guidance included a number of changes to existing guidance aimed at introducing "consistency" for the CPA as operated nationally, including the stratification of the CPA into two levels, standard and enhanced, and the abolition of supervision registers (DoH 2000).

Each successive set of guidance has attempted (in part at least) to respond to acknowledged difficulties of inter-agency working and fit amongst other various policy initiatives over the decade. It is not surprising given these acknowledged difficulties that alongside these initiatives have been a number of evaluations of CPA implementation, some of them government-commissioned (Bindman, Beck, Glover, Thornicroft, Knapp, Leese and Szmulker 1999; Davies and Woolgrove 1998; Kessler and Dopson 1998; North *et al.*, 1993; Schneider 1993; Schneider, Carpenter and Brandon 1999; Schneider *et al.*, 1993; Shepherd *et al.*, 1995).

In one of the earliest, and government-commissioned, reports on implementation of the CPA across four health authorities, North *et al.*, (1993) found overlap between

initiatives and thus confusion even at management level as to which initiatives applied to whom and how (e.g. *vis a vis* CPA, section 117¹³ of the Mental Health Act 1983 and care management). They also reported misunderstanding of the CPA, with services narrowly interpreting it to refer to complex care, applying only therefore to a sub-group of all patients receiving mental health care. In addition there was confusion over whether CPA was an ongoing process or patients could be discharged from it, and about the role of keyworker (e.g. who should be nominated within multi-disciplinary teams (MDTs) and the scope of such a role). Thus the original intention for the CPA to be a systematic procedure for organising care for all those referred to secondary mental health services had not been met two years after being introduced.

In a more recent study, Davies (1998) described the nature and circumstances of those placed on supervision registers across 27 different local authorities, and sought information of both a quantitative and qualitative nature via questionnaire administered face to face, by telephone and by post. This study reported inevitable shades of grey characterising decision-making in the volatile world of the high-risk client. Most striking were the huge variations in practice, which Davies noted reflected its informal and non-statutory origins, with the allocation of some patients taking on a haphazard quality.

As part of their study on changes in the role of two NHS regions during the early-mid 1990s, Kessler and Dopson, (1998), gathered information on the implementation of the CPA through interviews with NHS managers (20 purchaser chief executives or their representatives and 6 Trust chief executives). They found a number

¹³ Section 117 requires health and social services to provide aftercare for patients released from detention under the Mental Health Act 1983. It does not specify the amount or form of the aftercare.

of difficulties, with the focus of their discussion on the report mechanisms required by government on implementation of the CPA. Noting that the CPA is an initiative dependent upon a range of different decisions operating at different levels throughout the NHS, they argue that the various difficulties faced over the CPA are related to uncertainties and ambiguities surrounding the decision-making process. They note a series of dislocations both in terms of timing and in terms of relationships and responsibilities between central government and regions. Thus when the CPA was introduced the NHS was already suffering 'initiative fatigue' (e.g. the introduction of the Efficiency Index and Waiting List initiatives). Further, central government forced the regions to adopt a particular method of data collection and strict timescale reporting on the implementation of the CPA which was viewed critically by Trusts, thus damaging the regions' influencing role between the local services and central government.

Bindman et al., (1999) looked at targeting and prioritisation of mental health services between 1995-1997. They sought to test whether those in receipt of CPA and/or on a supervision register were predicted by a population-based measure of psychiatric need (the mental illness needs index or MINI). Two data sources were used. There was a survey of provider Trusts, with a postal questionnaire to the CPA coordinator or an equivalent in all Trusts in England. This sought information about the total population served by each Trust, the total number of patients under care and on the numbers subject to the various locally used tiers of the CPA and the supervision register. There was also a survey of centrally collected quarterly health authority data on total numbers of patients and numbers subject to the CPA and supervision registers. Bindman et al found wide local variations in the number of people subject to the CPA and supervision registers, which were not explained by variations in populations of

need. Thus they concluded that the prioritisation to receive specialist mental health services was carried out inconsistently.

Schneider et al., (1999), in a more recent government-commissioned study, conducted a questionnaire survey across all 183 NHS Trusts in England providing mental health services between 1997-1998. As with the Bindman study, the survey was administered by post, here to 145 individuals responsible for the administration of the CPA within each Trust. A response rate of 79% was reported. Respondents were asked to rate the involvement of professionals in the CPA processes of assessment, care planning, keyworking and review, while the part played by patients and carers in planning and reviews was also noted. This survey reported widespread multi-disciplinary working, though noted that CPNs were more likely to take a lead on assessment and act as keyworker than any other profession. Overall there were significant differences among English NHS Trusts in the involvement of professionals, carers and patients in the various stages of the CPA. The survey also reported on health and social service agencies' levels of harmonisation and targeting of SMI patients. Here, high levels of harmonisation between health and social services had been achieved in a few areas, while the extent of targeting SMI was variable. Schneider et al found that targeting and harmonisation ranged widely, and were found to be significantly correlated. Thus high levels of targeting SMI were positively associated with high levels of harmonisation.

It should be noted that many of these evaluations are of a questionnaire survey nature and as such carry shortcomings in their findings. Often the survey represented the views of one (albeit possibly well-informed) person in each Trust surveyed. Except for the Bindman study, such respondents do not figure among frontline clinicians actually delivering services, and respondents reporting an adherence to guidelines does

not indicate the nature of services delivered. However, such findings do indicate, if at a superficial level, problems of implementation¹⁴. Together, these studies provide evidence of continued difficulties of implementation due to problems of timing, and structural arrangements, as well as indicating wide variations in practice.

Building on these themes, the remainder of this chapter discusses the implementation of the CPA and the national scene using a framework to characterise the difficulties of implementation. It is also a framework which prefigures the local scene, and one which local participants found recognisable during feedback on the empirical research. This is, then, a framework that was developed from the simultaneous examination of external sources ('the literature') and local site fieldwork observations and interviews. The discussion which starts in the next section and follows through chapter 5 is the ethnographic 'theoretical memo' which was produced as a first sense-making device for myself on the formal organisation of mental health care, as well as for the participants as a feedback report on the application of the CPA (Ormrod 1997).

¹⁴ To address the reasons for such practice requires a different methodology - arguably the kind of qualitative approach adopted by this study, which presents data accordingly.

4.1.2 Problems of implementing the CPA

Superficially a CPA appears to be a relatively simple matter: in most respects it is what most practitioners would regard as good mental health practice. It refers to a pattern of mental health care practice where there:

- ◆ are systematic arrangements for assessing the health and social care needs of patients, leading to a care plan agreed with the patient, and where appropriate with any informal carer, and with the practitioners who will be involved in delivering the care;
- ◆ is the appointment of a 'keyworker' to coordinate and monitor the patient's progress and the implementation of the plan;
- ◆ are regular reviews, and if required, agreed changes are made to the plan.

By 1995, five years after the initial guidance was issued, one third of health authorities reported that they had not implemented a CPA (Care Weekly 1995, p1; DoH and SSI 1995a; DoH and SSI 1995b) and this does not take account of those health authorities who claimed to have implemented the CPA, but in reality had not, nor of the fact that in some health authority areas the CPA had only been implemented by some Trusts, and that within some Trusts the CPA was practised by only some teams. Moreover, the degree to which the CPA had been implemented, and the shape it took in localities claiming to have implemented it was, and remains, extremely variable.

and social services had been overwhelmed by organisational changes in the first half of the 1990s, such that implementing any one set of changes had been made difficult by the uncertainties created by other changes being implemented at the same time.

Important changes occurring at the same time at which the CPA was supposed to have been introduced included:

- ◆ Ongoing changes associated with the purchaser-provider split in the health service: a huge reorganisation in itself and marked by internal management reorganisations within NHS Trusts (Higgins and Girling 1994; Walsh 1995);
- ◆ Development of GP fund-holding, which produced a new kind of relationship between the primary care sector and the hospital and community nursing services (Audit Commission 1995; Glennerster 1994);
- ◆ Introduction of care management systems into social services (as within health, a change associated with the purchaser-provider split in public services). Nationally there was considerable concern as to the fit between care management and the CPA (DoH *et al.*, 1991b; DoH, SSI and SOSWSG 1991d);
- Prioritisation of means-testing and fee charging in social services (DoH 1994d);
- ◆ Psychiatric hospital closure programme, which tended to divert effort, if not resources, to the resettlement of long-stay patients, and at the same time close off options for 'new' patients, thus increasing the demand for CPA packages (Leff, Thornicroft, Coxhead and Crawford 1994).

All of this is to say that, nationally, implementing the CPA has been very problematic, and this seems also to have been the case in Westway where my research was conducted¹⁵.

The problems of implementing the CPA may be thought of as being of the following kinds:

- ◆ *problems of timing*
- ◆ *problems of resourcing*
- *problems of training*
- ◆ *problems of structures (at various levels).*

This chapter argues that most of the problems encountered nationally, including Westway, were of the last kind: problems arising from the way in which responsibilities for delivering mental health care were dispersed both between different agencies and between practitioners of various kinds, and the accompanying difficulties of coordination. However, a brief treatment of the other kinds of difficulties is also necessary.

4.1.2.1 Problems of timing

The government required the CPA to be introduced at the same time as a large number of other radical changes in health and social services. It might be argued that this was the most appropriate time for its introduction - on the grounds that the CPA should be bedded down alongside the other changes. In practice, however, it appeared that health

¹⁵ In order to preserve confidentiality and anonymity all names are replaced by pseudonyms.

and social services had been overwhelmed by organisational changes in the first half of the 1990s, such that implementing any one set of changes had been made difficult by the uncertainties created by other changes being implemented at the same time.

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These are, of course, all 'structural' changes, and will be picked up under this heading later in the chapter. The important point here is that they all occurred at the same time and that they were driven from different points in the overall structure, such that change was, in reality, disarticulated. This was experienced by many as overwhelming.

4.1.2.2 Resource problems

There is no doubt that implementing change is itself costly in resources, and that mental health care has always, and continues to be, poorly resourced by comparison with other kinds of health and social care (Audit Commission 1994, Chapter 1).

4.1.2.3 Problems of training

When new structures, procedures and practices are to be introduced, then, of course, training is an essential component. The DoH commissioned two CPA training programmes (NHS Training Division 1995; Open University *et al.*, 1996), while the Sainsbury Centre produced another substantial package (Bleach and Ryan 1995).

Two models of the relationship between training and implementation of change may be suggested. For one model, the nature of the changes to be introduced are first decided, and then staff are trained to implement them. This is a model of training which presupposes that what will count as proper practice has already been decided.

It is notable that none of the packages referred to above follow this model. Except insofar as they re-iterate the DoH specifications for the CPA (as given earlier) and various widely accepted nostrums of good practice, they all adopt a different model where the nature of what is to be implemented is to be decided among trainees via training. This is an organisational development model of training.

There are two main reasons for this feature of the officially sponsored training materials. First, in the DoH's own words:

The CPA is just what it says - an approach. The NHS Executive has no *intention of prescribing what should be done at a local level.*
(DoH 1995, para 1.3.5).

This was at one and the same time, politic, expedient, and problematic. Politic, because health authorities, and especially social services departments do not take kindly to having structures imposed upon them. Expedient, because it is inconceivable that central government could devise a single organisational form that would be appropriate in the face of enormous local diversity in the pattern of service organisation. And problematic, because it left to local agencies the task of designing the organisational means to reach the ends required by the DoH.

Second, all of these training packages take the line that changes should be 'owned' by the people who have to operate the new system. There are a number of justifications for this view, for example: that frontline practitioners are the experts in what needs to be done and what it is feasible to attempt and that when people are *involved in designing changes they are better committed to putting them into practice.* This notwithstanding, it is also the case that 'trainees' here are professionals of different kinds with a strong degree of autonomy, and drawn from different agencies with no overarching management structure. Put another way, there is no structure which gives anyone a mandate to determine what structures, procedures and practices will locally count as 'the Care Programme Approach', and therefore, desirable or not, training has perforce to be a process of negotiation.

Insofar as local structures and procedures for the CPA remained unclear, then training people to follow them was obviously not an option. Given the weakness of the mandate to order practitioners to practice in particular ways, their involvement in

designing the CPA was inevitable, as well as desirable - whether through training of the organisational development kind, or through other consultative mechanisms.

However, an issue that arises here is one of appropriate levels for decision-making. Although difficult to specify exactly, it must be the case that there are some organisational matters that must be decided at a high organisational level, if only because these are matters where frontline practitioners could not be expected to reach settlements among themselves. Whereas there must be other matters which are better left to front-line practitioners to decide within a framework imposed from above.

In short, difficulties about implementing the CPA cannot be seen as training problems. Rather training problems result from difficulties in implementing the CPA.

4.1.2.4 Structural arrangements for the CPA

It might be said that the very problems that the CPA was supposed to solve, were the very problems that made it difficult to implement.

Broadly speaking the CPA represented an attempt to coordinate the care of mentally ill people in the community where the extant structures for delivering care appeared to be designed to make this as difficult as possible. Major features of the structural set-up during the period of the research included¹⁶:

- ◆ The separation of health care from social care, and both from the provision of social housing, income support, and other relevant services: this is a separation in terms of management structures, service philosophies, legislative frameworks, and audit arrangements.
- ◆ The accentuation of differences between health and social services. This included the differential effects of purchaser-provider splits in the two services whereby in CMHTs health service practitioners were providers, whereas many social services practitioners were primarily purchasers: care managers who did not deliver hands-on care. And it included the growing importance of making charges for social care, while health care remained free.
- ◆ The separation of primary health care from the care delivered by the practitioners of a NHS trust. This was exacerbated by the development of GP-fundholding which gave GPs the power to ‘sponsor’ patients in such a

¹⁶ More recent changes since the completion of this research might be seen to reverse some of these trends, e.g. relaxations in funding arrangements and the advent of institutions such as Partnership Trusts and Health and Social Care Trusts.

way as to subvert the prioritising practices of a CMHT (Onyett, Heppleston and Bushnell 1994a).

- ◆ The dispersion of expertise, and the right to practise it among a wide range of different kinds of practitioners (e.g. psychiatrists, psychologists, nurses, social workers, occupational therapists), with different degrees of autonomy from each other and different line management systems.

In the ordinary sense of the term ‘management’ this constitutes an unmanageable system, insofar as there is no locus from which it can be managed overall. Rather it has to be ‘managed’ in the other sense of the term: “to contrive to get along or pull through” (Sykes 1976), as best one can.

It is apparent that the DoH envisaged coordination of care via the CPA being managed at two levels. From the ‘bottom up’ through the coordinating activities of front-line workers and especially via the keyworker role. And from the ‘top down’ through management putting in place the kinds of structures to make this possible.

In a legal sense it was the health authority that was required to implement the CPA, and health authorities were to do this by making implementation a contract requirement for NHS Trusts. So far as I am aware, no health authority prescribed the CPA in any detail, so this decision devolved to Trust management. Nor did it appear that any health authority regarded the non-implementation, or the deficient implementation, of the CPA as a default on contract. It thus appeared that those who were charged by the government with implementing the CPA actually left its implementation to a sub-contractor, and did not use their powers to enforce contract compliance. This is almost certainly because, contrary to the intentions of the National Health Service and Community Care Act, where mental health is concerned, provider

Trusts are usually in a monopoly position¹⁷. One of the reasons, nationally, why the CPA was not fully implemented for so much of the '90s then, was because its non-implementation had only been weakly sanctioned.

The management of a NHS Trust is not in a position to implement the CPA in full. It is only in a position to implement those elements of it that are operated by its staff: psychiatrists, clinical psychologists, community psychiatric nurses, and other mental health nurses. By contrast with the health authority and its sub-contractor Trusts which were 'required'¹⁸ to implement the CPA, social services departments were only requested to cooperate, and general practitioners not even this.

Thus, in order to implement the CPA, a Trust had to negotiate working arrangements with its corresponding social services department(s). Agency to agency, service to service negotiations by necessity have to be at a level above that of practitioners since frontline practitioners do not have a mandate to enter into binding agreements with other agencies when such agreements will determine the practice of many staff over a long period of time and a large number of cases. This does not necessarily mean that negotiations between Trusts and Social Services have to be conducted at the highest level (i.e. CEOs), but that they can only result in secure agreements if conducted at least within a framework decided between the two organisations at the highest level, with the results ratified at a senior level and embodied

¹⁷ A monopoly position at least with regard to services employing psychiatrists. Of course there are areas of provision where Trusts are sometimes not monopolistic e.g. day care provision.

¹⁸ The CPA was not actually a statutory requirement but termed by the DoH as a "management requirement", meaning that implementing the CPA was a condition of receiving DoH funding, although there are no instances of funding being withheld for non-compliance.

in some kind of memorandum of agreement between the organisations which commits them as organisations.

4.1.3 A system for managing risk

I noted at the start of this chapter that various public inquiries over the years into deaths resulting from failures of mental health care have been associated with attempts to reduce the risk factors identified by such studies. As Alaszewski *et al.*, note (1998), although they do not explicitly use the concepts of risk analysis¹⁹, public investigations into accidents are, in practice, case studies in risk analysis. Alongside a series of mental health care inquiries in the late 1980s and early 1990s, sharing similar recommendations for more rigorous coordination and monitoring of care, the government introduced the CPA. In this sense the CPA is a system for managing risk posed by, and for, those with severe mental illness.

Indeed, the inquiry into the killing of Jonathan Zito by Christopher Clunis highlighted the role of mental health practitioners as risk assessors (Alaszewski *et al.*, 1998; Ritchie *et al.*, 1994). The main thrust of the Ritchie report's recommendations was to develop an effective system for identifying risk, especially when patients who had been detained in hospital under the Mental Health Act (1983) were discharged into the community. Recommendations were that a standardised form be used for section 117 aftercare, to include details both of agreed care plans and, in cases involving violence, "an assessment ... as to whether the patient's propensity for violence presents any risk to his [sic] own health or safety or to the protection of the public" (Ritchie *et*

¹⁹ This refers to the specialist study of risk in certain technical and scientific disciplines such as statistics, engineering, and epidemiology.

al., 1994, para 45.1.2). In addition the inquiry recommended a nationally based register of patients subject to section 117 (para 45.2.3).

These recommendations were addressed bureaucratically through the development of the CPA and associated measures, namely the Supervision Register and Supervised Discharge. While the Supervision Register can be seen as a specific response on risk to one of these recommendations, the CPA itself represented a more broadly based measure. As noted earlier, government guidance outlining the CPA anticipated that risk assessment and management would fall out of a system of care that was coordinated and regularly monitored (DoH 1994c). No specific measures for the assessment of risk were recommended, though there was some indication of an expectation that this process might be formalised through local agency or team policy and the development and use of specific measures (NHS Training Division 1995, p40). The most specific that the government got on risk at this time was to require services to identify, with regard to those on the supervision register, the category of risk (from a three-part list of: suicide, serious violence to others, and severe self-neglect), and any known warning signs of such risks (DoH 1994a). And indeed more recently government guidance explicitly acknowledges that “risk assessment is not ... a simple mechanical process of completing a proforma”, but is rather an embedded aspect of an ongoing CPA (DoH 2000, p22). Moreover, government conceptualisation of risk in broad terms was also indicated by the fact that a CPA was a package of care that was to be applied to all patients under the care of secondary mental health services, and this was intended to provide support according to individual need.

Thus with the CPA measures introduced by government, risk assessment and management was both made an explicit aspect of care and at the same time conceptualised in a diffuse way. Of significance here is the shift in responsibilities and

accountability that this raised for mental health practitioners. As Alaszewski et al., note (1998, pp34-42) changing emphases in policy with regard to vulnerable people (broadly a shift from care and control by institutions to community), complicate the agenda for professionals, who are made more directly and individually responsible for reconciling conflicting policy objectives. To provide proper care professionals are thus expected to “assess and reconcile various forms of risk: risk to society; risk to the vulnerable individual; and the empowerment of vulnerable individuals to take risks” (p42). However, it should be added that it is only very recently that official recognition of risk in adult mental health care has clearly encompassed both positive and negative notions (DoH 2000, p22). Certainly throughout the ‘90s and during this study, risk management was treated in purely negative terms as the prevention of adverse events (see reference above to Supervision Register). Whichever emphasis, however, it was clear that with the conceptualisation of mental health care organisation as (at least in part) a system for risk management via the CPA requirements, mental health care agencies, if not individual professionals, were liable to be considered more accountable.

Chapter 5: The CPA – local scene

This chapter interprets the difficulties experienced by the local site in terms of the problems used to characterise the CPA. The chapter therefore performs two tasks. First, it describes the local setting from which data has been gathered and used throughout the thesis (scene as resource). Second, it presents a first take on the data, describing the local organisation of mental health care in terms of difficulties of an inadequate system (scene as data).

5.1 Problems in implementing the CPA: the local scene

While the problems in implementing the CPA discussed in chapter 4 were common to any locality in England and Wales, these were articulated alongside characteristics particular to Westway. But before these are discussed, and by way of introduction, a brief description follows about the size and nature of Westway.

Westway Community Services NHS Trust served a population of roughly 300,000 spanning a mixture of city and rural areas in England. These areas reflected a wide range of socio-economic conditions, with one electoral ward of the city being consistently identified over a number of years as figuring among the worst most deprived inner city areas within England and Wales, and some outlying rural areas figuring among the most prosperous. The Trust's mental health directorate (MHD) was organised via a mixture of acute and rehabilitation services. These services were provided in the form of three sector teams (referred to here as 'Teams A, B and C'), and a separate rehabilitation service. The sector teams each comprised a ward within the psychiatric hospital unit and a CMHT. The psychiatric hospital unit, situated alongside the district general hospital in a suburb of the city, provided 75 acute beds on three wards, and 46 beds were provided in five residential rehabilitation units in suburbs of the city. In addition there was community treatment from an assertive rehabilitation

team (ART), and central crisis assessment facilities provided from a psychiatric advisory service (PAS) and emergency psychiatric service (EPS), though there was not '24/7' cover (see Figure 5-1). The total number of referrals across the three sector teams was 3,400 during 1995.

The three sector teams each comprised 31-38 staff including medical, nursing and social services personnel, drawn from separate agencies of health and social care, and spanning more than one organisational base (see Table 5-1 and Figure 5-1). The number of district social services teams serving each sector varied, with Team A having five, Team B one and Team C three (see Figure 5-1). Each team also had multiple management arrangements with an overall Sector Manager, managers for ward and CMHT sides of the team as well as certain professionals being managed and/or clinically supervised either partly alongside or independently of the rest of the sector team (medical staff, psychologists, social workers) (see Figure 5-2)²⁰. Each team also had multiple inter-agency structural relationships with regard to relevant local authorities and social services, which in turn were bisected by the complexities of purchaser-provider arrangements (see Figure 5-3).

It will by now be apparent that the structures sketched here, by way of introducing the local scene, are somewhat problematic. The various aspects of this will be taken up and developed in later sections 5.1.4-5.1.5 as relevant to the specific discussions of structures. Right now I turn to consider the problems of implementing the CPA according to the framework set out in the previous chapter.

²⁰ While the figures and table depicting structural arrangements are to some extent 'tidied up' versions for the purposes of achieving some kind of clarity of presentation on what are in practice very messily complex arrangements, this is especially so with regard to management and supervisory relationships.

Figure 5-1: Westway Mental Health Directorate Structure and Social Services Involvement

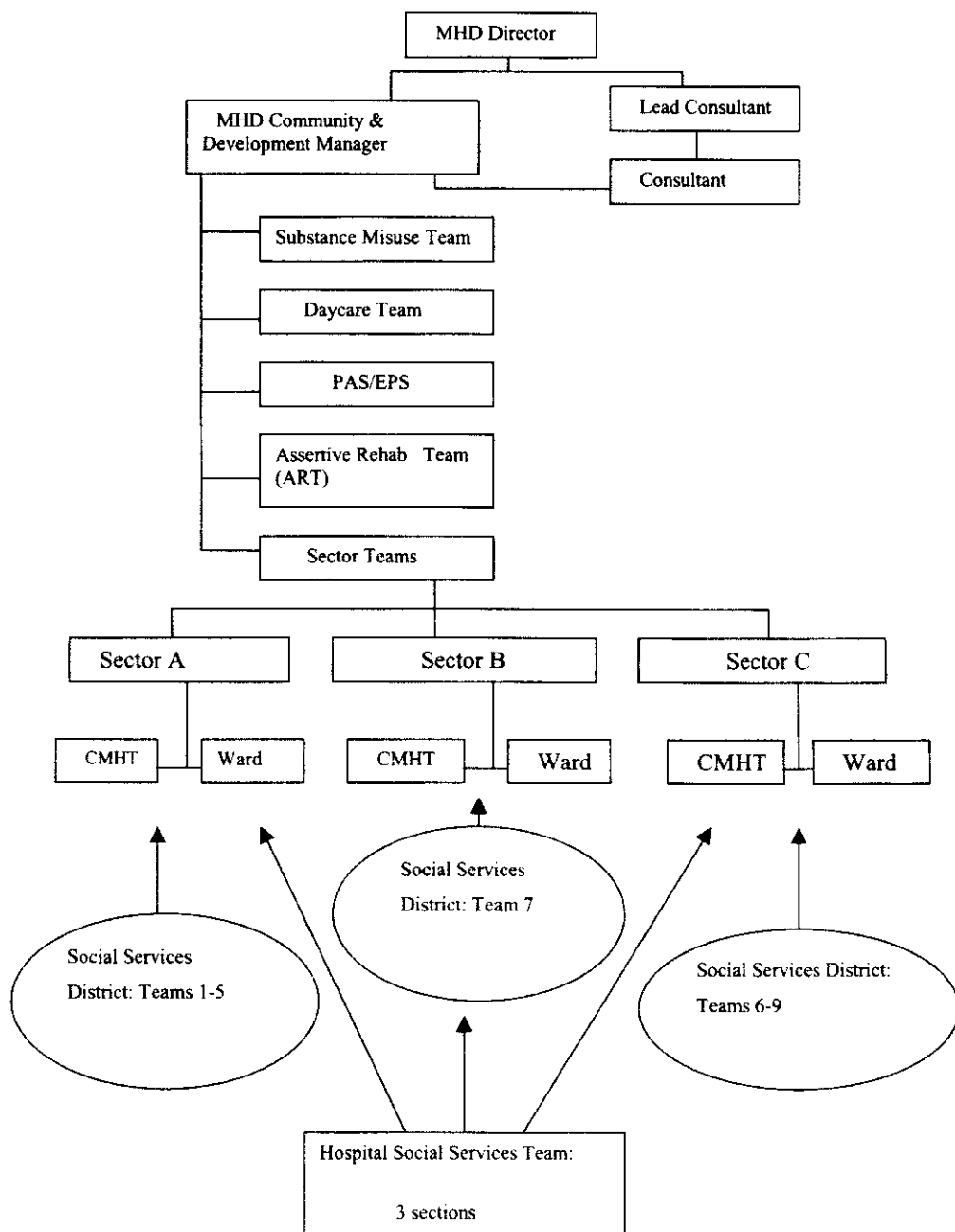


Figure 5-2: Sector Team Management and other Personnel and Deployment Relationships

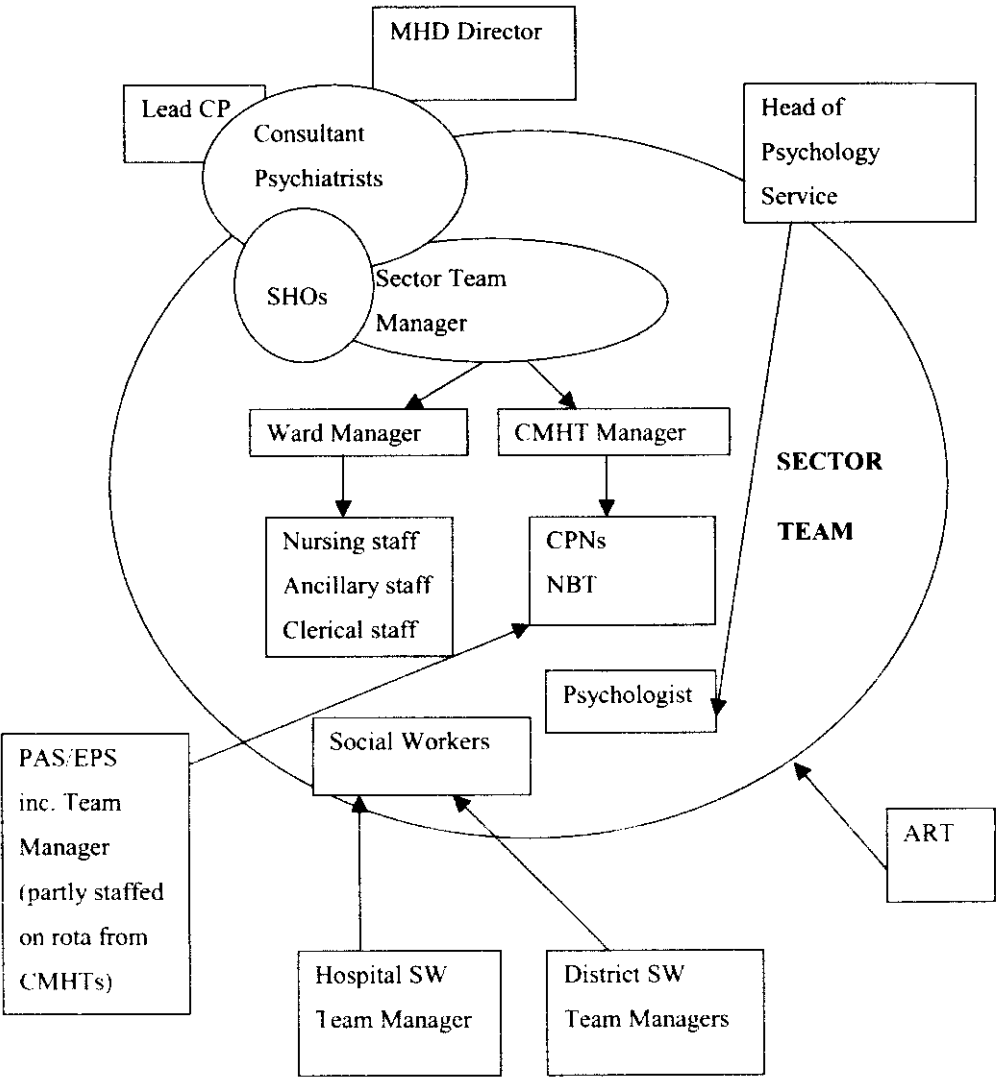


Figure 5-3: Inter agency structural arrangements relating to Westway Community Services Trust - Mental Health Directorate

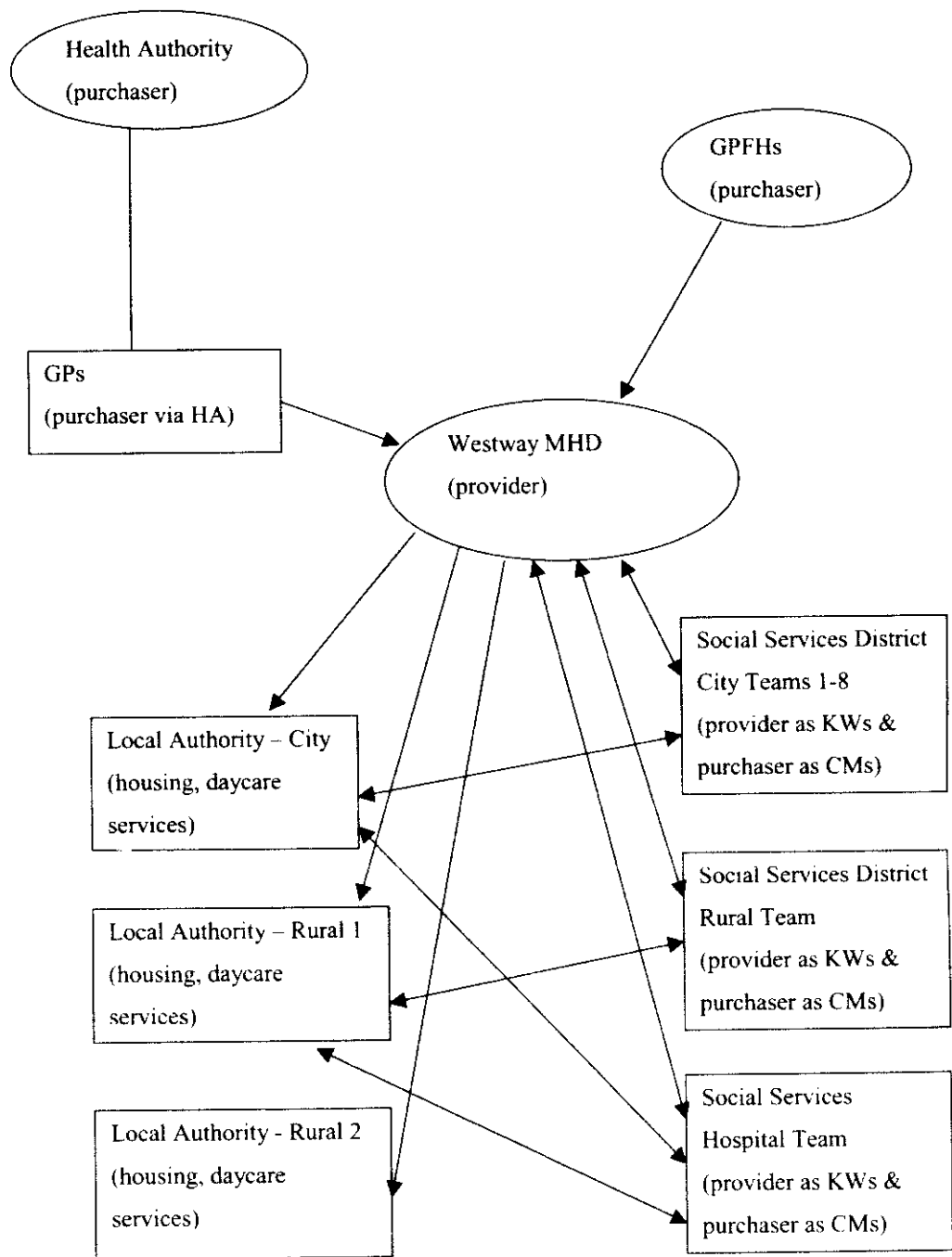


Table 5-1: Sector team personnel

Number	Sector-wide post	Ward-based post	CMHT-based post
Westway	MHD	Health	Personnel:
1	Sector Manager (non-clinical)		
2	Consultant Psychiatrist		
2	SHO		
1		Ward Manager	
12		Nurses (inc. 5-6 RMNs)	
1			Team Manager (CPN/NBT member of team)
1			Clinical Psychologist
1			Nurse Behaviour Therapist
6-8			CPNs
LA	Social	Services	Personnel:
2-3			Hospital ASWs & Community Mental Health Workers
2+			District ASWs

5.1.1 Problems of timing

There were a number of changes, either concurrent or rapidly following on from one another, within secondary health services as well as within primary care and social services which have impinged greatly upon mental health services. To recap, these covered changes in relationships and responsibilities over the purchase and provision of services and, charging arrangements, both within health care and between health and social care.

In addition, in Westway, as elsewhere, there were several management reorganisations as the Trust tried to develop more effective management structures. These included the introduction of Sector Managers in the early stages of the fieldwork. There was also the introduction of sectorisation, a reorganisation initially geared to facilitate a move from hospital to community-based services at the end of the 1980s, including improvement of in-patient bed management and, later intended to facilitate 'seamless care' across the in-patient and community sides of the directorate, in line with various policy initiatives. Finally, as the fieldwork ended, plans emerged to radically reconfigure the MHD in order to better organise and match what were complex and once more rapidly outdated relationships both within the MHD and with partner agencies in primary care, social services and local authorities.

Further, there was local government reorganisation during 1996-7 (unitarisation). For Westway this meant that the single forum for strategic liaison and decision-making for mental health care across the various local agencies, the Joint Consultative Committee (JCC), (comprising local authority & social services, the Trust, Health Authority, and independent charities and community projects), was replaced by more than one JCC, a city-based and two separate rural based committees. It also produced reorganisation in local social services bringing shifts in personnel and team

bases, with consequent changes in terms of liaison and allocated staff for Westway CMHT sides of the three sector teams. This took time to filter through as full unitarisation began to take effect, but towards the end of the fieldwork period this was adding to the uncertain conditions experienced by team members especially with regard to some district social services.

5.1.2 Resource problems

Nationally the picture was one of under-resourcing, with historic patterns of imbalances in funding between inner city and rural and suburban areas (Audit Commission)²¹. A follow-up survey by the Audit Commission comparing 8 Trusts in England, including Westway, provided some data with regard to the resourcing of mental health care in Westway which allowed bench-marking against situations elsewhere. On some measures provision was low in Westway relative to national comparisons. More specifically, in the follow-up benchmarking exercise, the Audit Commission identified several areas of reduced resource levels and costs. For instance, nursing costs for the acute wards in-patient service fell below the average by 14%. Also, there were fewer numbers of CPNs per head of the population than the national average. Such relatively lower levels in resourcing also need to be read against the Audit Commission commendation of Westway for appropriate targeting. Westway demonstrated just over half the sample patients (excluding medical caseloads) categorised as A (the most serious), compared with a 24% national average (sample of 84 Trusts nation-wide)²².

²¹ The Audit Commission Report sources are not referenced here in order to protect the anonymity of the Trust.

²² It is important to highlight the limits of these claims as the figures here are derived from samples of caseloads, and national comparison figures are also derived from a sample of Trusts.

While overall resourcing was an important matter, even more important was the way in which resources were deployed, as between, for example, hospital care and community care, between different areas of the service such as ART and the sectors, between managerial activity and the delivery of care to patients, between different kinds of personnel (as numbers of posts or sizes of caseloads), and between different kinds of patient group. In Westway, the rehabilitation service had disproportionately much higher levels of resource allocation compared to the sector teams (which included acute in-patient facilities) (Audit Commission). Moreover, the three sectors were designed to have approximately equal populations, yet their budgets were not equal and referral rates for 1995 indicated that population needs between sectors may not have been the same (Audit Commission). In 1995, Team A received more referrals than Teams B and C: by 8% compared with Team B; and by 31% compared with Team C. At the same time the differences in team budgets were within 5% of each other. (Audit Commission). So this apparently small financial discrepancy was likely to be magnified by the differences in population that each sector served. Moreover, these inequalities were compounded by the imbalance between sectors in community staffing (e.g. 3 more CPNs in Team B compared to Team A, less clinical psychologist time in sector A given the post-holder's other commitments as Head of Psychology Services). These were all, again, largely structural issues.

5.1.3 Problems of training

Earlier I described a model of training that has accompanied the introduction of the CPA nationally as one of 'organisational development', one which evolves through implementation proceeding via processes of negotiation. Such a model, it was argued above, demands clarity about appropriate levels for decision-making for the different aspects of implementing the CPA. That said, it seemed in Westway there was no clear decision as to what features of the design of the CPA should be allocated to decision at

which organisational level. Worse, it was never clear which body, task group etc., should be deciding what, nor clear what was up for decision, or indeed what had been decided. Without some sort of framework established for making decisions about the CPA then no decisions could be made about who should be involved in these decisions, via training or otherwise, and certainly no decisions could be made about more prescriptive training packages. Even worse, whenever some framework for decision-making had seemed to be emerging, it was swept away by the next wave of change (indicated in 5.1.1 and more fully illustrated in 5.1.5).

5.1.4 Structural arrangements for the CPA

As noted above, structural arrangements for implementing the CPA required firmly established inter-organisational agreements. The joint Westway Trust/Social Services document “CPA Operational Policy” dated 1995, constituted a written agreement and commitment between the two organisations as to working arrangements for the CPA. However, this contained only weak commitments to joint working, with for instance no firm obligations or mandates for either health or social services managers in terms of their servicing or obtaining services for sector mental health teams. In addition, a full understanding of the procedures outlined in this document among front-line practitioners across both health and social services appeared to be patchy. (Further comments are made below under 5.1.5 which may provide some additional explanation for this). Moreover, there was a fairly widespread sense of there being an uneasy relationship between health and social services at higher managerial levels within the MHD. This served to undermine the authority of the document outlining joint organisational CPA Operational Policy.

In Westway, as elsewhere, the main means for coordinating the activities of the Trust and Social Services at a case level were the sector/community mental health

teams, which pre-existed the CPA. For Trusts to implement the CPA, high level managerial activity was required from social services departments, but Trusts had no power to command such co-operation. In the absence of firmly established inter-organisation agreements in Westway, the amount and kinds of co-operation that could be expected between health staff and social services staff at team level was limited.

5.1.4.1 Sectorisation and congruent boundaries

Sectorisation was introduced in order to facilitate (in part at least) joint action between health and social services staff at case level, meaning that hospital based staff, specific social services district teams and hospital ASWs would relate only to one community mental health team. However, several social services district teams covered two of the three community mental health teams (A and C), (see Figure 5-1) and this was observed to present problems for the teams. Attendance at sector team meetings by the nominated district social workers was patchy. Minimally, the problems were a delay in allocation of KW for patients with ostensible social care needs. More seriously, there was the burden this placed upon the rest of the team, primarily, the hospital-based social work staff, as well as CPNs. Moreover, district social workers were restricted to only accepting patients who fell in their particular social service district, which was within only a part of the sector. There were several instances where the sector team was desperate to allocate patients, identified as those who would benefit from a social worker to keywork, and where social workers had space on caseload, but the patient address and district within the sector did not coincide. These barriers to allocation point up the lack of negotiations between the Trust and social services in the planning and later revision of sectorisation (whereby sectors were switched from social service congruent boundaries to ones organised around GP practices).

Moreover, lack of congruency in the organisation of sectorisation applied not only at inter-agency levels but also within the MHD itself, with an uneven distribution of budgets, staff and patient population among the three sectors (see section 5.1.2).

The lack of detailed consultation, at an appropriately senior level, to develop binding agreements between health and social services also pointed up further local structural problems for implementing the CPA - in terms of fulfilling the government requirement to maintain a CPA register, and determining eligibility criteria.

Both of these have to be decided organisation to organisation rather than within CMHTs: the first because a CPA register would be a Trust-wide device; the latter because a social services authority, at least, is required to provide a standardised service across its area, and not a different service according to which team is involved.

5.1.4.2 Common information systems

The CPA register refers to a database containing entries for all patients treated under the CPA. The responsibility for maintaining the database rested with a Trust as an aspect of its contract with the health authority. However, the register was supposed to provide a common database for both health and social services, listing details of each patient, their keyworker, and date and arrangements for the next scheduled review (DoH 1995, paras 3.2.20-3.2.22). Supervision registers (SR) were a sub-set of this same register and joint health and social services responsibility for the SR was more clearly spelt out (DoH 1995, chapter 4).

The maintenance and use of this common database required agreement with the social services authority, and if it was not to lead to wasteful duplication, the use by health and social services of the same set of proformas. This did not happen in Westway. There was no compatible and inter-linked system of information technology.

While proformas were developed by the Trust in consultation with social services, practice among individuals at team level was inconsistent: with some staff feeling they had to duplicate information using both health CPA and social services care management forms; others using one or the other; and others not using them at all. This indicated that negotiations between the two organisations on global administrative procedures prior to and since the implementation of the CPA was not adequate.

In some areas the CPA register had been elevated to an important coordinating device. For example in North Derbyshire, a Care Programme Coordinator, received initial documentation and updates from health, social services, and sometimes other kinds of practitioners, for input to the register; sent out updates to relevant practitioners and convened review meetings at the dates earlier agreed with the patient (North Derbyshire Health Authority and Derbyshire County Council Social Services Department 1994). This kind of arrangement clearly required protracted negotiations between the local Trust and the social services department as well as investment in the development of a workable set of proformas and in IT hardware and software. At Westway, managers within both health and social services admitted the kind of rapport and close working relationships which such negotiations require did not exist strongly enough at sufficiently senior levels.

5.1.4.3 Common prioritisation

Prioritising patients for service is an important aspect of the CPA. Concurrent with the implementation of the CPA all social services departments were required to draw up, publish and follow eligibility criteria referring to all client groups, but including people with mental health problems (DoH *et al.*, 1991b). The criteria defining eligibility for social care were not identical with those defining priority for health care under the CPA, which emphasised the clinically adjudged severity of the mental illness and the degree

of danger to the patient and others. Harmonising eligibility criteria was not something which could be done at team level, since for social services it had to be done on an authority-wide basis and with a view to their statutory responsibilities. It was a matter which had to be agreed at a higher level.

In Westway, there did not appear to be any formal agreement on such criteria between the two organisations of health and social services. During the fieldwork period the Trust began an exercise within the sector teams to define SMI, but this did not appear to generate any definitive or collaborative agreements between health and social services. From the outset the exercise was beset by some staff feeling this was too simplistic and likely to exclude some very vulnerable patients, and later the exercise was overtaken by a major reorganisation of the MHD.

