Transdisciplinary Working:

Evaluating the Development of

Health and Social Care Provision

in Mental Health

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Abstract

The NHS Plan (DH 2000), consistent with earlier policy documents, emphasises the need for integrated working between health and social care. However, the path to achieving integration appears to be littered with as many failures of teamworking as successes. This paper reports on an evaluation of the development of a team of practitioners working with clients with severe enduring mental health problems. Soft systems methodology enabled the researchers to inform service development rather than merely describing its process and outcomes. Care management was proactive rather than crisis orientated, with prompt response to subtle changes in clients' needs, facilitated by the employment of Community Support Workers. New care processes and structures enabled client and professional knowledge to be used as a resource to inform decisions about care. The practitioners managed this knowledge through informal trans-disciplinary exchange, promoting access to the fine detail of the relationship between user need and service provision.

150 words

Introduction

Inter-professional working within mental health services has been a continuing goal of UK government policy since the 1970's. Recent Government reports, including the NHS Plan (Department of Health (DH), 2000), advocate this as the way forward for modern health and social care (e.g. DH, 1989, 1996). The implementation of the NHS and Community Care Act (Department of Health & Social Security (DHSS), 1990) established the notion of team approach and co-operation between agencies in meeting individual need through a care management model (Couchman, 1995). This drive towards closer interprofessional collaboration has continued with the white papers "The New NHS" (DH, 1997) and "Modernising Social Services" (DH, 1998) with collaborative proposals such as shared approaches to inspection and regulation between social services and the NHS.

The National Service Framework (NSF) for Mental Health (DH, 1999a) suggests that, for the population with severe and enduring mental illness, the quality of assessments is enhanced when they are undertaken jointly by staff from both health and social care (Strathdee & Thornicroft, 1996). The NSF reiterates that care planning, service delivery and review should be a multi-agency endeavour. The 1999 Health Act (DH, 1999b) has created a new Duty of Partnership, which is now placed upon health and local authorities, providing for new flexible ways of working through pooled budgets, integrated provision and lead commissioning.

Effective care in any setting thus relies on strong, inter-collaborative working (Hunt, 1983). It should, however, be emphasised that "*co-operative working is not something that can be achieved by legislation alone, and it has rarely been totally achieved in practice*" (Watson, 1994).

Community Mental Health Teams (CMHTs)

People with mental illness have needs that require a variety of responses from service agencies, including suitable accommodation, employment, information, education, social activities and benefits advice. Thus, many people with mental illness will require help from more than one agency (Corney, 1995). With the move of people from hospital to the

community (DHSS, 1990), continuity of care and co-ordination of services have become even more essential. A co-ordinated service requires effective communication between the different practitioners involved. However, responsibility for operating services for people with mental illness in the community is fragmented between health authorities, local government, voluntary organisations and the private sector – bodies with different styles of working (Corney, 1995), which can cause confusion and lack of interdepartmental co-ordination in community provision (Couchman, 1995).

CMHTs were conceived because of their apparent benefits in achieving effective community care (Couchman, 1995; Chalk, 1999), including:

❖ Centrality to users' access to services and resources

❖ Multidisciplinary assessment and case allocation according to need

❖ Integrated, multidisciplinary care and access to a wide range of skills

❖ Team work benefits such as skill-sharing, supervision, support and good morale.

However, there have been few research studies evaluating the work of CMHTs (Couchman, 1995). What studies there are fall into three broad categories (Chalk, 1999): those which favour CMHT working (e.g. Onyett & Ford, 1996); those where an occasional benefit is highlighted in the midst of criticism (e.g. Moss, 1994); and those in which potential functions are outlined, but rarely attained in practice (e.g. Paxton, 1995).

Nonetheless, the majority of the research highlights problems within CMHTs (Chalk, 1999) including ambiguous roles and responsibilities of staff, and systemic problems with interagency and multi-professional working (Norman & Peck, 1999). These result in communication difficulties, and conflict about leadership, effective team management and role identification.

Norman & Peck (1999) propose four main reasons for the lack of good interprofessional working:

❖ loss of faith by mental health practitioners in the system within which they work;

❖ strong adherence to uni-professional cultures;

❖ absence of a strong and shared philosophy of community mental health services;

❖ mistrust of managerial solutions to the problems of interprofessional working.