5.1.5 Structures for implementing change

As noted earlier there are structures necessary to run the CPA, and structures necessary for implementing changes such as the CPA. There are a number of mechanisms required, incorporating both top-down and bottom-up processes, in order to implement organisational change. These include organisation-wide mandated management structures, strategic planning, consultation, dissemination of decisions and monitoring of implementation. Further consideration of CPA implementation in Westway demonstrates problems of structures for managing change itself.

One necessary feature of the structure required to introduce the CPA was some kind of joined-up senior management structure involving management from both health and social services. No such arrangement existed and in practice inter-agency relationships were messy and disarticulated and only existed in formal terms at lower (team) level (see Figures 5-1 to 5-3). Since roughly half the CPA was the responsibility of one organisation, and half the responsibility of the other, attempts by either

organisation to introduce the CPA unilaterally (or any other major organisational change connected with mental health services) were bound to be ineffectual.

Work was undertaken by a freelance trainer, employed on a consultant basis by the Trust, to liaise with both health and social services staff in developing and delivering training materials to introduce the CPA as well as a set of proformas to enable implementation of procedures to support the CPA. As will be seen from the discussion below, these forms and accompanying procedures were not successfully implemented and became the focus of several attempts to review and reformulate working practices in order to demonstrate that the CPA was indeed being applied by the Trust.

Although implementing the CPA, Trust-wide and SSD-wide, inevitably entailed a top-down approach, it was nonetheless important to involve front-line practitioners in the decision-making: this both because they did know better than senior management what was feasible in practice, and in order to develop ownership of change. At Westway, a series of CPA Feedback Meetings run over 1995 – mid-1996 provided one such forum for practitioner involvement. And in spite of the drawbacks acknowledged below, these were viewed by many staff as valuable forums for giving and receiving information about the operation of CPA.

The experiences and views reported at the Feedback Meetings were supposed to filter through to the MHD's CPA Steering Group to inform decision-making. However there was a widespread perception that this was not the most effective structure for amending and driving through refinements to operational practice. Thus this arrangement was substituted in June 1996 by a new forum, the CPA Review Group, convened by Team C's sector manager and chaired by a CPN from the same team.

The intention was for this forum to be composed of front-line practitioners from across health and social services. In practice this forum was compromised from its very start by poor communication and lack of adequate consultation and pre-planning within the Trust. At the outset, not all members were adequately consulted as to the most favourable meeting times; details and dates for the meetings had been circulated on several occasions to members without adequate notice; the timing for starting these meetings during the summer period at a time of many staff vacations did not help engender a wide or firmly committed membership; and attendance at meetings dwindled amidst confusion among some members as to the nature of the group's remit and status²³.

In September 1996 following a meeting of the MHD management group an 'offshoot' group to this forum was set up, referred to by some staff as the "CPA Audit Group". This latter group were charged with examining issues arising from feedback at the directorate management meeting presentation. By January 1997 a quorate meeting had not been achieved, amidst confusion about the membership of this sub-group and its relationship to the prior CPA Review Group.

Although the Feedback Meetings were supposed to continue alongside the new CPA Review Group according to the final meeting of the CPA Steering Group in May 1996, this did not in fact occur. There was some considerable confusion expressed by various members of Trust and social services staff, including at management level, as to the future arrangements for monitoring and developing the CPA. The difficulties faced

²³ Such confusion meant that it was not possible for me to establish a full finalised list of group members. The understanding among several participants was that membership was those from the respective three sector teams who volunteered to go to meetings as they arose and would minimally include team managers.

by the CPA Review Group and its offshoot added to a widespread sense of confusion among Trust and social services staff about the existence, progress and status of various groups.

A further potential sticking point for advancing the work of the CPA Review Group was the perception among some staff that there had been a rather hasty decision to focus upon the redesign of forms as a means to addressing operational problems of the CPA. There was widespread feeling that the initial forms were not properly piloted, given that they were introduced in Team C only one month prior to Trust-wide introduction without time for fulsome feedback and evaluation which could be communicated to all staff in advance of their introduction across the Trust. This, in turn, fed into misgivings among some staff within both health and social services about the later attempts to refine the forms used. There was some disagreement as to whether the forms were the major problem that needed addressing. There was also a feeling that a concern with forms did not address the more substantive issues of the process of the CPA, which the forms were merely there to facilitate. While the CPA Review Group may well have addressed issues of process in implementing the CPA during its August 1996 meetings, it failed to disseminate any deliberations and recommendations arising from such meetings to all the teams in a coherent and meaningful way.

Against such a background of lack of direction over the development measures for the CPA, or change more generally within the Trust, it is hardly surprising that one team (B) set up its own sub-group to look at the implementation of CPA within the sector. This sub group explicitly sought to look at issues of the CPA process as well as the use of forms in order to explore how these might drive a more integrated sector mental health service, which ensured continuity of care for patients as well as clarity of purpose for both patients and staff. While the group clearly valued the opportunity to

steer through refinements of operating the CPA at a level that was directly accessible to sector activities, there was a concern within this group about the authority of any measures they might develop, about how they would relate to the CPA Review Group, as well as concerns about lack of Trust direction, and possible duplication of effort. It was noted earlier that there were limits to devising procedures and policies at sector team level, when both the Trust and the SSD had to ensure a standard level of service for patients irrespective of which CMHT they related to.

At the end of January 1997 a one-day meeting of the CPA Review Group was held. This included a broader membership than previously, notably involving a GP, as well as three social services managers. The chair, the sector manager of Team C, introduced the session by explaining that this was to be the last meeting of the Group prior to rewriting Operational Policy for submission to the Directorate Management Team (DMT). The meeting was structured around the chair proposing a revision of CPA paperwork, followed by debate about CPA operational issues, under the topics 'paperwork', 'reviews', 'coordinating CPA', and 'the KW role'. The meeting charged a sub-group of five staff, (a CP, a CPN, a SW, an OT and Team C sector manager) to consider issues raised by the debate and incorporate them into a rewrite of the operational policy document over four meetings in the following two weeks. It was decided that the proposed revised document would be presented back to another full meeting of the CPA Review Group prior to submission to the directorate management team.

A key feature of discussions during the January meeting was debate among staff as to what were the problems for implementing CPA successfully. Some concern was expressed that the issue was being constituted as simply about unwieldy paperwork and was in danger of losing sight of the underlying processes involved. It was pointed out

by some staff, notably those from social services, that these processes hinged upon both multi-disciplinary and inter-agency working which might themselves require further development. In particular, several senior social services staff expressed concern about the proposal to substitute most of the existing CPA paperwork with a single 'summary sheet'. This approach was felt to be unacceptable to social services as it was felt it would not meet the need to be able to demonstrate that systematic and comprehensive assessment and care planning procedures were in place, as required of them for care management under the terms of guidance for the National Health Service and Community Care Act 1990 (DoH *et al.*, 1991d). There was considerable concern that the latest revisions to the CPA would produce a 'tool of accountability' that satisfied auditors but which side-stepped the difficulties in the underlying processes which the paperwork was merely there to expedite. Thus in the opinion of some staff, looking at joint philosophies, issues around training, eligibility criteria, etc., was a necessary step prior to devising appropriate working structures and paperware. Furthermore, for some staff there was an even prior step and that was to align the current attempts to refine and revise the CPA with the other much larger restructuring measures which were then starting to taking place - notably Reconfiguration in Westway and the local government reorganisation affecting social services.

Between early February and April 1997 (when the fieldwork ended) only one meeting of the CPA sub group had occurred and this did not include the social services representative. The key debate of the January meeting of 'forms versus process' continued into the first sub group meeting and it was not clear that inter agency agreement had been secured about the way forward on the tasks of this group, nor that agreement had been achieved even among health colleagues present. Due to illness the next two meetings were cancelled and subsequently the chair relied upon a series of

individual meetings with members in order to proceed with a rewrite of policy and revisions of paperwork. It was not clear when, or if, there would be future meetings of either the sub group or full CPA Review Group prior to proposals being submitted to the directorate management team. As the fieldwork came to an end, it was evident that concern remained among a number of staff about the credibility of proposals and of the revisions of joint operational policy because these seemed to be the outcome of a sub group which lacked the collective and inter agency discussion intended by the full CPA Review Group and (as charged) by the directorate management team meeting.

The events described above indicate that efforts were made to introduce the CPA within a bottom-up+top-down structural set-up for managing change. However, there were a number of shortcomings in how this was pursued, with problems in the degree of consultation between the agencies of health and social services as part of strategic planning, and dissemination and monitoring marred by numerous reformulations of groups with a consequent loss of direction or with the development of disagreement between key members as to goals set. Moreover, priority was given to system features at the expense of processual matters in the pursuit of such change structures. Exercises around the CPA reinforced the feeling at grass roots level that the agencies were working largely independently of each other at the planning levels, and that this in turn was likely to undermine the goodwill between social services and health colleagues at operational levels, and upon which the service relied.

5.2 Implementing the CPA at team level

I have characterised the difficulties of implementing the CPA in terms of numerous problems of structural arrangements, at both macro (regional changes in health and social care driven by national policy) and meso organisational levels (Westway MHD), which have complicated the ready application of this particular system for organising

mental health care. In this discussion the CPA has figured as a general entity ‘the CPA’, another structural entity to be accommodated alongside all the other structures. This is sufficient for organisational analysis at these higher levels. But having delineated the wider organisational context, the rest of this chapter will consider the practice of the CPA in Westway. I will do this in terms of the four tasks indicated by the CPA – assessment, keyworking, care planning and reviews. But first, it is necessary to say something about the way the teams were composed.

5.2.1 Structures at team level - multi-disciplinary team working

Given the difficulties described above, it is hardly surprising that during observation of the sector teams in their routine work of assessing and reviewing patients, I noted considerable uncertainty among members as to what the CPA entailed. Their problem was to put the principles of CPA into practice within the problematic context sketched above. As suggested earlier, the successful implementation of the CPA required both top-down and bottom-up initiatives. Senior management guidance on implementing the CPA was not fulsome. However, given that the CPA had to be delivered by a multi-disciplinary team it was appropriate that those people should be allowed to determine the way in which they related to each other in the team in order to deliver CPA packages. Senior management had certainly left team staff with plenty of scope for doing so, but scope to negotiate one with another will not in itself result in a set of stable agreements as to how the CPA will be implemented. For this it would have been necessary for some kind of mechanism to commit team members to a particular way of working. As the discussion in the previous section highlights, this kind of structure was not in place.

Community mental health teams are not well structured to negotiate, agree, and commit members to patterns of team working. This is widely the case and does not just

refer to the teams in Westway (Onyett, Heppleston and Bushnell 1994b). A major reason for this is that, on the one hand, these are usually collegiate structures rather than structures with a managerial hierarchy. And, on the other hand, most members are subject to line managements that extend beyond the team and involves line managers who have interests in addition to those of smooth team working. Thus in one respect there is no one in the team with a mandate to enforce agreement, team managers are only *primus inter pares*, and in another respect there are various authoritative people outside the team who can impede members from reaching or discharging agreements.

In Westway the line management arrangements within sector teams followed such a dislocated and messy structure (see 5- 2). Thus in each sector team there were several line management structures co-existing. There were also a number of different decision-making forums outside the team, which could impede its business and prevent members from reaching or discharging agreements. For instance: decisions by social services managers about the deployment of social services staff, especially in the district teams; decisions by consultant psychiatrists about the deployment of SHOs under their tuition; and decisions by team leaders in other parts of the directorate such as ART or PAS/EPS (staffed in part by CMHT staff on a rota basis).

In addition to line management arrangements which tended to pull team members in different directions, there were, of course, the different understandings of members of occupational groups and different commitments beyond the team - for example the psychiatrists had an interest in bed management which the social workers did not, while social workers had an interest in budget management which other members of the team did not, and I have already mentioned that there were other organisational requirements which health members and social services members did not share. In addition, fund-holding GPs, an increasingly powerful influence on rationing

care, were also able to exert a pressure on the Trust members of the team, but not on social services members (Muijen 1996). In the face of a range of purchasers/funders, each with different priorities, and in the absence of substantive management within teams, much was left to the cooperativeness and goodwill of team members.

As the remaining discussion in this chapter demonstrates, team members did have difficulty in practising the CPA. Sometimes the fact that people belong to different occupational groups may be cited as an explanation for difficulties in team working when in reality the difficulties derive from the structures that determine their work. In Westway, as elsewhere, occupational differences are laid on top of more fundamental structural arrangements. Thus, being a CPN is not just being someone with a distinctive occupational experience; but in addition being an employee of the Trust (rather than of the local authority social services department); being a nurse deployed in the community (rather than working on a ward); being subject to community psychiatric nursing line management (rather than, say, subject to the same line management arrangements as ward nurses, or even CPs). And, *mutatis mutandis*, the same is true for other kinds of practitioners.

While differences of occupational background are important, they are only one factor in a whole set that tends to pull members of a team apart, rather than cohere them together. A corollary of this is that it takes a great deal of effort and goodwill for members of CMHTs to transcend the arrangements that make it difficult for them to work together as a team. Moreover, as the composition of the team changes and critical incidents occur, then reserves of goodwill and 'getting by' on such a basis are severely undermined. The important point here is that, in Westway, overcoming the structures that tended to work against coordinated community mental health care was something that was left to teams to work out themselves.

5.2.2 Practice of the CPA

Practice will be considered in terms of the four tasks indicated by the CPA – assessment, keyworking, care planning and reviews. These tasks will be discussed in order to indicate how structural problems for implementing the CPA, and organisational change in general, of which the CPA is an example, may be seen to translate in Westway at team level in practice of the system.

5.2.2.1 Assessment

It has been suggested that a good practice model for mental health care would make a clear distinction at the referral stage between a) gathering information about patients, and b) allocating responsibilities for patients (DoH 1990b; DoH 1994c; DoH 1995). Nominally these are supposed to be linked such that responsibilities should be allocated in the light of information about the patient's needs. Government guidance on the CPA indicates this to be an important step in applying the principles of needs-led care (DoH 1990b; DoH 1994c; DoH 1995). In practice, however, it often seemed that responsibilities were allocated *before* an adequate assessment had been done, and then it was very difficult to re-allocate responsibilities. Two problems resulted from this blurring of assessor and KW role. The first problem was that patients were not necessarily getting the kinds of assessment they were entitled to, which was an open-minded assessment supposed to result in a recommendation about who should be the KW, not an assessment which proceeded from a decision made in advance as to who should be KW. The second problem related to being burdened with being KW when taking on the role of assessor: this developed as an inhibition about doing any assessment work.

Concerns were expressed by members across the three teams about the degree of consistency among all colleagues regarding the DoH requirement for a comprehensive

assessment of health and social care needs (1995). The Team B CPA working group considered the use of forms in this process. It found inconsistent use of the CPA assessment form across the sector, and this experience was borne out throughout all three sectors. This partial take-up may have been due to its introduction as an optional checklist/guide, but also reflected the difficulties of introducing the CPA into a range of environments, which each have their own already well-established recording systems: there were nursing, medical and community files/notes, each stored in different locations.

One proposal emerging from the CPA Review Group was to drop the CPA assessment form. It was proposed that each individual use whatever tool they prefer, with the CPA Operational Policy document reminding staff of the requirement for assessment of both health and social care needs. To a large extent this merely seemed to ratify what was in fact current practice. However, this did not address concerns among some staff about fulfilling the requirements outlined in “Building Bridges” by using CPA procedures (including paperwork) as an opportunity to establish best practice among staff and improve accessibility, reliability and continuity of assessment information that it was believed a common format would encourage.

These concerns extended to how the ward and community sides of the sector teams linked up. The CPA1 form (a filter assessment form to be completed after assessment, one of the original proformas introduced by the MHD to implement CPA) was felt by several staff across the sectors to be an inadequate tool for presenting information about new in-patients at the team meetings. In Team B, ward staff brought to team meetings patient files/fuller information from a new ward assessment tool which had been introduced (separate to the CPA tools). Furthermore, assessment for ward care and assessment for discharge to the community were frequently treated as

highly distinct processes involving different staff. This might arguably have undercut the aim to provide patients with comprehensive and needs-led packages of care.

Chapter 4 noted that the government linked the CPA broadly with ideas about managing risk. In some guidance it was also suggested that the procedures for ensuring systematic continuity of care for those patients in the community could be enhanced by putting in place explicit mechanisms for assessing and managing risk (NHS Executive 1994). While, at national policy and government level, the matter of risk assessment and management in the organisation of mental health care had come to figure increasingly in importance, attitudes to 'risk' were more ambivalent at Westway. During interviews on this topic, members expressed confusion, prevarication, and clear disagreement over the importance and meaningfulness of 'risk' in working out what to do with difficult patients.

Eventually in Westway, a task group was charged by the directorate management team (DMT) to investigate risk assessment (RA) measures and propose a set of procedures accordingly. It was understood at DMT level that the proposals made were to be piloted in Team B, although no information appeared to have been circulated amongst directorate staff about either the plan and/or the outcome of this exercise. Indeed Team B staff appeared to be as oblivious to this exercise as staff in other sectors. Use of the RA process was located most visibly with staff who were originally members of the RA task group. It seemed that the RA strategy and process had not been adequately disseminated among all MHD staff, thus hindering widespread ownership of what might be a crucial and potentially highly accountable procedure.

Some staff believed that RA was only to be called into play for those patients perceived likely to pose a particularly high risk of self-neglect, self-harm, or harm to others. Other staff believed that RA was already an implicit aspect of the assessment

process. Together with their misgivings about the RA measurement tools available (tied to different disciplines and specialised forms of professional training), the formalisation of risk in any more substantive way was seen to be possibly clinically misleading as well as pose the problem of further stigmatising patients. These manifold uncertainties translated into a variety of different practices with regard to RA: ignoring, occasionally dabbling with, and (to a much lesser extent) systematic application of some tool or other.

5.2.2.2 Keyworking

The keyworker role was the aspect of the CPA upon which most attention was focused in Westway. This is unsurprising given it was the point of individual responsibility for patients. Policy guidance issued by government made it clear that this was “the hub of the CPA” (NHS Training Division 1995, p30). The central point in the light of several high profile scandals over failures in mental health care was to ensure that individual professionals were identified as responsible for the care of individual patients.

Keyworkers were expected to be responsible for coordinating care within a MDT setting, keeping in touch with the patient, and monitoring their care (DoH 1990a; DoH 2000; NHS Training Division 1995). That said, the role of the KW had not been set out in detail in any of the early CPA policy documents (North *et al.*, 1993, p57). Little had changed by 2000, though by now guidance did run to three paragraphs specifically on the role and indicated the importance of appropriate authority in order to coordinate delivery effectively, and the term ‘keyworker’ had been changed to ‘care plan coordinator’ (see for example DoH 2000, p23).

It was against this background that at Westway considerable time was devoted, in some team meetings and the various CPA discussion groups, to debates about the

nature of this role as well the distribution of responsibility among the team vis a vis the KW.

KW allocation was seen by most members as happening by default following assessment, yet that did not end debate about the best ways to distribute this responsibility. Indeed such debates were probably fuelled by this perception, with consideration about the basic principles of who should KW, attempting to rule some staff in and others out. Thus some consultant psychiatrists (CPs) suggested they should not be KWs as it would be a waste of an expensive resource to deploy them in such duties. Psychologists raised similar arguments in relation to their expertise. Several CPN and SW staff suggested that the KW should be whoever sees most of the patient, regardless of professional role. This certainly seemed logical for simple CPA cases. It was perhaps not so clear cut in more complex cases where there was a range of logical possibilities. While the KW role indicated individual responsibility and activity, deciding who the KW should be was an important team activity, and, to some extent at least, the notion of keyworking implied the KW coordinating a 'team' around the needs of the patient. Thus, in more complex cases some staff argued the KW might be the professional who sees most of the patient but is of (relatively) low status within the team. Alternatively, the KW might be the professional with highest status involved with the patient, who may see little of them, but who had some authority with regard to other practitioners and agencies in convening reviews or handling defaults on agreements. In practice it was the first of these two options which usually operated, with CPNs and SWs taking the main burden for more complex cases with multiple agency and professional input.

This arrangement helps explain the perception among many team staff of the KW role as an especially onerous commitment. For lower status staff the burden of

coordinating across agencies and between colleagues and different professions, some of them of higher status, could pose a range of difficulties, which compromised provision of care as intended under the CPA. This included problems such as ensuring that all the relevant professionals involved in the most complex cases contributed to the ongoing monitoring of care through attendance at reviews.

The perception of the KW role as an especially binding commitment was also tied to the lack of flexibility observed around the role in practice. While, in theory, the KW role was transferable, in practice this tended to prove quite difficult to achieve, with the KW having to negotiate the hurdles that beset new referrals for assessment noted above, but without the impetus or priority that an unallocated new referral could command. However, the spirit of government guidance on the CPA was that the chosen KW should be the KW most appropriate to the patient and thus that changes of KW should be a routine feature of the CPA:

It is important to remember that key workers do not always have to be appointed on a long-term basis, and will not always be drawn from the people who are involved in the initial assessment of the patient. For people who pose little risk and whose needs are likely to remain stable, the keyworker role might change once the care plan is established.
(DoH 1995, 3.1.21)

Yet the process did not readily allow for changes of KW. This was most marked in Team A, where there was no firm commitment to routinely bring patients back to team meetings for discussion. To return to the team with a patient following assessment, or later as KW, was to raise the case as a particular problem. And in the context of rising caseloads and the frequent claim that everyone's caseload was full, this placed a bigger burden upon colleagues, as well as risked the possibility of constructing the individual KW as lacking competency.

In addition to these variations on the intended system, there was a trend to establish 'joint keyworking' arrangements, this despite the official notion of a KW as

one, and only one person to coordinate services around the patient. Arguably this (re)interpretation of one of the key structures of the CPA resulted from the difficulties experienced by staff in attempting to transfer KW role.

Who should be KW was also determined by agreements and understandings within the health service - between services within the MHD, between the MHD and other health services, and between the health service and other agencies, particularly the SSD. Some of these agreements were about inter-agency structures, e.g. district SWs were deployed to work only in specific patches of a sector and final authority for releasing them for CMHT work in that patch rested with their district social services team manager (see earlier discussion on this). Some of these understandings spanned services or kinds of practitioner with different ideas about specialisation and genericism. For example, occupational therapists (OTs) in Day Services did not act as KWs, seeing their role as a specialist one, thus limiting the KW role to members of the CMHT. Furthermore, some parts of the service, such as ART, would only accept transfer of KW role when the patient had been deemed 'treated' for any acute episode and was no longer 'chaotic'. This approach, in turn, led to a fairly lengthy administrative process of consideration. Definitions of such circumstances and states are highly fluid and not easily amenable to collective agreement, as team members pointed out often. And as noted above, even within CMHTs there were debates about the appropriateness of psychiatrists or clinical psychologists taking the KW role. All these things contributed to uncertainty as well as considerable frustration, about the support available to team members from other directorate colleagues as well as external agencies as patient needs altered.

Further, all staff expressed the fear that their expertise might be diluted and morale threatened by concentrating upon only a very narrow band of patients defined as

‘SMI’. and through systems of care that reduced their primary role to mere brokers rather than therapists. Debates among team members about the respective roles and responsibilities of care managers and KWs was not just about demarcating different organisational boundaries and arrangements, but also raised issues about skill mix and job satisfaction. Thus these fears were frequently expressed in terms of needing to achieve a balance of cases for all members that allowed both for (specialist) therapeutic contact and more generic work around brokerage or coordination.

5.2.2.3 Care planning

In policy guidance the care plan was a means of formalising arrangements made for care i.e. documenting who was responsible for what, thus also allowing for those arrangements to be properly coordinated and monitored (NHS Executive 1994, pp3-4). It was also intended that the process of care planning should begin for in-patients soon after admission in order to ensure properly managed discharge and aftercare in the community (NHS Executive 1994). However, in the early days of CPA there were no formal standards governing what was or was not an adequate minimum care plan. By 1995 further guidance, distinguishing between simple and complex CPAs, did at least indicate a difference in length of care plans, but the detail was still vague (NHS Training Division 1995, p13). This was then arguably an onerous duty – to put actions and responsibilities for oneself and colleagues in writing with little clarity about government expectations of such a document, especially given the likelihood that such documents would be consulted in the light of an adverse event²⁴.

²⁴ More recently, but long after the period of research at Westway had ended, the government provided more detailed guidance on the expected content of care plans (DoH 2000, pp24-25).

The CPA was intended to bridge the gap between hospital and community by involving community staff in discharge decisions and planning. However, the different ways in which hospitals and CMHTs are, and have to be, organised actually makes this very difficult to accomplish. At Westway, links between the wards and community teams were highly variable, determined by individual preferences rather than routine procedure or sector team agreements. Thus there was patchy involvement of community staff with ward colleagues.

This limited the possibilities for shared authorship of care plans and the opportunity for community and ward staff to acquire a more comprehensive picture of a patient's needs. This situation was also compounded by the variety of formats used for writing care plans. Westway's designated proforma (CPA 3) was not used consistently by all staff. This raised questions about the accessibility and transparency of care planning information available to both ward and community staff at the different stages in a patient's encounter with the service, which in turn arguably compromised the authority of the process. Moreover, Westway's CPA Review Group had planned to ratify this variation in practice through a revised operational policy which would make this form optional, along with most of the other proformas originally introduced to implement CPA (see discussion in the previous section of this chapter).

5.2.2.4 Reviews

Reviews of the care plan were envisaged as a documented monitoring device, one which would ensure that this process was ongoing and thus reduce the risks of losing touch with patients and any change in their circumstances and needs (DoH 1994b). By the mid 1990s reviews were required to be undertaken at 6 monthly intervals though anecdotal evidence from Westway team members indicated this not to be implemented. (However, see also earlier discussion of different understandings among members as to

whether the CPA was actually being followed - according to 'spirit or letter'). As with care plans, there was the same vagueness in government guidance over expected content of reviews, although as with care plans this has been tightened up in more recent guidance (see for example DoH 2000, p27).

As noted earlier, there was the administrative burden for KWs convening reviews involving several staff and agencies. Difficulties in ensuring attendance of medical staff at reviews was felt to be a particular problem. Attendance by medical staff was seen to be important both because they were seen as a source of expertise, and because of their senior status relative to, say, a CPN who was KW, when securing their agreement to any changes in care plan could become crucial.

There were attempts to address this latter problem by sometimes incorporating reviews into outpatient clinics or ward rounds, but this was still rather haphazard. Across all the teams there were differing forms of commitment to the ward rounds among individual professionals. For instance many health staff valued social services input and many social workers acknowledged the importance of their knowledge and expertise at such meetings. However, a perception of increasing pressures of caseload size meant that social work attendance became more sporadic. Similar constraints were also reported by the CPN members. To a large extent the ward round discussions were seen by staff as a form of ongoing review of individual (in) patients and afforded the opportunity for MDT working and development of clinical skills under the supervision of senior staff such as the CP. Some CPs also conducted 'community rounds' but these were not so well-established and happened sporadically, according to the whims of individual CPs. Thus reviews, especially for community patients, tended to be primarily an individual activity for the KW. This did not match the DoH notion of a CPA review:

as an opportunity for different professionals to review and revise the agreements for care between them.

5.2.3 Systems and MDT working: tasks, procedures and structures

As noted above, the Westway CMHTs operated on a collegiate basis, where the team manager was *primus inter pares* and had no authoritative mandate to command actions from others. In such circumstances the effective conduct of team business was everyone's responsibility.

The dynamics of teams are complex and it may be an oversimplification of matters to seek reasons, and the solutions, for difficulties in reaching agreements in the procedures of meetings. However, in both teams some of the reluctance to volunteer for the KW role did seem to be related to the concern that once allocated it was unlikely to be re-allocated. Volunteering then may be perceived as taking the risk of accepting a KW role inappropriately and permanently. Also, some staff seemed to perceive their own requests for the KW role to be transferred from them as being admissions of failure on their own behalf, particularly in the context of 'everyone's caseload is already full'. Changes of KW were not a routine feature of the work in either team: this despite clear government guidance to the contrary (DoH 1995, 3.1.21).

It is suggested that difficulties in teams in the organisation of mental health care either result from structural problems of the wider organisational context, and/or arise from structural conflicts at team level, which are themselves compounded by structural problems at the wider organisational level. Structural difficulties at team level arise, in part, because practices and procedures lack clarity and have not been agreed among the full team. Further, much of this chapter has described the wider structural problems that impinge upon teams attempting to implement the CPA in terms of: a series of concurrent inter and intra organisational structure changes; confusion on overlapping

and conflicting policy changes; incongruent and changing boundaries; uneven resourcing; multiple agencies lacking a singular mandate or point of authority within the mental health care arena; multiple line managements; and conflicting organisational roles. On this scene it is no wonder that Westway also demonstrated problems with the implementation of change itself. Whatever the 'presenting problem', of structural arrangements for the CPA, structures for implementing change or those more closely linked to team structures, the effects were one and the same – uncertainly authorised and delayed CPAs.

Chapter 6: Conclusion to Part 2

6.1 Understanding organisation through structures and systems

The orienting research question to help address the organisation of mental health care for Part Two was: 'does this organisation result in the authorised, coordinated care envisaged by the CPA?'. Part Two has demonstrated how responsibility and accountability were, at policy level, explicitly written into the organisation of mental health care through the introduction of an authorised system of care - the CPA. It has also demonstrated that, in practice, such formal coordination systems failed to fully materialise.

The discussion on the practice of the CPA in Westway demonstrated a range of difficulties and anxieties for practitioners in their attempts to implement this system of care. These were focused in the role of KW under the CPA. The KW was a named individual worker responsible for ensuring that people with severe mental illness had appropriate treatment plans in place, and for maintaining contact with mental health services to ensure ongoing monitoring including the assessment of risk. This individual point of responsibility, together with the documentation of arrangements made for all those involved in care for psychiatric patients via care plans and reviews, formalised respective responsibilities for professionals and agencies. This not only established a system for professional accountability, but also constituted a potential readier means of legal redress in the face of an adverse event.

Beyond Westway, decisions about who was appointed as a keyworker, the extent of their authority over the care plan vis a vis other professionals involved, and the distinctions between the roles of keyworkers and care managers, especially in the context of CMHTs, emerged early on as substantial matters of concern for many services attempting to implement the CPA policy (North *et al.*, 1993). These concerns

around the responsibilities of particular professionals were given an additional spin by the extension of the CPA between 1994-1996 via the introduction of Supervision Registers and Supervised Discharge (DoH *et al.*, 1996; NHS Executive 1994; NHS Management Executive 1994). Supervision Registers were initiated to ensure that individuals considered to pose a risk to themselves or others had adequate care and support. The supervised discharge measure was intended to ensure that patients previously detained who were discharged into the community, maintained contact with services and cooperated with the care plan drawn up for them. As one of the government's own documents claims, these two measures were introduced partly as a response to public concerns about community care and also to introduce risk management procedures (NHS Training Division 1995, p7).

In the context of policy changes during the past decade, the issue of professional accountability, at both individual and team levels, has become especially charged. Much of this concern was focused especially upon the introduction of Supervision Registers and Supervised Discharge where the roles and responsibilities of professionals in assessing and managing the risks raised by caring for mentally ill individuals in the community was made more explicit and thereby, arguably made them more accountable (Coid 1994; Davies 1994; Hampson and Davison 1994; O'Conner, Parker, Mumford, Cook, Kingham, Willems, Birkett, Dedman, Brown, Short, Arnott and Moore 1994). While the requirement to maintain Supervision Registers has recently been abolished, the framing of mental health care in terms of risk assessment and management has been explicitly broadened in government policy as “an essential and ongoing part of the CPA process”, conducted primarily now through the care plan and reviews (DoH 2000, pp6-7).

In theory CPA procedures, contemporary instruments for organising mental illness, are the means to render visible, at individual and team levels, mental health work and activities of professionals. Such visibility arguably makes such groups more accountable. In practice, however, Westway members did not apply the CPA as envisaged in policy guidance. And chapter 5 described a number of contradictions and deviations in practice of the CPA. Given this discrepancy, it is useful to consider just how ‘responsibility’ and ‘accountability’ figure for organisational members in the everyday life of mental health care teams. To do this requires that evaluation is left behind and an exploratory mode is adopted: one that can pursue a finer grained understanding of how work is defined in order to determine responsibilities, and how this is authorised, in a multidisciplinary, multi-agency team setting. This points to the orienting research question and ethnographic approach sketched out in Part Three.

Part Two has described a central government policy initiative, the CPA, which was intended as a way of organising mental health care. The process of implementing this at local level was tortuous, and as will be described in more detail later, the actual practice of mental health care at local level showed only a passing resemblance to what was written into policy documents.

The scene for organising mental health care has been described in a language that implies a ‘systems approach’ to organisation. In this approach organisations are structural entities which determine the courses of action which people follow, delineating systems of responsibility and accountability. Here, the goal of organisations is to adapt to the external demands made upon them, in this case adapting to the requirement to organise mental health care via a CPA. And the implementation of the CPA has been represented, in turn, as a structural matter. Making sense of organisation in this way is something which managers within such environments seek to do as a

matter of course. Such a model is a facility which enables the questions to be asked 'what is wrong or what is needed?' and 'how can we tackle it?'. It is one way of explaining what is happening and the constraints perceived therein. This process of sense-making necessarily builds organisation in advance of it happening.

In this view, organisations are distinctive structural entities with conscious plans and goals which integrate organisational members into a coherent and relatively stable unit through clearly mapped roles. Here the attempt is to provide systematic knowledge of the processes through which management can match organisational goals to external demands and thus effect successful organisational adaptation to the uncertainties of their environment (Burrell *et al.*, 1979; Hatch 1997; Morgan 1986; Reed 1992b; Thompson and McHugh 1995).

Some of the 'trade/managerial' literature in mental health, for example research and project work by the Sainsbury Centre and features in, say, *Community Care* are of this kind, where a key problem is construed as one of how managers are to develop structures and decision-making processes which will allow their organisations to deal effectively with different kinds of change in the mental health environment (e.g. over who should be prioritised, implementing government policies, etc). Government guidance, together with professional codes of practice which presuppose a recognisable system, take a similar structure and function form.

Systems theory focuses on how the internal structures of an organisation can adapt to changing external environmental contingencies. A core concept is of organisations as purposive social systems geared, particularly within contingency theory, to fulfil environmentally induced needs, managing the uncertainties which this relationship generates. As Reed notes, this approach views organisations as reactive or adaptive units which are largely determined by the character of the environment in

which they function (Reed 1992b, p83). Likewise, the discussion in Part two has characterised the implementation of the CPA in Westway as one determined by wider structures for each successive level of the organisation: for the team *vis a vis* the MHD, for the MHD *vis a vis* other agencies and policy changes and requirements.

Sense-making in this Part has proceeded from this systems view. Thus there is a system for organising mental health care imposed by national government, the CPA. And there are a host of local systems and structures (partly determined by other aspects of national government and policy) for health and social care within which the CPA system is expected to be applied. In this understanding, the expectation is that such systems will provide for clearly authorised mental health care. In particular, the CPA is seen to be an authorised version of care, much like the bureaucratic definition given initially in Part One. Thus the CPA itself assumes a situation in which there is one truth about the patient, and that action can be coordinated around this, and people held to account in terms of an authorised plan of action with regard to the patient.

However the structures described do not mesh together in ways that provide for such authorisation. Indeed Westway members behave as if they were working within different structures (e.g. different approaches to risk assessment). Thus there are not the kind of robust and harmonised structures in place against which people may be seriously held to account.

As Reed notes, a systems perspective is geared to providing managers with an intellectual technology with which they can cope with the complexities and problems that a changing pattern of external demands and pressures creates (Reed 1992b, p120). The account provided so far is one interpretative device that insiders particularly, and managers especially, use to understand what is going on: a point of indexicality in an area marked by frequent and rapid change.

6.2 Scene-setting

This account then, has given a particular picture of the ‘organisation’ of mental health care. Up to a point giving an account something like this seemed to be a necessity by way of introduction to this thesis. This is because readers need to be given some set of coordinates to answer their questions, such as ‘where is this happening?’, ‘what is the location like?’, ‘where do the members stand *vis a vis* each other?’, and ‘what are the forces which determine their actions?’.

While there is an infinity of ways in which these questions might be answered (see, for example, Morgan 1986), the more usual answers – as an aid to readers – are in terms of bits of this and bits of that all linked together in some kind of way. An institutional or systemic metaphor replete with hard-sounding words such as structure, routes of communication, lines of management, lists of personnel, all suggest the organisation’s tangible, physical, existence in the form described.

However, neophytes do not experience organisations – whatever they are – as systemically organised. Though they may well assume that the organisation in question has ‘a structure’ and a robust set of ‘processes’, as neophytes they do not know what they are – yet. As they develop their competence as members they come to learn ‘what the organisation is like’. Or at least this is their common-sense apprehension of their developing interpretative competence. However, what the new member learns is not so much what the structure of the organisation ‘really is’, but a facility in deploying a set of interpretative devices for making out what happens as being this or that feature of ‘the organisation’, and indeed, for doing such things as others will interpret as being reasonable for a person, located thus and thus within an organisation of the type they agree it to be.

This conception of organisation is nicely captured by Bittner's notion of 'organisational rubrics' (Bittner 1965). Writing from an ethnomethodological position, Bittner suggests that 'the organisation' is what it is which can be made out by members as 'the organisation'. Organisational rubrics are invocations of 'the organisation' to the effect that, for example: 'that's what the organisation wants', 'that's typical of this organisation', or 'that's what so and so should have done (as a competent member of the organisation)'. Of course, many such rubrics are inscribed in semi-permanent form, in job descriptions, protocols, policy documents, minutes, reports and memoranda of agreement and so on, such that they might be consulted from time to time. However, in my experience such documents were not often consulted, and, to paraphrase Garfinkel (1967, chapter 6), they were liable to different readings on each occasion of their consultation. Nor, of course, are all possible organisational rubrics in play at the same time, nor does each member utilise the same set or make the same sense of them, as I have already hinted with regard to the CPA.

So this is a different conception of organisation from that which informed the scene-setting exercise of chapters 4 and 5. However, had I started in this vein, I strongly suspect that readers would have felt lost. Just as new (and old) members of organisations need some metaphor to tell them what the organisation is, so also do new readers.

Ethnographically speaking, the account given so far is of the kind 'insiders' give. Sociologically, the analysis it entailed is better regarded as 'data' than as sociological analysis as such. It derives from the insider role I adopted during the period of participant observation, especially when called upon by Trust managers, as a

condition of my fieldwork access, to provide an evaluation²⁵ of how the organisation had implemented the CPA. In this sense the story told above is a kind of ‘folk model’ of what the organisation, Westway MHD, is like, told in terms designed to be comprehensible to the people, and especially to the management, there. To the extent that I was an insider in order to write this account of implementing the CPA, then I belonged to the organisation and borrowed their mythology in order to play a role akin to a management consultant. Following Bittner, the account is written in terms of local organisational rubrics.

In fact the report I wrote was very well received, both by management and by front-line staff, even though it is quite critical of the performance of the former. In this sense the account passed some kind of ‘fallibility test’, though I do not regard this as guaranteeing its verity. The report on which the account in Part Two was based has entered the world of Westway. It is now a locally invocable resource, which members cite in discussions about ‘what happened’, ‘what the problem is’ or ‘what should be done about it’²⁶. Thus the report was not just a recycling of local organisational myth, but a new contribution to it. Of course, as with any other resource, it will be subject to a range of different readings, and was probably soon forgotten. Moreover, the report was only one kind of account of the organisation which members might give of it. There were certainly other kinds, which emerged in interviews, team meetings or informal chats – one kind of alternative account, for instance, was in terms of personalities and motivations.

²⁵ (Ormrod 1997)

²⁶ Indeed, a couple of months after I left Westway, I was contacted by one of the team’s CPs who had been seconded to lead a reconfiguration project of the full MHD. He sought permission to circulate my report more widely as part of Westway’s inter-agency negotiations on project strategy.

By using terms such as metaphor, myth or folk model, I do not intend to imply that the account given earlier was 'untrue'. I certainly did not write the original report with a view to mislead. Quite the contrary, I wrote it with a view to enlighten those who were its intended audience – management and staff at Westway for the original report, readers at the beginning of this thesis for the paraphrase herein. However, on the one hand, all accounts are designed for a particular audience, and limited by apprehensions of what the audience will understand and find acceptable. And on the other hand, all accounts are incomplete, simply because reality is so complex that no account can ever capture 'the whole truth', and because what the truth looks like, looks different from different angles of view. Any phenomenon is amenable to a virtual infinity of different accounts, none of which captures the phenomenon entirely, but many of which have an equal claim to be valid²⁷. Thus the scene-setting account is not so much untrue as incomplete, and slanted in its incompleteness by having a particular scheme of relevance set by the purposes for which it was written and the audiences for which it was intended. From the point of view of this thesis its work is done. It was offered as an introduction to 'the data', and the introduction has been made and it is almost time to move on.

Before doing so, however, it is worth drawing attention to a major difference between the 'management consultancy' report and its paraphrase here as a scene-setting device, and the kind of picture that will emerge in later chapters. The scene-setting account has a paradoxical quality. It is a rather tidy account of a very untidy organisation. This effect falls directly out of the genre adopted to write it, and particularly derives from the metaphor of system. Thus throughout the account the

²⁷ See also discussion and references in Part One: on organisational narrative, on social constructionist methodology.

possibility of a smoothly operating system, delivering what it is supposed to deliver, is assumed, and what was really happening was contrasted with that. The tidiness of the account derives from the repetition of a format which says, in effect, this is what ought to happen, and it is not happening. It might be suggested that why the report was so well received was because it brought together a very wide range of concerns and frustrations experienced by managers and staff, and focussed them in terms of a single interpretative device: 'the system isn't working'. While the report solved no one's problems, at least it gave them a comprehensible shape. In addition it is probable that the report constituted an acceptable vision of the state of affairs, because it levelled 'blame' at the system, and not at individuals, and even where individuals might have been regarded as at fault, the account usually offered 'structural' reasons for why they could do no other than they did.

By contrast with this in what follows, no assumptions are made about the possibility of a smoothly functioning system, nor closely associated assumptions, such as, for example, that patients could be accurately and unproblematically categorised as 'severely mentally ill', or that the 'right' keyworker could be chosen if only staff could find the right recipe to do so. Rather organisational life is seen as incorrigibly untidy, with events forever amenable to multiple interpretations. From this point of view it ceases to be unsurprising that matters do not proceed as smoothly as participants would like, and becomes instead remarkable that they proceed as smoothly as they do. Again, the earlier account was evaluative. It took for granted that the CPA should be implemented and that it was a problem that it was not. Because the account was evaluative it focussed attention on what people were doing as a deviation from what they ought to be doing. From hereon I shall leave evaluation behind, and look at what happens without a prescriptive slant. Thus in the following chapters I will explore

different ways of understanding the organisation of mental health care and how this work is accomplished.

PART THREE: Teamwork

Chapter 7: Introduction to Part 3

Despite the problems identified in practising the CPA for team members, work did get done, in that patients were accepted for, and subjected to, treatment. This raises two questions: ‘how did this come about?’, and ‘what kind of organisation permitted this to happen?’. Moreover, did the resulting practice produce an authorised form of care, free from the uncertainties which government believed had hitherto compromised the organisation of mental health care? Part Three will address these questions by considering how the work was defined and responsibilities were determined among team members.

To do this, I adopt a micro level of analysis, focusing upon interactions within teams, in order to understand how members understood the work and their relationships with each other as professionals in a multidisciplinary team (MDT) setting. Several topics and literatures are indicated by this approach and will be discussed. First, there is the topic of MDTs and the kinds of conditions that such arrangements are believed to produce, and a literature aimed at practitioners for ‘team improvement’. Second, there are related debates about the impediments to different kinds of professionals working together smoothly, located in a literature around the sociology of professions. Third, there is the topic of negotiations and accounting practices in teams, the talk and encounters that enable the accomplishment of everyday activities. These sorts of matters are connected with a literature arising out of broader sociological approaches characterised as symbolic interactionism.

7.1 Multi-disciplinary teams in mental health care

In mental health care there is a now well-established expectation that multi-disciplinary teams (MDTs) are the best way to deliver the usually complex packages of care required, spanning both health and social needs, to those with severe and/or enduring

mental health problems (Audit Commission 1994; DoH 1995; DoH 1996; Mental Health Foundation 1994). Ovretveit (1993, p9) defines MDTs as:

... a group of practitioners with different professional training (multi-disciplinary), employed by more than one agency (multi-agency), who meet regularly to coordinate their work providing services to one or more clients in a defined area.

There is also a well-established acknowledgement of the difficulties of doing this successfully, as numerous government inquiries have indicated (Blom-Cooper *et al.*, 1995; Ritchie *et al.*, 1994; Sheppard 1995). There is, indeed, a widespread view of multi-disciplinarity as a problem generally, and particularly so in mental health. The complex structural arrangements in this field were discussed in Part Two and their contribution to the challenges faced in MDT working has been well documented (see, for example, King's Fund London Commission 1997).

While such research and inquiries indicate that there is certainly a genuine problem in coordinating community mental health care, the reasons for this are not necessarily to be found in multi-disciplinarity *per se*. Part 3 will examine how CMHTs work, principally through some ethnography gathered from team meetings, and in so doing will consider how multi-disciplinarity and the management of professionalism enter into the work of CMHTs and to what extent they can be offered as explanations for the problems of coordinating mental health care.

7.2 Theory and multi-disciplinarity

The literature on multi-disciplinarity has a rather curious shape and distribution - a flowering of the sociology of the professions in the 1970s, which peters out by the mid 1980s, and then a rash of literature addressed to practitioners on how to do, or improve, MDT work, which starts around the late 1980s and continues today (Atkinson 1981; Benierakis 1995; Buckholdt and Gubrium 1979; Dingwall 1976; Freidson 1970; Gubrium 1980; Lonsdale, Webb and Briggs 1980; Norman and Peck 1999; Onyett

1992; Onyett 1997; Onyett 1999; Onyett and Ford 1996; Onyett, Pillinger and Muijen 1995; Opie 1997; Ovretveit 1993; Ovretveit 1997; Peck 1999; Peck and Norman 1999; Soothill, Mackay and Webb 1995; Vinokur-Kaplan 1995; Wells 1997).

Post Talcott Parsons, the sociology of the professions features two main themes: professional dominance; and professional socialisation. It is these, most especially professional socialisation, that have featured principally in debates about MDT working. Each is considered in turn below.

7.2.1 Sociology of professions

7.2.1.1 Professional dominance

While the kinds of people who are supposedly dominated by professionals are usually their patients or clients (Freidson 1970), a sub-theme more closely relevant to multi-disciplinarity is that of some professions seeking, or actually dominating others (Cott 1997; Griffiths 1997b). Often the story starts with Hughes' (1977b) notion of licence and mandate, and goes on to give a picture of occupational groups, in agonistic relationship with each other, each jockeying to occupy much the same occupational space (Dingwall 1976; Dingwall 1980) to extend their licence and mandate to the disadvantage of each other. If this were the dynamic of professionalism, then it would hardly be surprising if there were troubles in multi-disciplinary teams.

7.2.1.2 Professional socialisation

Studies of professional socialisation consolidate the expectation of agonistic relationships. Merton (1957), Becker et al (1977), Dingwall (1976), and more recently Atkinson, (1981; 1995), all give a picture of professional socialisation as being a process through which new entrants to the profession not only learn the *habitus* and ways of understanding distinctive to the occupational group, but also learn how they are different from, and superior to, members of competing occupational groups. Thus the

will to succeed in competition with members of other occupational groups is added to a picture of training for mutual misunderstanding, if not mutual disregard.

It is not at all clear why this model of professionalism ceased to be so popular among sociologists in the mid-1980s. One set of reasons probably relate to paradigm shifts from the mid 1970s onwards. For example, the attempt to link professionalism with the critique of capitalism (Johnson 1972; Navarro 1976) dragged the sociology of professions off in one direction; the attempt to link professionalism with a critique of industrialism (1975; Illich 1977) in another; and the issue of professionalism and gender (Chesler 1972; Donnison 1977; Ehrenreich and English 1974; Roberts 1981) in yet another. For the two latter directions de-professionalisation was a political desideratum, as with the women's self-health movement (Boston Women's Health Book Collective 1976; Mackeith 1987) or the many movements taking inspiration from Paulo Friere (1972a; 1972b). The influence of Foucault refocused the issue of professions on professional knowledges rather than on occupational groups as such: no real people ever seem to talk to each other in Foucault's work, rather ideas seem to converse with ideas (1967; 1973; 1977). And the influence of ethnomethodology and its rhetorical turn transformed the idea of a profession from being the empirical characteristics of an occupational group, to being a set of rhetorical claims occasioned in particular settings (but not necessarily in others) (Dingwall 1976; 1980; Gomm 1986; Sharrock 1974; Sharrock 1979). It is also likely that the more extreme versions of the model, of ruthlessly competitive professionals trained to 'misunderstand' their rivals, simply did not fit the ethnographic facts.

All this notwithstanding, the model has not really gone away. It is there certainly in its professional dominance form in the work of Busfield (1986), and the idea of the power-crazed psychiatrist remains popular in the internal literature of the

users movement (Gittins 1998; Herefordshire MIND 1995; Wilson and Kyriacou 1996) and among their academic supporters (Pilgrim and Rogers 1993; Pilgrim and Rogers 1994). Griffiths' recent work on CMHTs gives the old picture of psychiatrists seeking to dominate, and lesser professions resisting (1997b). But the same assumptions also seem to underpin a newer 'how to do it' literature addressed at practitioners. The remedies for the problems experienced in multi-professional teams include different professional groups learning to understand each other, particularly through common training, and for a reorientation away from interoccupational competition towards interoccupational cooperation - as if the problems really did arise from interoccupational competition, and training for mutual misunderstanding (Benierakis 1995; Onyett 1992; Onyett 1997; Onyett *et al.*, 1996; Onyett *et al.*, 1995; Opie 1997; Ovretveit 1993; Ovretveit 1997; Soothill *et al.*, 1995; Vinokur-Kaplan 1995; Wells 1997).

7.2.2 Simply multi-disciplinarity?

There is yet a third thread, however, that focuses on the managerial structures within which the professions work (much of this was discussed in Part 2), with line managements and organisational priorities pulling different segments of teams in different directions. This suggests a different, or an additional, diagnosis of the problem of multi-disciplinarity. Perhaps it is not multi-disciplinarity which is the problem at all, but the way in which people who are supposed to coordinate one with another are distributed across a structure which makes this difficult to do. Perhaps any group of employees, deployed across the same structural faults, would behave in an uncoordinated way.

Thus three main reasons are suggested for the problems experienced by multi-disciplinary teams:

- ◆ Competitive dynamic of professionalism (structured perhaps by relationships between dominant and subordinate professional groups)
- ◆ Socialisation for mutual misunderstanding and disregard
- ◆ Organisational arrangements which impede cooperative working.

Of course these might be combined in various ways, and all three together might be a cogent explanation. In Part Three I want to examine these possibilities in relation to my data from Westway. However, there are two prior steps to take, which prefigure possibilities 1 and 2 above. One is to consider whether there is indeed a problem of multi-disciplinarity in Westway. The other is to consider what a problem of multi-disciplinarity would look like. We can take these steps together.

The purpose of team meetings is to secure agreements to action among a group of individuals working together, and, as indicated above and in Part Two, that can prove very difficult to do. In mental health care the securing of agreements for action is usually approached via the organisational device of a MDT referred to either as a sector team (which includes ward plus community staff) or a CMHT (community-based staff)²⁸. In Westway the weekly ‘team meeting’ was a sector team meeting, though members often referred to it as the “CMHT meeting”. Nevertheless, regardless of precision of terminology, these teams are most definitely MDTs. The difficulties of MDT working are notorious and have been widely reported for all health and social care

²⁸ With the policy shift from hospital-based to community-based care, and with renewed emphasis on continuity of care between different parts of the psychiatric services, in some areas CMHTs have been superseded by the potentially seamless arrangements indicated by sector teams. Thus weekly team meetings may still be referred to as the ‘CMHT meeting’ though to be more precise their composition and business is more accurately described by the term ‘sector team’.

client groups (Galvin and McCarthy 1994; Norman *et al.*, 1999; Onyett 1999; Onyett *et al.*, 1996; Ovretveit 1993; Patmore and Weaver 1991; Peck 1999; Peck *et al.*, 1999).

The teams I studied in Westway did have ‘problems’. This was something which members recognised and talked about. But they rarely diagnosed these problems as being of a multi-disciplinary kind. Yet the question remains as to whether these were problems of multi-disciplinarity.

If we draw on the traditional model of competitive mutually misunderstanding professionals, then a problem of multi-disciplinarity would show itself in two main ways.

- ◆ There would be evidence of strategic interaction of some sort, which could be made out as a competitive struggle between groups formed up in teams and alliances according to occupational affiliation.
- ◆ There would be some evidence of structured mutual incomprehension - members of different groups using different terms for the same thing, or the same terms for different things, drawing different conclusions from the same ‘evidence’, proposing radically different solutions to the problems of the same patient, who presumably would be constituted as a different patient for each group.

I will look at the data for such evidence later, but before that it is necessary to say something more in general about studying interaction.

7.3 Studying interaction

The previous section has suggested some ‘running themes’ around multi-disciplinary teams. But that leaves the theoretical matter of how best to study the organisational

work of teams so that these possibilities may be adequately examined. The remainder of this chapter will outline some ‘conceptual tools’ and thus propose a particular theoretical approach to organisations, already hinted at in passing in the discussion so far (above Part Three and end of Part Two). This also has some parallels with the discussion in Part 1 on methodology where I outlined the approach as an ‘anthropology of organisation’.

In Part Two we saw that practice of the CPA in teams was variable according to different interpretations of roles and activities among members. While ‘structures’ of the organisation were used as the key explanatory tool, nevertheless Part Two demonstrated those structures not to be firmly fixed or stable. This, in turn, indicates the importance of interactions between team members to achieve the coordination necessary to enable successful disposal of the team’s work. These points indicate the situated (and subtle) character of teamwork. They indicate that organisational order (including coordination) is reached through sense-making negotiations between team members.

Thus, two particular kinds of literature and approach are indicated – negotiated order, and ethnomethodology. Both are usually seen to be broadly located within a school of thought referred to as ‘interactionism’ (Coulon 1995; Gerhardt 1989; Reed 1992b). While the first includes studies that allow for macro structures of power and wider institutional analyses, the latter is identified with a focus upon the fine grain of micro level analysis in everyday practice. Both, however, are united in a rejection of viewing structures as entities that are externally imposed, and in their focus upon the locally socially constructed nature of organisational order and the processes through which this is achieved.

Here, 'organisation' is articulated as a more fluid and transient order of the ebb and flow of interaction and the networks that arise out of them. Thus, what might seem to be a formal and tangible organisational structure (e.g. Westway Trust, the CPA), turns out to be the epiphenomenon of a chaotic underlay of negotiation, local knowledge, and 'rules in use' which make the organisation of mental health care possible (or not). Thus as Part 2 was concerned with organisational machinery, Part 3 is concerned with the fine grain of organisational living.

7.3.1 Negotiations

The negotiated practice of organisational order has its roots in work conducted on asylums (Goffman 1961), business firms (Dalton 1959), and hospitals (Strauss, Schatzman, Ehrlich, Bucher and Sabshin 1963) in the late 1950s and 1960s. This work showed that formal structures are only significant if they become embedded in negotiating processes that establish the working agreements through which 'things get done'. Indeed structures may be seen as an outcome of negotiations in so far as they embody earlier agreements that have temporarily acquired the status of an institutionalised understanding as to 'how to get on'.

The term 'negotiated order' was first introduced into the literature by Strauss as a way of conceptualising the ordered flux found in studies of two American psychiatric hospitals (Strauss *et al.*, 1963). These studies were concerned with how social order was maintained in the face of change. Strauss *et al* attempted to show how negotiation contributed to the constitution of social order on the one hand, and on the other, how social orders gave rise to interactions, including negotiations. It was argued that previous organisational studies had overstated stable structures and rules at the expense of internal change. Instead it was proposed that a more fruitful framework would conceptualise the social order as 'in process', (re)constituted continually. Thus, formal

structures of organisation are a shorthand representation of agreements worked through by members continually engaged in sense-making and negotiations within a messy social reality.

One major charge against this approach, especially in its earlier development, is that it assumes everything is indefinitely negotiable and is thus unable to deal with limits in settings (Day and Day 1977; Dingwall and Strong 1985). However, in later work Strauss attempted to address these criticisms (Strauss 1978). He introduced notions of negotiation context and structural context to conceptualise the relationship between negotiations and extra-situational constraints:

... not everything is negotiable or – at any given time or period of time – negotiable at all. One of the researcher's main tasks, as it is that of the negotiating parties themselves, is to discover just what is negotiable at any given time.
(p252)

In this sense, the approach could be argued to overcome the macro or micro distinction that dogs the structure-agency debates in sociological theory (Allen 1997).

7.3.2 Ethnomethodology

The attention given in the later negotiated order perspective to wider institutional constraints might be argued to compromise the opportunity to study everyday interactions between members. Certainly, ethnomethodology remains firmly focused upon the micro level interactions between members, and takes a very strict line on how to understand the practices which constitute the social order (Reed 1992b, p150). Ethnomethodology means the study ('ology') of peoples' ('ethno') procedures for making sense of and acting in social/organisational life ('method') (Coulon 1995; Wetherell 1991). And in this particular development of interactionism, there have been studies that have contributed theoretically to organisational study in terms of routines and order, and in terms of talk and accounting practices.

A key figure in this approach is Garfinkel (1967). For Garfinkel everyday social life is seen as an accomplishment for its participants. This is primarily achieved through various accounting or practical reasonings used by people with each other. Moreover, examining the kind of talk that produces such accomplishments reveals the 'taken-for-granted' about the social (organisational) order in such interactions. Studying talk within this perspective is often known as 'conversation analysis': an enterprise that has its roots in both ethnomethodology and in pragmatic linguistics (Hutchby *et al.*, 1998; Levinson 1983). This approach has identified many kinds of regularities in talk, examining, for instance: the pattern of turn-taking in conversations, methods for closing down conversations, for topic changing, disagreement and negation (e.g. 'reasoned refusals'), repair of conversations (which go wrong), and the structuring of accounts (Atkinson 1984; Heritage 1988; Wetherell 1991). Thus in organisational studies the approach examines the methods by which members make sense of their activities and involvements and thus define – and do – 'this organisation'.

7.3.2.1 Organisational routines and talk

This approach has been advanced through several by now classic empirical studies, including: police-keeping routines on Skid Row (Bittner 1973), law enforcement agencies concerned with the regulation and control of juvenile delinquency (Cicourel 1976), and the everyday operation of plea-bargaining procedures in American courts (Sudnow 1973). Thus for example, in the Skid Row study, rules and regulations are required to be translated into common-sense frames of reference and practices – 'rules-in-use' – through which the contradictory demands of legal formality and operational policing are maintained in a kind of working balance. We might extend this view to the way mental health team members implement the requirement to do the CPA and continue to manage the day to day work as usual.

Bittner (1965) recommends the researcher seek out the various ways in which members invoke and use the concept of 'formal organisation' as "a generalised formula to which all sorts of problems can be brought for solution" (p76). Thus the practices of daily routine are the focus of analysis in order to arrive at an understanding of members' organisation-defining practices/work, and thereby 'the organisation', which is constituted through their defining.

More recent work, (presented in the canon of the 'sociology of knowledge'), studying the construction of scientific knowledge, combines both a focus on organisational routines as well as organisational talk (Latour *et al.*, 1986). In this study talk was shown as action that produced important results – discussions led to decisions about what is a fact and what is not, which led to papers, which eventually led to the Nobel prize.

Informed by the above approaches, as well as drawing directly from Goffman, Strong and Davis advance an argument for the study of medical encounters which looks at "routinised solutions" across a range of doctor-patient encounters (1977, p783). Their aim was to revive the concept of role in interactionist study. Strong and Davis note in Goffman's work the (somewhat underplayed) notion of situated roles emerging from encounters that are repeated by the same participants around the same tasks. They take this idea to spell out the conditions under which roles are generated and sustained. Important here is the concept of a 'ceremonial order' for such encounters. This is defined, following Goffman, as a 'working consensus', an overt accord, as to the nature of social reality. For Goffman, a working consensus (or ceremonial order) includes: the kind of social situation it is, who the proper participants are in such a situation, how they should behave *vis a vis* each other and, the appropriate rituals of conversation in the setting (Goffman 1959). Strong and Davis caution that the 'ceremonial order' is not

just some abstract norm, but “represents a technical solution to a variety of interactional problems” (p783). When these norms hold across a broad range of encounters then, they argue, a ‘routinised solution’ is liable to emerge. Such solutions they term ‘role formats’ to “encompass both the stability in relationships and the variability for which role itself does not allow” (p783). And in this sense such encounters over time become ‘*the* solution’, not simply ‘the way things are’, but, acquiring a moral tone, ‘the way things ought to be’.

Further, Strong and Davis found that roles are not tied to any particular individual or relationship but are used as and when seems possible and appropriate. They also found that multiple formats might be used within the same encounter. Thus there is room for both pattern/stability and variation/flexibility. Moreover, they note that formats are about overt behaviour – within an encounter it does not matter if actions ‘really’ match a ceremonial order, but whether they are appropriately dressed for the occasion. Thus, resonant of Bittner, Strong and Davis argue that formats are a “resource to which a variety of matters may be brought for settlement” (p785)²⁹.

Implicit in much of the above argument on medical encounters is the notion of ‘politeness’ or etiquette, which frames members’ interactions. This is pursued more explicitly by Strong elsewhere (1979a) as well as prefigured by Goffman (Goffman 1959) and by pragmatic linguistic work on politeness (Brown and Levinson 1978). Observing a ceremonial order usually requires a certain degree of gentility among

²⁹ To illustrate this point, consider the example of the widely known occasion, ‘a birthday party’. The role format of a birthday party constitutes a resource that people can use to do a birthday party, recognise a birthday party as going on, judge each others’ conduct as appropriate for a birthday party, or evaluate each others’ personalities in terms of adherence to, or deviation from, appropriate birthday party behaviour.

members to ensure the fiction or 'line' of 'this is how it's done here'. Thus, as noted earlier following Goffman, encounters are appropriately dressed.

The importance of conceiving of organisations in terms of negotiated orders, of organisational rubrics, routines and rules-in-use, together with a focus on specific encounters in terms of talk and the formats for such talk have now been outlined. These then are the conceptual tools for thinking about organisation which inform the analysis of empirical data which follows in the next two chapters. They will be utilised to help explore the 'running themes' for Part 3 about how MDTs work and accomplish the organisation of mental health care, and whether the problems which MDTs experience in accomplishing such work are to be explained by multi-disciplinarity.

Chapter 8: Getting through the meeting - due process in sector team meetings

In this chapter I will consider ‘due process’ in the Westway weekly sector team meetings through which the team business was conducted. By ‘due process’ I do not simply mean the formal procedure or machinery of meetings, but also the culture and custom of the meetings. So I will examine the ‘working consensus’ which prevailed in the Westway sector teams. The working consensus for collegial MDTs is constructed via interactions in teams meetings marked by politeness, an etiquette for negotiating each other and the work within this ‘fiction’ or ceremonial order. The ‘fiction’ is that ‘we are all equals here, all properly motivated and competent professionals and no one of us would dream of trying to order any of the others about’. While it will be demonstrated as empirically particular to the Westway teams, this kind of culture is very similar to that reported (at a general level) in the literature on MDTs in mental health care in the UK (Norman *et al.*, 1999; Onyett *et al.*, 1994a; Peck *et al.*, 1999).

In using the term ‘fiction’ I do not wish to suggest that this kind of working consensus is ‘not real’, but rather to emphasise the constructed and situated nature of such an interactional order (e.g. there were other ways of allocating work, other kinds of traditional medical hierarchical relationships, outside of the main ‘front-stage’ setting of the weekly team meeting, even if to a smaller extent). Thus there was in these MDTs the fiction of collegiate and egalitarian relationships, together with actual power disparities.

Using theoretical tools introduced in the previous chapter, drawing upon interaction studies, this chapter will set out the standard ways of working in these meetings. It will show that ‘the norm’ in this setting was an interactional order of collegiality and egalitarianism, which produced a particular kind of gentility among

team members, with consequences for the task in hand of determining mental health care organisation such that someone got treated, by someone, in some way.

8.1 Interactional order of team meetings

This weekly team meeting was the prime point for members to determine as a group how the work would be disposed, including the critical decision of KW allocation and management of individual caseloads. Despite some procedural differences, the two teams were remarkably similar in the way they achieved agreements over allocations for KW, in the kind of interactions which ensued in the disposal of each team's business – in terms of the kinds of routines, talk and etiquette that characterised the way they got things done.³⁰ It is to this interactional character of the teams' work that I now turn.

As already noted, the Westway teams were collegiate structures rather than managerial hierarchies, but some team members were subject to line management beyond the team. Members also had affiliations to different professional groups and to different agencies. Hence the team manager had a line management remit to certain members of the team only and even this was bisected by membership of different professions/disciplines. Thus managerial authority was not done too visibly in team meetings. Indeed the team manager and meeting chair role was a rather delicate one to handle in such circumstances.

So the meetings were chaired but this role was not seen to be the exclusive preserve of the team manager. Usually chairing was done by the CMHT manager or by the sector team manager. In their absence this role fell to another team member

³⁰ It is worth noting the broader similarities here between the Westway teams studied and CMHTs in general in terms of composition and caseload size (Onyett *et al.*, 1994a; Onyett *et al.*, 1994b). Moreover, while there are few ethnographic studies of MDTs, including CMHTs, those that there are (Goldberg 1997; Griffiths 1996) appear to be very similar in terms of process to the Westway teams.

designated by the team manager, or more occasionally to one of the team's consultant psychiatrists³¹. If not the formally designated Team Manager, then the main prerequisite seemed to be a clinical background, rather than a purely managerial one. The chair would lead the discussion and business of the team meeting.

In both teams only a small number of members spoke frequently on most cases presented for discussion, with most of the team members contributing only occasionally, usually when it was a case they had either assessed and/or already keyworked. The members who most frequently contributed to team discussion were the CMHT team manager (in Team A a CPN, in Team B a mental health nurse), ward manager, consultant psychiatrists and to a lesser extent SHOs. In Team B the sector manager (a nurse behaviour therapist) was also a frequent contributor, but notably she had previously been team manager and was temporarily acting up in the sector manager role. Also in Team B the psychologist and one of the social workers often contributed. This particular social worker had many years experience and although not formally accorded any senior status her long standing service was taken for granted. By contrast, in Team A the psychologist was only available to the team part-time and was an infrequent attendee at meetings. The manager for the hospital social workers across all three sector teams, would attend the team meetings in sector A and was also usually a contributor³². In effect speakers did not so much represent any one particular discipline or profession; rather they tended to be those who were least likely to become

³¹ In team A, the Sector Manager had a non-clinical background, whereas in team B the Sector Manager had a clinical background. In team B when the Team Manager was absent, if the Sector Manager was present she would chair in contrast to team A, where it would usually be any other clinical member other than the Sector Manager.

³² This manager took early retirement part-way through the research and the post was not filled subsequently. Thereafter the practice supervisor for the hospital social workers would sometimes attend the Sector Team A meetings.

keyworkers but who might have felt some responsibility with their managerial status or seniority to help expedite team business.

The general format for the meeting within each team is outlined below. The team manager or person chairing the meeting had a list of patients from both the ward and the community being referred to the team for allocation, either for assessment or keyworker. This information was supplemented by referral letters for community referrals and by a form (CPA1) used for ward admissions. Very occasionally a patient's file might also be brought to the meeting, more often in Team B than Team A.

These meetings were not fully minuted. In each team either the team clerk or, if the clerk was not present, then another member of the team noted the name of any member allocated to assess or keywork against the list of patient names presented.

The purpose of the business was that of ensuring each patient listed would be disposed of properly. This meant that they would be or had been assessed and, if accepted by the team, have a KW allocated. In practice this was often the worker who had assessed. If they were not considered to be appropriate cases, referral would be passed on elsewhere. But the procedural differences between the two teams around initial allocation for assessment did make for differences in the team meetings in interactions between the different members of the team.

The sub team (for assessment allocation) in Team B was multi-disciplinary and allocated cases across the full team (i.e. a directive approach rather than voluntarist). Therefore, in Team B all patients referred to the community and some of those from the ward had already been allocated for initial assessment at the sub team meeting, so almost all patients raised at the weekly meeting for Team B had an individual member

of the team nominated to their case. The exceptions were those admitted to the ward since the sub team meeting.

In Team A, by contrast, most of the referrals had no one nominated and the majority of assessment and KW allocation took place in the same meeting. For both teams the weekly team meeting was one where the approach was in principle voluntarist not directive. And in Team A there was far more business to be dealt with within this setting. Thus there was a considerable degree of tension around the table in the Team A meetings in contrast to Team B and the process of allocating patients between different members yielded far more instances of negotiations between members. So the fact that there were more undecided issues coming to the Team A meeting meant there were more opportunities for interactional trouble.

It is also worth noting that the different styles of chairing the meetings in each team by the respective team managers meant that the agenda in Team A was pursued in a somewhat chaotic manner in contrast to that in Team B. In Team A the manager did not impose himself upon the meeting as chair. Indeed many members found it difficult to hear him as he spoke very quietly. More often discussions in Team A were left inconclusive and interruptions were frequent and not controlled and not followed up by the chair. However, as will be discussed below, the interaction sequences in both teams for disposing of patients where allocation was yet to be determined was very similar.

8.2 Topic of the meeting - patients referred

The topic of the team meetings was the patients referred. Evidence about such referrals for the community were in the form of letters from GPs, other mental health agencies (e.g. MIND), and from the team's consultants following an initial assessment or out-patient appointment, supported verbally by members present who were currently or

previously involved. Evidence about in-patients came from the ward proforma supported verbally by the ward manager or a staff nurse present in the meeting.

This is initially how patients were brought into being as objects of discussion at the team meetings. Subsequent discussion about them would then turn upon the negotiations between participants as to who would do what. Hence patient characterisations are bound up with the team performing a gatekeeping role with respect to organisational targets and resources (e.g. the injunction to treat severe mental illness only) as well as with individual members managing their caseloads.

Interaction sequences that made up the team meetings would begin with a report on a patient with a request for someone to do something. What that something was and who might be best placed to do it would sometimes be specified, but not always. If it was specified, unless it was from an internal source, then it was likely to be treated with some scepticism by the team. Hence reports would be discussed in ways which formulated the patient's problem so that it could be acted upon, with an agreement secured for a particular individual within the team to take responsibility. This sequence is now unpacked in some detail below.

8.3 Securing agreements - commitments to assess and to KW

There were three courses of action available to the team in dealing with the patients referred:

- ◆ those which accepted a person as a client of the team - 'accepting them into the service';
- ◆ those which rejected a person as a client of the team, which usually entailed referring them elsewhere, or back to the original source of referral;
- ◆ those actions which, for the time being, neither fully accepted nor fully rejected the client - these cases were described as 'pending'.

To pursue this in a little more detail the range of possible moves for patient allocation in team meetings are set out in Table 8-1 below.

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Table 8-1: Standard possible moves in team meetings

Responses	Elicits		
	1. Individualised request 'I wonder if you'd take this one Monica ?'	2. Discipline addressed request 'This is definitely a case for social work'	3. General request or statement of need ('This is a patient who..') or unaddressed request such as 'Any takers ?'
a) Requests for further information	1 a 'What's the prognosis ?'	2 a 'What's the prognosis ?'	3a 'What's the prognosis ?' (Requests for further information, following an unaddressed request, were often taken as indicating a willingness to accept the role of KW)
b) Unconditional acceptance	1 b 'Yes'	2 b 'Yes, one of us will take it'	3 b (Unconditional self-nomination) 'That's one for me'
c) Conditional acceptance –shared version	1 c 'Only if (so and so) will do it with me'	2 c 'Not just a case for us. It needs an input from (other discipline)'	3 c (Conditional self-nomination) 'I'll take this if Monica will share it with me'
d) Conditional acceptance temporising version	1 d 'I'll take it for now'	2 d 'We'll hold it for the time being'	3 d (Conditional self-nomination) 'I'll take it for now'
e) Reasoned refusal via negation of need	1 e 'I don't think this case meets the team's criteria' (perhaps followed by j)	2 e 'This isn't a case which needs (someone of our discipline)' (perhaps followed by h or j)	3 e Since the request is not addressed to anyone there is no need for anyone to refuse on their own behalf, but negations of need for the team to take the case are heard, perhaps followed by h or j.
f) Reasoned refusal via citation of practical constraints	1 f 'Not with my case load as full as it is'	2 f 'We (all of us in this discipline) are completely overburdened at the moment'	3 f Since the request is not addressed to anyone there is no need for anyone to refuse on their own behalf.
g) Unreasoned refusal	1 g 'No' (but no examples in Westway data)	2 g 'No' (but no examples in Westway data)	3 g Since the request is not addressed to anyone there is no need for anyone to refuse on their own behalf
h) Re-direction of request to others in the team	1 h Via elicits 1, 2 or 3	2 h Via elicits 1,2 or 3	3 h . Usually silence, but perhaps re-direction via elicits 1, 2 or 3
i) Redirection of request to another service	1 i 'It would be a better case for ART'	2 i 'It would be a better case for ART'	3 i 'It would be a better case for ART'
j) Silence	1 j Silence	2 j Silence	3 j Silence
k) Unallocated pending	1 k Case left unallocated	2 k Case left unallocated	3 k Case left unallocated

In Table 8-1, numbers 1 to 3 are starting moves. When it is genuinely ‘the start’ it is usually a move by the team chair, but each might come up in the course of a meeting. So the sequence might start at 3 ‘any takers’ from the chair, go to 3c ‘I’ll do it if Monica will do it with me (a 3c) followed by 3b, Monica: ‘ok I’ll take this one’. It often happens when someone shows an interest in a case by asking for further information about it that their request for information is treated as a possible self-nomination for the role of keyworker. There are possibilities for moving from, say, a) to i), or h) to a), and so on and across columns too. Cells in rows b), c), d), i) and k) are possible end points: k) by default since the case is left pending; and thus the team can go a), e), f), g), h), i) or j) to k).

Several hypotheses may be considered in the light of the possible moves presented in Table 4.

- ◆ Hypothesis 1. In a team with strong managerial control and/or a dominant profession such as a consultant’s firm, most sequences would run down column 1. Examples of 1g) (unreasoned refusal), and 1j) (silence) if following an individualised request might appear like insubordination. We would expect few unallocated cases.
- ◆ Hypothesis 2. In a team with strong professional or agency boundaries neither the chair nor anyone else will make individualised requests to those who are not of his/her own agency/professional group. Rather, we would expect discussion *first to allocate cases to disciplines/agencies*, and only then for cases to be allocated to workers within these groups, and for that discussion only to involve members of the group concerned. Most sequences would run down column 2.

- Hypothesis 3. In a situation where the ceremonial fiction is one of *primus inter pares*, there will be few individualised requests. Instead the search will be for self nominations via the responses indicated in column 3.

The usual method by which the Westway teams accomplished their business was via the kind of moves indicated in column 3 Table 8-1. Moreover, on the rare occasions when moves indicated in columns 1 and 2 were made, this was done in a manner that tended to point up moves in column 3 as default ('exception proves the rule'). The rest of this chapter will present material to illustrate these kind of standard moves for the team meetings. This will enable me to elaborate on the working consensus at team level in Westway.

8.3.1 Voluntarism

As noted above, these teams are collegiate structures without a singular line management authority falling to any one individual for the whole team. In this situation the protocol for the team meetings was to behave as if no one had the right to determine anyone else's caseload. This approach was especially pronounced in Team A. Thus not all the options above were really feasible without leading to interactional trouble. It is not surprising therefore that the majority of reports were unaddressed³³ as these were the elicits that most obviously avoided appearing to order others around and reduced the need for anyone to make an explicit refusal (reasoned or otherwise), so that responses leading to an allocation took the form of self-nomination. Often in Team A this process would come about after a number of referrals had been presented, usually fairly briefly, and then the chair would ask of the meeting "any takers?". Individual team members

³³ An unaddressed report does not suggest that any particular kind of practitioner, or any particular person should take the case.

would then respond either for a specific patient or else say something like “I’ll take one”.

EXAMPLE 1

Team A weekly team meeting 9/9/96

Ward reports from ward manager: 10 admissions. All these run through briefly, noting those without a KW and those where already on someone’s caseload i.e. note who is nominated KW.

Also notes 4 patients not allocated previous meetings. Of these the team manger confirms that CP1 to be the KW for one, SW1 to be KW for another, and the comments which follow on the other two indicate that there is still confusion about who is taking up with other staff involved but not necessarily committed to action.

Community referrals from the team manager He notes that there is a list of 16. Given high number of patients already brought to the meeting from the ward and that everyone’s caseloads are full he decides not to run through the full list. He picks just one out for mention identifying it as the priority.

TM: This patient needs a quick assessment in the next 10 days. The GP is not happy with [name of team psychologist] not doing it until the end of October. Any takers then?

CPN : I’ll take one.

SW2 : I could take someone who’s going to be on the ward a while longer but not one already in the community.

CP1 then emphasises the problem of pressure on beds and at this point SW2 agrees to take a patient who needs to be discharged but who has problems with accommodation, noting that that is a social service problem anyhow

In terms of Table 8-1 the CPN’s response is an obvious example of a self-nomination (3b). The first response of SW2 is a conditional self-nomination (3d). The second response of SW2 is an unconditional acceptance but one made on the back of a disciplinary specificity: the presence of a housing problem (hence an example of 2b). Moreover the identification of a case as pertinent to any particular discipline would be done via the self-nominator, rather than the Team Manager/meeting chairperson or other managers. Thus, above it is SW2 in volunteering to take a case who reasons that the accommodation problems of the client indicate it as appropriate for social services.

Just as frequently however, there were no takers and the chair's question would be met by an uncomfortable silence, occasionally punctuated by someone protesting the full caseloads (these more troublesome exchanges are considered in chapter 9).

8.3.2 Qualified directives

Even self-nominations needed to be handled with some caution if there were implications for other colleagues. So a self-nomination from one of the social workers needed to be handled quite delicately with regard to his assistant, a mental health support worker:

EXAMPLE 2

Team A weekly meeting 14/5/96

In a sequence where the CP is noting the urgency of a case and there are no takers, one of the social workers intervenes:

SW1 says he and [name support worker] could possibly do joint work on it, adding

SW1: [name of support worker] is looking at me, presumably for the right reasons.

Moreover such examples of nominating another point up a further key feature of nomination - done with great care, it was usually prefaced by self-nomination, and presented as 'joint keyworking'.

On the rare occasions when individual nominations or more direction over the team was exercised, without occasioning resistance or some kind of interactional trouble, these directives were qualified. It should be noted that this was more usual in Team B with the more imposing sector manager who usually chaired the meetings. Such directives would be tempered though, for instance by an apology (Example 3), or by an undertaking to look at overall caseload (Example 4), or they were handled with some linguistic delicacy (Example 5).

EXAMPLE 3

Team B weekly team meeting 7/11/96

Ward reports:

WM Introduces next case [patient name] on a section 3. Assaulted staff. On admission he was very medicated and subdued, uncared for. Now he's been tidied up and presents similarly to other occasions - he sits and observes, there's no aggression and he's refusing medication. Then goes into some detail about instances of him defecating and urinating in his bedroom. SW expresses concerns at this saying there are differences in presentation and there is a clear deterioration from before.

CP: Are there physical problems or not?

SM: I hate to do this but can the team keep a special eye on this?

Sector Manger then goes on to note that the relative of this patient felt deterioration due to lack of care by staff and not down to the patient himself. Any queries from this relative should be directed to herself and she will handle.

EXAMPLE 4

Team B weekly team meeting: 5/12/96

In ward reports section of meeting and following on from case where CPN 1 has just noted caseload too full to take previous patient raised (see e.g. below).

Ward nurse: [patient name]. From Exeter prison. he's in for GBH. He's very ill - he's got a worm in his body. He was going to be picked up previously by [names CPN] just before he died.

SM: He's known to be difficult and he needs a male. [name CPN1] could you look at him. I'll talk to you at the end about your caseload.

EXAMPLE 5

Team B weekly team meeting 7/11/96

CPN2 discusses one she has assessed. [patient name]. Notes depression and concerns about her appearance. The GP felt that some cognitive work from a CPN might help. She's been involved with the practice counsellor who is also a psychologist - had 2 sessions per week for 3 months. Feels it's a complicated case - patient more like a 13 year old than her 27 years. The parents are very involved and important to her. But the home situation has not been assessed. CPN2 then paraphrases patient language in a child-like voice:

CPN2: Mummy and daddy don't know she's had a sexual relationship with her boyfriend for the past 4 years.

CPN2 Then goes on to note that there's more alcohol misuse than admitted to the GP.

CPN2: I really felt this girlie needed to grow up [exasperated tone]. I don't know what we can offer. I told her I would talk with the team and let her know the outcome.

SM: Did you discuss her nose and appearance problems?

CPN2: Yes, but I feel cognitive work is unlikely to help. The drinking indicates she's not responsible. And there's something odd about the parents. her relationship with them.

Other members of the team then comment that there is something more going on here.

SM: What does she want?

CPN2: To be less unhappy.

TM suggests a women's group.

CPN2 Feels this is not appropriate.

SM: I'm not surprised to hear this is still not resolved given our ex-colleague [names a doctor] is involved. Well the case is not SM1. But there are maturity, responsibility issues there.

CLiPsy: Possibly there could be psychological work about not growing up.

SM & TM: Is that an offer?

CLiPsy smiles wincingly and says she was just wondering aloud.

TM then says there's the potential for her to become more ill especially given the alcohol misuse.

SM then directs the CPN2 to talk further with the CLi Psy, adding:

SM: Neither one of us [indicating TM] is saying don't take her on.

In example 5 above, CPN2, as the team member who has assessed the patient, is the most likely candidate as a keyworker, but there are a series of contributions from CPN2 which indicate an attempt not to take the case, framing the patient as 'silly and immature' rather than 'seriously mentally ill'. The interchanges between CPN2 and the rest of the team can be read as a 'reasoned refusal'. Moreover, the refusal is carefully

structured by the interaction. As there is no outright directive from the Team Manager or Sector Manager to take the case, there is, therefore, no possibility for an outright 'no'. Further, the comment by the psychologist, which seems designed to alert the team to the possible 'seriousness' of the case and therefore as suitable for the team, is explicitly read by the team managers as a potential bid by her for the case. The effect is for both the CPN and the psychologist, despite their reluctance, to be politely enrolled to a course of action whereby the case will be pursued further, i.e. a commitment to take the work on board.

So we see that the due process of team meetings promoted careful handling of individual nominations (both 'for' and 'against'). Nomination of another, when it did occur, was most often broached indirectly through the device of noting the previous involvement of the worker. Sometimes this kind of individual nomination was initiated by the Team Manager, and sometimes this was raised as a question by another team member when there were no takers for the case. In this way a rather delicate attempt to nominate took place, which did not actually name or directly request:

EXAMPLE 6

Team B weekly meeting 5/12/96

Ward reports. Four mentioned by ward nurse including: [patient name]. She notes he's a university student. Schizophrenic problem. Notes that there's been an incident with a train and other serious attempts at self harm. Notes that CPN1 previously had contact with him. He needs a KW though he may not accept one.

SM: We need to be seen to offer it and try given the circumstances.

CPN1 says he's got problems with caseload size and a number of new referrals at the moment. Then.

CPN2: I'll hold for now. ... I'll try some gentle persuasion and see if that works. I'll pop down to the ward later.

That this was an attempt at nominating another is indicated by the response from CPN1 being an explicit refusal to accept the case, even though no explicit request was made for him to do so.

8.3.3 Provisional and conditional acceptance

This last example also demonstrates another frequent feature of nomination, the provisional and conditional acceptance of cases. Sometimes, as here, this featured as the ‘favour’ of temporarily holding for a colleague. In example 6 one CPN covers for another, but it was just as common for this to occur across different professional groups with social workers stepping in for a CPN and vice versa or the nurse behaviour therapist for either of these. At other times this qualified acceptance would take the form of a *quid pro quo*: ‘I’ll take this one if someone can take this one off me’. Sometimes this *quid pro quo* was more specifically employed to nominate a particular part of the service that they were waiting to transfer someone to such as the ART team or a worker in another team if the patient had moved sector.

The context for all this business, across all the teams, was the perception of overly large caseload size for every member of staff. Thus when cases were discussed with the intention of allocation in such pressing circumstances, then team members made it clear by such forms of self nomination that they were doing something over and above what could reasonably be expected of them, and thus preserved the principle of voluntarism.

The other frequent form of conditional acceptance was to take on a case jointly. This seemed to occur both in the face of ‘full caseloads’ and pressure for someone amidst ‘no takers’, as well as in the face of cases deemed to be especially difficult. (These cases are discussed at length in Part 4).

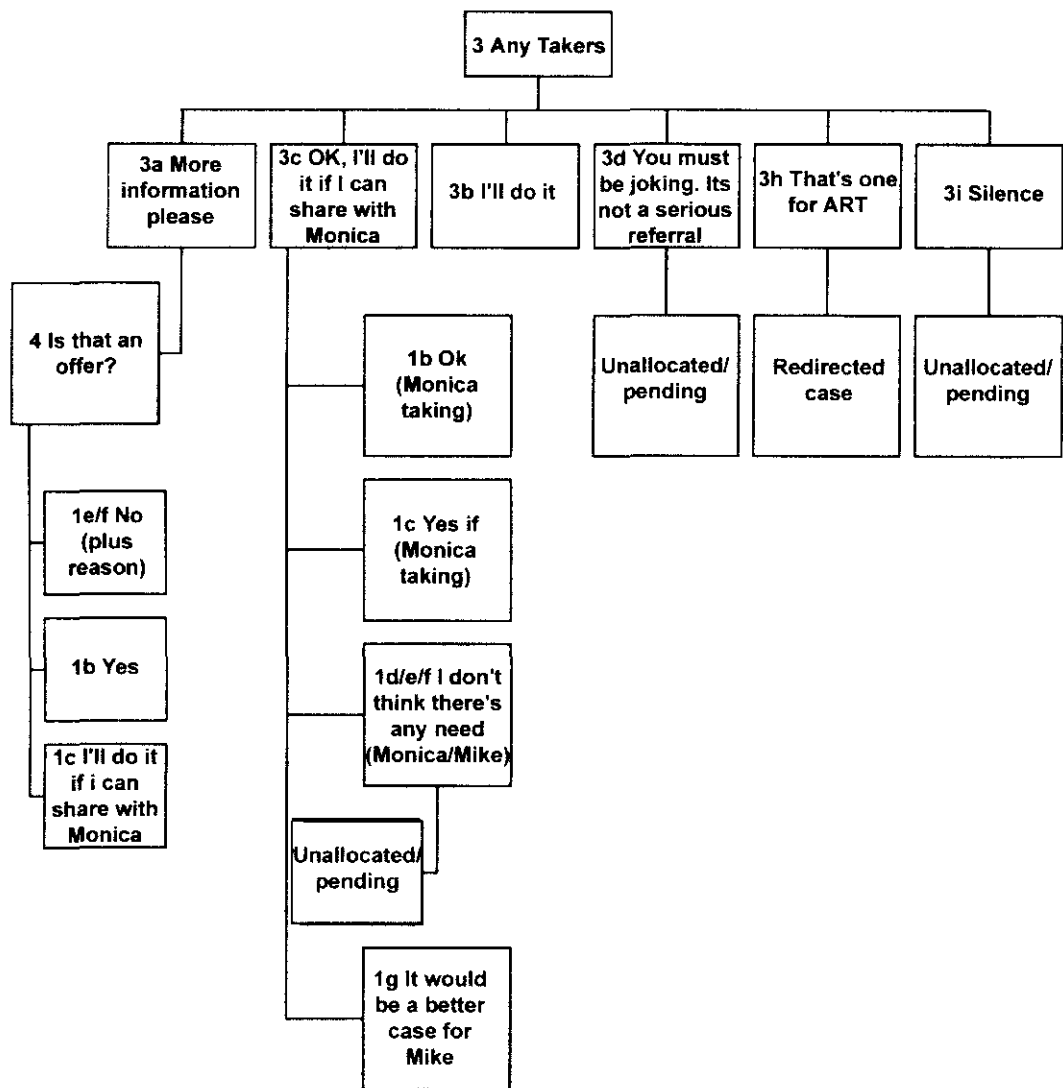
8.3.4 The significance and limits of the chairperson's role

In the examples above we see that the role of the chairperson is important but limited in the accomplishment of the team's business. There are two main ways in which the chairperson's role figures here. First, given their managerial position in the team, together with their role in the meeting as chairperson, they are relatively well-placed to rule in (or out) the kind of knowledge or expertise required by particular reports i.e. to identify a particular discipline or individual. Second, as chair of the meeting, they are better able than others to effect closings on the reports/requests made and thereby securing agreement from a team member to accept a case, to be KW. However, this management of team encounters is pursued with some delicacy, given the ceremonial fiction of *primus inter pares* in the weekly MDT meetings, and, because the chairpersons are not in line management relationships with all members of the team.