(Norman & Peck, 1999)

Models of Team Working

As Øvretveit (1997) observes, there are almost as many models of team work as there are multi-disciplinary teams. However, the main feature appears to be the shift in emphasis from individuals to teams as units of care delivery (Bond, 1997). Øvretveit (1997) presents four key ways of describing and defining an interprofessional team: degree of integration; team membership; team process issues; and team management.

Laidler (1994) highlights the importance of professional respect for successful multi-professional working. The ability to maintain and own profession-specific skills and to develop flexibility around common skills is a necessity if the team is to work coherently and to develop a shared ethos when working with service users. To expedite this process Bond (1997) emphasises the use of team learning. Through the sharing of knowledge and experience, situations can be reconstructed and understood in a client-focused way, even though the outcome for the team members may be a crossing of professional boundaries. Dombeck (1997) refers to such a process as the "*superimposition of social learning on professional educational experiences*" (p.10). The potential to pool individual learning is thus important to successful team working and occurs when the team becomes aware of itself as more than the sum total of its individual members (Hart & Fletcher, 1999).

Thus, teams do not spontaneously develop as a result of legislation and much work has to be done to facilitate team integration. However, where successful teamwork can be achieved there are evident benefits for team members, management and service users.

In line with current policy direction, the social services and mental health services in one Primary Care Group in North-east England have reshaped services for people with enduring

mental health problems. The key plank of this development is closer working between health and social services, to which end ten Social Workers (SWs) and four Community Psychiatric Nurses (CPNs) have been co-located. In addition to this common geographical location, the team includes six Community Support Workers (CSWs), who act as a shared resource for the SWs and CPNs, providing intensive intervention for clients who may otherwise require admission to hospital. The team described in this paper draws on the services of a wider group including disciplines such as psychiatry. It is acknowledged that this structure may be atypical within mental health, but it is an innovative local response to the complex needs of service users. The evaluation detailed in this paper focuses on the process of the development of this core team. In a parallel evaluation, the impact of this core team's service on service users has been evaluated (Ramprogus **et al.**, 2000), a key finding of which was that days spent in hospital during the first year of operation of the service fell to less than a third of the pre-referral figure. Of those service users who responded, the majority felt that their CSW had contributed to an improvement in their mental health during the first year of the service.

Methodology

Aims of the Team Development Evaluation

1. To inform the development of integrated health and social services in mental health.
2. To analyse the local social and political context of integration over time.
3. To describe the process of practitioner engagement with their changing role and the impact on their professional knowledge, skills and practices.

Research Design

Soft systems methodology was used to embrace an action research perspective on problems, focusing not merely on describing the problem, but actually creating change. An iterative debate is created between the practice situation and conceptual models that leads to decisions about action. The soft systems methodology has been developed by Checkland & Scholes (1990) and applied to a number of health care environments including psychiatric services (Wells, 1995).

Data Sources and Methods

This design combined four data sources to build up a rich picture of the development of the community mental health team.

Firstly, at the outset of the evaluation (four months after the team started), three uni-professional focus groups were held with the team members (SWs, CPNs and CSWs). These concentrated on each profession's perspective of teamworking and the key issues for the profession. Ten months later, two further focus groups were held with the team but with no professional division. These focus groups sought to locate the changes that have taken place in the team and to identify developments in care packages that had ensued.

Secondly, 10 collaborative learning group (CLG) meetings (a form of educational focus group with the whole team) were held monthly. The purpose of these meetings was:

❖ to be interactive with the team members;

❖ to capture the problem solving nature of the team's evolution;

❖ to allow the team to be responsive to the evaluation process.

Thirdly, 13 interviews were conducted with stakeholders (those with an interest in the team's development) from the NHS Trust, Social Services Department, the Health Authority and the voluntary sector, e.g. Consultant Psychiatrist, Social Services Divisional Manager, Senior Registrar – Public Health, Carer's Centre Development Worker. The primary purpose of these interviews was to understand the multiple perspectives of people involved in the development and operation of the team.

Fourthly, individual interviews were held with a sample of 10 of the team members, drawn from across the different practitioner groups. These interviews sought to identify individual experiences of working together, changes in professional identity and support, and the perceived impact of closer inter-agency care.

All interviews and meetings were tape recorded, supplemented by note-taking where necessary, and transcribed verbatim. A detailed analysis of each data source for topics and themes was undertaken separately by two members of the research team using standard methods of open coding. Validation of the findings was achieved through comparative exploration of the outcomes of this process. Analysis across data sets enabled thematic development to take place. This triangulation of data source and type allowed confirmation of themes and issues within the data sets.

As is appropriate for qualitative research, the quality of the work must be considered with reference to the trustworthiness of the data and its analysis (Guba & Lincoln, 1994). In this study, the credibility of the data is achieved through multiple data sources, which compensates for limitations in any single data source. For example, staff were interviewed by both individual and focus group interviews to provide opportunity for the confidentiality of an individual interview and the process of peer exploration experienced in a focus group. CLGs provided the opportunity to 'check-out' issues arising from data analysis. For example, one CLG focussed on mapping out the route of service users into and through the team, challenging the contradictions inherent in a team that claim integration but retain different referral processes and lines of accountability, yet ensuring that the research team's understanding of earlier data was accurate. The data from each source was analysed by two members of the research team with the meanings of the data considered by the whole group. The 'audit trail' from data to discussion is more fully expounded in the project report (Clarke **et al.**, 2000). These processes increase the dependability of data analysis. In qualitative work the responsibility for transferability of a study rests with the receiver, the researchers having a role in facilitating that through thorough description of the context in which the study took place. The team described in this study is atypical of many CMHTs but we aim to have provided sufficient indication of difference to enable the reader to judge the transferability of issues raised and as such the work has catalytic validity (Reed & Biott, 1995).

The data analysis suggests three key processes at work in the development of this team's practice – team building, role negotiation and trans-disciplinary decision-making.

Results

Team building

Most of the stakeholders perceived the employment of the CSWs as central to the structure of the team. They were seen as the cross-links, holding the SWs and CPNs together. The continuity of support that the CSWs provided to service users was viewed positively. There was a feeling among the stakeholders that the team was embedded within, not isolated from the organisation (demonstrated by top-down support from management across health and social care) and that there was strong leadership within the team. In turn, the strength and safety this provided bred confidence.

Team members experienced tremendous support from colleagues, enabling them to face the stressors within this challenging context. A range of supportive mechanisms were implicit in the team working arrangements including informal, open communication where individuals were able to explore difficulties, and shared knowledge and skills, which enhanced the problem solving and decision-making capacity of the individual team member:

> *I always feel able to see a more experienced worker, they're always very helpful and very supportive.* (CSW-Focus Group (FG))

The team members identified the following outcomes of working together:

❖ A sense of common purpose.

❖ More efficient inter-agency communication pathways.

❖ A more efficient and flexible service, increasing the responsiveness of the service to clients, allowing team members to manage 'red tape' more effectively.

❖ An increase in staff morale resulting from a decrease in isolation.

❖ A good level of team support through the availability and willingness of other team members to share with and listen to each other.

❖ Joint training opportunities.

Some team members felt that their professional role had been strengthened:

> *I think sometimes people worry about 'oh, we might lose our identity' and I felt that more when we were separate because I felt that sometimes CPNs were doing things that really were my role ... Now that we're integrated, rather than merging and blurring the roles, I think it's highlighted them. There's a greater understanding of what our specialism, what our knowledge is and what we can actually offer to the service ... we complement each other but our roles are specific. (SW-I)*

 However, while the drive behind the development of this team was integration between health and social services for people with enduring mental health need, at a structural level there was little evidence of integration. Despite shared goals, the team did not share the same structures and systems for their professional practice. They had very clear, but different, lines of accountability. Consequently, there was little congruence between the case loads of the CPNs and the SWs, each professional group having different entry points for clients, systems of case documentation and lines of professional support. The pathway of clients into, through and out of the team was dependent on whether health or social services were their primary contact agency. The different routes of access meant that there was no central point of case allocation within the team, apart from allocation to the CSWs, when the team leaders worked together and staff kept their own separate case records, although they made them available to each other on request. Within the team health and social care maintained separate mechanisms for professional supervision. Although there was some joint assessment in the team, different funding streams were perceived as a barrier to developing further joint assessments. Similarly, the different lines of accountability of team members, and the different statutory bodies of health and social services, were perceived to inhibit developing shared client records.