8.4 Team moves

Empirically I found that the predominant moves in team meetings in getting things done were those shown in column 3 of Table 8-1 (a flow chart of these indicating the usual moves in team meetings is presented below in Figure 8-1). Examples indicative of the scenarios suggested earlier in this chapter in hypotheses 1 and 2 do not occur frequently, if at all. Indeed even when nomination did take place it was then frequently prefaced by a self-nomination or was handled in a most indirect manner. The data are most consistent with a *primus inter pares* picture of the social relations in the team and not with either a picture of a strongly managed team, or a system of negotiation between organised groups. Thus, hypothesis 3 seems to make better sense of the data, which is to say that these teams were neither dominated by a 'leader', nor their process marked by inter-professional rivalry.

Figure 8-1: Usual Moves in Team Meetings



8.5 Gentility

The role of ‘politeness’ is crucial to the way teams effect their business. As noted earlier, the work of CMHTs takes place in the potentially fraught context of a multi-agency and multi-disciplinary setting. Given the pressures already upon staff, avoiding interactional trouble is important. Thus when pressure is, of necessity, exerted, as in seeking to appoint keyworkers, then this is done with some subtlety. The work of the team is accomplished through interchanges characterised by a particular pattern of politeness - or gentility as Strong (1979a) would have termed it - i.e. managing their speech in such a way as to promote or at least not to violate a fictional state of affairs, or ‘ceremonial order’. In this case the ceremonial order is that:

- ◆ we are all autonomous and competent professionals here;
- ◆ none of us would dream of pushing others in the team around;
- ◆ we are all motivated towards achieving what is best for patients.

Evidence for this lies in the virtual absence in the meetings of any personal criticism and in no one attempting to order anyone else about. Thus, for example, there were no complaints when someone refused to keywork a patient, and things were managed such that individually directed requests which might generate explicit refusals were generally avoided. Hence also the liturgy³⁴ in meetings from the chair “any takers?”. Thus keyworkers were not usually ‘appointed’ but volunteered. This is the ceremonial order or fiction of the team meeting. To make an explicit request for a particular person to keywork was to claim a right to make a request. And when the

³⁴ The term ‘liturgy’ is used following Atkinson (1995) to indicate the recurrent and ritualised forms of talk in this setting.

request is about how people ought to be doing their work this comes dangerously close to claiming the right to direct the work of another professional. The alternative is to issue the request as a report of the kind that implies some action is required by persons such as those to whom the report is addressed (i.e. the team) in terms of ‘there is this patient: s/he is thus and thus; s/he needs a keyworker’.

Sometimes (quite often in Team A), as noted in the first example, this approach resulted in some patients remaining unallocated. It is worth noting that some ‘pending’ cases did get allocated outside of these meetings via individual supervision sessions between the team manager and his health care staff: i.e. scripts for ‘professional autonomy’ etc., are contingent upon the ceremonial order of the team meeting, but other types of working relationship allowed for different kinds of encounter and thus allocation processes.

This kind of ceremonial order meant that some business was not conducted (failure to allocate referrals and cases left ‘pending’) or conducted with some uncertainty where allocation was temporary or conditional on other agreements being reached at some other time/place. Thus, mental health care was not organised with the kind of certainty intended by the government’s guidance on the CPA. These outcomes of team encounters hint at some problems of interaction and these are now considered in the next chapter.

Chapter 9: Interactional problems

Interaction research helps examine collective action in particular settings. The last chapter set out the case for there being a particular kind of working consensus in collegial MDTs. The emphasis, *a la* Goffman and Strong for instance, was on smooth encounters between members. A different approach in interactionism, pioneered by Garfinkel, examines the trouble that ensues in particular encounters in order to access the common sense or collectively shared meanings which define the group and its activities (1967). Although in Garfinkel's terms it would be more accurate to describe collective meaning as 'shared agreements' (1967, Chapter 2). In an ethnomethodological sense, shared meaning is an agreement on method rather than substance (the 'how we do things around here/in this organisation/team') (Czarniawska 1992, p119). For Garfinkel, disruption reveals the social rules we live(work) by. In this sense, a consideration of trouble in social encounters can confirm and help elaborate on the working consensus set out above. For it is when the taken-for-granted are tested or violated in some way that the culture of MDT work in the organisation of mental health care becomes so apparent.

9.1 Lack of closure and failure to make binding commitments

A feature especially prevalent in Team A was the number of cases which remained unallocated at the end of team meetings. Even with those cases where some members might have thought there had been an allocation, it was sometimes necessary to revisit these decisions at future meetings particularly where the original agreement to KW had been given grudgingly. Part of these problems might be due to the rather chaotic style of these meetings with a style of chairing which allowed members frequently to interrupt each other and which did not clearly or formally summarise agreements made and thus did not formulate them as commitments resting with specific team members. The upshot

of this was a lack of closure over decisions made and, in some cases, failure to establish binding commitments.

EXAMPLE 7

Team A meeting 3/6/96

One of the CPNs raises a patient for discussion. [NB It is not routine for Team A members to raise patients for discussion at meetings unless there are problems including wanting to pass the case over]. The discussion is about the need for a medical assessment because of a possible change in medication being required when the only doctor present is bleeped out of the meeting. The social work manager deals with this interruption by asking one of the social workers (SW) what is happening with a particular patient 'Valerie', raised earlier during ward reports as still remaining unallocated from last two meetings. [This was a case where SW had been trying to resist the allocation, and it had been left inconclusive]. SWM explains this query arises because she wonders if SW could take on CPN1's patient just being discussed if she has not actually taken on Valerie [The implication here is that SWM thinks SW has the space to take a case on]. SW explains that she's very ambivalent about anorexia cases [which Valerie is], especially given the CP's plan to engage very closely with the illness. SW says she has told the CP about her reservations and that the CP would have to accept her ambivalence if they were to work together on the case. When pressed by the TM and the SWM to explain this further, SW talks about a previous experience with an anorexic patient who eventually died under a very similar treatment programme to the one planned by the CP here. SWM then responds it's a question of which of these two patients SW should take. SW then wonders if she should take on Valerie as it might help her work through her own difficulties.

At this point the SHO returns to the room and discussion returns to the other patient currently with CPN1. SHO suggests that the CP [in another team] should see the patient. Then CPN2 suggests that CPN1's student could do most of the work with CPN1 nominally down as KW. CPN1 agrees hesitantly:

CPN1: It would take most of the load off me for now because I can't give her the time that she needs.

The TM then returns to patient Valerie and suggests that SW talk again with the CP in a one to one meeting, not the team meeting as they tried to do last week, and then return with a decision at next week's team meeting.

This does not actually happen at the meeting the following week and another week elapses where the outcome is still inconclusive:

EXAMPLE 8

Team A weekly meeting 17/6/96

Ward reports raises Valerie again. Ward manager notes that she understands SW is now the KW. But SW responds that she has not yet seen the CP so she has not yet pursued the case. Discussion then turns on whether SW should take on another case just raised immediately prior to this one in this week's ward reports, which ward manager noted as needing accommodation sorting out and therefore problems are largely social. SW is not keen and notes her concern that she may get lumbered with both patients. Discussion is inconclusive and moves on to the community referrals.³⁵

Here the exchanges involved some concerted attempts to nominate a particular team member though these were resisted by the member against a background of chaotic meeting style and the collegiate team principle of not actually ordering others to do things. This seems to afford some latitude for the member to ignore even these fairly explicit attempts at allocation by her own line manager. Notably also, the negotiations over patients were not bound up with particular disciplines, nor was that a line of argument used, for the possible choices identified by the social work manager for the SW are between patients held by a CPN and by a CP, including one presented with a medication problem. The overriding issue here was one of taking a share of the load within the team.

Lack of closure also characterises the next example, though here this turns more upon the report presented through the routine and more polite form of being unaddressed. This did not however avoid trouble, as the case was pressed most forcefully:

³⁵ This patient continued to remain unallocated, and then not contacted by the (reluctant) nominee KW, with brief references/queries about the case at some of the subsequent team meetings. Delays were reported due to absence of the CP involved and then the nominee KW. Eventually the patient was raised again at the team meeting of 2/9/96 as a query now for referral to a London hospital given that the patient planned to move out of the area. The patient thus remained unallocated from mid May through to September '96.

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EXAMPLE 9

Team A weekly meeting, 21/10/96

The NBT, who is chairing the meeting this week in the absence of the TM, goes through the referrals via list and/or letters, including first [name of patient] via a PAS fax to the meeting.

CP: She needs to be picked up by us. She's got a care manager, [name], but she needs picking up by us, she needs a keyworker.

CP then runs through her background.

CP: She has cerebral palsy, and there's a history of sexual abuse, a very disturbed woman. She's possibly not appropriately placed at [name of residential unit]. The care manager has not had anything to do with it. It's quite strange.... If she ends up in [name of hospital unit] we're in deep doo doo because she's very difficult to handle. There's been a lot of hassle recently which we've fended off. But we need to pick her up now.

NBT: Anyone?

CPN 1: We're all feeling really, really stretched. You need to give a steady commitment to a case like this. It's too much right now.

WM: Day Therapy?

CP: She's bed-bound so very unlikely.

CPN 1: Do we have to find her a place?

CP: There's a mental health problem with category one problems. There's been incoherent management on social services' part but with the mental health element we're obliged to step in.

NBT: She's with us.

CP: The family are very unhelpful too. She's been handled like a piece of meat. If she's treated like a human being then she's likely to pick up.

SSM: Both [social services staff name] and [social services staff name] need to clarify what social service support is available. I know that doesn't help immediately.

CP: It will be helpful.

SSM: I'll telephone [name of care manager] and find out about both patients mentioned so far relating to her as care manager.

Discussion then moves to next patient on referral list.

The same patient was raised again in the meeting a little later:

Summing up the cases that remain to be allocated:

NBT (temporary chairperson): So that leaves [patient name].

CPN 2: What input would be required?

CP: It may not be much.

Discussion on patient ends there, inconclusively, without 'any takers'.

As noted earlier, the *dramatis personae* in many exchanges in team meetings, were senior clinical staff and managerial members of the team, those perceived to have ultimate responsibility on behalf of the team organisationally for ensuring that referrals are properly handled and that the patients accepted get allocated. Thus regular

contributors to meeting talk were those with this overall functional responsibility. Given that, in practice, these staff were least likely to be the ones to take on the keyworker role, then when others from the team entered the discussions on particular cases they could be seen as potentially bidding in this delicate process of effecting allocation of a keyworker or someone to assess (as seen above and Table 8-1, column 3). So interventions, by those who were not senior members of the team and who did not wish to be seen bidding for a patient, had to be carefully constructed, explicitly reasoned refusals, as that effected above by the CPN, if they were not to be construed that way. Such explicit refusals were only necessitated by others pressing, usually repeatedly, for someone to take a case against silence or ‘no takers’ coming forward.

The discussion in the example above ended with no particular outcome i.e. ‘no taker’ and discussion moved on to other patients as often happened when no agreement was reached about a particular patient.

We see that such unaddressed linguistic manoeuvres are more easily resisted by other team members compared to some of the more directive exchanges discussed earlier. This last example also indicates another source of interactional trouble: that connected with the formulation (or not) of the consultant psychiatrist’s authority.

9.2 Professional dominance (or not): formulating consultant psychiatrist authority?

In the above example, what is perhaps most striking is how careful the consultant psychiatrist is to not direct others in the team. He treats the CPNs, for instance, as autonomous colleagues, he can, at best, only seek to persuade. Indeed his power as a team senior, (consultant psychiatrist with managerial responsibilities such as bed numbers on the sector’s ward and a clinical responsibility for management of patients), seems particularly circumscribed by the collegiate nature of the team meeting. Yet this

is something which the literature on multi-disciplinarity indicates as a source of problems - one professional group, especially doctors, being dominant over others. If anything it appears to be that it is the tension between various members of the team as they negotiate caseload size that is the source of team working difficulties.³⁶ Moreover, one might argue that the CP demonstrates himself to be highly competent in his team membership in *not* ordering others about, and by seeking to get others to do things of their own volition.

Here is another much briefer example of such an exchange with this same consultant psychiatrist on an occasion when (in the absence of the TM) he is chairing the meeting:

EXAMPLE 10

Team A meeting 16/4/96

The CP "wonder[s]" about nominating a new member of staff (not present at the meeting) when faced with a case that urgently needs someone as standby for when RMO status is transferred to him. He is met with a chorus of irritation from others [CPNs and SWs] who protest him loading up a new member of staff in such a way before they have even got to a team meeting. The patient remains pending.

While in this instance the CP is keen to get the referrals allocated, framing the case as 'urgent', he poses his solution in an exploratory way, as a question ('wonders') for the team. He quietly drops the proposal when the others indicate it is not good collegial practice – to dump on a new member, and moreover, one who is not yet present to say 'no'.

The kind of linguistic manoeuvres we see in these two examples also illustrate the claim set out in chapter 8 that predominantly the Westway teams sought to

³⁶ Nor is this only applicable to one particular CP: caseload balance and sharing equally across the team despite hierarchy as the determining factor is supported later in the chapter (see for instance Example 15).

accomplish the work of allocation within a protocol of favouring unaddressed reports as the most hearable within the teams.

On the rare occasions when the consultant psychiatrists did attempt to formulate their authority within the meetings then the most extreme kind of trouble ensued and in the example that follows, for a time the meeting broke down entirely:

EXAMPLE 11

Team A weekly meeting 7/5/96

TM asks if any assessments have been done and need discussing for allocation.

CP1 [raises a patient]: There's been NSPCC involvement in the past and she's pregnant again.

TM [clearly irritated at CP1 raising this]: We've discussed this one before!

CP1 carries on regardless of TM's response. She explains that the patient gets post natal depression with every baby. So thinks they will be asked to get involved again just after the baby is born, and that this is appropriate.

TM: The service is too strapped now.

CP1 says the patient has a drug induced psychosis and is borderline psychotic. She's been holding her for 12 months now and wants a KW. Problems in past because social services view is that when the patient is not psychotic she does not pose a risk to her children. So she seems to be falling between services. She feels the patient needs service ongoing but is only being offered it when ill.

TM: We'll review again later.

CP2 [then interrupts saying to CP1]: This patient is a high priority because she has babies. [Given exchange of glances between them, it seems aimed at TM though addressed to CP1].

TM: We need to review where we're at with the referrals so far today. We need to allocate KWs. We've got to sort out 3 in-patients, 2 team referrals and we need an assessment doing.

Then CP1 starts a conversation with the WM and the meeting breaks down into small discussions between pairs/small groups. TM reconvenes/calls the meeting to order and all except CP1 'return'. CP1 continues with her private chat with WM. Yet the meeting is now trying to discuss a patient where CP1's input is required - SHO says she doesn't know what CP1 would advise which is clearly a cue for CP1 to respond but as she's still engrossed with WM she either doesn't hear or ignores. TM then asks CP1 directly about this patient.

CP1: Yeah, OK [with complete disinterest and clearly without a clue as to what's been asked of her]. [The room bursts into laughter at this point.]

CP1: Sorry, but I'm hoping to get someone to London tomorrow.

Then CP1 swiftly exits the room. Everyone is clearly quite perplexed at her verbal response and clearly embarrassed and outraged by her, given looks exchanged between people around the table. CP1 returns a few moments later and nothing more is said. The meeting moves on to the next item.

The points at which a patient, who is not a new referral for that meeting, becomes mentionable in some depth by a consultant (or anyone else) is when they want someone else to take on the case from them i.e. transfer KW responsibility. At first sight this appears to be an instance of struggle between members of the team formed through alliances according to occupational affiliation, where the consultants support each other against the team manager, a CPN. But this does not seem to be a struggle which is brought about by multi-disciplinary differences and nor is it formulated as such. Rather this seems to be more a contest of managerial authority between the team manager as chair of the meeting and leader of the team against the consultants as the most senior clinicians within the team who also carry managerial responsibilities for team business (e.g. bed management on the ward, being seen as answerable to GPs for dealing with referrals to the team). It is also notable that this kind of example where same group occupationals/professionals are seen to support each other like this was most unusual.

Also of note here, and in the previous examples focusing upon the role of psychiatrists, is that team talk was not usually psychiatric talk, whereas if psychiatrists were dominant one would expect a psychiatric vocabulary to be used, either generally, or as a particularly authoritative way of speaking.

The professional dominance thesis as a strand of the problems of teams due to multi-disciplinarity does not really figure here. CP1 is not automatically deferred to by the team manager and when CP2 intervenes to support her it is done with care not to question the team manager directly and certainly not on the grounds of any particular clinical judgement. The way CP2 intervenes means he can avoid direct confrontation with the team manager and allow him to stand down and save face as team manager in

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response to the challenge to his authority from the consultants. Here external realities (of babies possibly at risk) are cited as forces 'that we have to take note of'. This is an example of how pressure upon others is exerted quite delicately. Here the participants in the meeting avoid direct citations of their own professional autonomy or specialised knowledge and interact with same fellow professionals to make their points by citing external realities rather than specialist clinical judgements, challenging another team colleague indirectly. Indeed, the factor which is cited as the reason for the case being a priority is the patient's children, a concern, if anything, belonging conventionally with the social work profession not medical staff. This is not so much a challenge of one professional to another as of one team member to another. The interactional trouble here seems to emerge from organisational arrangements whereby the team manager does not have overall managerial authority for all the members of the team but is expected as chair to carry responsibility for running the team meetings.

However, this is not quite the end of this encounter. When CP1 cannot effect the response she desires on this case, she opts out of the meeting and the meeting itself appears to break down temporarily. This might indicate that, as a consultant, CP1 has a professional dominance within the team that enables her to counter the conduct of the meeting. Yet when the incident draws to a close with the embarrassed return to order of the meeting, it is perhaps at this moment that we see the participants as not only remembering the appropriate ceremonial order that they have deviated from, but also rejecting the manoeuvres and behaviour enacted by CP1. Indeed, the response of the rest of the team, including CP2, is expressed outright in the form of outraged amusement at CP1's conduct, and is so embarrassing for her that she retreats from the room (and the meeting) momentarily.

In terms of the ceremonial order, the consultant psychiatrist as dominant professional is a threat to the script that we are all *primus inter pares* here, and claims to professional power or superiority are something which team members, including psychiatrists, avoid realising in linguistic terms. So in this latter example the 'rudeness' of CP1 seems to be constituted in her violation of the ceremonial order. The order in relation to psychiatrist members of the team appears to be not to formulate their authority as consultants, and when behaviour can be interpreted as an attempt at pulling rank it is roundly rejected, and rejected by another consultant as well as by others of different rank and discipline.

There was, however, another place where CPs were clearly in charge with regard to some of their sector team colleagues. This place was the in-patient ward round. Here the CP would chair the meeting, often orchestrating the talk among members in contrast to the weekly CMHT meeting. But what is significant is that this is a very circumscribed role – it only applies to some patients, in one particular setting for the work, and thus with regard to only some of the team (i.e. those who are already designated KWs). Even then KWs would attend the relevant part of the ward round (i.e. for their patient) infrequently, seeing the weekly team meeting as the main forum for discussion. Moreover, the forum itself was not one that allocated work (i.e. identified assessments and KWs for patients) – these powers resided with the weekly team meeting. This demonstrates that it is important to attend to the situatedness of discursive practices. The weekly CMHT meeting was formulated by members as a MDT, but while many different professionals (including the same people) attended the weekly ward rounds, these were not formulated as MDT meetings, and were located instead within the more traditional domain and practices of the hospital where doctors are the most senior personnel and deferred to accordingly.

As noted above, consultants attempting to pull rank in the team, and the subsequent trouble it produced, was rare. Moreover, when it did occur, members were forthright in their rejection of such conduct. In Westway, there were no particular professionals, psychiatrists included, who were formulated by the team members as having greater authority within/over the team meeting. This kind of empirical finding is at odds with the *professional dominance thesis*.

The professional dominance thesis has been advanced recently by authors, working in the kind of interactional approach pursued here, and with respect to the work of mental health professionals, through studies of humour in CMHTs. Thus in a study by Griffiths on CMHTs, it was argued that consultants are professionally dominant and thus challenging such authority was only possible by indirect means – primarily through humorous interactions in team meetings:

... organisational subordinates use humour in the presence of superordinates, and ... this serves clear interactional purposes, both in negotiating respective roles in a division of labour and in seeking to influence emergent decisions about cases. The significance of humour in hierarchical work organisations is that it allows subordinates to signal dissent, short of a serious statement of opposition or withdrawal of cooperation. Humour signals that social tensions exist, without exposing the dissenters to the consequences that would follow from a direct challenge to authority.
(see also Griffiths 1997a; Griffiths 1997b, p2; Griffiths 1998)

Goldberg also relates humour to power disparities, but although Goldberg's data seem very similar to those cited by Griffiths (and by myself), he does not read them as evidence of subordinates contesting the power of superiors, but as evidence of superiors controlling their subordinates:

Overt and repeated negotiations of power relationships may be laborious and stimulate the power struggles they are designed to avoid. Informal mechanisms, such as the 'joking exchange' may be used to negotiate hierarchy and thus avoid open conflict. Such informal mechanisms can succeed in reinforcing hierarchies of responsibility while maintaining the ideal of an egalitarian multidisciplinary team.
(Goldberg 1997, p242)

These quotations bear witness to the fact that humorous interchanges are common in CMHTs. Certainly my research shows much the same. However, my data do not show the kind of determinate relationship of humour and hierarchy within MDTs as argued by Goldberg and Griffiths.

While arguing for the importance of humour in hierarchical relationships among the team, Goldberg and Griffiths come to different conclusions. For Goldberg, humour is organisationally functional – it helps get the work done. The referrals which need to be allocated to various team members can be effected with less trouble if the psychiatrist plays the business humorously. For Griffiths, humour is used to thwart, or at least blunt, the power of psychiatrists, and thus stops the work getting done in the way psychiatrists would prefer. Here referrals and the psychiatrists who sponsor such requests are parodied in ways that reduce the seriousness of the case and thus the likelihood of acceptance by the team. So humour either upholds a hierarchy (Goldberg) or subverts a hierarchy (Griffiths).

So how do we choose between these? Moreover what if there are data from a very similar setting (as here in Westway), which do not necessarily support either conclusion? Consider the following examples from Westway.

EXAMPLE 12

Team A 2/4/96

There are 21 patients requiring allocation So many that the TM notes there is insufficient time to go through them all so he will pick out the main priorities.

Then the CP raises a patient admitted to ward who needs to be allocated a KW in preparation for discharge. Admission following serious suicide attempt. Patient's wife has separated from him and he now has accommodation problems. He also has problems with women.

WM: He likes to have affairs and then gets upset when his wife finds out and throws him out [derisory laugh].

SW: Does he have a mental health problem?

CP: Well he's made a serious suicide attempt – he's done serious damage to his wrists.

SW: That's a physical problem isn't it? [much laughter around the room]

CP [remains serious and now quite agitated]. Relates at some length and in graphic detail the wrist injuries.

Patient remains unallocated.

The above example might be said to follow Griffiths' argument of team members subverting the will of the consultant psychiatrist by making out as less serious the case he presents. In particular the main problem is characterised as housing which would tend to locate it with social services and the main quip is supplied by one of the SWs present, although it is the WM who initiates the joking sequence with her irony. And the only one not laughing here is the CP trying to get the patient allocated. And the patient does indeed remain unallocated (at least in this meeting). Yet it was just as often, if not more common, that CPs initiated joking sequences, including at their own expense, and while attempting to secure allocation. Thus:

EXAMPLE 13

Team A 2/4/96

The CP raises a patient with whom it is difficult to maintain contact. There are concerns because previously she has suffered frostbite through self-neglect. She has also given concern to neighbours, who hear her screaming loudly when shut away in her flat. The team then talk at some length recalling difficulties of previous contacts and attempts to treat her, unsuccessfully. The patient refuses psychiatric help, including contact with the CP.

CPN1 notes her only contact is the milkman.

CP: Perhaps we can get the milkman on the team – he could be KW?

Several team members including CP: Or perhaps [name of CP] could become a milkman, then she might talk to us!

Team then wind discussion on this patient and decide to assign three members as KW – the CP, CPN1 and SW1.

Here the CP initiates and continues with the joking sequence which turns on impropriety. First, there is the impropriety of an ineligible person – the milkman – taking the role of KW. Then there is the joke made by several team members, including

the CP himself, that the CP should take on a role that psychiatrists should not take, and become a milkman. In spite of the difficulties of this case and the jokes, including at the CP's expense, his bid for allocation is swiftly accepted following the joke. This might, of course, support Goldberg's thesis, that the joke helped ease a hierarchical move on the team by the CP. However, the result here is a joint KW arrangement that includes the CP. Moreover, just as often jokes followed allocation:

EXAMPLE 14

Team A 2/9/96

The TM notes high number of referrals this meeting – 11 from today's ward and community referrals lists and a prior waiting list build up of 15.

Team talk about who to prioritise. Various members are offering to take. One has offered to take 3 and the CP notes concern that he's taking so many and some others are not offering at all.

SW1 then offers to take one or two of the females from the waiting list. After some discussion about how much space SW1 has available, he takes one from the waiting list and one female due to be discharged from the ward. Then on the ward patient:

WM: She needs gentle follow-up.

CP: She needs massaging back into society.

Then WM and CP tease SW1 about his "gentle way with young women" and wonder if it's linked to his winning ways and good looks. Others join in with querying innuendo about the SW's preference for females.

This last joking sequence actually follows the allocation, one moreover which is accomplished via a series of unaddressed reports and various volunteer 'takers'.

One aspect that the Westway data share with those from Goldberg and Griffiths is that many jokes are about referral sources, and usually these sources are absent from the meeting. In Griffiths' team the CP was frequently absent from meetings but sponsored and fielded referrals into the team. In Goldberg's team, referring social workers were the most frequently joked about among external and absent referring professionals. In Westway, many jokes were about referral sources from outside the team and since GPs were the majority here, they were a frequent butt of jokes (often

taking the form of brief quips and plays on the name of the doctor), and sometimes these cases were allocated and sometimes not – there did not seem to be any particular kind of decision-making connected with the joking. So across these data sets as a whole it seems that vulnerability to being the butt of a joke comes from the very act of making a request or referral, *irrespective* of the requester's status relative to the team making the decision. And, what seems to increase vulnerability to being made fun of, is not being present at the meeting.

Further, although not the focus of her argument, Griffiths' data demonstrate several examples of humour in the teams casting patients as improper patients (Griffiths 1997a, pp 66-68; Griffiths 1997b, pp 6-7, 10-12, 13-15). Similarly in Westway there were many such examples relating to the characterisation of patients (these will be considered in more detail in Part 4). In other words, jokes are not simply, if at all, channelling hierarchical relations among team members.

The assumption made by both Goldberg and Griffiths is that there is some kind of definitive relationship between, on the one hand treating a request as a joke and not acceding to it, and on the other hand treating a request seriously and granting it. Griffiths makes the assumption in terms of humour being a safe way to refuse a psychiatrist's demands, although in her only example where the psychiatrist is present to press a request in person it is granted even though accompanied by much joking (Griffiths 1997a, p70-72; Griffiths 1997b, p13-15). Goldberg links the butt of the joke to the outcomes of decision-making. At first sight it may look as if where the 'joke's on them' then cases are less likely to be immediately accepted, and where the 'joke's on us' they are. And indeed this is shown in his data. However, the differences in numbers is equivalent to only 7 decisions out of 90 – the majority of cases allocated (65%) were in fact allocated where the 'joke's on them' and 'not on us' – largely because more

cases were allocated than not, and most of the joking was about them and not us (see table on p239 Goldberg 1997). The question this raises is: does making a joke of a case cause it to be given a lower priority, or are lower priority characteristics the cause of joking about a case? In Westway requests backed by psychiatrists who were present were sometimes made fun of, but sometimes the psychiatrist him or herself participated in this. It is actually difficult to determine who or what were the butt of jokes when looking across the Westway data.

Considering Westway CMHTs alongside those CMHTs studied by Goldberg and by Griffiths, I conclude that there is no determinate relationship between making a joke of a request and whether or not that request is granted. Nor I would argue is there any kind of determinate relationship between humour and the relationships between participants. Sequences of funniness amidst much serious talk produce enjoyment, enable members to display their humorous capabilities, and to display their competence as a team member. Knowing how to make and take a joke appropriately, mark out those inside and outside any particular group. In this context referral requests are a kind of stimulus material, which is appraised by participants for its humorous possibilities, any humorous possibilities, within the limits set by the locale (here a collegiate team). Thus humour in these circumstances is like a kind of 'play time' (Bateson 1955). Instead of humorous interactions within teams indicating the management of the professional dominance of doctors, I suggest that the main intentions of making a joke in CMHTs (as much as anywhere else) are to raise a laugh (Gomm and Ormrod 1998).

Finally, it is worth noting the reason for this extended discussion on team humour here. This is to do with addressing a literature that makes much of a notion of 'hidden power'. Griffiths and Goldberg stand as examples here of writers who assume that somewhere hidden beneath superficially convivial and egalitarian situations there is

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Finally, it is worth noting the reason for this extended discussion on team humour here. This is to do with addressing a literature that makes much of a notion of 'hidden power'. Griffiths and Goldberg stand as examples here of writers who assume that somewhere hidden beneath superficially convivial and egalitarian situations there is

some 'real' power. The idea of hidden power constitutes a dire analytic problem: for, if power is hidden, how shall we know about it? On the face of it, my data, Griffiths' data, and Goldberg's data do not show clear evidence of psychiatric dominance. But Griffiths and Goldberg both impute power differentials as between psychiatrists and others, and both take the presence of humorous interchanges as evidence for this. Indeed, both take humorous interchanges as at one and the same time evidence of such power disparities and as evidence of how such power disparities are hidden from view. At this point they part company however, since for Griffiths humour is evidence of covert attempts to subvert power relations, while for Goldberg humour is evidence of the skilful way superiors have of manipulating their subordinates without the latter noticing; and note, both are appealing as evidence to jokes which sound very similar. As a way of evidencing hidden power this approach seems to have little to commend it if much the same evidence can lead to radically different conclusions.

I have taken a different line. If there seems to be little evidence of psychiatric dominance on the surface of these situations, then perhaps that is how things are. This relates closely to my use of the idea of ceremonial order. Earlier I referred to the *primus inter pares* 'working consensus' of teams as a fiction: the fiction the ceremonial order of team meetings is designed to uphold. However, referring to this as a fiction does not make it any less real. It is true that, for some sets of participants, equality in these meetings was not matched by equality in other circumstances. For example in the hospital some of the same participants were related together in hierarchical consultant 'firms', and for others, in other circumstances, line management and appraiser-appraisee relationships were salient. Nonetheless, these team meetings transacted real business with real consequences, and the medium through which they did this was this ceremonial order, which constrained everyone on the occasions when it was in play. It

would be a mistake to regard this as some kind of fictional veneer hiding something more real beneath it, for while they do not feature largely in this thesis, consultant firms and line management relations have their own ceremonial orders which reproduce other fictions. It would be odd to argue that a dictatorial performance of a psychiatrist on a ward round was a thin veneer hiding the more egalitarian relations shown in the sector team, and that the latter were more real. And it should seem equally odd to regard the consultant's firm as showing a reality which is hidden out of sight in the sector team. They are simply different situations.

9.3 Nominating a profession : occasioning occupational identities

As the above discussion indicates, so far there does not seem to be strong evidence for strategic interaction within team meetings which can be seen as competitive struggle between groups formed as professional alliances. Where such an interaction might be seen is when a particular profession is nominated for a case. This more directive method for disposing of referrals is far less common than unaddressed reports and self nominations. Mostly when it did occur, no debate was raised. For instance, when the referral was a patient who had applied for a mental health tribunal to contest a section then an ASW report would be required by law for this process.

However, part of the backstage complaints from the social workers as a group *vis a vis* the rest of the team was that social work was not properly understood and they were just seen as useful for cases where there were problems with housing or benefits. What is interesting about this, however, is that, in practice, cases were not presented and discussed in such crude terms during team meetings. Moreover, sometimes when social workers did self-nominate they would play that script themselves and indicate it was appropriate for them because of accommodation needs (see for instance Example 1 in chapter 8). During interviews subjects found it difficult to say what the distinctions

were between, say, themselves as social workers and other colleagues such as CPNs and *vice versa*. Indeed at such questions many would start out trying to say what these were and finish by acknowledging that apart from some statutory duties with respect to sections and tribunals for ASWs there was much overlap between team members in their everyday work with patients. (If there really were a large measure of inter-professional competition, then, irrespective of the realities of working practice, one would expect to find an accentuation of differences in the way professionals told their occupation to a third party).

This picture of a more generic approach within the team was supported by exchanges in meetings such as the one below which turned on the way the hospital social work manager intervened and (re)directed the nomination:

EXAMPLE 15

Team A weekly meeting 14/5/96

Discussion of patient raised by one of the CPs. Notes area she now resides. Interesting case of juvenile Parkinson's disease. Was living very independently until recently when returned to live with parents. Patient now got extreme grief problems since father's death a few months ago, with panic attacks and eating disorder. Patient now very thin and tremor getting worse. Feels this patient needs a home assessment.

TM: How much is this neurological and how much psychiatric?

CP: It's both. There's a mixture of anxiety and panic attacks which has made the Parkinson's worse.

CP then goes on to say she thinks a home assessment is required because she thinks the mother may be the key to the panic attacks. The patient also needs one to one anxiety management work. The GP feels this is too complex for the practice counsellor and she agrees with this view.

SW1 [hospital based SW] nominates himself.

But TM then wonders whether this might be one for SW2 [he is the district social worker for the area where the patient resides]. TM then asks what the boundaries are here [not clear to me if he means geographical or therapeutic or both].

SWM comes in on the back of this to ask SW2 if he's got training in anxiety management.

SW2: Yeah [curtly].

SWM: I thought you might but I didn't know.

SW2: I'm surprised [name of his practice supervisor] hasn't passed this on to you already [SW2 joined the team a few weeks earlier]. [All this is said very tersely and he looks most displeased]

CP: Yeah, I don't know [responding to TM's earlier question].

TM then suggests that the senior registrar get involved with SW2. It's agreed.

The exchange above suggests that SW2 was irked by the hospital social work manager's question because, although a relatively new member of the team, he was a mental health social worker of some years experience. The question was not whether social workers could do anxiety management, a task which CPNs often did, but whether this particular individual was competent. Two things seemed to be happening when the SWM posed her question to SW2. First she was indirectly nominating him, though she was not this member's line manager, and though she was not his line manager, the suggestion might well be seen to carry more authority and be more difficult to resist given her membership of social services management. Individual nomination is always a source of tension, as the discussion above has shown, and here it was done via a tactic where SW2 was forced to confirm his competence but by so doing make it difficult to avoid his nomination to the case. The case being one which is suitable for social workers is indicated first when the CP identifies the issues as connected with the family and home environment and this is reinforced when SW1 (a hospital based social worker) suggests that he himself might take the case (self-nomination). It is only then that the team manager (a CPN) intervenes to wonder if the team social worker from the district involved could take it on. This is done tentatively with the question about boundaries leaving the way open to decline. But the debate here is not about which profession has claims to particular kinds of work: rather 'boundaries' is a resource that can be used to accept or decline a case. Notably, responsibility for the case is made a joint one between a social worker and doctor, not because of competitive claims to expertise for this case between professionals, but in order to ameliorate a more directive

allocation being made on this occasion. Such trouble as there is seems to turn upon the rather manipulative exploitation of the voluntarist aspect of team meetings, rather than this being an opportunity to assert a claim for social workers as a professional group in terms of a particular competence to do anxiety management. Although there was some tangible tension in the air, the whole interchange can be read as a cooperative attempt to find the most suitable worker for the patient concerned.

When such nominations did on rare occasions generate discussion then it was not clear that it was particularly an opportunity to register the rights of one occupation *vis a vis* others in the team, so much as an opportunity to defend the nature of the team as collective and voluntarist in nature. See the examples (16 & 17) below:

EXAMPLE 16

Team A weekly meeting 17/6/96

Ward manager presents a patient currently being handled by a consultant from another team covering for absent CP from Team A. Patient is being keyworked by one of the district social workers. She notes that the consultant has requested a CPN as keyworker.

TM queries why CPN as KW now?

WM says because the CP now thinks the patient should be on the supervison register due to fears over risks she poses (she stabbed her husband).

TM: I'm not sure that a CPN is able to do more than a SW.

SWM: No, I'm not either.

WM: Well all I know is that the notes say we need a 'KW with medical knowledge'.

Discussion then follows about a CPN being able to deal with medication issues. TM asks about the level of dangerousness. WM explains the patient is delusional and has assaulted her husband, although he now knows how to access the services in an emergency.

Discussion left at that. Case remains as currently allocated.

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Discussion left at that. Case remains as currently allocated.

Two weeks later the case is presented again:

EXAMPLE 17

Team A weekly meeting 1/7/96

This meeting is chaired by one of the team CPNs as the team manager is away. The Ward manager first presents this case in the ward reports introducing it as left over from a previous meeting

CPN chair notes that this patient has currently got an ASW as KW [name noted] but now needs a CPN.

SWM queries this.

CPN chair repeats adding this time that [CP name] is behind the request.

SWM again queries.

CPN chair says there are issues around medication and [CP name] wants a CPN so this can be monitored more closely.

SWM again challenges this saying a social worker can also monitor medication.

WM: The medication needs monitoring and also because their behaviour was so dangerous on admission.

And then specifically on SWM's query the WM says the patient needs to be on the supervision register. WM then goes on to say she's unsure about the reasoning but perhaps it is because [name of district SW] is a district social worker and [name of CP] feels they need close contact.

WM: But I don't know exactly why - but it's not a reflection upon [name of district SW]'s practice.

CPN chair suggests they keep an eye on this and notes that [name of ward's outreach nurse] is covering meantime alongside [name of district SW].

WM says they need an unmet need form.

CPN chair asks [name of outreach nurse] to do an unmet need form.

Jokes then follow among the discussants about what it looks like and what to put on it

At first sight, the above example might well appear to be the one instance, in all the data gathered by myself, demonstrating interactional trouble arising from competitive struggle between different kinds of professionals. Yet the first discussion on this case generated similar responses from both the team manager (a CPN) and the social work manager, indeed they were in agreement that the request was not reasonable and ignored it. It was a request made by a doctor who was not a regular member of the team and was not present at either discussion. When the case was revisited in the team manger's absence the staff followed a similar exchange where they tried to suggest possible reasons for the consultant's request but admitted there was no particular logic for it. The ward manager was perhaps in the position organisationally of feeling more

directly answerable to the consultant and likely to be pressured by him for action in line with his request. This may explain why the WM seems to advocate the CP's demand. Eventually the team dismiss the request by using the tactic that there is no available CPN, hence the use of an unmet need form. This is a response that allows the staff to refuse the consultant's request but does not challenge his judgement directly. Thus, debate is not structured around the protection of professional expertise as such: rather it seems a response to defend the voluntarist nature of the disposal of patients by the team acting as a collective against what seems like a directive. In this case the directive is from a CP, but one can imagine a similar response to directives coming from any source.

In sum, the occasioning of occupational identities was not in itself a source of trouble for the team. The trouble that came about in connection with interactions 'dressed this way' turned either on attempts to make individual nominations or to ignore the collectiveness of the team. Where discipline-based expertise was invoked it tended not to be done in any kind of exclusionary way. With the limited exception of certain statutory requirements (e.g. ASWs must undertake reports for mental health tribunals, assessments under the MHA must include both an ASW and a doctor, prescribing is the prerogative of doctors), most tasks seemed potentially within the remit of any team member. In this sense, I would agree with Prior that the broad array of psychiatric practices that now characterises modern psychiatry means professional roles have become "decomposed" (Prior 1993, p78). However, Prior also argues that such decomposition leads in "many psychiatric settings [to] members of professional groupings ... seeking lines of demarcation" (p79). Data from the Westway teams suggests that such decomposition of roles in an MDT setting did not produce any such search: 'decomposition' was only perceived to be a problem in theory (e.g. during

interviews when participants were specifically asked to reflect on such matters), not in practice (observation of teamwork).

9.4 Inter-agency arrangements

The occasions where interactional trouble between different professional members of the team did figure prominently turned on relationships between the two agencies of health and social services.

EXAMPLE 18

Team A weekly meeting 22/7/96

The ward manager runs through the ward reports and there are several requiring allocation of a KW. The team manager then starts to go through the community referrals and presents the first one. He interrupts himself wondering what to do/who from list to deal with.

CP: What we need to know is who is available.

*TM notes it's going to be very difficult to do any allocating as coming into the six week summer period when most staff holidays.
There then follows a discussion about social services.*

CP: How do I access social services if I've got an out-patient who needs social work help?

TM replies that's a policy issue for the SMG [sector management group] to address.

CP says that neither she nor her secretary has been able to access the appropriate district

CP: How do we know which district to approach and who to contact?

CP goes on to say she picks up the medical assistance required for anyone, but does not feel this works in reverse from social services.

SHO [indicating with her glances to some of the social workers around the table]: I just go up to the social work office and chat to one of you there.

CP however feels this is a "global problem".

CP: How do we each individually in the team access social services - is this via social workers on the sector team [i.e. hospital based ones] or should we ring the district direct?

TM: We need to nurture links with ASWs at district level.

CP: I'm used to teams where the team social workers do that for us.

SW [hospital based]: As we don't have authority over the districts it is a problem, and if the district say no then you're left with the responsibility for finding someone.

CP: But it is not cost-effective for me to chase this up and I'm more ignorant about social services than yourselves.

SW: There should be an agreement with the districts for their regular representation at these meetings.

WM: But there's also the added problem that we get referrals via GP districts. [Meaning that they had to traverse a number of different social services district teams as these did not coincide with GP practice areas].

CP: I appreciate your concern, [name of SW], but I'm left with it completely as it is, so it would be nice if we could have a look at that.

There were numerous occasions in team meetings where the problem with allocation would be construed in terms of there not being the relevant district social worker present at the meeting. This was heightened in Team A which had to cover four different LASSDs in contrast to just one in Team B:

EXAMPLE 19

Team A 11/11/96

TM raises a patient currently on the ward with an eating disorder.

CP & NBT both indicate that she should be put in touch with the Eating Disorders Association and kept on the ward.

NBT: Theoretically its minimal keyworking.

TM [to CCW] [SS District 1] – that yours?

SW1: It's difficult to assess the eating disorder because the patient described herself as a compulsive liar.

TM: Anyone?

SW1: No [smiling]

TM: So I'll just have to go back to PAS and say we can't take.

TM then notes the lack of CPNs available in the team.

CP reminds him that there are social workers too.

CPN1: On that subject – I need one.

TM notes there are also 3 referrals which are [SS District 2] but [SW2] not here today. Asks if anyone else got ideas?

CPN2 notes that 3 of the women have similar difficulties – low self-esteem and relationship problems.

CP notes that often when a patient is first assessed it helps diffuse the crisis and so possibly they just need one-offs, advice to send them on (e.g. to women's groups). ...

CCW wonders about the possibility of the Day Service women's group for some/all of these women.

TM reckons there's a problem of funding with that.

CPN2: [carefully] I could see all 4 in the next couple of weeks but I want to be quite clear what that means for me in terms of caseload.

TM: Three are [SS District 2].

SSM [SS practice supervisor not district manager]: Well as [SW2] is not here today, shall I say I think I can help.

CPN2: I'm not happy with that as [SW2] is not here. It really needs a woman colleague here now to agree to do it with me.

CPN3 then volunteers to assist via checking with CPN4 that she can be let off their joint clinic session on the afternoon CPN2 suggests to do the work. It's agreed that CPNs 2 & 3 will take 3 of the women identified.

There was great tension in Team A meetings around all referrals because of the perception of overload and reports were frequently met with uncomfortable silences, i.e. 'no takers'. As it was most unusual for allocation to be made to a member in their absence (the couple of times it occurred was conditionally by a worker's line manager present), it is not surprising that non attendance at team meetings was much resented by those present. District social workers were line managed by staff outside the sector team and the organisation itself, and had responsibility for work within their own social services teams in addition to duties for the Trust sector team. Thus CMHTs were not necessarily a priority for district social workers and, once present at the weekly meetings, there was pressure upon them to take on work if the patient resided within their district. Such circumstances meant that the problem of allocation was often located with inter agency organisational arrangements.

The problem of multiple agencies operating without a single point of line management to provide one seamless service yielded instances of the most extreme trouble:

EXAMPLE 20

Team A 9/12/96

TM runs through the referrals. First one on the list has come from PAS [emergency arm of the Trust's service]. Patient has a child who resulted from rape. She is at risk still of violence. There are now behavioural problems with the child and the patient wishes to separate from her child. She has attempted suicide and is now in a very withdrawn state. The initial assessment at PAS by a social services member has indicated the need for a female KW. There is a high risk of admission to the ward if the patient is not picked up soon by a regular KW. The PAS SS worker has got involved and referred the patient to the women's refuge.

SWM: That work is now done and that's the limit of [PAS SS worker]'s role.

TM makes a case for a social services KW given the child care issues. He suggests that the existing PAS worker continues for now given the urgency and that some rapport and trust has been established in what is a difficult case.

SWM resists this strongly. He goes on to clarify that this worker was bridging the gap between possible hospital admission and the sector team. Moreover this worker is a junior staff member, not an ASW, and this disqualifies her from keyworking, besides which her brief is for PAS, which only engages in short-term interventions. This patient now needs a proper KW to avoid admission. Furthermore, the hospital social services staff are very hard-pressed just now. Although he accepts this patient has pressing needs for service, he does not accept it must be picked up by social services staff. TM gets very annoyed with the SWM at this point.

TM: Why are you taking this line? I'll discuss it with you later!

SWM: [very firmly] I don't intend to argue.

TM then notes the very full caseloads also of the CPNs in the team. Both TM and SWM then wonder about the availability of district SWs (3 of whom are female), but acknowledge that it would depend on which part of the sector the patient resided, and whether this would square with space on caseload anyhow, and the agreement of their district social services team manager [No district SW staff are present at the meeting].

SW [male and hospital based] offers to take the case, which is accepted.

The case is presented in terms that mark it out as both serious and urgent.

Outright hostility was expressed between two senior members of the team representing health and social services respectively in the bid to allocate the patient. At first sight, this might appear to be a problem of multi-disciplinarity, of occasioning occupational identities in a way which was territorially offensive, with the Team Manager (a CPN

and health representative) attempting to define the case as rightfully 'one for social services', thus treading on the toes of the social work manager. Yet on closer inspection this reads more as a case of organisational arrangements between agencies impeding cooperative working.

The source of the trouble is framed by the usual practice of blurring the assessment and KW role. As we have seen in the preceding discussion, whoever currently holds responsibility tends to get stuck with it. Here it started out with a social services member. The identification of childcare issues would often indicate such a case a candidate for social services involvement. However, the complicating factor is that the referral was first accepted by a social services agent in another part of the service (PAS, the emergency service), not the CMHT. Thus the Team Manager, in an extension of the working consensus, made a play for this initial agency designation to continue. Moreover, again as in the preceding discussion, negotiations over allocation were cast against concerns of inadequate resources and rising caseloads. All this was played out among different parts of the overall service, made up of both health and social services. And no one had the right in this kind of organisational arrangement to order anyone else about. Interestingly, the trouble was finally resolved by one of the hospital social workers (SW1) volunteering to take the case, a self-nomination which undercut the SWM's resistance to any of the SW staff taking it³⁷.

Perhaps a problem in the literature on MDTs is a tendency to conflate multi-disciplinarity and multi-agency. Yet the material discussed in Part 3 indicates that they are importantly distinct. The complex of multiple line management arrangements,

³⁷ SWM was a practice supervisor with regard to some of the social workers present but not their line manager.

representing both the different agencies involved and different arrangements within agencies, meant allocating patients across the various fault lines did result in eruptions. It was at the meeting point of the different agencies involved that the constraints that framed the working consensus were most tested.

9.5 Team trouble

In sum, interactional trouble ensued from four sources, though with varying degrees of significance. First, there was the trouble connected with weak chairing of meetings (most notably in Team A), unaddressed requests, and the preference for self nomination over nomination of others. Here, it was the failure to adequately manage interactions between members (e.g. to foreclose on interruptions and ensure closings on topics), or it was the strength of the 'working consensus' that reduced the possibilities for direct line management within this team setting, which meant that cases were not allocated and so remained pending. Second, there was consideration of the formulation of professional dominance, with particular regard to the presumed authority of psychiatrists. This was a much less significant source of trouble for the teams, with only rare instances of psychiatrists formulating themselves in such terms *vis a vis* their colleagues, and these were not usually successful given the working consensus of egalitarianism. Third, was the occasioning of occupational identities. Here there was little evidence of competitive struggle between groups as professional alliances. However, the implication of an individual nomination, underlying some of these citations of a specific discipline as suitable for a particular case, did sometimes produce trouble: but not often. Finally, trouble arose from the team's organisational location at the intersection of a number of different agencies (e.g. wards, district social work teams, PAS). As I have illustrated, the team behaved as if the cooperation of these agencies was necessary for the disposal of cases, yet often there were no representatives of these agencies present, and even if there were such representatives, they behaved as if they were not in a position to

commit others of their agency to take on a case. I have no doubt that had they tried to do that, this would have caused them problems with their colleagues and managements elsewhere.

As indicated at the start of this chapter, these instances of trouble have helped elaborate on the taken-for-granted routines for disposing of the work in the Westway teams. This builds on the discussion in chapter 8 to demonstrate the working consensus of *primus inter pares* and the consequences that flowed from this in terms of accomplishing the organisation of mental health care. One such consequence was a situation of much uncertainty over the disposal of cases referred, especially in team A. The organisation described lacked the kind of coordination which would lead to authorised decisions against which future conduct could be readily held to account.

Chapter 10: Conclusion to Part 3

10.1 Hearable constraints

The discussion of data from team meetings in chapters 8 and 9 draws attention to what we might call ‘hearable constraints’ upon the allocations of cases to team members or to others without the team. What I mean by ‘hearable constraints’ is the citation of Bittner’s organisational rubrics (1965) by members as impediments to some courses of action, or as warrants for other courses of action. In citing such constraints members thereby created a constraining organisation.

There are no formally articulated rules for these meetings, no constitution as such, but there is a sense of due process in the meetings. This shows itself in the strong similarities as between meetings and some of this similarity in turn arises from members citing much the same kinds of constraint over and over again. In this sense the most hearable kinds of constraint in the determination of allocations are:

- ◆ Circumstantial/Procedural matters (‘rules-in-use’) – whereby members invoke caseload size, presence/absence at the meeting, geographical boundaries, lack of agreements between the Trust and LASSD about deployments of district social work staff, and the nature of the patient as one who can be worked with/is suitable for the team (this last item will be elaborated in Part Four), all as grounds for/against allocation.
- ◆ Ceremonial matters (ritual) – whereby members interact in the spirit of professional respect between team members, acknowledge each individual member’s sphere of autonomy, are cautious about nominations of others, and observe an ideal of egalitarianism, invoking an organisational order (at team level) of *primus inter pares*.

Together these constraints demarcate the working consensus for the Westway team members. They indicate how members engage with each other and the kinds of colleague relationships permitted. Thus, these kinds of hearable constraints indicate the 'role formats' (see discussion of Strong and Davis in chapter 7) that team members used in negotiating each other in the business of KW allocation. It is important to note that the 'use' of such formats is probably best described as a matter of unreflecting routine rather than self-conscious strategy (Strong *et al.*, 1977, p791).

As Goffman notes (1959) (and cited in Strong *et al.*, 1977) situations are created as much by what is excluded as by what is included. And this notion underpins the idea of a role format. Thus in writing about 'hearable constraints' one is equally drawing attention to the kinds of things which are not said, and which if they were said would not serve as justifications for decisions and might be regarded as objectionable. The important exclusions include professionally chauvinistic talk, anything that might be heard as someone issuing orders, and any talk implicating that someone present is not pulling their weight, or is incompetent. Whichever role format is in play, what is hearable represents the team as a group of co-equals, of unquestionable competence and motivation, but all beset by the same array of organisational constraints.

These, then, are the conditions of team working in Westway. Rather than treat this as a process of adhering to rules, it is more accurate to think of team members making out their activities as consistent with the spirit of a framework which might be deemed to put them in jeopardy. Should things 'go wrong', and a patient either seriously harms themselves and/or someone else, then team members need to be able to account for their actions. In such situations members need to be able to elaborate on the distribution and nature of responsibilities and how these were determined. Looking at

team meetings in Westway we see attempts to accomplish a kind of ‘constitutionality’ of MDT working.

10.2 Multi-disciplinarity: symptom or cause of problems in team working?

In the absence of substantive management within the sector teams, or organisational agreements between agencies represented in the teams, much of the daily business of mental health care was left to the cooperativeness of team members. This begins to explain why the conduct of team meetings and disposal of patients was handled on a largely individualised basis, rather than constituted in terms of professional disciplines or occupational groups. Trouble in the accomplishment of this work was not found to be the result of multi-disciplinarity per se, but of multi-agency arrangements. Trouble for teams has been shown to result from a lack of sufficiently authorised personnel and procedure. Multi-disciplinarity, and it being a problem, featured in Westway sector team working in terms of there being more than one agency, health and social services, involved in mental health care within the teams.

While in practice team meetings did not construct the difficulties of team working in terms of the differences between members as members of different professions, this script did exist at an abstract level for members outside of meetings when reflecting upon and trying to address the problems and tensions experienced within the meetings. Perhaps we can understand these abstract scripts as part of the folklore of what the problem is with MDT team meetings i.e. different professions misunderstanding each other. In this sense multi-disciplinarity served as a resource through which team members expressed their difficulties with the organisational process of disposing of referrals among the team.

In Westway sector teams there was a notable absence of the doing of professional solidarity, or structured mutual incomprehension between different

professionals. Thus, ‘the problem of multi-disciplinarity’ seems to be a symptom rather than a cause of the difficulties of team working.

10.3 Interpreting organisation through the culture of teamwork

The orienting research question to help address the organisation of mental health care for Part Three was ‘how is the work of the team defined and responsibilities determined among multi-disciplinary and multi-agency members?’. In addition, a related question was considered: ‘what are the consequences of such tasking processes for professional identities?’. These questions have been approached through examination of the sense-making processes in the Westway teams. In other words, Part Three has examined how team members produce a negotiated order, one where they define their work and their roles through the everyday interaction of the team meeting as *primus inter pares*. In examining such matters the focus of Part Three has been upon the organisational culture of mental health care as it is produced in teamwork.

The kind of organisational perspective adopted here is one that aligns with the interpretative and processual ethnographic approach outlined in Part One. This is a perspective whose focus is ‘organising’, as opposed to organisations as entities.

For Weick sense-making is the fundamental process in organised social life (1979; 1995). It points up the (inter)subjective origin of organisations and the social construction of reality. ‘Sense-making’ refers to the creation of reality as an ongoing accomplishment that takes form when people make sense of their situations – asking questions, providing answers, defining, agreeing/disagreeing, etc. It is this activity which produces ‘the organisation’. ‘Organisation’ emerges from everyday interaction between members that creates constraining and guiding subjective realities. So people in organisations do not so much respond to their environment and thereby produce a strategy for action. Instead they act and thereby create their environment.

Earlier in Part Three I drew upon theories of organisation emerging from studies within interactionism. Weick notes that people who talk about sense-making often invoke the imagery of interactionism because it is a theory which “keeps in play a crucial set of elements, including self, action, interaction, interpretation, meaning and joint action” (Weick 1995, p41). These elements are key to determining sense-making. In particular, it is an approach that examines talk because that is how a good deal of social contact is mediated. In the case of CMHTs we see that members ‘talk the work’ as a matter of course.

The focus in this approach is upon the patterns that emerge out of interactional processes in which members are routinely involved. ‘Structures’ that might thus be discerned, such as ‘organisation’, are not imposed on members but constructed by them. Hence ‘organisation’ is articulated here in rather more active terms than those advanced in Part Two.

This approach to organisation provides workable tools for understanding what is happening in mental health care work today. Indeed Onyett suggests that it is the extremely challenging nature of the organisation of CMHT work in terms of its fluid and negotiated membership qualities which underlies why it has received such scant research attention (1997). He argues for studies to be conducted which focus precisely on the work of such teams in terms of the processes by which the meaning of particular projects is negotiated among interdependent actors, and commitments to action are achieved. This has been the project of Part Three. Rather than examine teams as entities in terms of a structural definition of organisation or the people who work in them, a social constructivist approach is favoured, which attends to organisation as fundamentally processual.

This kind of sense-making provides a different view to that advanced in Part Two on the organisational features that enable authorised care, or not. As noted in Part One, by authorised care I mean a situation in which people are clearly committed to a set of rights and obligations defining who should be doing what with regard to whom. Here, the concept of authorisation in its relational sense has been explored. The focus has been on the kinds of rights and obligations, expectations and commitments that exist among team members as defined by the *primus inter pares* working consensus of the weekly team meetings where patient referrals are decided upon.

The *primus inter pares* assumption in the context of the team meetings means both that there is no hierarchy sufficient to mandate superiors to order subordinates (though some of this happens outside of team meeting contexts), and peers cannot pressurise each other into accepting binding commitments. The processes I have described in Part Three do not create any strongly binding and lasting commitments about who should do what to whom.

The corollary of rights, obligations and commitments around these, are sanctions to uphold them. This is a way of thinking about the moral tale indicated in Part One around the themes of responsibility and accountability. Sanctions around organisational roles, such as mental health care work, which might be expected to have high levels of accountability may be thought of in terms of an 'accountability structure' (as advanced by Shakespeare and Gomm) with the following kinds of characteristics:

- ◆ Explicit rules and protocols about how the role should be played. These might be written down in a job description, in a contract and/or included in codes of conduct. Role requirements might be specified in terms of tasks, performance targets or statements of outcomes.

- ◆ Systems for making performance or outcomes observable. This might include surveillance and supervision, and/or reports on activity.
- ◆ Penalties and sanctions against inadequate performance. There might also be rewards for excellent performance.
- ◆ Mechanisms for bringing someone to account. Examples include supervision and appraisal, annual reports on performance, and complaints and disciplinary procedures – all with their own special sets of roles and accountable in their own ways.

(Shakespeare and Gomm 1996. p64)

Yet in the Westway teams members did not move beyond first base in the accountability stakes since it was always rather indeterminate as to what they were committed to do. While all the above kinds of ‘accountability structures’ existed in Westway, their applicability was uncertain, because it was not clear precisely what the commitment was for each member at team level.

When I started out I had thought that the moral themes of responsibility and accountability would flow throughout the thesis as orienting themes. Yet by the end of Part Three it is clear that they are not prominent aspects of the way in which team members work. What the ‘accountability structure’ above indicates is a set of mechanisms to assess against defined responsibilities and situations. Accountability can only be worked out with regard to ‘the facts of the matter’, some fixing of how things are with regard to responsibilities (roles) and circumstances. Yet in Westway, team members did not operate with any such firm definitions around either their roles or the circumstances. And responsibilities, and thus accountabilities, remained ambiguous, somewhat secondary, matters.

Overall the discussion in chapters 8 and 9 point up a situation which lacks the kind of coordination which would lead to authorised decisions against which future conduct could be held to account. In Part Three, the process of ‘authorisation’ (what counts as authorised care) has been considered at a micro level in terms of interaction within teams. The kind of interactions which occurred in the Westway teams demonstrate the limits on achieving authorised care in the manner envisaged by the CPA.

Given the degree of indeterminacy that defines the allocation of work at team level, a further question is raised about how the object of such work, namely the patients, are construed. Part Four moves on to consider this aspect in the organisation of mental health care work, explicitly addressing the question of how members come to agree on patients, and thus as work to be accepted by the team, and how patients are thereby given an organisational personality.

PART FOUR: Patienthood

Chapter 11: Part Four Introduction

Part Four considers mental health care organisation in terms of patient characterisation (which informs the disposal of referrals considered in Part Three). It looks at the same kind of material as covered in Part Three but through a slightly different lens. It is located in terms of the sociology of deviancy literature, in particular the labelling thesis. As with Part Three, the ideas utilised here are informed by elements from both interactionism, with its attention to organisational routines and negotiated orders, and ethnomethodology, with its attention to the accomplishments of linguistic exchange.

In the literature on mental health what I call 'characterisation' is more often referred to as 'labelling'. But the term labelling is associated with ideas about the lives of some people being determined to a very large degree by the ways other people characterise them. This presumes some kind of authorised process, which allows that to happen: whether authorisation is via authoritative action within a hierarchy, or via processes creating strong consensus among equals. A label having the effects that are often ascribed to labelling is, of course, an authorised version. Here, this idea is put to use to continue the theme of the previous two Parts - consideration of the kind of organisational conditions necessary for authorised versions of care to prevail, or not.

Chapter 12 is an analysis of some cross-sections of the careers of several psychiatric patients raised at the weekly team meetings. This is the 'flip-side' to the two empirical chapters on teamwork in Part Three, and indeed some of the same examples are drawn upon in order to highlight the inextricable dual and complementary work going on here – allocation of referrals/disposal of patients (Part Three) and characterisation of patients as suitable tasks (or not) for the team (Part Four). Chapter 12 then relates patient characterisation to the strategic moves described in earlier chapters.

In chapter 13 the analysis is pursued via the story of (part of) the career of one patient. This chapter moves beyond the bounds of the weekly team meetings, to include ward round and other meetings concerned with defining the patient and thereby attempting to determine courses of action and responsibilities therein. Rather than suggesting that a strategic rationale is a complete explanation, patient characterisations are considered to be examples of problem-solving talk amidst uncertainty.

These analyses allow for a critique of the labelling thesis that examines some underlying assumptions about the kind of organisation that this thesis presumes.

11.1 Illness as social construction and moral evaluation: from the 'sick role' to labelling theory

Part One referred to Parsons' conceptualisation of illness as a social category with a clear moral dimension (Parsons 1951). His analysis of the components of sickness suggested that it was a form of social deviance. The notion of the 'sick role' through which relationships between the sick and non-sick are redefined in terms of respective rights and obligations, allowed for such deviance to be legitimated and controlled. I argued that this designation was heightened with regard to mental illness where such rights and obligations are reconfigured with regard to notions of diminished responsibilities on the part of patients and increased responsibilities of the part of mental health professionals.

The sick role as a mechanism for social legitimation and control where the aim is to return sick people to conventional social roles or otherwise contain them, anticipated the deviancy model of mental illness that figured in sociology of the 1960s and 1970s (Prior 1993, p139; Turner 1987, p39). This model of mental illness has taken slightly different turns in various contributions, with some treating labelling as aetiological, others more broadly geared to revealing the stigmatising consequences of

labelling, and yet others focused upon stereotyping in terms of 'normal patient-hood' with regard to mental illness (Goffman 1961; Lemert 1951; Scheff 1966). What many of these various contributions do share is a background within symbolic interactionism (Bowers 1998; Pilgrim *et al.*, 1993; Samson 1987).

Generally the symbolic interactionists were interested in the reciprocal effects between the psyche and society in producing the 'self' (Samson 1987). In particular there was an interest in the roles people took up and the meanings they exchanged with others in taking up such roles. Those who were deemed to not act appropriately for their role and/or to have broken some social rule of conduct were seen to be deviant, and labelled (and dealt with) accordingly. Lemert is an important source for this thinking (Lemert 1951). In the classic formulation of this thesis, he postulated three components to labelling: i) primary deviance – the initial infringement; ii) social reaction to this infringement; and iii) secondary deviance – the response of the deviant to social reaction. Bowers (1998, p8) unpacks this formulation with an example in terms of criminal activity, viz: i) robbing a bank; ii) the arrest, conviction and imprisonment of the bank robber; and iii) the bank robber identifies with other bank robbers and prisoners and embarks upon a criminal career thus confirming the expectations of custodians about recidivism.

With respect to mental illness, this kind of thinking was used to consider when people become 'mad'. But as Gove argues, labelling theorists attached little significance to primary deviance, except insofar as others react to the primary act (Gove 1980). In this approach deviance did not exist as a quality of an act but was the product of interaction between the 'deviant' and 'reactors' (Becker 1963, p9). As Lemert himself noted, the interest for labelling theorists was in secondary rather than primary deviance:

Primary deviation is assumed to arise in a wide variety of social, cultural, and psychological contexts, and at best has only marginal implication for the psychic structure of the individual; it does not lead to symbolic reorganisation at the level of self-regarding attitudes and social roles. Secondary deviation is deviant behaviour or social roles based upon it, which becomes a means of defense, attack or adaptation to the overt and covert problems created by the social reaction to primary deviation. (Lemert 1967, p17)

Thus, sometimes this way of explaining mental illness is described as the ‘social reaction’ perspective (Gove 1980; Pilgrim *et al.*, 1993). Scheff was a key early source for this kind of thinking with regard to mental illness (Scheff 1966). In a theoretically-based paper, he argued that what is regarded as mental illness is actually a form of residual deviance that is publicly labelled – rule-breaking behaviour that could not otherwise be categorised (say, as criminal). Such rule violations (as ‘residual’) are a matter of contextual relevance as other interactionists have demonstrated (Goffman 1972; Rosenhan 1973).

In his famous ethnographic work, *Asylums*, Goffman located mental illness within the social context of the hospital. Institutional conditions affected the orientation of the inmates and the perception of mental illness, such that the mental hospital (in common with prisons, monasteries, and barracks, say) was a ‘total institution’ (Goffman 1961). Thus ways of relating, being and reacting in the asylum were locally interpreted within a mental illness label or framework. Moreover, being subject to this kind of reasoning was found hard to escape. Thus Goffman’s idea of ‘looping’ refers to the process whereby any kind of behaviour by a psychiatric patient was interpreted as symptomatic of mental illness (so, for example, both acceptance or rejection of mental illness, or insight and lack of insight by a patient regarding their mental illness diagnosis could be taken as further evidence of their illness). This links with Rosenhan’s notion of both the arbitrariness and ‘stickiness’ of mental illness labels (Rosenhan 1973). This derived from a study which concluded that psychiatric staff in several hospitals were unable to discern between sanity and insanity in an experiment where several

'pseudopatients' presented themselves and were admitted to hospital. Initially claiming to hear voices, the 'pseudopatients' immediately ceased fabricating psychiatric symptoms following admission. However, most were given mental illness diagnoses (of schizophrenia) and when discharged described as 'in remission'. Rosenhan argued that the 'normal' behaviour of the 'pseudopatients' was reinterpreted by staff as mental illness behaviour. Thus, the argument advanced by Rosenhan - once applied, mental illness labels are difficult to shift and all kinds of behaviour can be interpreted to fit such a framework.

To some extent studies of the attribution of a mental illness label were also informed by ethnomethodology. This approach emphasised the role of language, ascriptive practices, where the kinds of reasonings and logic used were treated as constitutive of a mental illness label. Coulter (1973) and Smith (1978) are classic examples of such work. Another classic, which arguably prefigures such understandings, is Scheff's paper (1965) on 'typification' in the diagnostic practices of rehabilitation agencies. This picked up on ethnomethodological thinking via the notion of what counted as a 'normal case' or 'patient/client stereotypes' as a means to understand the process of recognition of problems/illness and decisions for support/treatment provided by public agencies.

Scheff's analysis was informed by Sudnow's work published in 1965 on 'normal crimes' (1973). Sudnow described how the judicial system came to associate particular kinds of criminal offences with typified knowledge regarding the behaviour and characteristics of those associated with those offences. His argument was that plea bargaining depended on the perception of the offence as a 'normal crime' -- meaning that the crime did not differ markedly from others typically of its kind and so invited a standard response. For Scheff, 'normal crimes' became 'normal cases'. Here the idea

was that patients are identified in terms of ‘conceptual packages’ that define the essential features of the case and help determine the treatment process. He emphasised the tightness of this conceptual work by the phrase ‘diagnostic stereotypes’.

Scheff’s paper was not the result of empirical study and his ideas were presented as hypotheses for further research. In it he proposed a continuum for understanding health care organisations. In some, patient typifications would merely be a starting point which are then retained or rejected following further investigation; in others, such as rehabilitation agencies, they would be both the start and end point. The major ideas in Scheff’s article on typification have now been widely disseminated and been most influential on the way sociologists think about typification in medicine and translated into several empirical studies across health and social care, including studies of psychiatry (see, for example, Atkinson *et al.*, 1981; Byrd 1981; Goffman 1961; Hughes 1977a; Prior 1993).

11.2 Typification: a routine lexicon for psychiatric patients?

More recently, some studies (mostly in the field of psychiatry) have revised Scheff’s thesis in the light of empirical work which indicates a more contingent form of typification than that originally suggested by Scheff (Barrett 1996; Byrd 1981; Griffiths *et al.*, 1993; Prior 1993). These studies have argued that the categorisation of patients is best understood by empirically charting particular instances of different kinds of medical settings and work. Such studies suggest that patient construction (labelling) needs to be understood in the particular organisational context in which it occurs: that the patient is an organisational product.

Taking up Scheff’s notion of ‘patient stereotypes’, work by Hughes in hospital A & E settings identified just such a simple lexicon of patient categorisations (Hughes 1977a; Hughes 1988). A more recent attempt to apply this approach was taken by

Griffiths and Hughes in their article charting the admissions process in a neuro-rehabilitation centre (1993). What they found here was that staff had little recourse to diagnostic stereotypes. Instead a special form of ‘triage’ occurred which selected in those patients felt likely to benefit from admission and sifted out those felt to be too damaged or already sufficiently recovered to not be suitable for admission. The choices made did not correlate easily with any particular diagnostic labels, with the majority of cases surrounded by considerable clinical uncertainty. However, this did not mean typification was absent, rather typifications were made in ways that allowed much scope for variable responses to similar cases. Griffiths and Hughes argue such typifications were shaped by the work priorities and concerns of the staff, developing a version of clinical orientation which emphasises teamwork.

Byrd (1981) had earlier produced similar findings. Charting the selection criteria and treatment decisions in a psychiatric clinic in the States, she found that diagnosis was determined by available treatment openings with similar patients/problems characterised differentially according to staff interests and resources available at specific times. Similar findings were reported by Prior in his study of the closure of psychiatric hospitals and shift of patients into rehabilitation wards and/or ‘community care’ during the late 1980s where psychiatric characteristics of patients were redefined in order to ‘fit’ with organisational constraints (1993, pp171-2).

Furthermore, all these authors describe discussions for handling cases which, far from being rooted in clinical (psychiatric) discourse, are predominately defined by an everyday, common sense language (Barrett 1996; Byrd 1981; Griffiths *et al.*, 1993; 1994; Prior 1993). This is referred to variously by these authors – for example, Griffiths & Hughes refer to this as ‘natural rhetorics’ or an everyday narrative frame, Barrett refers to this as ‘phatic language’ – but what they all signify is a non-specialised

language that practitioners use in talk about patient referrals or cases. These contain a mixture of social and motivational characterisations to produce a moral evaluation of the patient. The dilemma, it seems, is to determine if the patient is 'really ill' or simply suffering the 'normal stress' to be expected with particular life events, in the face of the wider context of resource constraints, the uncertainty of care outcomes, and the dynamics of multi-disciplinary teamwork.

Of these authors, Byrd provides both the earliest and the most extensive analysis of the kinds of categorisations that are applied to patients in efforts to dispose of them properly. These might be summarised broadly in terms of matters related to motivation imputed to patients. Moreover, this was circumscribed by the specific setting, which in this case was an outpatient clinic following a psychotherapeutic approach. Thus, patients were discussed in terms of their intelligence, insight and articulacy which were used to gauge their ability to engage with therapy. The potential to attend regularly for treatment was important. Demeanour also figured as a means to judge possible unsuitability of the service for patients deemed to have problems such as aggression, a passive orientation to treatment and externalisation of problems (including somatic complaints and blaming others rather than taking personal responsibility for problems). While the presence of such problems might well describe precisely the kinds of people one might expect to find in therapy, in practice such patients were screened out. Byrd explains this to be the result of organisational matters connected both with staff therapeutic interests and efficient use of resources.

With regard to 'doing motives' Bryd notes that the:

... assumption of pathology parallels the assumption of guilt in the everyday world of criminal justice (see Sudnow 1965). In a parallel manner, staff attempt not to evaluate the existence of pathology in building a case, but rather to articulate its form in any given instance. Since only evidence which supports the assumption of pathology is sought, the assumption commonly takes the form of a self-fulfilling prophecy (1981, p45)

Thus a variety of motives were imputed to patients in assessing their candidacy for treatment, and applied in ways that might seem contradictory taken as a whole across all the cases at different times. Yet, when these were considered with regard to level of clinic openings available at specific times, they were seen to vary, but consistently according to a logic of clinic resource and capacity. During times of greater clinic availability 'lack of focus' or vagueness regarding one's problem served as evidence of pathology, whereas at times of reduced availability this was often a reason for not providing a service; similarly, with regard to more 'ambiguous' aspects such as dress, demeanour and affect for which there are no standard criteria as such. These were mentionable when there were more clinic openings when, Bryd argues, in order to build up cases, there was a need to look beyond more concrete indicators to signs, whose meanings were less obvious. Conceptualising problems as extra-psychiatric in terms of environmental problems or 'real' life events (as opposed to pathological distortion) also featured at times of low availability where a problem for the patient was acknowledged.

Byrd notes that this 'doing' of motivation resulted in two major kinds of responses when resources were limited: that patients were 'not really ill' or were 'too ill to be helped'. Regarding the former, patients were defined as eccentric or as having mitigating circumstances. For the latter, chronicity, especially alongside some kind of stability of the problem was highlighted. Overall, such definitional work indicated a more voluntaristic conception of patient actions when clinic availability was low and more deterministic characterisations when clinic availability was higher. Thus, for Byrd

typification is understood in a functionalist and rational strategic sense: variations in categorisations of patients matches clinic resource levels.

A final point of particular interest here relates to the kind of discourses staff were heard to deploy. Byrd suggests that when treatment openings or caseloads are full then professional conceptions of mental illness are closer to lay understandings. She argues that with a reduction in service then such a closing up is useful as it serves to demonstrate the adequacy of organisational activity. Staff must ultimately account for their actions to the public and can do so most effectively by referring to the public's own conceptions of mental illness and what are appropriate responses.

Barrett also notes the 'layness' of case conference talk among MDT members in a psychiatric hospital setting. Rather than resource availability, the reasons for this are located by Barrett in terms of team communication, a kind of generic, egalitarian language that bridges differences between professions. Hence his term "phatic communication". Barrett does not provide such a detailed rendering of the definitions applied to patients as Byrd, though similar kinds of processes appear to be at work in terms of assigning motive, responsibility and value, and in terms that are either deterministic or voluntaristic. A key difference to Byrd, (perhaps as much a product of the organisational setting as the interests of the author), is that definitions of patients are argued to follow a trajectory from deterministic to voluntaristic conceptions. The aim of treatment in this setting, Ridgehaven Hospital, is argued to be the transformation of "a case of schizophrenia into a person who could be held responsible for his or her actions" (p144). This trajectory was also a moral one in that it entailed "suffering, work and progress and was the principal conceptual scheme through which staff attributed worth to patients" (p156).

In Barrett, patient typifications, whether following a normal or abnormal trajectory, are presented as totalising – a product of the team “encompassment” of each case, paralleling the encompassment of team members (p97). However, conflicting evaluations of patients were reported to be frequent (p167). Yet, this is discussed primarily in terms of conflict between different and rivalrous professionals to produce segmented (but not necessarily fluid) cases. Thus, for Barrett, MDTs in Ridgehaven Hospital function to deconstruct patient cases through bringing different professionals to bear and then reconstruct them through the integrative work of the team meetings. The result is patients labelled according to (stage in) the illness trajectory, identified within the life-course of a mental illness career. This work is argued to be held together by the hegemony of psychiatry within the hospital and a particular form of organisation whereby teams were structured in terms of specific diagnostic categories (e.g. ‘the schizophrenia team’) and headed up along traditional medical lines by a consultant psychiatrist.

As with Byrd and Barrett, Griffiths demonstrates the common sense language used between members within CMHT allocation meetings and social and moral evaluations as key in acceptance of cases (1996, chapters 5 and 7; 1997a). Again, these are framed similarly to the above around motivation and motive in terms of: personal responsibility of the patient, secondary gains for the patient from occupying the sick role, degree of cooperativeness with treatment, and extra-psychiatric circumstances or ‘normal responses to life events’. In contrast to Byrd, Griffiths points up not only different ways of responding to seemingly similar cases, but also different ways of responding to the same case. This is portrayed as the outcome of interactions among team members over suitability of cases. Thus individual patient characterisations are not always consistently developed in moves seeking to persuade colleagues to accept or

deny a case. For Griffiths, contingency of categorisation may sometimes be the product of strategic moves to effect acceptance.

More attention, however, is given over to categorisations that are seen to be more stabilised such as ‘SMI’ or ‘worried well’. utilised especially as a shorthand to draw boundaries of eligibility more or less narrowly in the different teams studied. In this respect, Griffiths advances similar kinds of arguments to Barrett in terms of definitions of patients with regard to professional/disciplinary differences between MDT members. So, while this allows for various categorisations of patients, these are treated as cohering around different professional groupings or hierarchical divisions and/or status as inside or outside the team. Hierarchy here takes two forms, located both with the psychiatrist team leaders and/or with referrers/sponsors of referrals. In one team this was primarily the psychiatrist and, in another external GPs. Arguably, though in a rather different organisational setting, Griffiths’ treatment produces similar conclusions to Barrett’s. Categorisations vary between teams, but are represented as fairly stable phenomena within each team as more or less inclusive in terms of severity of illness (SMI). Again, in this sense typifications of patients are described by the authors in a way that is closer to more classic versions of the labelling thesis. That is, they are fairly stable categories reflecting enduring and conventional forms of medical power in the determination of mental illness.

11.3 Utility of the labelling thesis?

Despite some doubt that the labelling thesis is still in vogue (Pilgrim *et al.*, 1993), others do not doubt its continued popularity with sociologists in studies of psychiatry (Bowers 1998; Luske 1990; Rogin 1987; Samson 1995). Indeed Bowers argues that Pilgrim and Rogers’ stance of social constructionism in understanding mental illness is really another term for labelling theory. Moreover, the continuing prevalence of such

thinking is not just a topic for sociologists. These days such ideas are common components of training courses for both psychiatric nurses and social workers with reports by practitioners both in my study and in others (see, for example, Prior 1993, p139) of the negative effects of labelling and the stigmatisation that results from a mental illness designation. Moreover, the idea of labelling is now a popular one among people who have experienced mental health care as patients (see, for example, Read and Reynolds 1997, or many issues of OpenMind).

Given both current popularity with some practitioners and (still some) sociologists, as well as controversy among some other academics, it certainly seems worth considering the utility of the labelling thesis in understanding current mental health care settings. Thus, how salient are aspects of classic labelling theory - arbitrariness, totalising, and stickiness - with regard to the contradictory reasonings found here in discussions of patients? Do findings from more recent reworkings of the typification of patients in psychiatric settings apply in the same way here? Given the demonstration in Part Three of the twists and turns in team meeting discourse within Westway teams' etiquette of egalitarianism and collegiality, this might not prove to be so. In light of the above discussion it is useful to consider how patients in the Westway data are characterised and thereby to develop the story of mental health care organisation.

Chapter 12: Characterising patients – strategic moves in MDT discourse

This chapter considers a number of descriptions of different patients to demonstrate that patients are ‘organisational exigencies’. The way in which descriptions are framed is in terms of who the patient will be (treated as) in relation to what the team ought to do about them. This argument is presented through further consideration of the standard moves in team meetings for the disposal of patients (set out in Part Three) but combined now with exploration of the various ways that patients are configured and ‘tasked’ in such manoeuvres. This is a mutually constitutive relationship: for the way in which patients are tasked gives their character, and *vice versa*.

This chapter will consider the Westway data in the light of the labelling literature to argue that the objects of mental health care work - the patients- are brought into being in ways which are indeterminate, temporary and local: they are configured primarily in terms of organisational imperatives. By ‘organisation’, here I am primarily referring to the small scale work of organising encounters so that they are the kinds of encounters that participants recognise them as being: encounters such as team meetings, rather than to broad-brush socio-structural models of organisation featured in Part Two, though that Part does sketch out a framework in terms of which members organise themselves in face-to-face encounters. Thus patients are categorised, but this is diffuse and embedded in the ‘doing of team’. Moreover, following the previous chapters on teams, this chapter will consider further the argument that organisational requirements derive from the way teams are organised, in Westway the primary organising element being team members as *primus inter pares*. And so it will look at the implications of this for determining what (and who) is legitimate work for team members.

12.1 Tasking the patient

‘Tasking the patient’ is a way of conceiving of the work that goes on in the weekly team meetings. The notion is informed by Berg’s work on the construction of medical disposals in the field of urology (Berg 1992). This is an approach that is theoretically informed by actor-network theory and the concept of translation in the making of something to be relevant/suitable/eligible (see, for example, Callon 1986; Latour 1986) (see also section 3.1). Thus:

... the physician ... *transforms patient problems into solvable problems*. A patient is defined as whatever a person and/or his environment perceives to be a problem for which a doctor should be consulted ... The term ‘transformation’ implies a process in which the patient problem is not simply translated but is remoulded. A problem is solvable when the doctor is able to produce a disposal: a limited set of actions which she perceives to be a sufficient answer (at this time and place) to a specific patient problem (‘a prescription of aspirin’, ‘referral to a urologist’ or ‘advice’). This does not necessarily imply that the patient problem is relieved: what matters is that the physician knows what to do next. The physician makes a patient problem solvable by reducing the infinite array of possible actions to just one disposal. (Berg 1992. pp155-156)

Berg’s work describes transformations of patients into medical tasks which are largely single-handed: doctors who are able to do the transformation without the need to negotiate with other practitioners (though he does give examples of discrepant transformations by GPs on the one hand and consultants on the other). In the situation of mental health care in Westway such transformations have to be done via a protracted process of negotiation (as demonstrated in part Three). The particular organisational form for disposal in this case is thus recapped below.

12.1.1 Patient disposal in Westway: recap on team context and standard moves

Three main courses of action were available to the teams: to accept a referral as a patient of the team; to reject a referral as a patient of the team; or to not immediately decide on either of these so that such cases were described as ‘pending’. Part Three concluded that these actions were pursued in a particular manner, which was

circumscribed by the team meeting culture of egalitarianism and collegiality. This resulted in a set of ‘standard moves’ with regard to the three possible actions:

- a generalised request or statement of need by (usually) the meeting chair;
followed by one or several of the following responses:
 - ◆ a request for further information;
 - ◆ unconditional acceptance;
 - ◆ conditional acceptance;
 - ◆ negation of need;
 - ◆ reasoned refusal;
 - ◆ unreasoned refusal;
- redirection of request to others in the team;
- ◆ redirection of the request to another service;
- ◆ silence.

(see also Table 8-1).

I have already noted that observation of Westway team meetings showed that in making decisions on referrals and assessments not all patients listed for the meeting were occasioned for discussion. An initial question for this chapter is how are we to hear such descriptions? There are two possibilities:

- ◆ to hear them as ‘views about patients’ held by practitioners, shared among them, contributing to the construction of an organisational personality for the patient. This is the kind of analysis which takes utterances as evidence of thoughts and cognitive structures;
- ◆ to hear them as the semantic content of moves in discourses through which mental health care is organised - that is as adjuncts to linguistic actions such as asking for agreement, making refusals, issuing complaints and so on. This is the kind of analysis that finds the reasons for utterances in the immediate context in which they are uttered.

While both views are possibilities this chapter will pursue, and argue for, the second line of analysis. This follows the discussion of methodology in Part One where the case was made for an ethnomethodologically-informed approach, given the problem of treating meaning (or subjects’ perspectives as learned from interviews or observation) in cognitive terms. In this sense, language, including talk (about patients in team meetings) is treated in terms of what it ‘does’: meaning does not apply to cognitive representation or experience, but to performance. Thus, I will show how characteristics are attributed to patients to warrant particular courses of action in order to effect the business of the team meeting.

As noted above, the majority of moves in allocation discussions are general requests and statements of need initiated by the chair of the meeting. Responses to this

initial general move may take a variety of forms but are moves that best lend themselves to a team defined along the lines of *primus inter pares*. And these are moves which take place in the policy context of the CPA, specifically with its requirements to target those considered to be severely mentally ill (SMI), to nominate one individual to take responsibility for such patients via the keyworker role.

The main argument of this chapter is that patients are characterised in the course of making moves in case allocation sequences. Such descriptions are used interactionally by team members negotiating each other and the framework of organisational imperatives that team meetings create. In other words, patient characterisations are rhetorical devices used amongst a group of co-workers for the purposes of persuasion and justification. This is what is meant by ‘tasking the patient’. The rest of this section considers how this occurs.

12.1.2 Doing seriousness – the ‘SMI’ category

The CPA requires mental health care staff to target those considered to be SMI. Government guidance (referred to in Part Two) is written as if ‘mental illness’ is a simple phenomenon, such that different cases are capable of being ranged along a single scale of greater or lesser severity. It also seems to make the assumption that different practitioners in different places can come to the same conclusion about the severity of a particular case. In Westway, attempts were made to conceptualise such a scale by designating categories from 1 through to 4, with 1 being most severe. In practice what is ‘severe’ and indeed what is ‘mental illness’ is something which has to be decided in each particular case, in terms of the immediate local circumstances, for example: case-loads, different practitioners involved, source of referral, presence or absence of patient advocates and so on. And all of these are likely to make a difference as to who falls on which side of the boundary between severe and not so severe mental illness.

For those patients deemed serious enough to fit within the SMI target, then the next step is to nominate one individual to take responsibility for such patients via the keyworker role. Being appointed as keyworker conveys responsibility for the management of the case to an individual and may leave them culpable in the event of something adverse such as death by neglect, a violent attack etc.. Acceptance of a referral to the team is marked by the nomination of one member of the team as keyworker. Thus the procedures for acceptance entail attempts to get a member of the team to accept the keyworker role and assume individual responsibility (and hence liability).

12.1.2.1 Seriousness as a warrantable criterion

Following on from Part Three, which examined how the teams accomplished allocation of patients, it is worth thinking further about how cases might be refused. Two strategies are suggested. One is global – not a case for the team, and here ‘not SMI’ is the best example of such a strategy. If requests/referral reports are not addressed then it is easy for anyone to refuse the case on behalf of the team, which has the effect of refusing it on one’s own behalf without doing so as such. The other strategy is particular – not a case for me. This is rarely heard, mainly because most requests are unaddressed. In practice, with the category of SMI, this means that a characterisation of someone ‘as SMI’ or ‘as not SMI’ is a warrant, respectively, for either accepting them or rejecting them.

The following example illustrates how a patient could be seriously mentally ill as a rhetorical device to persuade someone in the team to nominate themselves as keyworker, and also how the same patient could not be seriously mentally ill for the same reason. It points up sharply how such characterisations are indeed resources,

which the team use in their interactions with each other in this kind of team. To revisit an example introduced in Part Three (as Example 9):

EXAMPLE 21

Team A weekly meeting, 21/10/96

The NBT, who is chairing the meeting this week in the absence of the TM, goes through the referrals via list and/or letters, including first [name of patient] via a PAS fax to the meeting.

CP: She needs to be picked up by us. She's got a care manager, [name], but she needs picking up by us, she needs a keyworker.

CP then runs through her background.

CP: She has cerebral palsy, and there's a history of sexual abuse, a very disturbed woman. She's possibly not appropriately placed at [name of residential unit]. The care manager has not had anything to do with it. It's quite strange.... If she ends up in [name of hospital unit] we're in deep doo doo because she's very difficult to handle. There's been a lot of hassle recently which we've fended off. But we need to pick her up now.

NBT: Anyone?

CPN 1: We're all feeling really, really stretched. You need to give a steady commitment to a case like this. It's too much right now.

WM: Day Therapy?

CP: She's bed-bound so very unlikely.

CPN 1: Do we have to find her a place?

CP: There's a mental health problem with category one problems. There's been incoherent management on social services' part but with the mental health element we're obliged to step in.

NBT: She's with us.

CP: The family are very unhelpful too. She's been handled like a piece of meat. If she's treated like a human being then she's likely to pick up.

SSM: Both [social services staff name] and [social services staff name] need to clarify what social service support is available. I know that doesn't help immediately.

CP: It will be helpful.

SSM: I'll telephone [name of care manager] and find out about both patients mentioned so far relating to her as care manager.

Discussion then moves to next patient on referral list.

When this example was first introduced in Part Three, it was to illustrate how unaddressed reports in team talk are more readily resisted. Now we can expand on that interaction by looking at how the patient who was the topic of this discussion was characterised, to what end, and with what consequences.

In this example the psychiatrist directed the team's attention to the 'seriousness' of the case. This is in the nature of issuing an organisational imperative. The description of the patient as 'serious' is an organisational act, part of the process of accomplishing

the task the team is supposed to accomplish by persuading someone to accept responsibility for the case.