Negotiating roles within the team

Working in the new team highlighted commonalties and differences in working practices within and across traditional professional groups. The data indicated that practitioners used a process of 'role negotiation' within the context of the team, particularly where there was

overlap in roles and responsibilities. This involved recognition of the different approaches used in addressing an issue and agreeing best practice. As such, some areas of practice such as the statutory duties of SWs were outside the process of role negotiation.

The stakeholders perceived the team as a collective, with no strict demarcation of role or point of contact within the team. Stakeholders reported that you *"don't have to find the right person"* – an indication of the team taking collective responsibility for service users. Although the team members had different professional backgrounds they had in common the goals of care for their clients. In achieving these goals, team members found that there were opportunities for discussion and direct input from colleagues.

> *The further knowledge I'm getting from working so closely with the social workers and the support workers* (is good) *because we're getting good feedback and actually getting things sorted out. It's definitely helping to intervene quickly but also to keep the mental health of people stable.*   (CPN-I)

Compared with the previous way of working – often in isolation – team members felt their current working practices made them much more confident in what they did and in their own abilities.

> *I used to refer him to social services ... the social worker used to either send a letter – he wouldn't respond, they would go along and try to make a visit, and again, he would either not answer the door or he wouldn't be in, so therefore social services had to discharge him without seeing him ... But since we've come here, I've been able to work with a social worker, and with working so close together, in the same room, we've been able to discuss what's the nursing part of his care plan, what's the social part. We can address lots of issues, you know, work as individuals but also as a team together.* (CPN-I)

Thus the role negotiation within the team led to joint care planning, with multi-disciplinary support leading to a much more flexible service. The team members felt able to implement more creative, flexible and responsive care packages, drawing on a wider range of resources than before. They gained a greater awareness of their colleagues' roles and a better understanding of both health and social service agencies.

> *... if you know how an agency functions then you can obviously access different parts of it with more ease. You can perhaps get a better understanding of their point of view on a particular issue.* (SW-I)

The new working arrangements resulted in a collective of expertise within the team with individuals using this as a resource to enhance their individual interaction with clients. Although there were formal structures such as case discussion, the informal exploration of situations as they presented were also extremely valuable:

> *If we have concerns about one of our clients … we can just explore issues with* [the CPN] *and that helps us understand a little bit more and then we can take that information back to the client and explore it with them…. and that's something that wouldn't have happened before because they haven't been referred to the CPN team.*
> (SW-FG)

Trans-professional decision-making

The development of the team created an infrastructure that facilitated flexible ways of working to achieve common goals across most aspects of service provision. Where necessary, caseloads were adjusted in response to team or client requests to facilitate the achievement of therapeutic goals. Service provision was therefore tailored to individual need, providing the potential to enhance or reduce intervention intensity according to the client's personal and

social situation. This facilitated a proactive rather than crisis intervention approach to service delivery, characterised by:

❖ "fine detail" assessment by the CSWs of the service users' mental health:

> *Sometimes with ourselves we go out and we're working with him a lot more closely than a SW or CPN, we can hopefully if there are any problems nip them in the bud early on by coming back and seeing the CPN and letting them know that the client is not taking his tablets, this or that is happening, or the SW that he's fallen behind with his rent, there is a problem here and we may be able to nip it in the bud straight away instead of letting if fester for weeks and months.* (CSW-FG)

❖ flexible service provision with out-of-hours and weekend service;

> *… if we can see that things are not going right then we can discuss it with each other within the team and change care plans, you know ask for extra visits from colleagues and put a CSW in place maybe to do extra visits. Again, they can do visits up to nine o'clock, weekends and sometimes just a short visit over the weekend might tide over a crisis on the weekend. So it's … averting it rather than responding to a crisis…* (CPN/SW-FG)

❖ integration of services across sectors minimising duplication and enhancing integration of the care package.

> *Shared care planning is important – who's responsible for what, who's meeting when and it cuts down confusion for the client … about who's doing what for them and who they go to when there are certain problems.* (CPN/SW-FG)

Team members generally felt that their decision-making ability had improved with the development of the team (Cook **et al.**, 2001). Decision-making was reportedly easier due to less bureaucracy in terms of paper work and referrals to other agencies. As a team, the pool of knowledge available to inform decisions was greater and the speed of decision-making was

increased, as was the individual's confidence for decision-making. The support of the team was also valued as an aid to decision-making.

> *You don't feel the need to make hasty decisions and you know you can discuss it with somebody and you've got their opinions and support and again there's this feeling of back-up, you know, you say to somebody 'right, we're going to do this', you know that everybody is in agreement and that they support you in that.* (CPN-I)

Thus, team members and stakeholders perceived a positive impact of the team development on service responsiveness, flexibility and pro-activity. Critical factors in achieving this included: the shared geographical location and shared resources of the CSWs which were essential to the information management and interagency working of the team; and the personal and professional support provided by the close, collaborative working arrangements for the practitioners.

Discussion

Although the team evaluated in this study fails to meet recognised characteristics of multi-disciplinary teams (Øvretveit 1997), the reduced use of secondary care facilities suggest that it is "successful", and indeed the service has received local and national acclaim for its work. Most important here is an analysis of what contributed to its success and the implications for policy and practice. Hart & Fletcher (1999) describe successful teams as those that recognise that they are more than the sum of the individual members. It is this that points to the apparently positive development of this Team. In stating this, it is necessary to explore the processes that allowed the parts to gel together. There are three themes which will be addressed:

❖ The service model of team-working;

❖ The importance of resource management in the work of the team;

❖ The interface of the team with the service users.

Team-working

Although this team was a new development, several of the practitioners who became part of the new structure had an established practice history within the team's locality. Good interprofessional relationships and cross agency working practices had been developed and consequently the process of developing a team philosophy, aims and objectives had commenced before the creation of the team.

These interpersonal and team processes were perceived to be an essential precursor to effective and efficient decision-making relating to individual clients. Responsiveness to client need, duplication of service provision and role overlap could be addressed within the team structure to ensure the optimal use and valuing of the distinctive yet complementary skills of team members.

Little is understood about team learning and development that can help explain the sense of common purpose felt by the team members despite their apparent lack of opportunity for structured and shared exchange. Rather than the phases of team learning described by Dombeck (1997), in which initial individual, task-focussed learning is replaced with collaborative learning as the team matures, this team demonstrates an evolution of team working – a blurred but persistent process of continual individual and team learning, that commenced before the team itself was constituted.

The team enjoyed some of the advantages of CMHTs described by Chalk (1999) - access to a wide range of skills, support and general good morale – but not others – multidisciplinary assessment, case allocation according to need, integrated multidisciplinary care. In this respect the Team cannot be considered to be an integrated team. Using Øvretveit's (1997) definition, an integrated team would require closer working practices, including joint assessment and documentation, and team decisions to be governed by a central point in the team.

Although there was little evidence of cross-professional learning in the team, the 'superimposition of social learning' described by Dombeck (1997), each member did have a clear sense of their own purpose and the team was perceived to have clear and effective leadership – key issues identified by Norman and Peck (1999) in CMHT development.

Poulton & West (1999) argue that goal focussed methods of working – team participation, valuing of individual roles, and commitment to team objectives – are essential to successful team working, which provides some explanation for the work of this team. It is the mutual respect of team members, their core beliefs and focus on their care for people with enduring mental health needs, and their very close participatory style of working on a day-to-day basis which points to the success of the team. These are features that would be valuably replicated in other developing teams.

Resource and Knowledge Management

One feature that had a major effect on team functioning was its internal communication networks, which were most often very informal – a discussion in an office or simply 'catching' someone at the resource base. Their effect was to minimise the time taken to exchange information and, at times, to recognise information that team members held and of which others were otherwise unaware. For example, they were able to share their knowledge of individual clients, which had developed during previous contact with them. By minimising the information transaction time, the team members felt that they provided a more responsive service to their clients.

The CSWs played a crucial role in the care of clients. Through their close working relationships with clients, they developed an intimate knowledge of the client – their norms of behaviour and preferences. This allowed the CSWs to undertake a 'fine detail' observation which informed swift decision-making by the appropriate SW / CPN. Without this mechanism, alterations in the needs of the client would only be appreciated when the care plan itself needed adjustment – i.e. when the 'large detail' was affected. As a consequence the team as a whole was much more flexible, responsive and therefore proactive in the care of clients.