There are a number of other aspects of the case which explain this organisational act. First, it is notable how parsimonious the description is. Generally descriptions of patients uttered in these team meetings were rather sparse which raises the question of why these characteristics were mentionable and not others³⁸. As argued above, the answer to this question is found in looking at the way in which description is shaped by the linguistic interchanges in which it occurs, and these linguistic interchanges are themselves the means through which organisational tasks are carried out. Thus the patient was described as 'serious', because the task at hand was that of allocating a key worker, and this was a means of applying pressure to the team, such that one of them would feel obliged to volunteer to be the keyworker. The second point to note, in passing, is this very characteristic of relying on volunteering. This relates to the absence of any overall managerial authority to allocate cases between team members, and at the same time to a pattern of gentility in these meetings where members show respect to each other as occupationally with unique contributions to make to the work of the team and as professionals with rights to exercise choice over their work. What this means in linguistic terms is that descriptions were rarely made in the course of one person ordering another to do something, and more frequently descriptions were done in the course of persuading others to commit themselves to a course of action. Third, hardly any documentation was used in these meetings. Case files were rarely present, referral

³⁸ 'Sparse' also in the sense that not all patients were discussed. Others would be noted in terms of name, and area, previous contact and name of any (key) worker involved. Barrett also points up the terse talk of team meetings. This was geared to the business of practical decisions around tasks for members *vis a vis* a number of patients, abridged discussions in swiftly flowing conversation, where definitions of patients frequently took the form of 'epigrammatic appraisals' (Barrett 1996, pp89 and 95-7).

information was often sparse, the meetings were not documented except to list the patients for allocation and to minute the name of the key worker appointed. Aside from some direct quotations from referral documents, sometimes read aloud by the team chair, descriptions of patients uttered in these meetings did not seem to arise in any determinate way from documented sources, and descriptions uttered in the meeting never themselves entered the documentation relating to the patient. In this sense these descriptive utterances cannot be seen as contributions to an ongoing, integrated process of building up an organisational picture of a patient.

The continuation of Example 21 above illustrates further how descriptions of patients can be read as adjuncts of organisational work. The discussion in the example above ended with no particular outcome i.e., no taker and discussion moved on to other patients as often happened when no agreement was reached about a particular patient. The same patient is raised again towards the end of the meeting:

Summing up the cases that remain to be allocated:

NBT (temporary chairperson): So that leaves {patient name}.

CPN 2: What input would be required?

CP: It may not be much.

Discussion on patient ends there, inconclusively, without 'any takers'.

In the earlier part of the example the patient was described in terms denoting the seriousness of her condition. I suggested that this was part of a move designed to elicit an agreement from someone to accept this case as keyworker. In this part of the example the same patient is described as not so serious after all, but still in such a way as the description to be hearable as a persuasive act. Not being so serious means, not being a difficult case, or being the kind of case which someone might accept without difficulty. This demonstrates that descriptors implying seriousness or not are being used as a linguistic resource - in this case as a resource for persuasion- rather than as straightforward characterisations of the patient's condition - though in neither instance

was this successful. Put another way, had we heard only the first part of the example we might naively have heard it as a description of a patient in a serious condition -someone definitely SMI. But had we heard only the second part of the example we might have heard it as a description of a patient in a less serious condition. Hearing both parts of the example we might hear them as contradictory, but only if we thought that the participants should be providing straightforward factual descriptions. There is nothing contradictory about the two halves of the example if we hear them as both being linguistic manoeuvres to accomplish the same team business of allocation.

12.1.2.2 Seriousness as a non-warrantable criterion

Given the performative definition of ‘seriousness as a warrantable criterion’, it is therefore less odd or surprising to find that the opposite could also occur. That is, that ‘seriousness’ was indicated but it was this that made the patient non-eligible. Using descriptors that implied serious mental illness was not inevitably associated with attempts to accomplish an allocation. Sometimes this descriptor was used in order to disbar a patient from the services of the team as in the following example:

EXAMPLE 22

Team B weekly meeting, 11/4/96

NBT: Mr Riley. The GP referred for assessment saying “He’s a pig and I want him sorted”. The GP has provided very little information and what he has said appears largely to be inference bordering on the libellous, given the stuff he said about sex abuse. The GP received a letter from MIND and generally there seems to be a feeling of disquiet, but I think there’s little we can do for him. He’s got problems - he’s a psychopath but we can’t help him.

NBT goes on to explain that the patient has a high sex drive and has not worked for 12 years, has no contact with his family including his twelve year old daughter.

NBT: The patient doesn’t feel he has any problems. Yet clearly he’s bothering MIND - their problem is their open door policy. It seems this man is preying on MIND’s vulnerable female members. However there’s no obvious mental illness presenting.

Cli Psy: How dangerous is he?

At this point a lot of concern is expressed by the rest of team with comments and asides around the table.

Cli Psy: I wonder if the combination of lots of sex, relationships with vulnerable women at MIND and the lack of family involvement might indicate involvement in child sex abuse?

NBT: There's a lack of info, nothing factual, it's all supposition, so we must be careful.

SM: Why are we now making it more of a problem?

NBT: The GP referral letter is vague and very unhelpful - it's a problem doing an assessment in such a context - what are we looking for?

SM: The question is how to write up the assessment and dismiss him, not take him on.

NBT: I feel the GP might also feel there's little that can be done but he 'wants the assessment done'.

Cli Psy: There is the matter of risk assessment and the issue of our responsibility now that the GP has referred.

CP: Can we check with social services on his background and see if he has a prison record?

SM: Well the GP has been pushed to act by the MIND letter to him.

NBT: I only saw the MIND letter later, it wasn't enclosed by the GP. But this letter does not make things any clearer. MIND reckons he's got PTSD following the suicide of his mother when he was twelve years old! [Obvious amusement at this suggestion around the table]. None of the story hangs together.

Decision then taken, led by SM, with team agreement, that NBT write up the assessment saying this man is not suitable for CMHT and pass by the TM before sending to the GP.

In this example, a patient is described as a 'serious case' but in such a way as to justify the team not accepting him. It is worth noting that this decision is made before the meaning of the assessment of the patient has been determined:

SM: The question is how to write up the assessment and dismiss him, not take him on.

To understand this example it is necessary to think about the relationship between the team and the GP who has referred the patient, and with MIND who are involved in this case. Both of these presumably desire that the patient is taken on, and therefore the team's decision not to do so requires particular justification. It is not entirely clear what this justification will be. But what is clear is that the team, (or at least the SM), see the need not just for a decision, but for a decision which will be justifiable to this audience. Their discussion suggests a search for resources, which will justify a decision not to accept the case. In this respect, much is made of there only being anecdotal, suppositional evidence about the patient: that is no firm basis substantiating the seriousness of his condition. On the other hand, there is no doubt that

the team themselves feel that this is a case that is too serious for them to handle, a psychopath³⁹. Thus the team's descriptions - to each other - are in terms of the seriousness of the case, its unhandleability for them, but the description which will go to the GP is in terms of there being insufficient evidence that this patient is a serious case.

Questioning the referral requires careful handling. For, in terms of the GP, it could imply a querying of medical expertise and an external colleague's judgement. In addition, the referral has the support of a local mental health charity with a record of campaigning for patient rights. Yet querying the referral is a legitimate, if not favoured, device within the team meetings for effecting a reasoned refusal, for it allows the rejection of a case without putting any individual team member 'on the spot', thus preserving the team fiction of *primus inter pares*. Thus, as in the above example, though for different reasons, the patient is both serious and not serious. The policy that teams must gatekeep and target SMI becomes a linguistic resource used differentially in the management of the team's work among themselves and with other agencies.

12.1.3 Doing motives

Imputing motives to others to understand what causes them to act and/or what is their degree of interest or investment in an action is not unique to psychiatry. These are the kind of topics that are invoked whenever any action or individual is subject to some kind of evaluation or inquiry. Several sociological studies of psychiatric care have noted the importance of the concept of motive in undertaking such evaluation.

³⁹ While those patients described as 'psychopathic' are among the most serious cases, they are also often rejected by mainstream mental health services on the grounds of 'untreatability'. This is a somewhat controversial matter, of much debate within psychiatry. But they are well-recognised as labour-intensive and unremitting (Reed 1992a).

Drawing upon work by Blum and McHugh (Blum and McHugh 1971), Byrd unpacks the concept of motive in terms which align with the ethnomethodological stance adopted here: “as observers’ methods for conceiving social action” (Byrd 1981, p43). She points out that this process involves the creation of a biography of key characteristics of the actor seen to be relevant to the situation (p43). Moreover, for Byrd, this imputation of motive in the assessment of psychiatric patients was more likely to be framed by a voluntarist conception of the patient when clinic resources were limited (pp53-60).

Certainly, there are similarities with my data here in that the ‘doing of motives’, particularly in the form of considering the personal responsibility of the patient, was a regular resource used by members in characterising patients referred to the Westway teams. In this sense, such an approach might be considered a form of typification of psychiatric patients. But, whereas Byrd found a variation around such characterisations that turned upon resource availability, in Westway the variations appear far more contrary.

Personal responsibility, and the capacity to take personal responsibility is, like the concept of SMI, another key resource which teams deploy in order to handle particular referrals and assessments. As with ‘SMI’, ‘personal responsibility’ is not a simple matter. As a device that can warrant action, ‘mental illness’ entails the assumption that a person is not responsible for their actions; and that this responsibility devolves to others. Thus it may be expected that one of the characterisations necessary to express a person’s eligibility for service is the person’s inability to take responsibility for themselves. However, the matter is not so straightforward. The distinction between what might be termed ‘legitimate patienthood’ and deserving of service, and incapacity to take personal responsibility but not worthy of the service, is one that is fluid and

utilised variably depending on the outcome sought. So service is offered to patients seen to be suitably cooperative, who demonstrate an insight into their illness and recognise they have a problem which they need help to address. However, it is also recognised by teams that there are patients who lack such insight during their 'poorly phases' and will require, indeed deserve, service input. And then there are those patients who are not seen to fall into either of the previous two categories. Such definitions may also incorporate the deployment of the linguistic resource of 'seriousness' in its various guises, as noted in the previous examples. Thus, only some kinds of incapacity or inculpability are permissible, although there is little consistency in what these are. Indeed, judgements such as these need to be understood as part of the process whereby team members agree workloads within the team: patients are thus 'tasked' accordingly.

12.1.3.1 Personal responsibility - voluntarism

The last example was one where a referral was queried with the effect of non acceptance by the team. Another key resource deployed in attempts to reject a case for keyworking, was consideration of the patient in terms of their motivation and responsibility for dealing with perceived illness. Such discussions turned on whether the patient was actually ill or not, not ill enough or too ill to treat successfully. When the move was one aimed at refusing a referral or keyworker allocation, patients were seen much more as directing themselves by conscious will rather than as subject to uncontrollable pathological processes.

EXAMPLE 23

Team A weekly meeting, 17/6/96

The NBT introduces a case, a male patient, [name], of 55 years.

NBT: He uses an inhaler to an extent which is detrimental to his health. There's a query by the physician as to whether it really is a bronchial problem, or addiction. The patient says he has chronic anxiety and depression due to his chest problem. I think he's very different to the way the chest doctor has presented him. The doctor sees him as a 'malingerer', although there may well be inhaler addiction. But the tone of this doctor is really disrespectful and he talks about him as a "wimp".

NBT then discusses patient's childhood.

NBT: His parents were alcoholics. He was in trouble with police and ended up in care. He was in prison at 18. He's had respiratory problems for some time, possibly starting around the time in prison. He's been married three times and has kids but little or no contact: all three wives left him. He does not take responsibility for anything in his life.

SR: Perhaps the detox unit may be useful. They'll get him off the inhaler and take a hard line over the responsibility issue. But it's difficult for the patient - will it work? It depends if he wants to address his problems. It's tough. There again it helps us, otherwise we just get sucked in with this type of patient.

CPN 1: Whose got the problem? Us, him or the GP?

NBT: He soaks up resources but then very short-term work is unlikely to be adequate.

TM: This patient falls outside the team's threshold and doesn't appear to be interested in changing.

NBT: Except he has made a couple of suicide threats.

CPN 2: Unless the patient is highly motivated to change then it's a waste of resources.

CPN 1: Perhaps [NBT] could talk further with the GP about the situation?

SR: Contact the GP and suggest a medical route to get off the inhaler and psychological back-up while on a medical ward.

Discussion then of whether the addiction threatens the patient's life.

NBT: Yes, I think it possibly does, and he has made suicide threats. I feel that this patient must want to change given this.

TM: This patient has got huge secondary gains invested in addiction so he's unlikely to change. And if you put him on a medical ward it may just confirm his own view of the problem.

It's then clarified that NBT meant detox unit in psychiatric ward.

WM: But then there's the problem of the psychiatric label and he remains in the service forever.

TM: Well, he's travelled on holiday recently. So I reckon he cannot be all that desperate if he's able to do that.

Decision then summed up by TM with SR's and others' nod of approval:

TM: [NBT] should write to the GP and say all that can be done has been done.

NBT: Well I know that the GP did try changing the inhaler but the patient refused and that's when the problem became evident. I now feel happy with this decision and OK about not taking him on having discussed it like this.

TM: I agree and I think it's worth reminding all the team about the value of doing this more often, to critically assess the potential of our involvement.

In this example the notion of ‘seriousness’ is elaborated alongside a definition of incapacity to take personal responsibility. Though the apparent addiction may well be perceived as ‘serious’ by professionals both within and outside of the team, other aspects of the patient’s life, his own perception of his problems and his previous actions are weighed alongside this. Thus his failed marriages and his refusal to see the problem at the outset as one of addiction, are cited as resources to support the view that the patient lacks the capacity to take personal responsibility for his problem and thus is unlikely to be worked with successfully. The linguistic manoeuvre that clinches the decision to reject the patient, when the team manager notes a recent holiday, is one of moral disapprobation that appears to turn the issue of personal responsibility on its head. This action could be understood as the patient demonstrating a capacity to take responsibility for himself, improving his well-being. As it is, what counts as legitimate patienthood is a variable notion, contingent upon personal as much as professional judgements.

12.1.3.2 Personal responsibility - determinism

So far the doing of motive in terms of lack of personal responsibility has turned upon the bid to reject a case, and in this sense could be seen to support Byrd’s finding that patients conceived primarily in voluntarist terms coincide with limited availability. However, it is also worth considering deviant cases – those cases that are similarly described but where members utilise such a characterisation to a very different end, to accept the patient. Again, in order to highlight the relationship between patient characterisations and interactional moves among team members in disposing of the work, the following example is revisited from Part Three (there Example 5):

EXAMPLE 24

Team B weekly meeting 7/1196

CPN2 discusses one she has assessed. [patient name]. Notes depression and concerns about her appearance. The GP felt that some cognitive work from a CPN might help. She's been involved with the practice counsellor who is also a psychologist - had 2 sessions per week for 3 months. Feels it's a complicated case - patient more like a 13 year old than her 27 years. The parents are very involved and important to her. But the home situation has not been assessed. CPN2 then paraphrases patient language in a child-like voice:

CPN2: Mummy and daddy don't know she 's had a sexual relationship with her boyfriend for the past 4 years.

CPN2 Then goes on to note that there's more alcohol misuse than admitted to the GP.

CPN2: I really felt this girlie needed to grow up [exasperated tone]. I don't know what we can offer. I told her I would talk with the team and let her know the outcome.

SM: Did you discuss her nose and appearance problems?

CPN2: Yes, but I feel cognitive work is unlikely to help. The drinking indicates she's not responsible. And there's something odd about the parents, her relationship with them.

Other members of the team then comment that there is something more going on here.

SM: What does she want?

CPN2: To be less unhappy.

TM suggests a women's group.

CPN2 Feels this is not appropriate.

SM: I'm not surprised to hear this is still not resolved given our ex-colleague [names a doctor] is involved. Well the case is not SM1. But there are maturity, responsibility issues there.

CliPsy: Possibly there could be psychological work about not growing up.

SM & TM: Is that an offer?

CliPsy smiles wincingly and says she was just wondering aloud.

TM then says there's the potential for her to become more ill especially given the alcohol misuse

SM then directs the CPN2 to talk further with the Cli Psy, adding:

SM: Neither one of us [indicating TM] is saying don't take her on.

In Part Three this example was considered as an attempt at a 'reasoned refusal' (which in the event failed). This was against the background of team gentility and discussion framed not quite as individual nomination (which might have produced an outright 'no'), thus requiring some linguistic delicacy from all parties on both 'accept' and 'reject' positions.

At first it appears that this example is the same as Example 23. CPN2 deploys the notion of ‘lack of personal responsibility’ strategically in order to facilitate a rejection of the case: characterising the patient as one not likely to benefit from intervention, rather she ‘needs to grow up’. The patient’s social circumstances and personal demeanour are cited as evidence not of illness but of immaturity. It certainly seems also as if other members can hear this manoeuvre. There is the more unusual extended discussion, including a series of quite specific questions from the SM designed to elicit more detail about pathology as well as motivation.

But here the similarity ends, because it seems that in this instance the SM and TM, in contrast to the TM in the previous example, are keen to see this case allocated. So while the SM and TM acknowledge that there are responsibility issues, with all that implies too about motivation of the patient, they nevertheless employ a deterministic gloss on this material. In this respect the characterisation approximates the more usual Parsonian take on illness. Here the notion of mental illness allows that a person is not fully responsible for his or her actions. Here, in contrast with the last example, it is the very presence of an addiction, this time alcohol rather than prescribed drugs (inhaler), which is cited as the decisive factor with some team members to accept the case. The result is for both the CPN and the psychologist to be politely enrolled to a course of action whereby the case will be pursued further.

This example illustrates the instability of the category of ‘personal responsibility’ in handling team business. It is just as likely for descriptors that denote lack of personal responsibility to be utilised deterministically to accept a patient, as to reject them. Moreover, at no time during the study were significant changes reported for either Team A or B regarding levels of referrals and team availability: they were always experienced as relentlessly high. So rather than the somewhat stable relationship of

contingent characterisation calibrated according to availability that Byrd reported, this study finds much more contrariness.

12.1.4 Doing risk

A key principle of the keyworker role, as set out in government CPA documents, was that *one* professional had responsibility for a case. The aim was to avoid some of the high profile mistakes of the past few years where lack of coordination between colleagues and/or agencies due to no one professional taking responsibility had been identified as the primary problem. Yet this concept of the keyworker was not always so clearly embraced by the Westway teams. Sharing the keyworker role was a strategy observed on a number of occasions. Against a background where the role of keyworker was seen to be an onerous one, and the perception was that most members' caseloads were already full, perhaps sharing the keyworker role was a diplomatic solution for the teams. But as joint keyworking was not *always* the solution pursued by the team, it is interesting to consider what kinds of patients were seen to require such an approach.

The first of these examples was introduced in Part Three (section 9.2 Example 13). There it was discussed with regard to joking, the professional dominance thesis and attempts to secure allocation. Now I wish to revisit this example to consider how a patient already on the books is framed for re-allocation involving more than one practitioner.

EXAMPLE 25

Team A weekly meeting 2/4/96

The CP raises a patient with whom it is difficult to maintain contact. There are concerns because previously she has suffered frostbite through self-neglect. She has also given concern to neighbours, who hear her screaming loudly when shut away in her flat. The team then talk at some length recalling difficulties of previous contacts and attempts to treat her, unsuccessfully. The patient refuses psychiatric help, including contact with the CP.

CPN1 notes her only contact is the milkman.

CP: Perhaps we can get the milkman on the team – he could be KW?

Several team members including CP: Or perhaps [name of CP] could become a milkman, then she might talk to us!

Team then wind discussion on this patient and decide to assign three members as KW – the CP, CPN1 and SW1.

For the team, the major aspect of this patient was her vulnerability (liable to extreme physical self-neglect) combined with a refusal to engage with the psychiatric services. There was an extended discussion recalling various ‘atrocious-like stories’ of how the patient had declined psychiatric services on previous occasions and how threatening she had been when the current lone KW (CPN1) or the CP had tried to make contact with her. These features mark the case out as one which is both hard work for the KW and where the KW is likely to be especially liable, in terms both of the patient’s and (to a lesser extent) her own safety. In contrast to the previous discussion where motives were done with specific, and tightly coupled, reference to patient actions, here the patient is categorised with the rather generalised catch-all of “risky”. The result is that two other team members come forward to support the existing KW, providing a formidable multi-disciplinary tripartite of consultant psychiatrist, approved social worker and CPN, now sharing the liability as a mini-team.

The patient in the following example is also one that is framed in terms of needing more than one KW.

EXAMPLE 26

Team A weekly meeting 23/4/96

TM: Male patient [name]. First episode of schizophrenia. Severe psychosis. Report from [name of clinic for men with violent behavioural problems] with very worrying indications. Prior to this [name of CPN1] had been his keyworker. The feeling now is that the patient requires two KWs. [Amused response around table to this suggestion given earlier references in the meeting to full caseloads]. Perhaps this patient needs to be on the supervision register and a section?

SpR notes he was in hospital for some time and wonders about "the risk". There's a forensic report that indicates a high risk when psychotic as he threatens to kill his family. He's already assaulted his sister. And he's very disturbed by sexual thoughts. The feeling is that he should go to ART. But ART won't take him on after only a first episode.

CPN1 wants another keyworker now – he's pessimistic about ART taking up.

CP suggests CPN1 carries with SpR's help.

CPN1 and CPN2 resist this [NB. CPN2 is CPN1's clinical supervisor].

CPN2 then asks SpR further questions about the patient's background.

CPN1 says [very firmly] that he needs two male keyworkers.

[NB. CPN1 is male; SpR is female].

Discussion then follows about risk and if the team report that two KWs are required and they are not available then there could be problems for the team.

CPN1 then proposes that he carry the case for now with SpR and review it carefully. This is agreed.

The requirement for two KWs is flagged almost at the outset. It is a requirement that unpacks in terms of 'risk'. Perhaps even more than the patient in the previous example, there is much to be concerned about here, which can be captured by conceiving the patient 'as risk'. As before, there is a similar concern with safety. This time safety is about others: first staff and then other members of the patient's family. Moreover the concern is framed by the threat of violence. And previously it seems the patient has directed violence at women in particular. Thus not only is this patient to be managed by two KWs, but this manoeuvre also deploys gender: the requirement for male staff in effecting the allocation. This is not completely successful. But, CPN1 does manage to effect a temporary and shared responsibility for the case. Though it is the TM

who first mentions the ‘two KW’ requirement it seems this has been considered prior to the meeting, as “the feeling is” and exchanged looks indicate. It is useful here to recall discussion in Part Three about a prior involvement being a strong indicator for the rare occasions of individual nomination, or more often an expectation for self-nomination. Thus, this framing of the patient as needing two KWs appears to be a more polite form of enrolment of CPN1 to a visibly tough case. The rest of the manoeuvre also allows for a conditional acceptance, given that the preferred duo, of two males, has not emerged.

The above examples might be seen to suggest that of all the categorisations of patients so far, ‘doing risk’, is the one which appears to be applied in a unified manner: constituting a more stable kind of organisational identity work in the case of these particular patients. That would be the case if all such patients (with similar sorts of biographies) were configured this way, manifest through the move to appoint more than one KW. But that was not the case: there were plenty of examples of similarly alarming patients who, while characterised in terms connected with potential violence and threatened safety to others or themselves, were not tasked in this manner. Moreover there is a postscript to Example 26 that makes clear the contingency of even this way of categorising patients.

EXAMPLE 27

Team A weekly meeting 23/4/96

[Following immediately on the back of end of Example 26].

TM starts to move on to next patient on referrals list when he is interrupted by CP. CP insists on talking now about a patient he's very concerned about.

CP: I'm more worried about this patient than the one we've just discussed.

CP then runs through his background briefly but emphasises that "he has guns and hates kids" [NB. shooting of children and teacher at Dunblane Primary School a few weeks ago].

CP: He's more of a risk than [name of previous patient above]. I want to make sure we've got a handle on him. We need a strategy because he's a very devious man.

Discussion then continues about the potential risk. It emerges that CPN1 has had some initial contact. CPN1 chips in with some more information about the patient. He also notes that a further detailed assessment is to be done by [name of CliPsy] and is scheduled for 14/5/96.

CP: Something needs to be done! [most emphatic] I'm worried that we have to wait for an appointment in May.

CliPsy: I can't see him before then.

CP: I'm worried it will drift.

TM then winds up the discussion by reassuring CP and saying CP can have responsibility to oversee the case saying that way he can keep tabs on it.

While the Dunblane shootings⁴⁰ were not specifically mentioned, there were references along the lines 'given what has happened recently', and it was recent enough for the image of a man with guns who expresses a hatred for children to be a ready reference. So this last example would seem to be no less a risk than the others - a tactic of persuasion the CP himself attempts to use. The issue of competing resources would seem to be informing an alternative play by the CP, possibly even for CPN1 given he has also had some prior involvement with this case too. Further, there is with this example an explicit recognition of the strategic work which 'risky' characterisations perform in expediting team business – "We need a strategy because he's a very devious

⁴⁰ On 13th march 1996 Thomas Hamilton, armed with an assortment of guns, walked into Dunblane Primary School Scotland, and murdered sixteen children and one teacher, before killing himself.

man". All this notwithstanding, the strategic move by the CP fails, and for the time being the case remained 'pending'.

'Risky patients' were framed as especially complicated and more potentially troublesome. Certainly what was already known of them suggested the potential for at least social nuisance and at worst law-breaking, and serious crime, which would place the care provided to such individuals in the public arena should an adverse event occur. Strategically such manoeuvres in categorising these patients might be seen as attempts to reject them as 'too serious' (see previous section of doing 'seriousness'), but often these were cases where doubting eligibility was likely to prove more hazardous for the teams. Indeed, there was a sense that these were just the kind of cases to hit the media headlines. In circumstances where eligibility appeared less contestable, and voluntarism of the KW role more heightened, 'doing risk' enabled such patients to be tasked in ways that allowed the sharing of such responsibility.

Those patients seen to require a joint keyworking solution were presented as particularly intractable and difficult - patients usually with a lengthy psychiatric service history, subject to sections, who would not comply with treatment regimes, and who were perceived to pose highly visible risks to themselves and/or others in the community. These are the cases, then, that the CPA single keyworker notion was supposed to address. These are cases, in other words, where things are most likely to go wrong or least likely to show positive results and thus incur a sense of greater accountability amongst those working them. In these circumstances it is argued that teams characterise patients in terms of being especially problematic and thereby task them in ways which will spread the risk of culpability out among the team. Yet there was nothing especially systematic about such categorisations in the Westway teams:

characterising patients in terms of ‘risk’ was another kind of organisationally contingent, strategic move.

12.2 Patients as organisational imperatives

Like any other kind of work, mental health work is organised and it is a constituent feature of this organisation that the objects of that work are construed in terms of ‘what must be done’, and by when and by whom: that is, they are configured in terms of organisational imperatives. This chapter has looked at the ways in which characterisations of patients and their circumstances generate imperatives for action (or not, as the case may be). However, as earlier Parts of this thesis has shown, the organisation of community mental health care is an uncertain affair. This is work that goes on at the meeting point between different agencies and different occupational groups. There is always the potential for competing definitions of what the imperatives are. In this respect the discursive construction of patients features as part of a discourse among practitioners about how community mental health care should be organised. And as Part Three has already demonstrated, negotiating these various boundaries needs to be done with some care.

The context set out there demonstrated a collegial gentility for managing interactions within a ceremonial order of an egalitarian team. Sometimes this approach resulted in patients remaining unallocated. Any discord was handled delicately, at least at team level. One of the implications of such ceremony for descriptions of patients is that there are rarely competing descriptions which team members are asked to choose between. Instead there are presentations which, when made, are equivocal - specific versions of the general use of utterances of uncertainty as a means of avoiding conflict and facilitating consensus. In terms of hypothesis 3 presented earlier to describe the ‘team principle’ (chapter 8), it would seem that unallocated patients are the cost of

consensus. Directives and individual nominations were rarely imposed, hence no refusals were required, thus there were no disputes about refusals. The quality, then, of 'being difficult to allocate' found in a patient thus derived from the way teams were organised.

In Part Three particular attention was drawn to the strategic manoeuvring of team members as they negotiated who among them was to do what about the patient. In this chapter the analysis has been extended by considering how this manoeuvring led to particular characterisations of patients. This interpretation is counter-intuitive with regard to the teams' own orientation to the task. They behave as if 'the facts about the patient' determine the proposals made about them, but it is just as cogent to argue that what comes to be regarded as 'the facts about the patient' follow from and provide grounds for the proposals made. This is to use a line of analysis similar to that used by Garfinkel in his famous study of jury deliberations (1967, Chapter 4), treating such deliberations as having an iterative, retrospective-prospective quality. It is not that proposals about the patient are wholly determined by what the patient is like (as a rational, evidence-weighting model of decision-making would suggest), or that what the patient is like is determined (retrospectively) by the proposals made about them. Rather, the patient is constructed as an organisational entity by a logic which shuttles backwards and forwards between evidence and proposal, until some kind of coherence is created between the patient being the kind of person who needs the team to do what the team has decided, and the team needing the patient to be the kind of person who warrants the decision the team has made. As noted, these deliberations often involve discrepant versions. One reason for this, the focus of this chapter, is that different resolutions have different consequences for different members of the team, particularly in terms of workload, such that team members can be regarded as differentially interested parties

preferring different framings of the patient, and negotiating with each other in this regard. Put crudely, who the patient comes to be, depends on who wins the discussion. However, there is another reason for discrepant versions. This is that team members simply find it difficult to make sense of (some) patients, and hence difficult to decide what to do for the best. And it is this other reason which is the topic of the next chapter.

Chapter 13: Characterising patients – problem-solving talk among uncertain team members

This chapter will examine data gathered in respect of just one case as it was raised in Team A over a period of 12 months. By contrast with the snapshots of several different patients occurring at weekly team meetings, seen in the previous three chapters across Parts Three and Four, these data provide a more longitudinal look at a case. This moves us further on in the treatment process from mention in weekly team meetings for the purposes of intake to a more intensive period of intervention with a patient occasioned by a section under the mental health act and admission to hospital.

The previous chapter showed how patient characterisation is open-ended and contingent, arguing that who patients are is the result of organisational imperatives that emerge from the interaction of team members. In this chapter I will look at one particular patient case – that of ‘Beryl’⁴¹ – to consider this argument further.

Where the previous chapter argued that such patient characterisations are a product of strategic moves by team members negotiating the KW role or more generally taking responsibility for doing something, this chapter raises another theoretical dimension to understanding such data. This chapter considers the possibility that there is not necessarily firm evidence to determine if strategic manoeuvring is always the meaning of team members’ discussions. Like the previous chapter, matters such as ‘who the patient is, what is wrong with them and what ought to be done and by whom’, are inconstant. However, here it is suggested that team members simply find it difficult to make sense of (some) patients, and hence difficult to decide what to do for the best,

⁴¹ This name is a pseudonym and other minor details in the case have also been changed in order to protect patient anonymity.

while ‘winning the discussion’ is often only a temporary matter as versions of the truth are constantly deconstructed.

As in the previous chapter, this chapter picks up on the labelling debate to consider under what organisational conditions robust authorised versions (of patients) can be formulated and maintained. Or rather, it approaches this question from the rear, by considering under what organisational conditions it is possible or unexceptional for people to ambiguate situations, such that labelling of patients is at best a fleeting, fragile matter, which prevents the emergence and maintenance of authorised versions of care. This is debated further by considering the kinds of situations that allow for people to express doubts, counter proposals and change minds.

13.1 Narrating the case - ‘Beryl’

Before I begin the tale about Beryl, I want to say something about ‘telling tales’ – both the kinds of tales presented here, as well as the relationship of approach to argument advanced here. This chapter presents local debates and uncertainties with regard to one patient over a period of time. These occur both within individual clinical (and research) occasions and accumulate through a range of meetings and forums over the research study time. Hearing these multiple stories or debates during the fieldwork, with participants creating enigmas around Beryl for themselves, as well as for me as researcher, led me to wonder further about the function of such talk in this kind of organisational setting.

Such situations are messy, extended both in terms of time and accounts. To tell about such a situation *requires both the presentation of a large volume of disparate details, and a method to marshal such detail together in a readable form*. Bearing in mind discussion from Part One, it is important to acknowledge the moves I (attempt to) accomplish here. I am referring here to the ethnographic practice of turning

observations and conversations into narratives with meaningful plots and understandable and empathetic characters, and in so doing reconfiguring the data to demonstrate the participants and/or the researcher as excellent story-tellers. Atkinson makes these points most cogently in his book *The Ethnographic Imagination* (1990). Thus it is just as likely in the tales that follow that I have created a spurious sense of coherence, as to have ‘missed’ coherences that were actually there.

I have therefore attempted to create readability or coherence, in order to explore what is a fundamentally messy organisational process, through two kinds of narrative. The first narrative presents a structure and overview of the situation through consideration of time, place, people, and plot. These elements are fundamental to most stories, though as Atkinson points out, they are usually only distinguished for analytic purposes (Atkinson 1990, p150). Indeed given the topic of this chapter is the characterisation of one particular person, Beryl, then Atkinson’s reference to the inextricability of ‘character’ with the description of social scenes and narrative portrayal of action in ethnography is especially apt (Atkinson 1990, p150).

Narrative I draws on the conventional narrative style of a linear story, presented as a sequence of events (time) conveyed via a set of characters (people) in particular settings (place) to produce a plot. It uses these conventions of story telling to introduce and set the scene for Narrative II. In this sense it is a reader’s aid for the non-linear story that follows. This text is summarised in Table 13-1 at the end of Narrative I (pp267-8).

The second narrative is a thematic one. It is construed in terms of ‘tropes’ of Beryl. By this I mean that who Beryl came to be, how she was understood and how her problem was construed, and thus plans of care advanced, resulted from the way she figured for participants in their talk about her. There were a number of tropes whereby

Beryl was characterised, such as her social background and her civil liberties, as will be detailed later.

I turn now to the first narrative.

13.2 Narrative I: time, place, people, plot

13.2.1 Time

Beryl featured as a case for the research study throughout the twelve-month fieldwork period. She was first mentioned in this context at the second Team A weekly meeting that I attended, under the ‘patients to discuss’ slot. Beryl had been a patient of psychiatric services for more than twenty years, receiving a range of treatments, from asylum to hostel to out-patient care. Her latest in-patient episode had occurred a year previously and she had since been receiving community care on CPN1’s caseload.

Beryl was next raised in formal team discussion (and thus was an occasion of research observation) at the ‘community round’ meeting some six months later. Things went quiet again for almost 3 months, when the ward manager reported on admissions to the in-patient unit at the weekly team meeting that Beryl had been admitted. Of course these gaps between observed occasions do not mean that Beryl did not feature at all in these intervening periods, either during other formal occasions (e.g. clinical supervision) or informal conversations or other meetings, not observed by the research. However, interviews conducted with CPN1 (study month 8) did establish that, except for a meeting between CPN1 and the ART during study month 2, these two formal occasions had been the main times of mention.

Following her admission to the psychiatric unit, Beryl then featured for discussion at every weekly ward round during the next three months (study months 10-12). As the research fieldwork came to an end the team were looking to prepare a

discharge plan which would allow Beryl to return home, and which would include the transfer of the KW role over to a member of the ART. While the substantive story for the research ended there, and I do not know if, or when, these plans came to pass, I did hear on the grapevine some four months later, that CPN1 had only that day transferred KW responsibility for Beryl over to ART.

13.2.2 Place

The key forums where Beryl was mentioned were the weekly team meeting, the community round and most especially in this story the weekly ward round. The nature of the weekly team meeting featured extensively in Part Three and the previous chapter here of Part Four so I will not revisit this again.

As the ward round is the main forum featured in this story I will say a little more about it. Patients on the ward were divided up between each team's two CPs who acted as RMO. Each CP held a ward round in order to manage this responsibility, most of which was delegated on a daily basis to more junior medical staff and nurses. One morning a week three hours was spent reviewing each in-patient, in turn, each patient raised for discussion (of varying lengths) in alphabetical order. Case notes stored in a mobile filing cabinet drawer would be used to run through each patient and further action recorded therein. The SHO would usually present each patient using the case notes. The ward round was treated by the CP as an opportunity to actively tutor the SHO. The 'rounds' were also more intimate occasions, with a much smaller group of staff – those linked as KW or named nurse, say, with patients also on the CP's caseload. And there was a higher degree of informality and friendliness in this smaller group with more time than in the weekly team meeting. The particular CP involved with Beryl

(CP1) usually brought along his coffee jar and a plate of jam doughnuts for everyone (including the researcher)⁴² to share.

There was also one CPA review for Beryl during the research period. This was held in the same room as the weekly ward round, though it was much more formal in nature and included a much expanded group, covering both those internal and external to Westway involved with Beryl. Further, given the complexity of the case and establishing a care plan agreeable to all these parties, this meeting was chaired by the Team A Sector Manager, who offered to do this saying it would free up the clinical members of the team while ensuring there was steering of the discussion.

13.2.3 People

There were at least 20 people involved with Beryl's case, most of these during the time she was an in-patient. This number refers to those who played some part in clinical discussions of her case. Most of these people were Westway employees, with the exception of some social services staff and Beryl's relatives. There were others who were involved with Beryl's care such as other nursing and domestic staff on the ward.

⁴² When I first attended these rounds I endeavoured to keep a low profile in the room and did not want to clamber over others in the rather cramped room to get coffee and a doughnut. I was also aware of my visitor status and did not want to seem presumptuous of the hospitality. However, the CP made a point of inviting me to join with them in the coffee break and on the couple of occasions when I arrived after the break, he interrupted the meetings to joke with me as to whether I would take a doughnut or not. As noted in Part One, there was no point when participants were not aware of my presence and indeed would take opportunities to 'play' with this. This 'awareness' might well have some bearing on the deliberations I observed regarding Beryl, given my declared interest and sampling of her case. However, the nature of the round meant I tended to observe reviews of one or two other patients in addition to Beryl and these did not seem to appear significantly different kinds of discussion.

There was a core of people involved with ward rounds from week to week. This included the CP, the SHO, the WM and sometimes one or two other nurses and one of the OTs. In addition, KWs from the community side of the sector team (CPNs and SWs) to those patients on that particular CP's list would also attend. The number was usually around 8 staff, with some changeover as some of the community-based staff arrived for 'slots' in the round when their patient was expected to come up⁴³. As with other team meetings, patients were not invited to ward rounds⁴⁴. Beryl was a participant by proxy in the sense that people spoke for and on behalf of Beryl, and thereby produced many Beryls with different view points and preferences.

As I have hinted already, though there was a core of people involved with the case during ward rounds from week to week, the composition of this core varied. While the ward rounds were made up of those linked as KW or named nurse, say, with patients also on the CP's caseload, these were not necessarily always specific to Beryl. Thus SW2 was a frequent attender at these rounds and seemed to be there both for her own keyworked cases as much as her colleague's, SW1, who was the named SW from Team A involved with Beryl's case, but who was not always present. Similarly with regard to CPN1, the original KW for Beryl – she was assisted by a student CPN who was actually supervised by CPN2, and on some occasions when CPN1 was not present but CPN2 was (for other patients in the round), queries were sometimes directed her way. Indeed CPN1 was not present for many of the ward rounds during the three months studied.

⁴³ I too was invited for the slot on Beryl. This was a rough appointment for all of us as patients were usually covered in A-Z order unless a KW could only make a specific time, and so invariably those visiting for part of the meeting would usually be participant for discussions about one or two other patients, and depending on timing of the coffee break this might occur after as well as before 'one's slot'.

⁴⁴ Only one of the three sector teams' six CPs regularly invited patients to ward rounds. This practice was mostly frowned upon by staff as too intimidating for patients.

And again SW1 also had a student on placement with him for some of this time period, who attended some of the ward rounds, though, not surprisingly as a novice, his role was mostly limited to reporting information back to SW1 rather than contributing to discussions. Further changes in personnel resulted from both medical staff leaving during the period of Beryl's stay on the ward. Thus, there was the regular six monthly rotation of SHOs (5 weeks into Beryl's admission) and the psychiatrist, CP1 was seconded to a development project, to be replaced by a locum, CP2 (9 weeks in to Beryl's admission).

These various comings and goings of different people need to be read against a further caveat. Those mentioned as 'key players' in Table 13-1 (below p267-8) were those who were main contributors to the discussion of Beryl on those particular clinical (researched) occasions. On some occasions there were others present (as noted above) who either did not participate in the discussion or only did so in minor ways, and there were others who were doing or saying things which affected Beryl's case who were not present.

13.2.4 Plot

As noted above, Beryl was 'on the books' of Team A, and had been for some time. Her keyworker, CPN1, noted in April 1996 that she was having trouble in getting access to Beryl, that this was nothing new, but given Beryl was on the Supervision Register and deemed to be at high risk of self-neglect, she sought help in management of the case. She had received messages via the social services district office manager, who had been contacted by concerned relatives, having had no contact with her themselves. The team discussion resulted in the decision to establish a three-way KW group, comprising CPN1, CP1 and SW1. Little more was heard about the case. Some six months later in October 1996, CPN1 raised the patient with CP1, noting that despite countless letters, telephone calls and trips over to the patient's flat, she had still been unable to make

contact. She had also drawn a blank with neighbours and the milkman (sources of indirect contact previously). She now wondered if Beryl should be placed under section, though CP1 favoured maintaining Beryl on the Supervision Register and persisting with attempts to make contact, agreeing to be more proactive himself. This was how matters were left. Then three months later at the beginning of January 1997, Beryl was admitted to the team's psychiatric ward under section 2 of the MHA. This followed Beryl's admission initially to the adjoining general hospital's medical ward for treatment of frostbite to one of her feet. The team then faced the problem of how to proceed from this point.

The basic plot was 'what do we do about Beryl?'. She had been presented to Westway staff as someone needing their treatment via the concerns and involvement of other people and agencies (social services, neighbours, the police and general hospital medical staff), which had resulted in her admission as a psychiatric patient under section 2 of the Mental Health Act. In order to determine what to do, the various people involved with her treatment/care needed to work out what the problem was, and this in turn was pursued through working out *who* she was. Thus the secondary plot was 'who is Beryl?'. As earlier chapters in Part Four have shown, the process of acceptance of someone as a psychiatric patient, and even possibly diagnosis of psychiatric illness, is one pursued (at least in part) through understanding a person's actions and personality – characterising the person in order to serve as a warrant for some kind of action.

This process of characterisation was not straightforward, however. Westway staff were acutely aware of the moral terrain upon which such work placed them. There are a number of social and medical matters to be understood in characterising someone as a psychiatric patient. With respect to Beryl, this included the ascription of motive and delineation of personality, which in turn were seen to be informed by issues of family

background, ethnicity, age and life experiences including previous psychiatric experiences, and possible confounding factors with regard to current physical health status. And all this had to be balanced against the rights of the patient and responsibilities of staff as mental health care professionals that come with, and are heightened by, enforced psychiatric care. Thus issues of safety and civil liberties also figured in this process of understanding Beryl. This is a lot to handle, among a number of different people, and so it is not surprising that Beryl figured as something of an enigma throughout this process. From the perspective of narrative, however, Beryl as enigma serves the essential function of many stories whose plots turn on the resolution of some muddle or mystery.

Amidst the muddle of what to do, there also emerged a sub-plot. Two different care plans began to emerge over the period, one with CPN1 *vis a vis* the ART and a long-stay rehabilitation residential option; the other somewhat more nebulous and uncertain for a long while, but pursued by many others, and geared to respecting Beryl's perceived wish to live in her own home.

During the three-month research period when Beryl was an in-patient, she was transferred to a section 3 of the MHA. Beryl lodged an appeal against the section and later, guardianship proceedings started to be pursued in the run up to a CPA Review. The review was arranged with a view to establishing who was doing what and agreeing a common plan, given the dual preparatory discharge plans that had emerged by the end of March 1997. This review was held at the beginning of April 1997, a full 12 months after Beryl had first been raised by the team. The fieldwork then ceased.

It is not clear exactly when Beryl was discharged from the ward or the precise terms of her actual aftercare. However, she continued under the care of CPN1 as KW for approximately four more months prior to KW transfer to ART.

This is the nature of the first narrative. But there is more to the story of Beryl.

That is where Narrative II comes in.

Table 13-1: Narrative I The story of Beryl

<u>TIME</u> <u>(Research Study</u> <u>Period)</u>	Month 1 wks 1-5	Month 2 wks 6-10	Month 7 wks 27-31	Month 10 wk 40	Month 10 wk 41	Month 10 wk 42	Month 10 wk 43	Month 11 wk 44
<u>EXTERNAL</u> <u>EVENT</u>				Admn. Medical ward. Frostbite to foot				
<u>CLINICAL</u> <u>OCCASION</u>								
I-I or Informal Contact		Request transfer Beryl to ART						
Team Meeting	Lost contact				Admn psy. unit			
Community Round			Still no contact. Sup. Reg. Or Section					
CPA Review								
Ward Round					Guardianship v SD? Section 3? Physical ill health	Apply Section 3? Displace nearest relative? Physical v. mental problems? SSDM & SW1 no show/no apologies	B. much improved. No discernible MI. Still apply Section 3?	Anticipate Section 3. Anticipate B. appeal.
<u>KEY PLAYERS</u>	CP1, CPN1, SW1	CPN1	CPN1, CP1		CP1, SHO, WM, SW2	CP1, SHO, WM, CPN2, SW2	CP1, SHO, WM, SW1	SHO, WM, SW2
<u>ACTION</u>	3-way KW	Provisional agreement to transfer	Put B. on Sup. Reg.		Invite SSDM to next WR - explore MHA/other options	Arrange Section 3: SW2 to pass on to SW1	SW1 & SSDM to visit B's brother. Pursue guardianship idea.	
<u>UNDER MHA</u>					<u>Section 2</u>	<u>Section 2</u>	<u>Section 2</u>	<u>Section 2</u>
<u>STAGE</u>	Community care			General Hospital	Psy In-patient wk 1	Psy. In-patient wk 2	Psy. In-patient wk 3	Psy. In-patient wk 4

Table 13-1: Narrative I The story of Beryl

TIME (Research Study Period)	Month 1 wks 1-5	Month 2 wks 6-10	Month 7 wks 27-31	Month 10 wk 40	Month 10 wk 41	Month 10 wk 42	Month 10 wk 43	Month 11 wk 44
EXTERNAL EVENT				Admn. Medical ward. Frostbite to foot				
CLINICAL OCCASION								
1-1 or Informal Contact		Request transfer Beryl to ART						
Team Meeting	Lost contact				Admn psy. unit			
Community Round			Still no contact. Sup. Reg. Or Section					
CPA Review								
Ward Round					Guardianship v SD? Section 3? Physical ill health	Apply Section 3? Displace nearest relative? Physical v. mental problems? SSDM & SW1 no show/no apologies	B. much improved. No discernible MI. Still apply Section 3?	Anticipate Section 3. Anticipate B. appeal.
KEY PLAYERS	CP1, CPN1, SW1	CPN1	CPN1, CP1		CP1, SHO, WM, SW2	CP1, SHO, WM, CPN2, SW2	CP1, SHO, WM, SW1	SHO, WM. SW2
ACTION	3-way KW	Provisional agreement to transfer	Put B. on Sup. Reg.		Invite SSDM to next WR - explore MHA/other options	Arrange Section 3: SW2 to pass on to SW1	SW1 & SSDM to visit B's brother. Pursue guardianship idea.	
UNDER MHA					<u>Section 2</u>	<u>Section 2</u>	<u>Section 2</u>	<u>Section 2</u>
STAGE	Community care			General Hospital	Psy In-patient wk 1	Psy. In-patient wk 2	Psy. In-patient wk 3	Psy. In-patient wk 4

<u>TIME</u> <u>(Research Study</u> <u>Period)</u>	Month 11 wk 45	Month 11 wks 46	Month 11 wk 47	Month 12 wk 48	Month 12 wk 49	Month 12 wk 50	Month 13 wk 52	4 Months after end study
<u>EXTERNAL</u> <u>EVENT</u>							GP visit B on ward	
<u>CLINICAL</u> <u>OCCASION</u>								
1-1 or Informal contact		Res. Int. B. reasonable/logical. Previous social/healthcare abuse problem? Passive madness?	Res. Int. B. should be in Rehab. Resid. B. SWM.. Hypothermia led to MI.	CPN1 visit B. on ward Contact 'hopeless'.	CPN1 + ART staff visit B. on ward. Rehab resid future?			
CPA Review							Explore/agree risks. Consider resid. options. Clarify remit guardianship. Consider who best KW? Other support?	
Ward Round	B. appealed against Section 3. B angry & aggressive. B. isolates self. B. claims foot septic. B. getting worse?	Foot septic but B resist wound dressing. B. refuses cooperation prepare for appeal/Tribunal Report B. not psychotic but delusional. B. logical. B. Obsessional.	B. delusional? Schizophrenia? Foot worse - risk amputation Rehab. Residential unit L/T!?	Foot worse. Review Psy. Meds. Debate: B. better or worse? Staff responses to B.	Review depot via C&R. Limits of MHA/civil liberties. B. improved - less hostile.	Confusion/disagree- ment over Rehab. Resid. idea. Caused setback in B. Need to est. who involved in case and how.		
<u>KEY PLAYERS</u>	SHO2, WM, SW2, OT	CP1, SHO2, WM, SW1	CP1, SHO2, SN, OT, CPN1	CP1, WM, CPN1	CP2 SHO2, WM, N x2	CP2, WM, OT, N x2	SM, CP2, SHO2, CPN1, SW1. WM, N, GP, ARTM, B's brother	
<u>ACTION</u>	Specific invite to CPN1 & SW1 to next WR	Pursue guardianship	Depot via IMI using C&R. Wound dressing	Confirm further depots. Arrange Tissue Nurse examine.	Increase psy. meds dose so less frequent admin	Arrange CPA review.	Prepare discharge plan. Apply guardianship. Aim remain own accom. Agree transfer KW to ART	Case transfer CPN 1 to ART
<u>UNDER MHA</u>	<u>Section 3</u>	<u>Section 3</u>	<u>Section 3</u>	<u>Section 3</u>	<u>Section 3</u>	<u>Section 3</u>	<u>Section 3</u>	
<u>STAGE</u>	Psy. In-pat. wk 5	Psy. In-patient wk 6	Psy. In-patient wk 7	Psy. In-pat. wk 8	Psy. In-pat. wk 9	Psy. In-pat. wk 10	Psy. In-patient wk 12	

<u>TIME</u> (Research Study Period)	Month 11 wk 45	Month 11 wks 46	Month 11 wk 47	Month 12 wk 48	Month 12 wk 49	Month 12 wk 50	Month 13 wk 52	4 Months after end study
<u>EXTERNAL EVENT</u>							GP visit B on ward	
<u>CLINICAL OCCASION</u>								
1-1 or Informal contact		Res. Int. B. reasonable/logical. Previous social/healthcare abuse problem? Passive madness?	Res. Int. B. should be in Rehab. Resid. B. SWM.. Hypothermia led to MI.	CPN1 visit B. on ward Contact 'hopeless'.	CPN1 + ART staff visit B. on ward. Rehab resid future?			
CPA Review							Explore/agree risks. Consider resid. options. Clarify remit guardianship. Consider who best KW? Other support?	
Ward Round	B. appealed against Section 3. B angry & aggressive. B. isolates self. B. claims foot septic. B. getting worse?	Foot septic but B resist wound dressing. B. refuses cooperation prepare for appeal/Tribunal Report B. not psychotic but delusional. B. logical. B. Obsessional.	B. delusional? Schizophrenia? Foot worse - risk amputation Rehab. Residential unit L/T!?	Foot worse. Review Psy. Meds. Debate: B. better or worse? Staff responses to B.	Review depot via C&R. Limits of MHA/civil liberties. B. improved - less hostile.	Confusion/disagree- ment over Rehab. Resid. idea. Caused setback in B. Need to est. who involved in case and how.		
<u>KEY PLAYERS</u>	SHO2, WM. SW2, OT	CP1, SHO2, WM, SW1	CP1, SHO2, SN, OT, CPN1	CP1, WM, CPN1	CP2 SHO2, WM, N x2	CP2, WM, OT, N x2	SM, CP2, SHO2, CPN1, SW1, WM, N, GP, ARTM, B's brother	
<u>ACTION</u>	Specific invite to CPN1 & SW1 to next WR	Pursue guardianship	Depot via IMI using C&R. Wound dressing	Confirm further depots. Arrange Tissue Nurse examine.	Increase psy. meds dose so less frequent admin	Arrange CPA review.	Prepare discharge plan. Apply guardianship. Aim remain own accom. Agree transfer KW to ART	Case transfer CPN 1 to ART
<u>UNDER MHA</u>	Section 3	Section 3	Section 3	Section 3	Section 3	Section 3	Section 3	
<u>STAGE</u>	Psy. In-pat. wk 5	Psy. In-patient wk 6	Psy. In-patient wk 7	Psy. In-pat. wk 8	Psy. In-pat. wk 9	Psy. In-pat. wk 10	Psy. In-patient wk 12	

13.3 Narrative II: tropes of Beryl

Each mention of Beryl at team meetings and ward rounds occasioned attempts to characterise this patient for the team. Such efforts were attempts to gain an understanding of what the problem was and what solution was required. This was by no means an easy task, for staff reported their attempts to engage with Beryl as very difficult with contact only at times of crisis or in extreme events. Beryl figured in many different ways for team members, and not just differently for different members, but also differently for the same team members. These somewhat contrary descriptions of Beryl can be traced through a number of ‘tropes’ that characterise the accumulated talk on this case. These tropes represent the ways in which Beryl as patient figured for members as they tried to make sense of her/determine the problem. Some of these overlapped and intertwined, and some featured in more minor ways than others. Several of the sub-sections below contain extended chunks of data as it is only in this way that it is possible to capture the shifts both within and between meetings which demonstrate the way this case proceeded and how Beryl figured as work for the team.

13.3.1 Arrival

The circumstances of Beryl’s admission and how she initially presented during the current episode was a matter of different opinion. The ward manager focused upon Beryl originally being admitted to the general hospital for her frostbite and hypothermia, but being quickly discharged to the psychiatric unit because they could not deal with her on the medical ward (Ward Round, Beryl in-patient wk 1, section 2; CPA Review, Beryl in-patient wk 12, section 3). The KW, CPN1, however, believed Beryl was admitted following a report from the milkman who had got concerned about her (Interview, Beryl in-patient wk 4, section 2). (On previous occasions staff

had noted that Beryl's main contact was with the milkman.) However, by the time of the CPA review we heard a fuller, documented account of Beryl's admission. The SHO reported that Beryl had been admitted following a neighbour calling the police having heard her screaming. The police had called the medics in, resulting in her admission to the general hospital for frostbite (CPA Review, Beryl in-patient wk 12, section 3).

So there are a range of knowledges and 'facts' about the case, a mixture of assumption and interest in different stages of the process leading up to admission that figured variously for participants in the story of how Beryl came to be sectioned and admitted on this occasion. Circumstances of arrival are important however, as this is the beginning of the story and feeds into accounts of Beryl as staff attempt to evaluate her condition.

13.3.2 Social background or pathology?

One resource which team members resorted to in trying to make sense of Beryl and identify her problem was to look to her background. But here again what this was and how it was used with reference to Beryl varied greatly depending on who was speaking and when.

First there was the matter of Beryl's ethnicity. At the first ward round, while running through the background to the case, CP1 notes she is "half Spanish". When a different psychiatrist, CP2, takes over the ward round, and having already spent some time with Beryl and staff as part of the handover earlier that week, she queries if she is South American (Ward Round, 12/3/97, Beryl in-patient wk 9, section 3). In response the ward manager and a nurse describe her as "Caribbean – St. Kitts. She talks with one of the nurses who also comes from there." At the CPA Review a couple

of weeks later the SHO reports, using the medical notes that Beryl “was born in Surinam” (CPA Review, Beryl in-patient wk 12, section 3).

While none of these descriptions prior to the CPA Review was totally off-beam, neither were they precisely correct. Yet as later discussion will show, part of evaluating Beryl included reference to her ‘cultural background’. From the outset Beryl figured in somewhat enigmatic form: she arrived in the psychiatric unit through some kind of drama, which is shrouded in mystery for some while; and further back still she arrived from somewhere far away, some other, unknown part of the world.

Another aspect of Beryl brought in as significant was her family background. SW1 introduced Beryl’s family background positively, giving some credence to the views of her relatives locating Beryl’s present difficulties in the mental health system and her previous treatment:

EXAMPLE 28: Interview, Beryl in-patient wk 6, section 3.

The other interesting thing about it is that the family are fascinating, they’re ever so nice, the brother is a lovely bloke. ... Basically they feel that she’s like she is because she had a minor breakdown [around 25 years ago] and that at that point she was taken in to [name of old local asylum] and given ECT. And I don’t know at that point, I’m guessing, but I don’t know if they gave ECT under anaesthetic, and they gave her the very strong anti-psychotic medication, which was like sledgehammer stuff in those days. And that, that, her mental state now is a direct result of that, which is why they are so anti-medication. Because they feel it’s already really screwed her head up. And I think that’s quite interesting, and they might even be right, and they know her pre mental health.

While CP1 had also shown some regard for understanding Beryl in a socially dynamic sense, at other times he also demonstrated a much more conventional, and arguably contradictory, medical modality. During one ward round the discussion turned to racism and to the discrimination Beryl might well have suffered since coming to live in Britain as a possible significant explanatory factor in her ‘oddness’. At this point CP1 reminded the group that old notes indicated problems of mental

illness with the patient's mother, though no problems with the siblings who were all deemed to be successful adults. The CP then abruptly summed up this part of the discussion saying "possible cause is family pathology" (Ward Round, Beryl in-patient wk 7, section 3). While there was a pressure to move on with the agenda, especially when the ward was full and/or there were many particularly problematic patients to discuss, this latest contribution produced yet another element of sense-making that held off ready closure on the 'facts' of the case.

Here the family was a resource in the production of two quite different senses of Beryl. In one the family is used to understand Beryl's past and to accept her as someone who did not always have a serious mental illness. Whereas in the other, details of social background, a family history of mental illness, is referenced as pathological evidence.

13.3.3 Diagnosis: physical or mental problem?

The accumulated discussions about Beryl indicated a good deal of confusion about just how to diagnose her. Some of these confusions turned on whether Beryl's problems were the result of physical illness, which would have consequences for mental health. While at other times, or even moments within the same meeting, there was a sense that there was a clear, independent, mental illness. Moreover, the physical also figures variously as evidence for both negative and positive evaluations in the assessment of mental illness or not.

At the first ward round CP1 says she is "definitely psychotic" (Ward Round, Beryl in-patient wk 1, section 2).

But then by the following week CP1 starts off the discussion by saying:

EXAMPLE 29: Ward Round, Beryl in-patient wk 2, section 2

CP1: She's much improved. There's now no discernible mental illness.

Three weeks later discussions are going over the ground of the previous two rounds where Beryl's frost-bitten foot is now seen to be much more of a problem: she has refused to let nurses dress it and there are fears it may have to be amputated. Further, she has refused medication and while she has appealed against her detention, she has refused to cooperate with SW1 for the tribunal report he is preparing. The sense is that Beryl has deteriorated. The CP then states:

EXAMPLE 30: Ward Round, Beryl in-patient wk 6, section 3

CP: The problem with the patient is that she is not psychotic but delusional.

This last statement demonstrates an intriguing use of terms, since delusions are usually diagnostic of psychosis. Although given references also in the past few weeks to Beryl's thyroid problem it is possible he has in mind a physical illness rather than a mental illness *per se*.

The following ward round begins with reports from a ward nurse and the SHO. They seem to be running with the diagnosis proffered by CP1 the previous week:

EXAMPLE 31: Ward Round, Beryl in-patient wk 7, section 3

*Report from ward nurse and SHO: Beryl is delusional.
CP1 reminds them of the need to note the content of the delusions - to be sure of this and note the evidence.
Nurse & SHO note that Beryl thinks the ward staff are undercover police officers.*

CP1: There's a case here for schizophrenia.

...

Nurse: Her foot's got increasingly worse - it's dripping now. And the sedation is having little effect.

CP1: This is an indication of how aroused she is. So it's becoming apparent she's psychotic and her physical health is at significant risk now.

So we see some shifts in diagnosis made by CP1 over this seven week period, including some within the space of a few sentences of one discussion. This is not something which appears to trouble other team members - it is not occasioned for discussion during the ward rounds including those where CP1 is absent, nor is it mentioned in interviews. There is also some interesting use of *ad hoc* terms. Not all these terms are mutually exclusive but they do suggest different emphases and perception of what the main mental health problem is at the very least.

This ‘looseness’ could also be related to another layer of the story about Beryl, which was her physical health state and how this might then in turn be the cause for her mental ill health state. Or was it the other way round? This was another debate that framed discussion about Beryl during the three months observation of her admission.

Beryl’s frostbite and hypothermia were interpreted by staff as evidence of severe self-neglect. Beryl was reported as claiming not to like heating on in her flat, preferring to keep warm by walking about. She found the temperature on the ward uncomfortable. However the thyroid problems may have led to changes in perception, which in turn might explain the self-neglect:

EXAMPLE 32: Ward round, Beryl in-patient wk 2, section 2

CP: ... It’s possible the mental illness is due to thyroid problems and there are breast lumps too.

Nevertheless, whether it is physical illness that has produced a perceptual problem or whether there is a mental illness that has produced self-neglect is not determined. Instead there is a shifting back and forth between different versions of Beryl.

13.3.4 Eccentric or ill?

Thinking in terms of a social modality amidst the complexity of medical modalities referred to earlier, also creates another spin on characterising Beryl, realised through the trope which wonders if Beryl is really mentally ill or simply eccentric. Some of the thinking on her draws on other tropes discussed so far with regard to Beryl's cultural and social background.

At the first ward round the psychiatrist sums up for the group:

(EXAMPLE 33: Ward Round, Beryl in-patient wk 1, section 2)

CP1 notes Beryl has had several MHAs and refuses intervention. She only eats curdled milk. She's half-Spanish. She's been admitted now suffering frostbite and hypothermia.

SW2 thinks the curdled milk may be a cultural thing noting that she remembers from her own childhood how her grandma would leave milk to get 'yoghurty'.

...

CP1: A formidable woman. On visits she waves the tribunal report about being allowed to live an eccentric lifestyle and then tells us to go away.

And by the following week:

Example 34: Ward Round, Beryl in-patient wk 2, section 2

CP1: We need to get the balance between what's psychotic and what's simply eccentric. If her mental health is stable then we need to look at her environment. I'm unhappy forcing medication on her and would be happy if she can be made safe.

WM agrees with this.

The meeting ends with a decision to go for a section 3 to keep Beryl admitted for longer while they can attend to her environment on discharge, ensuring suitable accommodation and support with meals.

While this debate doesn't figure quite so obviously at further ward rounds, it is still present for certain participants. It is the subtext to discussions about the degree and type of intervention that is appropriate and respectful of Beryl's civil liberties

(discussed below). And some weeks later at the CPA Review the debate is raised again, this time by the GP, a new player to the group discussions so far. He raises his concerns that, though he has not seen her in the past three months, it is possible that Beryl's problem is eccentricity more than mental illness especially when one looks at her eating habits (CPA Review, Beryl in-patient wk 12, section 3). Similar concerns are also expressed by team members individually. Thus SW1, in reference to Beryl only eating curdled milk, notes that "we all like to eat cottage cheese" but also that "there's no two ways about it, she's got an ulcer on her foot which I'm guessing is a direct result of the frostbite" (Interview, Beryl in-patient wk 6, section 3).

In contrast, the interview with CPN1, indicates some exasperation with debating such possibilities.

EXAMPLE 35: Interview, Beryl in-patient wk 7, section 3.

... Beryl needs some kind of supervision, or she will starve herself or neglect herself until she dies. And every time I've brought this up at a meeting everyone's said [adopts a wimpy tone] 'well umm, well umm' and that's as far as we went. And even this time when she was taken in with frostbite and hypothermia, there were still discussions whether this lady should be allowed to do this or no. My belief is that erm, one doesn't intentionally die of hypothermia, one becomes so, you know, there's psychological retardation and depression. These are people who are unable to do anything about it. And I, I felt that if, there was something which *should be done*, a lot, lot of well-intentioned people er were saying 'I'm sorry we can't do anything about this'. And I think that's even worse because it's happened several times before.

Not only did CPN1 have little time for considering the merits of respecting eccentricity but her understanding of Beryl contained an interesting take on the attribution of causality. For her, hypothermia impaired mental capacity, but elsewhere, as noted above on the ward rounds, it was also considered that it was impaired mental capacity that led to hypothermia. Causation is important, as which came first, mental or physical problems, had implications for treatment and the kinds of intervention the team felt were legitimate. Though, to add further to the

contrariness, here the notion that the physical problem leads to the mental does not in turn raise constraints for CPN1 as to type of intervention: contra colleagues views in the ward rounds it is precisely this problem for which “supervision” is seen to be required. Certainly what is evident are different frameworks for staff (each containing their own particular mix of professional and moral discourses) as to how they make sense of Beryl, how they problematise the case and as a result consider intervention.

This last point also raises the issue of what was allowable and what was acceptable. This is considered in the final part of this section below.

13.3.5 Civil rights v welfare/safety

The tropes discussed so far, in particular the last two, have indicated moral dimensions to the evaluations. This was explicit for the staff in the last trope to be considered. The issue of ‘what should be done’, was underpinned by concerns to balance Beryl’s civil liberties with staff responsibilities for her welfare and safety. Beryl’s resistance to intervention from the mental health service combined with self-neglect that brought her into hospital periodically under sections of the MHA, posed dilemmas for the staff about how best to proceed. This debate featured throughout the period of observation, though with different supporters on each side of the debate within the staff group at different times. The other spin on this debate was the evident uncertainty among the group about the legal powers available to them and how to apply them.

CP1 introduced the dilemma of how much intervention, if any, at the first ward round. There was also uncertainty about the use of supervised discharge versus guardianship. The legal side of the case seemed to be complicated by the fact that Beryl had been admitted under a section 2 by staff from another (emergency)

psychiatric team. This was felt to be inappropriate because of her other admissions and the known objections of the nearest relative.

EXAMPLE 36: Ward Round, Beryl in-patient wk 1, section 2.

CP1: This is a woman who will one day die from chronic mental illness and neglect and there are limits to what we can do. There's also a moral issue here too as she refuses intervention. So what do we do?

SW2: Guardianship?

CP1 queries the use of this. Discussion then among CP1, WM, SHO and SW2 on the merits of guardianship versus supervision register⁴⁵ and supervised discharge. SHO, WM and SW2 all agree that all supervised discharge offers is the power to convey. But there's uncertainty about the supervised discharge and when to use vis a vis guardianship. SW2 suggests they consider supervised discharge when they all meet again next week and with SSDM present [who has been involved previously].

CP: Anything else?

WM [shaking her head]: We've demonstrated we've thought about it.

CP: I wonder if we should re-grade the section to a '3' and possibly seek guardianship?

WM: Re-grade sooner rather than later.

CP: That needs to be on the agenda as well then for next week.

These debates and uncertainties about due legal procedure continue at the next ward round. The first part of the discussion is devoted to trying to work out which is most appropriate, guardianship or supervised discharge, then:

⁴⁵ Guardianship allows for the supervision of a person in the community by granting legal powers to 'the guardian', usually an employee of social services, or more rarely, a relative. The powers include being able to impose requirements about residence and attendance for treatment, though this does not include power to compel a person to accept treatment. Commonly used where the person has limited needs for medical supervision, but pressing needs for social supervision. Supervised Discharge was introduced by the Mental Health (Patients in the Community) Act 1996 to deal with 'revolving door' patients. It has the same powers as guardianship together with the power to convey a person to the address specified for treatment, but as with guardianship not powers to compel treatment or enforce detention (Open University *et al.*, 1996).

EXAMPLE 37: Ward Round, Beryl in-patient wk 2, section 2.

CP1: The aim is to ensure she does not die versus not being too intrusive. Do we enforce treatment? What are the benefits of this? Are they outweighed by disadvantages - we've got to think about the patient's dignity. It's possible the mental illness is due to thyroid problems and there are breast lumps too. ...

CP: We need to get the balance between what's psychotic and what's simply eccentric. If her mental health is stable then we need to look at her environment. I'm unhappy forcing medication on her and would be happy if she can be made safe.

WM agrees with this.

Decide to go for a section 3 and if necessary displace the relative⁴⁶.

However, despite this apparent sense of clarity, at the next ward round CP1 starts off the discussion by noting that Beryl is much better and then goes on to question the decisions he himself initiated the previous week. He now suggests they concentrate on her living conditions rather than her mental health:

EXAMPLE 38: Ward Round, Beryl in-patient wk 3, section 2.

CP1: She's much improved. There's now no discernible mental illness. Should we still do a section 3? I wonder about guardianship?

No one responds. CP then says they need SW1 to join them now [it seems he's in the building]. ...

CP: There's a moral issue here. I want to be clear why we're doing what we do because we cause the patient much distress by aggressive intervention and detention.

WM: The choice is you end up in the coroner's court or she stays here and it could be that is what she wants.

CP: To be sure we need to look at the balance of risks.

At the same time as still wondering whether to intervene there is also the issue of precisely the right way legally to do it, so a little later in the meeting:

⁴⁶ This reference is to the 'nearest relative' under the MHA 1983 who can veto their relative's detention under the Act. However, the Act allows them to be displaced in order to effect a detention. It is often a mystery as to who exactly is the 'nearest relative', and in practice detentions are often made without a relative being involved at all.

EXAMPLE 39: Ward Round, Beryl in-patient wk 3, section 2.

SHO notes how Beryl insists that she can only be seen under an 'Act of Parliament'. CP1 not sure what this refers to, and SHO says she's not sure. She turns to me.

SHO [to researcher/me]: Do you know what Act of Parliament this is?

Before I can reply SW1 has entered the room and says:

SW1: That's my responsibility isn't it?

SW1 checks they still want a '3'. ... Then he explains he's due to see Beryl's brother next week with SSDM. Also started to re-look at the '2' and pursue guardianship, which means "an automatic extension of the '2'".

On the last statement by SW1 there are two ways of reading the reference to 'extending the 2'. There is no automatic extension of a section 2, which terminates automatically after 28 days. It is possible that even the social worker, as an ASW who usually is most knowledgeable about mental health law, is unclear about the terms of the section. But, it also possible, (and likely), that this is a rather loose and shorthand figure of speech to explain that the initial detention under section 2 is being extended via the application to apply a section 3. However, there is room for doubt and for those members of staff who lack expertise in this area or who are training (such as SHOs) this creates yet more ambiguity.

Four weeks later as both the condition of Beryl's foot and her resistance to being detained are thought to be getting worse, CP1 shifts his position in the debate again, now in favour of actively attempting to treat Beryl's mental state (see Example 31). It transpires through further discussion that this means forcibly injecting her with psychotropic medication.

But while this latest exchange indicates the pursuit of a more interventionist approach for now, this does not necessarily apply beyond the immediate situation, as the dispute with CPN1 indicates on her arrival at the meeting a few minutes later:

EXAMPLE 40: Ward Round, Beryl in-patient wk 7, section 3.

CPN1 arrives. CP1 then checks with CPN1 about when Beryl last had a depot?

CPN1: Ages.

CP1 then discusses amount of medication.

CPN1: Is [name of rehab residential home] still an option? What's the long term plan?

CP1: [frowning and surprised]: Who raised this?

CPN1 recalls it as a suggestion by the ART team.

CP1 is concerned about this idea because:

CP1: An institution is not on for a patient who is non-compliant.

CP1 would prefer to explore the housing option where she can't switch off the heating. Results from pursuing guardianship.

CP1: Are you not aware of this?

CPN1: I've not been able to get to the ward rounds.

CPN1 then asks CP1 to consider that Beryl is at more risk and wonders about the number of times she can endure such problems, now she has frostbite. ...

Further discussion then about residential unit option. Decide to leave long term plans for now. But CP1 clearly very unhappy with this option.

Return to discussion about medical treatment. Nurse and SHO2 talk about Beryl's hostility and her energy to resist. Very unpleasant - last time she was injected the needle bent.

CP1 then admits he was previously more ambivalent but increasingly concerned about both her physical and mental health now. It's becoming necessary to treat more aggressively.

CP1: OK if no one else has got any moral or political objections, we'll do the depot and hold off further decisions about discharge and care plan long term 'til we've got her more settled and well as an in-patient.

At the following ward round CP1 revisits what they are doing and whether it is appropriate. The ward manager feels the medication is helping. CP1 disagrees saying "it didn't feel like it" when he saw Beryl the day before. This leads him on to urge that they all consider their own reactions to Beryl and how they feel about her carefully as it is likely to be colouring their discussion about what to do. Despite this, further depots, to be administered via control and restraint (C&R) if necessary, are decided upon:

EXAMPLE 41: Ward Round, Beryl in-patient wk 8, section 3.

CP1: The problem is if we remove the psychosis but we're left with an empty shell and then it's no better. OK, give her 400 of [drug] and we'll know if it's of significant benefit. Review mid April after 3 doses at 2 weekly intervals.

WM: There are problems using C&R when it's not an emergency, but planned medication.

CP1: There's the possibility of losing her foot, which is an emergency. ...

CPN1 & WM joke [though more than half serious feel to it] about what to do and CP1 joins in - not a problem that could lose one of her feet better still cut off both her feet so she would be in a wheelchair and could deal with her more easily.

CPN1: And I could take her flowers and give her a big hug.

CP1: More seriously, that might be what you need to do. The danger and problem is that we, and she, institutionalise our responsibilities and there's Beryl's history plus what she's learnt from her mother.

Wind up then by agreeing to do a CPA review in a couple of weeks as discussed.

So a decision about treatment (enforced medication and attempts to be more personable) is reached, for the time being. The trope used to effect this move turns on rights and responsibilities framed by the possibility of Beryl's foot being amputated. This would be a most visibly negative outcome and thus functions as a most powerful trope within a discussion trying to 'do the right thing' on both patient and staff sides. Indeed staff demonstrate themselves to be highly conscious that these responsibilities have a moral and political flavour, with specific questions asked as to objections of that nature, and thinking about institutionalised responses.

At the next ward round, due to a secondment, CP1 has been replaced. The new psychiatrist, CP2, queries with the staff both the legal procedures being pursued and the forcibly administered medication. Once again these queries turn on the respective rights and obligations with regard to both the patient and staff involved in her care:

EXAMPLE 42: Ward Round, Beryl in-patient wk 9, section 3.

CP2: How do the nurses feel about doing this and every two weeks - it's quite frequent and sounds disheartening?

WM [carefully]: We do what's prescribed.

Nurse: We don't like it but if the patient is better off for it then for me it's a question of balancing out these pros and cons. And it seems to be of great benefit to her. ...

CP2 notes they can't continue this outside the hospital so they need to consider if it really is worth doing.

Discussion continues inconclusively, then CP2 checks BNP and confirms increased dosage of the same drug.

Two of the nurses then say Beryl's foot is still a cause of concern, to which CP2 notes they can't use physical problems as a reason to treat and enforce treatment under the mental health act.

CP2: People with infections like Beryl's foot, get better usually out of hospital.

WM then notes Beryl won't allow access in the community.

CP2 then says it's because of the mental health problems that get self-neglect and then she has to remain here.

Move on to next patient.

Despite these challenges by the new CP to the procedures and treatment being followed, the discussion remains fairly inconclusive. If anything it presents yet more balls to juggle with, as now the possibility of supervised discharge is resurrected together with sooner rather than later discharge. And, while medication, at an increased dosage, is confirmed, the problem of appropriate treatment for this kind of patient has again been raised to be left hanging in the air.

At the next ward round, the option of the rehabilitation residential unit is raised again, following a visit to Beryl by ART staff (Ward Round, Beryl in-patient wk 10, section 3). This has caused great consternation among the ward staff as they had no forewarning of this visit and it seems contrary to the spirit of discussion at a previous ward round (see Example 47). In addition, Beryl has been very distressed by the suggestion and staff feel it has caused a setback in her and in their relations with

her. The group decide to call a CPA Review and move discussion to that arena with a view to drawing up and agreeing a discharge plan with all the various staff involved.

This event raises yet another spate of confusion on the debate about what to do while balancing rights and responsibilities safely - the apparent pursuit of two different and contradictory care plans. One care plan seems to have been pursued by sector team staff through ward rounds; the other pursued by one of the sector team staff the CPN1 and the ART.

13.4 Making sense of 'Beryl'

How can we make sense of these discussions about Beryl? It is difficult to present a coherent account of just what happened. An initial attempt was to tell this story sequentially (Narrative I), but while this puts events in some kind of order, it fails to show what happened to give Beryl a character or to constitute her as tasks. Indeed the linear narrative of a timeline might erroneously suggest an orderliness that this case lacks. And, I have already referred to the spurious kinds of coherence, or even incoherence, such tellings might create. Next, the data were presented thematically (Narrative II), as an approach to examining the movement of ideas and fleeting nature of decisions both within and across the various events about Beryl. The data illustrate just how changeable the situation appeared to be, both between various participants, and for the same individual participants at different moments.

13.4.1 Truth or rumour?

The most striking feature of all this is that there never seems to be a consensus reached about Beryl. The discussion over the various meetings continually invokes uncertainty and a diversity of views without reaching a firm closure on an authorised version of the patient and the problem. Of course the story told here presents a

number of closures, but these were fragile and quickly opened up again. Indeed, it is not possible for me to know whether, and if so how soon, the last strategy I observed being pursued was revised. This was the end of the story for me, but not for Beryl.

Also to say that practitioners have difficulty in producing closures on versions of the patient or strategies of care is not the same as saying they never do and never can. The point is that authorised versions are not impossible, but are difficult to produce, and difficult to maintain.

Perhaps it would be more apt to think of this process as ‘rumours of Beryl’ on the grounds that ‘the truth about Beryl’ seems perpetually problematic to those discussing her and to shift not only from meeting to meeting but within meetings. This is a very different scenario in the processing of patients to that conceived by a labelling perspective. This is potentially a finding with radical import, for while the labelling perspective may not so obviously characterise discussions of clinical settings nowadays, patients still tend to figure in both academic and practitioner accounts as fairly static constructs, or as cases which, while not neatly typified, nevertheless still demonstrate the accomplishment of categorisation (Barrett 1996; Griffiths 1996; Griffiths *et al.*, 1993; Opie 1998). So it is interesting to consider what was happening here and how it was possible.

13.4.2 Doing ambiguity

The first thing to say about what is happening here is that there seems to be a desire on the part of most staff to think as open-endedly as possible about Beryl. But perhaps this is a product of the situation. The situation is one where staff confront an intractable patient. Beryl was a patient who at times experienced severe physical health risks while being very resistant to engagement with the mental health service,

(hence her previous placement on the supervision register). So this admission provided staff with a rare opportunity to deliberate on her with a view to actively engaging with her while she was under their immediate scrutiny and care.

And in deliberating the staff actively seem to perform a ‘rhetoric of ambiguity’. Specifically, they render the situation ambiguous⁴⁷. This is not to infer an intention to cause confusion or uncertainty, but rather indicates through the counter-proposals and blind alleys heard in the talk, a failure to settle on an unambiguous version of the situation. And there are several resources for doing this as the previous section outlined, such as Beryl’s ethnicity, the role of her background, the eccentricity versus illness debate, the physical/mental illness dichotomy, ignorance about mental health law, and so on. Indeed, thinking of ‘rumours’ proposed above, each meeting seems to be an occasion for more snippets of news about Beryl which are available as resources for retelling who she is and therefore what should be done about her.

In interactional terms what is missing from these meetings about Beryl is any closure around an agreed version of the truth about Beryl which persists for more than a few utterances, which entails a commitment to a particular coherent strategy by those present, and against which they could be held to account for not acting either ‘as we agreed’ and/nor ‘in the light of the facts’. So how is this to be accounted for? Two possibilities are considered below.

⁴⁷ The notion of ambiguity is used as a conceptual tool to explore how case talk proceeds. In line with the thesis so far, this allows for a performative analysis of how the situation of this case emerges interactionally without getting caught up in tricky debates about intentionality.

13.4.3 Constructing accountability?

One way of thinking about the various deliberations of Beryl is to see such talk as part of a process whereby decisions could eventually be made accountable, that is, rehearsing the grounds that might be provided if a particular action were selected and then made the subject of censure. In this instance the trope of Beryl's frost bite might be understood as a key resource which is used alternately. First, to signal the limits to respecting Beryl's refusal of medication and claim to be left to live an eccentric lifestyle, should they have behaved in a coercive fashion and should anyone complain that they should not have done so. And second, (and quite contrarily) frost bite as physical condition might be cited as a reason for respecting Beryl's wishes should anyone complain that staff should have used the coercive powers of mental health law inappropriately as a means to enforce a 'physical' treatment.

Treatment decisions need to be set in both a wider organisational and social-political context. In this regard the injunctions from government to mental health care organisations to actively assess and manage risk, places staff in such organisations in the position of possibly needing to be seen to have performed such work, and with regard to this case, there is a very explicit acknowledgement of that at one point (see Example 36). This is to depict staff rather as Garfinkel (1967, Chapter 6) depicts clinic staff as acting (in his case, recording) with a view to the possibility of future censure, while always being uncertain as to what might cause such censure, from what quarter it might arise, and by what criteria they might be judged. However, it was not my impression that staff at Westway were persistently conscious of such risks, and they were only rarely topicalised.

With regard to Beryl's treatment on the ward while an in-patient, it might be argued that all the deliberation about Beryl and what it is legitimate to do, serve to absolve anyone of particular responsibility for doing anything. For, however the truth of a matter is described, it implies that certain actions are legitimate or necessary, and in reverse, that whatever people say is necessary implies that the facts are thus 'such and such'. So whatever is said about Beryl implies the necessity or the inappropriateness of certain actions by somebody present at those discussions. And, the very fact that staff do render the situation ambiguous means it is rare for clear *prescriptions for action by anyone in particular to emerge*. There are some counter instances (the medication by IMI and dosages for instance) but they are beset with doubt and revisited several times.

However, while inaction or lack of a particular care plan seems to be the consequence of what happens, it is not clear if this is the motivation of what happens. Rendering Beryl ambiguous means no one gets committed to doing anything much about her, but it is not necessarily the case that this can be seen as motivated by the desire to avoid doing something or anything. Two proposals are possible: people render situations ambiguous and therefore it is difficult for them to decide who should do what; or, people render situations ambiguous *in order* that they can avoid being committed to doing something that they do not want to do.

It is worth pursuing this by considering under what (organisational) conditions it is possible or unexceptionable for people to render situations ambiguous. The question now raised is 'what are the social conditions for open-ended, problem-solving talk?' This is a way to tackle from the rear one of the central thesis issues, of the

organisational conditions required for robust authorised versions of the truth to be formulated and maintained.

It may be that people are ‘genuinely trying to understand’, it may be that this is ‘consensual, problem-solving talk’, or it may be that this is ‘strategic manoeuvring’. But there is still the question of what kinds of situations allow for people to express their doubts, make counter-proposals against each other, change their minds, ignore what has been agreed previously. One kind of situation this is not, is the kind of situation where one kind of professional dominates all the others. Thus these data stand against the general applicability of the theme of psychiatric dominance (discussed in Part Three). Indeed, although I have referred to the culture of team members in terms of a ceremonial fiction of *primus inter pares*, this turns out to not be such a fiction after all. And there is a material base for the absence of psychiatric dominance insofar as different team members have organisational resources which make them autonomous of each other to some degree. In addition, the way things are organised make it difficult for a psychiatrist or anyone else to police the actions, still less the understandings of all those others involved.

13.4.4 Understanding in uncertain situations

It does not seem that the case of Beryl is so much a ‘contested matter’ or strategically defined. The same people give different versions of Beryl and propose different actions at different times. Perhaps what is happening here is that people are simply trying to understand. It seems that staff are genuinely taxed by the situation and do not know what to do about it. Their discussions are maybe simply attempts to clarify matters and in this sense the talk should be heard as genuine, fairly open-ended, consensual, problem-solving talk. The difficulty for the staff is that clarification is

precisely what eludes them. For as Dennett (1995) illustrates rather nicely, the paradox about using open-ended consensual techniques for problem-solving is that they rarely work, and the more people involved the less they work. The paradox is resolved because reaching an agreement or making a decision is a process of exclusion and unless someone (or some circumstances) rule out all other options, nothing gets decided:

By and large we must solve this decision problem by permitting an utterly 'indefensible' set of defaults to shield our attention from all but our current projects. Disruptions of those defaults can only occur by a process that is bound to be helter-skelter heuristics, with arbitrary and unexamined *conversation-stoppers* bearing most of the weight.
(Dennett 1995, pp510)

There are instances of such arbitrary *conversation-stoppers* in the ward round talk. Those occasions where some action is determined (if only temporarily), do not necessarily follow any prior established logic. For instance in Example 41, having established serious doubt about the efficacy of the medication twice during the discussion, CP1 suddenly moves from an argument about making the problem worse by continuing the medication to an instruction about dosage with regard to the same medication, and that begins the move to wind up talk, which leaves the medication instruction as the decision made on that occasion.

A similar example occurs with CP2 – see Example 42. In the course of a discussion bemoaning the action of administering medication by force and asking the nurses to reconsider this, the CP moves to talk about dosage of the very same medication initially queried and to be administered as before. At some point some sort of action has to be decided upon, however arbitrarily in terms of the rest of the conversation.

Dennett is writing as a philosopher. From a sociological point of view there is the question of *who* is able to stop the conversation. In the data here, almost anyone can. And while it is consultant psychiatrists who are seen to do this most in ward rounds, is not always so. And such conversation-stoppers do not commit anyone, including themselves, much beyond those moments. Almost anyone can stop the conversation and send it off on a new tack, but it seems that no one can easily bring the conversation to a final conclusion. For an authorised version of the patient to prevail, there needs to be someone who has the prerogative to impose an authorised version of the truth on others, commit them to actions which follow from this version, and hold them to account for their actions against this authorised truth. The various meetings observed in Westway were ceremonially messy, which is perhaps not surprising given the lack of a clear power structure. But in other kinds of decision-making fora, the way that closure is brought off is often highly ceremonialised. Thus as Gomm notes with regard to examination boards, irrespective of who originates a proposal which comes to be agreed regarding a candidate's result, it is not the authorised version until it has gained the agreement of the external examiners, and has been formulated as a decision of the meeting by the chair (Gomm 2000). An even starker example is the *obita dicta* of a judge, *following* the announcement of a jury decision (Atkinson and Drew 1979).

Various people, (for example Gomm 2000; Myers 1991), have suggested that uncertain talk does not necessarily betoken uncertain minds. Rather, they suggest that where people make very 'certain' utterances they invest themselves in their talk, such that contradictions become personal attacks. Hence, pre-sequences of doubtfulness, (e.g. 'maybes') and ready back-downs in the face of disagreement avoid conflict in general, and in this case may avoid conflict crystallising around occupational

hierarchies and occupational affiliations, or around issues of the relative competence of individual practitioners. In this sense doubtful talk, and the entertaining of multiple possibilities for the truth, seems consistent with the *primus inter pares* fiction of these occasions.

Of course Beryl is only one case. While not necessarily ‘representative’, it is a case that illustrates important characteristics of the organisation. First it is easier to reach a consensus version when the patient will sign up to it. Hence compliance can be an important factor in the provision of authorised forms of care. Second, there are some very real limits to the actions available to the team with regard to the legal framework in which they operate (though these are limits they do not know about in detail, and they are sometimes breached elsewhere). Third, this is the kind of organisation that allows for open-ended, problem-solving talk, but does not make it easy for robust authorised version of the truth to be formulated and maintained.

I have argued that what seems to be happening is staff doing the best they can to make sense of a difficult situation faced with a seemingly intractable patient. Contra the classic thesis of Szasz (1972) that the process of mental illness diagnosis hides moral issues behind a medicalisation of ‘problems of living’, the data here show staff striving to do quite the opposite. It is the moral agenda that staff address quite openly. With the case of Beryl staff formulate what they are doing as trying to characterise Beryl: to be self-reflexive and review their own interactions with, and evaluations of her, and thus of how they arrive at ‘what should be done’ (Beryl as task). In these circumstances there is no stable or unitary story of Beryl, which staff share and which serves as a lens through which she is interpreted. As in chapter 12, the classic process of labelling does not seem to operate.

This chapter has concentrated upon ward rounds as opposed to team meetings for another look at how mental health care is accomplished. The ward round is a different arena with a different purpose to the team meetings. The latter is geared up to process referrals; the former is primarily about sense-making once that referral is within the service. This analysis also shows that what happens in team meetings (see earlier chapters) over a patient such as Beryl does not necessarily determine what happens to her thereafter. Here it can be seen that the ward rounds *vis a vis*, say, the team meetings within a sector are disarticulated.

But then the Westway organisation is a disarticulated organisation with no clear leadership as shown already in previous chapters. Thus the organisational products (or kinds of patients) that emerge are ambiguous, confusing, polysemic patients about which people often do not know what should be done.

Chapter 14: Part Four Conclusion

14.1 Labelling theory revisited

The orienting research question identified in Part One to help address the organisation of mental health care for Part Four was 'how do members agree (or fail to agree) on patients and with what consequences?'. In addition, a related question was proposed: 'what are the consequences of such tasking processes for patient identities?'. These questions have been approached through examination of the sense-making processes followed by teams with regard to patients. Conventionally, such processes have been tackled within labelling theory, so this approach has framed the discussions across chapters 11-13 on the characterisation of patients. The discussion below therefore revisits labelling theory by way of 'answers' and conclusion to Part Four.

14.2 The classic version

Head-on critiques of classic labelling theory, such as those of Gove (1980) or Bowers (1998) have focused on issues of cause and effect as mediated through the psychosocial mechanisms of personality formation. My critique takes a different tack by suggesting that for labelling to have the psychological effects claimed for it, requires a particular form of social organisation. Classic labelling theory presupposes a form of organisation wherein large numbers of people are constrained to behave towards the labelled person in ways that convey the same message to them about their identity. Goffman's (1961) notion of a 'total institution' seems like the kind of organisational form which would best provide the necessary infra-structure for the process of labelling to have the effects claimed for it in its classic form. But the data from Westway show that instead of discussions about patients creating robust organisational identities for them, such identities as they acquire are fleeting, often ambiguous and sometimes contested. Whatever happens under organisational

conditions elsewhere, it is unlikely that labelling at Westway will have the classic effects.