The team viewed themselves as better able to avert crisis in their clients, and indeed the results of the parallel evaluation (Ramprogus **et al.**, 2000) indicated a reduction to one third of the pre-referral total number of days in hospital, following referral to the team.

The trans-disciplinary nature of knowledge in the team also allowed them to problem-solve specific client care issues, drawing on a breadth of knowledge, and to refine their understanding of individual team members' roles and responsibilities with a specific client. Bond (1997) places such an emphasis on team learning – that through the sharing of knowledge and experience, situations can be restructured and understood in a client-focused way.

Decision-making in Client Care

Factors affecting decision-making

Client-focused decisions within the framework of the team were enhanced as a result of trans-disciplinary team-working and knowledge management (Cook **et al.** 2001). This enhanced decision-making capacity was directly related to, and potentially limited by, the composition and multi-disciplinarity of the team. Co-ordination occurs as a product of bureaucratic procedures or through inter-agency agreements such as access and referral arrangements as indicated in the Local Authority Joint Working Survey (SSI, 1998).

Enhanced decision-making capacity

The service development resulted in practitioners with diverse skills, knowledge and practice experiences working together. This was a catalyst for the pooling of expertise and knowledge as a resource for all team members to draw on to enhance their individual practice or the activity of the whole team. This facilitated creativity and diversity in problem solving within existing structures and facilities, contributing to an enhanced decision-making capacity.

The whole process of decision-making was generally accelerated by team dynamics and communication structures. Team members described a cyclical process of information gathering and action. Decisions were proactive and responsive, rather than crisis orientated,

achieved through effective communication between team members, minimising delay in responding to identified client needs. This proactive approach to the identification of need and swift response had the potential to limit client deterioration and maintain stability.

The team members were required to make decisions, often rapidly, about those perceived to be 'at risk' or vulnerable. That the team members were able to do this was dependent on a number of factors. Firstly, they must identify that there is a risk (to the individual, the family, community or indeed the practitioner themselves). Such identification depends on the knowledge that the individual holds and values. However, there are marked differences between the dominant knowledge of and between practitioners and clients (Clarke & Heyman, 1998). Practitioners have their own individual professional background, and a knowledge base emanating from their professional training and experiences of working with people with enduring mental health needs, whereas, service users and their families have a knowledge of their individual lives, based on their personal beliefs and values. To identify risks that reflect the values of both practitioners and service users, it is essential to hold a knowledge derived from both domains. In this respect the CSWs were in a unique position – they had a highly regarded training programme and their working practices allow them to develop a far more intimate knowledge of individual clients than the SWs or CPNs.

Secondly, for an issue to be perceived as a risk, it must also be perceived to be controllable (Heyman, 1998). Both team members and stakeholders felt that the team had the resources and capacity to be responsive to client needs. For example, CSW involvement could be increased in the short-term, there was often trans-disciplinary discussion about clients and inter-agency communication allowed effective use of available resources such as day care.

Thirdly, any course of action is judged on the perceived significance of its outcomes. The significance of any outcomes of a decision should not be solely dependent on the practitioner's view, and again the CSWs appear to help the whole team accommodate the service user's perspective. Additionally, perceptions of significance are located in policy and the dominant beliefs of a community in a way that is sometimes invisible at the point of

decision-making about care. For example, the high value placed by policy and services on preventing admission to hospital places parameters on many of the decisions made by practitioners.

Conclusion

This evaluation has sought to describe the ways in which practitioners engage with their role in a new service and in the context of a volatile social and political environment. Moreover, the study has worked towards being part of that development, informing professional development issues and team-working.

The results of the study are able to describe the processes that contribute to the perceived effectiveness of the new service. These can be summarised around three areas. Firstly, team working is enhanced by the shared goals of the team members. Secondly, these goals are realised through the effective management of resources in the team. This is both material resource such as the shared office base and shared resource of the CSWs, and knowledge as a resource. The team manages knowledge through trans-disciplinary exchange and through accessing the 'fine detail' knowledge that the CSWs have of their clients. Thirdly, the team-working and knowledge exchange enhances the decision-making capacity of the team members. This positions the service to be responsive and proactive in the care of their service users. To do so is entirely consistent with the policy directives surrounding the care of those with a major mental illness and is very much valued by those who are responsible for the delivery of care services.

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