Some kind of classification has to occur as part of the sense-making process required by such work. In a recent critique of labelling practices, Boyle (1990) advocates conceptualisations of mental illness that eschew formal diagnostic categories and which recognise that behaviour cannot be discussed independently of context. But Boyle's critique of practice was not based on any empirical study of practice. Rather it was based on analysis of clinical literature, which may bear little relationship to the actual methods used by clinicians in dealing with their patients. Certainly the empirical material considered in this thesis suggests that formal diagnostic categories actually play little part in the definitional work that is done by groups of practitioners at Westway. Instead the patients are made sense of through a generic, multi-disciplinary team talk which utilises a common-sense style of communication. In this sense such practitioners might be argued to be applying Boyle's injunction. Rather than formal diagnoses, behaviour and mental state are interpreted in terms of notions such as motive, degree of personal responsibility, life circumstances, cultural background, family history, personality and civil rights. And, although tropes of these kinds figure routinely in the transformation of patients into tasks, they are utilised variously in specific organisational contexts where practitioners and their cases come together. Thus typifications of patients are organisationally contingent and this does not seem to give patients a fixed organisational personality which would elicit the kind of personality changing reinforcements envisaged by classic labelling theory.

14.3 Supply and demand labelling

As others have noted elsewhere (Byrd 1981, Prior 1993), it is organisational demands which determine client/patient fates. Clients can only be matched to the availability of openings in the organisational structure itself. And clients/patients are likely to be reclassified at various stages in their service careers in order to 'better meet organisational requirements' (Byrd 1981,p3). While these more recent revisions of labelling theory depict labelling as organisationally contingent, they still give a picture of the process as much more tidy and deterministic than what I observed at Westway. For example, in her study of an American psychiatric outpatients clinic, Byrd (1981) suggests that variations in patient typification are tightly tied to resource rationing under different conditions of scarcity. It worth considering what would be the necessary organisational conditions for there to be an observable calibration of typification with supply and demand. These seem to be the necessary requirements.

First, there would have to be a form of organisation which delivered similar information about resource availability to all the sites and occasions where patients are categorised. Second, there would have to be some common response set associated with different levels of demand. This might occur because of shared understandings, or common interests, or because of subjection to an authoritative decision-maker or to a protocol for decision-making with some sanctions for following it. Third, for such a calibration to be seen to occur it would be necessary for there to be significant supply-demand fluctuations.

Throughout the period of research, Westway staff spoke as if demand on case loads and beds perpetually outstripped supply. Even if that had not been so there was no tidy way in which robust categorisations could have been calibrated to supply and

demand conditions. On a daily basis resource constraints were not felt evenly across the system. Rather they were experienced individual by individual in terms of their own case loads, or bed-block crises, or as pressures on a particular group of staff subject to a particular line management. Sometimes the pressures would be more acute for one individual or group, sometimes for another. Again, in the economy of the Sector team, the scarcity was of assessors and key workers, but some people in sector team meetings were implicated in a ward economy of beds and ward staff, and others in the economy of district social work teams where CMHT cases competed for attention with other kinds of case. 'Solutions' in terms of any one of these economies could make things worse in another; for example, as hospitalising a patient relieved pressure on community staff, but increased pressure on the ward, or as take-up by a district social worker reduced pressure on hospital social workers, but created more trouble for district teams. The point I am making here is not that supply and demand factors were uninfluential in the characterisation of patients at Westway. I have no doubt that these could influence responses to the request for 'any takers' in terms of utterances characterising the patient concerned. Rather, my point is that the set up at Westway was such that all these characterising moves were unlikely to stack up to show any determinate relationship between the patient characterisations most common at a point in time, on the one hand, and the state of resources at that point in time, on the other. It is reasonable to expect a determinate relationship between patient typifications and supply and demand conditions under some organisational circumstances and not under others. The circumstances at Westway did not provide the necessary organisational conditions.

14.4 Labelling and professional dominance

In the study which most closely matches this one, of two CMHTs in Wales in the early 1990s, Griffiths (1996, 1997a & b) argues, following Byrd, that organisational concerns drive patient categorisations. However, in the later of these publications she argued that this applies only to a proportion of cases. She argues that the key factor is the degree of professional dominance of the different psychiatrists attached to each team. One of these was an active team player who, according to Griffiths carefully manipulated discussion of cases in defining eligibility. This team thus utilised more inclusive definitions of SMI and accepted more patients. The other psychiatrist was rarely present at team meetings and the team frequently rejected his referrals, using characterising moves to frame SMI more narrowly, and accepted fewer cases, or at least delayed their acceptance.

Griffiths handles this in terms of a model of CMHTs as sites of attempts by psychiatrists to exert professional dominance and the resistance of subordinate occupationals to this (as detailed in relation to joking behaviour in Section 9.2). Now it actually seems quite credible to me that in some teams psychiatrists will be more influential than others, and that this influence might be shown in the pattern of acceptances and rejections. Similarly I would find it unsurprising if in a particular team a particularly assertive social work manager had a stronger influence on the disposals of the team than did other participants. But the important point here is that if, as Griffiths claims, psychiatrists sometimes have more and sometimes have less influence, then we are dealing with the kind of organisational form which allows for this kind of variation, and hence for a variation in the characterisation of patients which relies on matters such as personal style. Put another way, so far as patient characterisation is concerned we are dealing with a form of organisation which will

allow a wide variation in typification practice, both as between teams, and within the same team on different occasions according to who happens to be present, who is feeling more assertive than whom on the day, and so on.

I shall continue this discussion of labelling and organisation in Part Five, which is the conclusion of the thesis.

PART FIVE: Thesis Conclusion

Chapter 15: Reconciling and authorising different stories

In the introduction (section 1.2) I promised to give a number of different accounts of organisation; to narrate the organisation in several different ways (Czarniawska 1997, p26). This is what I have done. I also said that I was prepared for these accounts to be incommensurate with each other. Put another way, it was not my initial intention to engage in theoretical triangulation, an enterprise about which there is much scepticism among ethnographers (Bloor 1997; Hammersley 1992), and which those of a post-modernist persuasion regard as absurd.

However, as things have turned out, the various stories I have told, while perhaps not quite commensurate point by point, are at least not contradictory. They are told in different ways, using different vocabularies and categorisation systems, and different narrative conventions, focussing on different aspects of mental health care and at different grain sizes. They are different stories, but they all seem to be stories about the same phenomenon. (see section 2.1.1.1 and quote from Murphy *et al*, 1998, p69).

To say that these all seem to be different stories about *the same* phenomenon is to suggest that phenomena topicalised in research can have some existence and some obdurate qualities apart from a researcher's conceptualisation of them, and that therefore, against a post-modernist view, there is a possibility of telling stories which 'correspond' with 'reality'. Despite his scepticism about the possibilities for theoretical triangulation Hammersley (1992) does allow for this in his version of 'subtle realism' (section 2.2.1.1), and hence must allow the possibility that different theoretical approaches must, sometimes at least, point to similar conclusions about their shared topic of enquiry.

For this conclusion then, I will try to put the different stories together, first in a way that relates to differences of 'level' of analysis, and second in a way which comments on the evaluative nature of tales

15.1 The same story at different levels

All the stories were, partially at least, answers to the question 'what kind of organisation is this, that allows this to happen?' One of the problems of putting these stories together is that they entail different notions of 'organisation'. For chapters 4 and 5, organisations were rendered as 'structures', whereas for most of the remainder of the thesis it was a process, organising, which was the topic.

This structure-process distinction is a troublesome one. The point I am making here is best approached by revisiting earlier discussion about 'negotiated order' As noted in section 7.3.1., the original formulation and exemplification of the idea of negotiated order (Strauss *et al.*, 1963), gave rise to the criticism that it assumed that everything was infinitely negotiable (Day *et al.*, 1977; Dingwall *et al.*, 1985). The response by Strauss was to draw a distinction between 'structural context' and 'negotiation context': the former being, as it were, a fixed space within which there was limited room for the process of negotiation (Strauss 1978, and see quotation in section 7.3.1). As an ontological distinction this would not be particularly satisfactory. But I take it that what Strauss means is that boundaries of negotiation for one group of people will be created in the negotiation space for others. And the distinction does seem to square with experience that what is negotiated, say, between high level managers, will put limits on what can be negotiated among their subordinates and that, in relation to subordinates, managers will be able to make particularly authoritative citations of organisational rubrics (section 6.2) to put limits on the courses of action which subordinates can take without encountering sanctions against themselves.

In this vein, one way of thinking of the structure: process distinction is that the ‘structure’ is what is going on ‘over there’, while the ‘process’ is what I can see ‘right here’. Thus the ‘structures’ are what we put into the background, as context, told without much detailed examination, held still while we look closely at the fine detail of something in the foreground. Thus we know that the Care Programme Approach itself originated through a negotiated process going on among civil servants, the SSI, professional advisers, lobby groups, politicians and so on -and that various twists and turns of policy revision resulted from this . But while we are looking at the deliberations of a Westway sector team we disattend to this as negotiated process, and treat it instead as part of the structural context of the team’s deliberations. A structure: process distinction of this kind seems harmless, useful and almost inevitable; inevitable simply because we cannot deal with everything that is going on everywhere at the same level of detail at the same time.

Table 15-1 (below p 305) presents two ideal-typical forms of organisation. In terms of the foregoing, these are two kinds of ‘structural context’ within which the process of organising might go on in community mental health care. The first column represents the kind of organisational form that might generate and sustain robust versions of the truth, police them and hold people to account against them. Empirical examples with these conditions include the end stages of judicial proceedings (Atkinson *et al.*, 1979) and of examination systems (Gomm 1986). The ideal typical of the first column then, is that of a legal-bureaucratic form of authority *pace* Weber (see section 1.1.1). And as such it is not too far removed from what seems to have been intended by government as the form which should be taken by the CPA (chapter 4). As the thesis has demonstrated, this is not how things are at Westway. The second column better accommodates the data from Westway.

The story told in chapter 5 gave a picture of Westway in terms of disarticulated structures, conflicting and unclear lines of management, overlapping waves of change and so on, and some illustrations of the negotiated process of organisational change. This was presented as a matter of interest in its own right, and as illustrating what might have been problems of implementation with the CPA more generally than at Westway, but the main purpose of recalling this material here is to point to evidence that at Westway the ‘structural context’ for team activity was something like that proposed in the second model of Table 15-1.

Table 15-1

<u>Forms of organisation that allow for robust versions of the truth</u>	<u>Forms of organisation in which there are likely to be discrepant, conflicting and fleeting versions of the truth</u>
A dominant source of authority – a person/role (or perhaps handed-down protocol) which determines ‘the last word’ on the matter.	No dominant source of authority.
A single coordinated system of decision-making (this might include the same personnel being involved at each stage of decision-making).	Many sites of decision-making which are not closely articulated with each other (this might include different constellations of personnel being involved in different decision-making situations).
An inscription of the authorised version, and no other versions, and a possibility, if not a requirement that this is consulted by all on each and every occasion of decision-making.	Multiple inscriptions, referred to severally and in an ad hoc way.
An effective means for holding participants to account for their actions in terms of being consistent with the authorised version.	No effective means for holding participants to account, or with conflicting versions/disarticulated strategies, discrepant systems of accountability.
A common interpretative framework such that everyone at least makes themselves out as sharing the same schemes of relevance and makes similar interpretations.	Multiple interpretative frameworks are allowed, leading to the airing of discrepant interpretations.

By the end of Part Four the thesis had suggested four different reasons why authorised versions of the truth were not easily produced at Westway. These were:

- ◆ That this arises from the strategic manoeuvring of staff largely with regard to controlling work-loads.
- ◆ That it arises from positioning and repositioning with regard to different apprehensions of being held to account in the future.
- ◆ That it arises from the *primus inter pares* fiction in that never committing oneself to a certain position avoids conflict around hierarchy and professional affiliation.
- ◆ That staff are simply puzzled - because there are so many different ways of making sense of patients, of predicting the reactions of their colleagues and of predicting futures, and, where many staff are involved, so many discrepant views entering the discussion.

Two other popular kinds of explanation did not find much support from my data. These are that:

- ◆ Lack of authorised versions relate to a persistent unresolved state of conflict between members of a dominant profession, and members of other occupational groups this seeks to subordinate.
- ◆ Lack of authorised versions relate to inter-occupational rivalry between factions constituted on occupational lines, each faction supporting its own versions of the truth against the others.

Although there were few instances in my data to support these latter explanations, it is not difficult to imagine Westway teams reconfiguring themselves, either to resemble ‘resistance movements’ against a dictatorial psychiatrist (*pace* Griffiths 1996. 1997 a and b), or in terms of agonistic factions based on occupational affiliations, or more likely based on ward *versus* community affiliation or CMHT *versus* District affiliation. These seem to me to be possibilities which might arise within the ‘negotiated order’ of Westway, though they would severely test, or perhaps displace the current ceremonial order of team meetings.

The second column of Table 15-1 represents a ‘structural context’ where those involved have a wide latitude to ‘work things out among themselves’. But the reference to ‘working things out for themselves’ is perhaps a little misleading, for despite changes in personnel, teams tended to operate in a similar way throughout the research period, and there were not huge differences between the two teams observed, even though they were composed of different people. Though these commonalities were reproduced on each occasion it is obvious that they were not invented and re-invented *de novo* at every meeting. The idea of a role-format occurred to Strong and Davis in trying to explain something similar: why doctor-parent encounters in paediatric settings were so similar, even though they were enacted by doctors who had never met each other, and involved people who were often first-time attenders. As noted in section 7.3.2.1, Strong and Davis represented role-formats, particular kinds of ceremonial order, as ‘routinised solutions’ to recurrent problems. The problems they had in mind were the mundane ones of how people should comport themselves one with another, about mentionable and unmentionable topics, about appropriate sequencings of events, about forms of address and so on. The key to understanding their ideas lies in the word ‘routinised’. These are not forms of organisation invented occasion by occasion (and not infinitely

negotiable either) but in some way emerge over time as general purpose ways of going about things, which may not work satisfactorily every time, but seem to work most of the time. Recalling Dennett's observation (section 13.4.4) an important function of such ready-made social forms is that they 'decide by default' and limit the range of decisions to be made, and allow people to concentrate on the task at hand. In addition, Strong and Davis argue, such ways of doing things get the sanction of usage and become 'the proper way' of doing things. As such they are available as bench-marks for judging the performance of participants: deviations being warrants for some kind of disciplinary or remedial measures.

An important implication of the idea of role format, or of ceremonial order is that what goes on *cannot* be explained satisfactorily in terms of the intentions and motivations of those involved, save in the limited sense that they have intentions and motivations to do what they do within the limits of the 'kinds of things which are usually done around here'. With this in mind the 'reasons' suggested in the thesis for the lack of emergence of authorised versions, do not really seem to be 'reasons' at all. Within the normative order of team work it was possible for participants to realise intentions to limit their work loads, or evade individual responsibility, or to avoid conflict with each other, or to make fun of each other and their patients sometimes, or to pursue the truth through open-ended discussion (though they didn't do much of the latter in the sector teams). They probably had such intentions from time to time, sometimes one kind and sometimes another. But these intentions do not constitute an adequate *sociological* explanation for the organisational form of their encounters. Rather, matters are the other way around. These were the kinds of intentions the ceremonial order of the team allowed to be pursued, if 'properly clothed', and which

the wider 'structural context' did not prevent. It is the ceremonial order of the team which is the explanation, rather than *vice versa*.

And if the ceremonial order of these occasions allowed for some intentions to be pursued, and some consequences to happen, it also made others unlikely. Pulling rank, brow-beating, giving orders, refusing to back down, standing on disciplinary affiliation, forming up into competing teams, drawing attention to commitments not discharged, or indeed, pinning people down to well-defined commitments, were all likely to be regarded as objectionable behaviour. They were largely avoided, and, where they did occur, caused interactional trouble and remediation which resulted in the restoration of the ceremonial order (see chapter 9). All, or some of these kinds of behaviour are necessary, though clothed as morally proper conduct, if authorised versions of the truth are to be created, policed and perpetuated (see column 1 of Table 15-1).

Thus in a sense my stories fit together from micro to macro. The circumstances of team working as told in Chapters 8, 9, 12 and 13, suggests ways in which participants might be motivationally engaged with what they were doing; wanting to limit their work, wanting to make sense of patients, wanting to avoid conflict, wanting to preserve the dignity of their profession and so on. These motivations were imputed by me on the basis of observing their behaviour and making assumptions about the way their circumstances might motivate them, and no doubt motives of this kind were imputed by them, one of another. But motivations provide only an inadequate explanation, and are not directly observable anyway. Thus in drawing attention to the ceremonial order of team work and detailing its operation I displayed the apparatus through which some (but only some) intentions could be pursued, and in terms of which they had to be 'dressed' to avoid objection. And by looking at interactional troubles (in chapter 9) I charted some of the limits of acceptable behaviour. The managerial tale in chapter 5 provided

the context in terms of which it was possible for teams to sustain this ceremonial order, which was one in which there were no effective means for others to impose change on them. From ‘top to bottom’ then this was the organisation of mental health care at Westway. My tales about characterising patients can be set against this background (chapters 12 and 13). If the organisational identity of patients is a product of the kind of organisation this is, then the kinds of identities patients will be given will be indeterminate and fleeting as is to be expected from an organisation where there are no easy means to generate authorised versions of the truth and hold people to account against them.

15.2 Moral tales and narrative persuasiveness

Tales differ in the extent to which they are prescriptive, and hence in the extent to which their authority relies on readers sharing the same values and interests as writers. It is patently obvious that the ‘management consultant’ tale of chapter 5 tells the circumstances of Westway as a set of deviations from what (allegedly) ought to have been happening. And the circumstances of that tale were, in turn, a government diagnosis of community mental health care as something which ought to be like the CPA, but was very different. In both cases the contrast is between current circumstances and a prescription not too far removed from an ideal-typical bureaucratic model. Thus the way the tale was told uses something like the ideal typical model of column 1 in Table 15-1 as a set of *desiderata* against which the actual circumstances of Westway were told as deficient.

Later in the thesis (chapter 11) I introduced another kind of organisational tale with an opposite evaluative slant. This is a kind of tale which is told about ‘labelling’ patients with adverse effects for them. As I have suggested earlier, classic labelling theory assumes a form of organisation which again has the characteristics of the model

in column 1 of Table 15-1, but here this constitutes a model of a pernicious organisation where authorised versions of the truth fix patients in misery.

There is in fact a dearth of compelling evidence that care programming (or case management) is more effective in promoting the well-being of patients, than the 'control' conditions against which it has been compared in effectiveness studies using randomised controlled trials: control conditions which would be more like the pattern I described for Westway (Brugha and Glover 1998; Marshall, Gray, Lockwood and Green 1997). Indeed, given the complexity of the processes, the diversity of ways in which the CPA might be implemented locally, the diversity of patients, and the diverse criteria that might be employed in judging outcomes, it is difficult to see how research could arbitrate this matter (Brugha *et al.*, 1998). Even if there were sound evidence that a particular way of organising care were beneficial for a majority, this would not guarantee that it was effective for a Beryl in particular. The CPA, or something like it, has its enthusiasts. But the enthusiasm seems to be under-determined by the evidence. Rather than being driven by evidence I suggest that enthusiasm for the CPA is a version of a common story format which treats more systematic organisation as 'better' organisation, which, by the magic of being 'better' must lead to better outcomes - any textbook on management will provide examples. The story of 'better management leading to better outcomes' is counterpoised by another story line that has the opposite evaluative implications. In this format systematic and coordinated organisation constitutes a conspiracy against the patient's welfare, as in classic labelling theory, or a constraining set of 'bureaucratic' impediments to the successful exercise of professional expertise, or the illegitimate but hegemonic control of a super-ordinate profession. Again such stories are often told to make a moral point without convincing evidence (Bowers 1998).

It is less obvious perhaps, that Griffiths' analysis of CMHTs (Griffiths 1996; Griffiths 1997a; Griffiths 1997b), which has provided a foil for my own from time to time, is also prescriptive. Her analysis of team interaction proceeds from the assumption that psychiatrists have power which they should not have and celebrates the 'resistance' of other team members to this (section 9.2). In this her analysis is similar to a great many in other fields but which celebrate alleged 'resistances' to power. These range in time from the celebrations of the National Deviancy Conference in the 1970s (for example, Cohen 1987) to a more recent genre of 'power and resistance' stories drawing authority from Foucault (see for example Scott 1990).

The major difference between these tales then, is an evaluative one, and I note here how often tales about the NHS (and other human service organisations) take one or other of these modalities. Either there is too much management, or too little; the men in grey suits have displaced the doctors and nurses to ill effect, or the doctors and nurses are left free to conspire against the patients and spend money like water; there is a well articulated and clear system, or this is a pettifogging set of bureaucratic rules; what's wrong is that professional colleagues are not treated as equals, and/or what is wrong at the same time is that there is no clear leadership among them. And the same people will sometimes tell one kind of story and sometimes another. There were instances of this in my interview data. Since the main differences between contrasting stories of these kinds is in their evaluative slant, believing one, or believing the other, depends much on someone's moral values or material interests.

By contrast, and apart from the story told in my 'management consultant' role, I have tried to avoid evaluation in the stories I have told. It might at first seem as if the story of Beryl (chapter 13) is intended as a tale of how mental health care should *not* be. If so the evaluation has been provided by the reader and not myself. Terms such as

‘inconsistent’, or ‘incoherent’ appear in the story, but to read these as *pejoratives* it is necessary to make a case that a more consistent and coherent treatment of Beryl would have been better than what actually happened. That in turn raises questions about ‘better for whom’ and ‘better in what ways’. So far as Beryl’s welfare is concerned my study provides no evidence what so ever that an organisation of care looking like the official version of the CPA would have been better for her. After all, a single authorised version of the truth with everyone committed to it, would not necessarily be the same thing as the most propitious version of the truth for Beryl. And remember that effective and, possibly damaging labelling, is one possible outcome of ‘well’ organised care.

These points about ‘organisational stories’ suggest a danger to avoid in attempts to narrate organisation. While this may involve the re-telling of participants’ tales, in the formats they use themselves, it is important that they are rendered for what they are; participant tales, and a topic for analysis, not a straightforward account of the truth about what is ‘going on around here’. And participant tales are almost always moral tales. Much recent sociology, particularly that in a feminist genre (Stanley and Wise 1983), mistakes participant tales for accurate accounts of local reality. While they recognise that such tales constitute complaints, celebrations and other kinds of evaluation, these writers see the sociological task as one of giving such evaluations a public hearing. Such approaches locate ‘reality’ in the minds of the participants. Authorisation is by reference to some idea of keeping faith with the tellers of the original tales (Rock 1973) and signing up to the right kinds of values (Hammersley 2000).

One inevitable result of this approach is to produce tales which are indeed incommensurate and to justify this on the grounds that ‘reality’ is ‘multiple’ or to engage in privileging the accounts of some people over others, often on the grounds that

the more oppressed people are, the more likely they are to know the truth (Mies 1983). But, as I think I have demonstrated, the activities of consequence, those which actually produce organisation, are often not seen for what they are by the people who enact them. On the whole, people do not experience themselves 'citing organisational rubrics' and creating organisation thereby. They apprehend themselves as describing the organisation as it is. And people do not think of themselves often as doing characterisation, or imputing motivations in the course of negotiating a work load and thereby creating a organisational identity for a client and reconfiguring the constellation of relationships among themselves. They are more likely to experience themselves as trying to capture the characteristics of a real person and plan an appropriate strategy in the light of the facts about her. It is difficult then, to imagine participants at Westway making the same stories as I have made from the mundane details of their interaction in the teams. In this sense then, the narration of organisation should mean that the source of the narration is the researcher, and that any authority the story has is that granted by readers in terms of the extent to which the story is supported by the evidence.

I turn therefore to a brief methodological evaluation of the research.

15.3 Methodological evaluation

The methodological orientation of this study was laid out in chapter 2, and developed on and off throughout the thesis. The methods used were described in chapter 3. Now that the reader has read the thesis it is in order to make some further comments.

First, there are issues of sampling. Given my interest in the implementation of the CPA on the one hand, and on the creation of patient careers on the other, it was necessary that this was a longitudinal study. But the research took place at a particular historical period, and I have no adequate data from the period before or after. Thus there

are some issues about which I must be circumspect. For example, I expected to find that teams would be extremely sensitive to the possibilities of featuring in a newsworthy inquiry following some disaster happening to one of their patients - and indeed one such enquiry happened not long before the research period began. In fact, I found that teams topicalised such risks rarely, and did not engage in formal risk assessments, despite official injunctions to do so. However, because I do not have data on an earlier period I cannot say that these teams' attitudes to risk were not more heightened than they had been at an earlier period. Similarly, throughout this period, demand for service greatly exceeded supply so I was not in a position to see whether team behaviour would be different at a lower level of demand. In that sense my study limits me with regard to making comments about the calibration of patient characterisation to supply and demand conditions. I have suggested that the organisation of community mental health care at Westway would not allow for a neat calibration (see section 14.2), but it would have been nice to test this against data.

On sampling within the case, I could not be everywhere. The data are a *sample* of many events spread throughout the research period. As detailed in section 3.2.4, I did attend a large number of meetings of two of the three sector teams over a period of time long enough to accommodate any important variations associated either with the calendar, or with other recurrent changes such as staff turn over. The two teams were similar in some ways and different in others. The differences suggest that I captured some of the ways in which such teams can vary. Observing the unobserved sector team might have shown features not shown in the other two. But about this I can say nothing. However, one of the two sector teams observed was much more stretched than the others (section 8.2), and for this, or perhaps other reasons, this was the team which had the most unallocated cases. Examples from this team are more numerous in the text than

those from the other. This is largely accounted for by more examples from Team A featuring in chapter 9 on interactional problems and because Beryl was a Team A case. This team did have more interactional problems than the other, but their over-representation in examples, may give the impression that across all teams interactional problems were more common than they were. It is worth remembering here that interactional problems were not presented as a way of showing how trouble-some was the process of disposing of patients. Most business was transacted in both teams in a trouble free way, and without any kind of discussion which would make practitioners accountable to each other. Team trouble was described as a way of showing the limits of acceptable behaviour in team contexts. While team A had more problems, both teams seemed to work with similar notions of what was acceptable, and both used similar tropes for problemicising the acceptance of particular patients.

My selection of ward meetings and ‘community ward rounds’ was largely determined by my prior selection of patients to track, and therefore by the vagaries of what happened to them. It is probable that the patients I chose were atypical (see below), but my observations of the discussions of other patients at the same ward rounds suggest that these were not meetings made unusual by a focus on atypical patients. Again, the ward meetings observed, occurred over a protracted calendar period and showed a wide range of different combinations of staff. It was difficult to make in advance a principled selection of patients to track through the system, since the success of any selection could only be judged with hindsight. It was actually very difficult to keep track of the patients chosen. This was partly because it was an inherent feature of the organisation that it was difficult to keep track of the patients, and partly because, for longitudinality, I was restricted in my choice to those patients who were in the system near the beginning of the research period. Many of these either disappeared from

the system itself, or disappeared from research view by being dealt with entirely through one-to-one clinical encounters, and not being topicalised in any meeting I observed. Very soon I found that I was left with only three patients to track, though by accident I encountered many patients occasioned more than once.

To have observed one-to-one meetings, or to have interviewed patients myself would have required ethical clearance which I predicted I would not have been granted. The absence of any observational data on one-to-one clinical encounters is perhaps the most serious omission in the study and may exaggerate the impression I have given of lack of continuity and inconsistency in dealing with patients, particularly in chapters 12 and 13. After all, the very idea of appointing a KW in the CPA was as a device to provide continuity of care in between multi-practitioner meetings. This may have happened with regard to some patients, but I note that, for those patients I looked at most closely, KWs seemed to be as inconstant in their notions about the patient as was everyone else, and that often they rarely saw the patient anyway. I note also that in team and ward meetings, the views of the KW about the patient were rarely treated by others as privileged: as being authorised by the KW's more frequent contact with the patient (see Chapter 13). Thus there was little evidence of continuity of patient typifications being 'carried' by the KW backwards and forwards between one-to-one encounters and meetings with other practitioners.

I certainly cannot claim that the patients I actually did manage to track through the system were typical of all patients, and this applies particularly to 'Beryl', who is the one such patient written up in the thesis. But choosing for representativeness in terms of demographics or in terms of patient career trajectories was not my goal. Had it been so I would have had to select a very large number of patients and spend most of my research time tracking them, and most of the thesis writing about them. This might

have resulted in an interesting study, but would have left no time for anything else. Instead of selecting clients for their typicality then, I selected them to serve a purpose analogous to a radioactive trace, animating the organisation as they passed through it, or constituting points around which I could see people actively organising mental health care. For this purpose there was an advantage in choosing patients who were more challenging of the system than others and who, as it were, ‘visited more places’ in the system than others. I chose to feature Beryl in the thesis partly because I was able to track her career more adequately than any others, and that in turn was because, more than any other patient in the set, she remained ‘in view’ by constituting a problem for the team when in the community, and hence being topicalised frequently in team meetings, and by being hospitalised which led to her being the focus of discussion at least once a week. And partly I chose Beryl because her career as a patient took her to more places in the system than any other: CPA case in the community, A&E, MHA Section 2, Supervision Register, MHA Section 3, Mental Health Review Tribunal, candidate for Supervised Discharge, candidate for a Guardianship Order, CPA review, assessment for ART.

In these respects, Beryl served as a useful illustrative case. But by the same tokens she was far from typical. This needs to be considered in relation to claims made about the organisation of mental health care at Westway on the back of evidence from Beryl’s case study. These claims were about the way in which the absence of any devices for producing and fixing an authorised version of the patient created Beryl as an enigma for staff. It has to be admitted that if any kinds of patients are going to challenge the sense-making capacities of staff, they will be patients like Beryl. So my account is vulnerable to the challenge that it exaggerates the incoherence of the local organisation, by picking on an atypically ‘difficult’ patient and that the puzzlement arose with regard

to Beryl, because she could not be fitted into some repertoire of 'normal cases' which would serve for a large number of other patients. In response to this I would say that while the puzzlement about Beryl was particularly acute, staff seemed to find all of their patients puzzling. *Pace* classic labelling theory (see chapter 11) I never found anything which looked like practitioners squeezing patients into one of a repertoire of normal case typifications and fixing them there. On this the studies of both (Byrd 1981; Griffiths 1997a; Griffiths 1997b) seem to agree.

I took great care with the interviews to sample in a way that was representative of roles, disciplines, genders, seniority and agency (see Appendix II Table 1). Although I conducted 61 tape-recorded interviews, interview data is rarely presented in the thesis, so the care taken in sampling turned out not to be very important. Nor is it necessary here to agonise about the artefactual nature of interviews and the way the interviewer's performance structures the responses of the interviewee. In the main the interview data served for me as 'background' in the sense that news reporters use the term. They particularly informed the 'managerial' account in chapter 5. These interviews (and various other 'out-of-meeting' interchanges) allowed me to make relationships with people I would observe in team meetings, to clarify matters which could not be clarified in meetings, and they allowed for the articulation of views which were not expressed in meetings. As a corpus, the interviews represent a large diversity of views as to 'how things were' at Westway, and how they ought to be, and there was more discipline-bound talk in the interviews than heard in meetings, though not particularly chauvenistic, and more complaints about status and hierarchy: both about high-handedness and about weakness of leadership. But these were interviews, set piece conversations, off-lined from the routine activity of the team. The fact that, in an interview, someone distances themselves from a decision made in a meeting is

interesting, but it is in the meeting that the real organising work goes on. The only place at which interview data are presented directly as evidence in the thesis is in relation to the case study of Beryl, at points where observational data were lacking.

Second, there are issues about recording data. I did not tape record any of the meetings that were the subject of observation and upon which much of this study relies empirically. I did take fulsome notes, seeking to capture what was going on rather than to summarise, and this included verbatim quotes. Of course, since I could not record everything, my data set must have a sampling bias. I tried to make this bias systematic in that the collection of language data was in terms of illocutionary chunks, because I tried to capture the language which was doing the organising. But had I been able to audio-record, and analyse transcripts, the data would have been more complete. This however, would have changed the point of trade-off between covering a large number of meetings but patchily - which I did, and having more thorough and accurate data about a few of them, with the cost of not covering such a diversity of meetings. As noted in chapter 3 there would have been several practical impediments to tape recording, and implications for subject reactivity, given the association of my role as researcher with the evaluation of staff performance.

On accuracy, I take some comfort in the comparison of my data with those of Griffiths (1996; 1997a; 1997b), who did tape record CMHT meetings. This comparison was made *after* my data were collected and put into their final form. Though I would not always draw the same conclusions as Griffiths does from her data, the data themselves would be indistinguishable from mine, save for the indications that one set was produced by note-taking and the other by transcribing a tape. Goldberg's written field notes also look very similar in content to mine (1997).

The data drawn from team meetings were usually the only data I had which had a bearing on what happened to patients in other circumstances. In this sense I was in exactly the same position as most other participants to these meetings, except that I had a fuller record of what transpired. However, I was obviously not in the same position as a participant who attended the meeting having themselves assessed a patient, and who subsequently worked with that patient one-to-one and perhaps discussed the patient with a professional supervisor. I assume that for such practitioners there would be a greater sense of coherence about who the patient was, and what had been, or should be done. In this sense then, restricted to the data sources I had, my impression of community mental health care may have been as something more incoherent than it was experienced to be by some practitioners and some patients, and that my account may therefore give a misleading appearance. However, for most of the central topics of the thesis it was what happened in the ‘team’ contexts of mental health care which were important. These include the notion of accountability which for CPA purposes was supposed to be allocated and maintained by teams (Chapter 4), and that of labelling, which, if it is to have the consequences argued for it has to involve mechanisms to commit people to similar versions of the truth. I note that when I did look for the use of similar typifications for the same person in different settings, as in the case of Beryl, I did not find them.

Third, there are issues about the choice of data to present in the thesis. I could, of course, only present the data I actually collected. However, in analysing the data I was careful not to ‘cherry pick’ that which best supported my arguments. I always looked for disconfirming data. As readers will have seen there were plenty to find, which paradoxically perhaps, did lead to and support my argument that participants were ‘consistently inconsistent’ in that they *ad hoced* between contradictory ideas,

though in the course of accomplishing similar kinds of work. *Ad hocing* was also a characteristic found by Griffiths, Byrd, Prior and Goldberg. I am fairly confident that the data I collected, but did not enter into the analysis, do not disconfirm the points I made, but are of the kind of which I can make no relevant sense.

In choosing the data to present to readers, some kind of ‘cherry picking’ is inevitable according to the narrative at hand. There are some data which would require too much ‘insider’ commentary before readers could make sense of them, and on the whole I chose to present those data which I thought would be most easily comprehensible to readers. In presenting the data I have tried to bring readers alongside me, so that they have before them at least some of the same evidence as I had in drawing my conclusions. Only occasionally, and only where absolutely necessary for comprehension, have I changed the wording in the field notes presented, and never the *verbatim* quotes, so readers can read the same data as I used in analysis.

Fourth, there is the matter of my shifting role as researcher with both insider and outsider status. As insider I was a member in the guise of an organisational consultant, there to produce an evaluation of Westway’s implementation of the CPA. This evaluative position presumed a script (the CPA as official system) that should be followed, and against which I asked questions and related to organisation members. As an outsider I tried to be present and relate to members in more neutral terms; the stance of conventional ethnography. These two roles occurred in tandem, and I made little effort to explain the niceties to members, except at my first attendance of any particular kind of meeting. This may have muddied the waters with some members and may have influenced the way they related to me. Given the fluctuating personnel of meetings, however, many must have missed any explanation of my presence at all.

Other matters worth noting relate to generalisability. There are two dimensions here. First, this thesis is my rendering of the situation at Westway, produced by the methods I used, based on the occasions I observed and the selection of people I interviewed, informed by the theoretical considerations I allowed to influence me, and written up in the way I chose. Another researcher, researching a similar topic at Westway, at the same time, would have written a different account. Of course, if every researcher's account is essentially different from that of every other, and no account can even approach an authorised version of what is going on in one locale, then no generalisations are possible. Whether another researcher's account would have contradicted mine in essential features is a matter for speculation. But in outlining the methods I have used, and in presenting large amounts of the data from which I drew my conclusions, I hope I have given readers some means to reach their own judgements on this.

Then, there is the well-known problem of making generalisations from case studies. As Gomm, Hammersley and Foster (2000) point out, there are two main kinds of generalisation 'from the case'. One of these is empirical generalisation, which is the kind that survey researchers try to achieve by selecting representative samples. However, particular cases - Westway for example - are unlikely to be representative of the entire population of cases in their empirical particulars. Thus it does not follow that because it was like this at Westway it will be like this in any other mental health MDTs. Work by others on CMHTs and mental health care organisations does actually indicate that there are other teams which have similar features to those at Westway, even though authors have drawn rather different conclusions from mine from similar looking data. Again, the trade literature suggests that there were many Trusts, SSDs and CMHTs who experienced difficulties in implementing the CPA as the government intended. Perhaps

these were the same difficulties as I identified for Westway. But the purpose of the thesis was not to draw empirical generalisations.

Analytical generalisation is a different kind of generalisation. This refers to the demonstration of the applicability of theoretical ideas to a wide range of cases, even though the cases may otherwise differ in a wide variety of ways. An obvious example here is Goffman's notion of ceremonial order, particularly as used by Strong and Davis (Strong 1979, Davis and Strong 1978). I can take no credit for this idea, but I hope I have demonstrated the extension of its applicability to community mental health teams, and similarly with other conceptual tools I have borrowed from others. Most of my own analytical generalising has been about the production of organisation through the interaction of those involved. This is perhaps best summarised by reminding readers of a question I frequently asked, which is 'what kind of organisation (or organising) is this, that allows this to happen?' I hope the thesis answers this question adequately in various guises. However, the very openness, fluidity, indeterminacy, or incoherence of organising at Westway, whichever term the reader prefers, itself suggests the possibility of great diversity among community mental health teams when they exist on the interface between agencies which are only weakly articulated. For example, given my data, it is not too difficult to imagine a team at Westway, beset by a dictatorial psychiatrist and engaging in the kind of resistance movement claimed by Griffiths (1996,1997a, 1997b). Nor is it difficult to imagine a Westway team reconfiguring itself into antagonistic discipline groups. Neither happened at Westway, but, to put it crudely, there seemed to be nothing much to stop either happening. Nor, despite my strictures about labelling theory (chapters 11 -14), is it impossible to imagine the kind of organisational circumstances under which labelling works according to the classic formula (see Table 15-1). So perhaps the most important general statement arising from

this thesis is that, before we make assumptions about what must be happening in some organisation, it would be wise to look at the organisation first, and to look at it at the sites at which the organising work is done.

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Appendix 1 Glossary

Abbreviations

General

ART	Assertive Rehabilitation Team
CM	Care Management
CMHT	Community Mental Health Team
CPA	Care Programme Approach
DMT	Directorate Management Team
EPS	Emergency Psychiatric Service
GP	General Practitioner
GPFH	General Practitioner Fund-holder
HA	Health Authority
JCC	Joint Consultative Committee
KW	Keyworker
LA	Local Authority
LASSD	Local Authority Social Services Department
MHD	Mental Health Directorate
PAS	Psychiatric Advisory Service

Team-related

ASW	Approved Social Worker (i.e. with statutory duties under the Mental Health Act)
CCW	Community Care Worker
CP	Consultant Psychiatrist
Cli Psy	Clinical Psychologist
CPN	Community Psychiatric Nurse
NBT	Nurse Behaviour Therapist
RMN	Registered Mental Health Nurse
SHO	Senior House Officer (junior doctor)
SM	Sector Manager
SpR	Specialist Registrar (senior doctor)
SSM	Social Services Manager
SW	Social Worker
TM	Team Manager
WM	Ward Manager

Appendix II Primary Sources

This appendix lists the interviews and observation conducted, and the documents consulted for the research.

Table II-1: Interview sample

<u>No.</u> <u>interviews</u>	<u>No. x Post (grade)</u>	<u>Profession</u>	<u>Agency</u>	<u>LoS</u>	<u>Gender</u>
5	4 x Cli. Mgt (Directorate, Sector, or Ward)		Health	>10yrs	F
6	2 x Cli. Mgt.		Health	>10yrs	M
3	2 x Cli. Mgt.		Health	0-4 yrs	M
2	2 x CP	Medicine	Health	> 10 yrs	M
1	1 x CP	Medicine	Health	5-10 yrs	M
1	1 x CP	Medicine	Health	0-4 yrs	M
1	1 x Psychologist	Psychology	Health	>10 yrs	F
5	2 x Psychologist	Psychology	Health	>10 yrs	M
5	3 x Nurse (G)	Nursing	Health	>10 yrs	F
5	3 x Nurse (G)	Nursing	Health	>10 yrs	M
2	2 x Nurse (G)	Nursing	Health	5-10 yrs	F
1	1 x Nurse (G)	Nursing	Health	0-4 yrs	F
2	2 x Nurse (F)	Nursing	Health	>10 yrs	F
2	2 x Nurse (F)	Nursing	Health	0-4yrs	F
4	2 x Nurse (F)	Nursing	Health	0-4 yrs	M
1	1 x Nurse (E)	Nursing	Health	0-4 yrs	F
2	2 x SS Mgt	Social Work	LASS	>10yrs	F
1	1 x SS Mgt.	Social Work	LASS	5-10 yrs	M
1	1 x ASW	Social Work	LASS	>10yrs	F
2	2 x ASW	Social Work	LASS	5-10 yrs	F
1	1 x ASW	Social Work	LASS	5-10 yrs	M
5	5 x ASW	Social Work	LASS	0-4 yrs	F
1	1 x ASW	Social Work	LASS	0-4 yrs	M
TOTALS					
61	44				F = 23 M = 21

Table II-2: Observation sample and sources

Event	Dates	No.	Source
Weekly Team Mtg	Mar-Jly 96	16	Team A File Notes
Weekly Team Mtg	Sep 96-Feb 97	16	Team A File Notes
Weekly Team Mtg	Oct 96-Feb 97	16	Team B File Notes
Weekly Assessment sub-gp	Oct 96-Feb 97	16	Team B File Notes & Notebook 1
CPA Review	Oct 96	1	Notebook 1
CPA Review	Dec 96	1	Notebook 1
CPA Review	Apr 97	1	Notebook 3
Ward Rounds Team A	Jan 97-Mar 97	12	Notebooks 2-3
Ward Visit	Mar 97	1	Notebook 3
Ward Visit	Mar 97	2	Notebook 3
MHD CPA Mtg	Jan 96-Jan 97	9	Westway File Notes & Notebook 2

Table II-3: Documents sample and sources⁴⁸

Document Type	Date	Topic	Source
Audit	95/96	Trust MHD audit	Audit Commission
Audit	Mar 97	Team B CPA practice	Westway Team B
Audit	Oct 96	MHD CPA practice	Westway MHD
Report	Nov 94	CPA pilot study Team C	Ext. consultant
Operational Policy	Jan 95	CPA	Westway MHD
Report	Mar 96	MH Strategic Plan	Local JCC
Report	Apr 97	Reconfiguration Strategy	Westway MHD
Report	Jan 96	Multi-agency Mtg	Westway MHD
Report	Sep 96	Multi-agency Mtg	Westway MHD
Report	Dec 96	Multi-agency Mtg	Westway MHD
Report	Oct 92	Cli. Psychiat. Role	Westway Wkg. Pty.
Report	Sep 92	Cli. Psychol. Role	Westway Wkg. Pty.
Report	Sep 92	MH SW Role	Reg. SSD Wkg. Pty.
Report	No date	CPN Role	Reg. HA Wkg. Pty.
Report	Aug 92	Coord. & CMHT Mgr. Role	Reg. HA Wkg. Pty.
Report	Mar 96	Cli. Supervision	Westway Wkg. Pty.
Report	Jun 95	Service Review	Ext. consultant
Report	Oct 97	Business Plan	Westway Team B
Pamphlet	No date	CPA Guide	Westway & LASS
Pamphlet	Oct 94	ASW Guide	LASS
Pamphlet	No date	Guide to CM	LASS
Discussion doc	Nov 96	Psychol. Therapies	Ext. consultant
Proforma		CPA 1-10	Westway MHD
Proforma		SS 1-4	LASS
Proforma		SS 617	LASS
Proforma		SS461	LASS
Memo	Jan 97	Reconfiguration	Westway MHD
Memo	96	CPA	Westway MHD
Memo	Oct 96	Risk Management	Westway MHD

There was also the ‘management consultancy’ report which I myself produced for the Trust on the implementation of the CPA. I did consult this from time to time, and in addition, it proved important as a kind of ‘stimulus’ material provoking comments from staff and management, which informed the thesis.

⁴⁸ For purposes of anonymity, full publication details are not supplied.