"Gateway to the Gatekeepers" - Single Point of Access meetings:
Evaluating the client case referral procedure within an NHS Trust

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ABSTRACT

This ESRC funded CASE studentship PhD project provides a comprehensive investigation into the referral allocation process within an NHS Trust's adult mental health facilities, known as Single Point of Access (SPA) meetings. These meetings provide a multidisciplinary environment in which mental health practitioners consider client referrals in the form of letters from, primarily, General Practitioners (GPs) and direct them to appropriate services and interventions. Participants in these meetings can be seen as gatekeepers authorising access to other mental health services. The study was formally identified by NHS Research Ethics procedures as a service evaluation. From an academic perspective it is sociological research heavily informed by Glaserian Grounded Theory (GT) methodology. This approach has uncovered an internal Basic Social Process (BSP) underpinning SPA meetings. It has been named "Handling Role Boundaries", and it describes how SPA meeting attendees endeavour to work together as they make crucial decisions about clients. Initial research plans included the collection and evaluation of quantitative data which would assess the relative validity of SPA meeting decisions. Unfortunately the quality of available data proved insufficient for this purpose. This provided brief insight into tensions between administrative systems and the real life mechanisms of SPA meetings. Overall, the unfulfilled evaluative purposes of the study provided an opportunity to focus more on clarifying the BSP underpinning SPA meetings. Also explored is how this BSP has wider implications for an understanding of how "mental health difficulties" are framed and provided for. The thesis concludes that Handling Role Boundaries is a highly innovative theory offering major contributions to understanding one social space of mental health professionals. Furthermore, it offers plentiful scope for further research and will be appropriate for many avenues of dissemination.

ACKNOWLEDGEMENTS

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ABBREVIATIONS

AO	Assertive Outreach
APA	American Psychiatric Association
BSP	Basic Social Process
CASE	Collaborative Awards in Science and Engineering
CAT	Community Assessment and Treatment
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Treatment
CSI	County South Integration
DH	Department of Health
DHSS	Department of Health and Social Security
DPM	Department of Psychological Medicine
DSM	Diagnostic and Statistical Manual (of mental disorders)
DSPD	Dangerous and Severe Personality Disorder
EIP	Early Intervention in Psychosis
EMA	Education Maintenance Allowance
ESRC	Economic and Social Research Council

GP	General Practitioner
GT	Grounded Theory
IAPT	Improving Access to Psychological Therapies
ICD	International Classification of Diseases
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMBY	Not In My Back Yard
NRES	National Research Ethics Service
NSFMH	National Service Framework for Mental Health
OT	Occupational Therapist
PD	Personality Disorder
PhD	Doctor of Philosophy
PHQ	Patient Health Questionnaire
QRMH	Qualitative Research on Mental Health
R&D	Research & Development
REC	Research Ethics Committee
RMO	Responsible Medical Officer
SPA	Single Point of Access
SPSS	Statistical Package for the Social Sciences
UK	United Kingdom
WHO	World Health Organisation

1) Introduction

"A journey of a thousand miles begins with one small step."

~ Old Chinese proverb

This thesis investigates and elicits thorough understanding of a critical juncture in clients' pathways through mental health services: The Single Point of Access meeting. Clients are absent from this arena. It is the terrain of individuals charged with decision-making responsibility. Thus, obtaining an understanding of this process has depended upon access to the lifeworld of these gatekeeping mental health professionals. A Glaserian Grounded Theory (GT) approach to data collection and analysis, has demonstrated that such individuals' contributions to this decision making process reflects something other than their professional capacities. This is revealing given the conventional focus upon a multidisciplinary membership of such meetings. The identified GT, christened "Handling Role Boundaries" reflects the dynamics between identity, roles and interaction in the process of decision making. It makes unprecedented sense of a complex and, from clients' perspectives, crucial process.

Planning the project required acceptance that Single Point of Access (SPA) meetings are part of other procedures representing the referral process of the local NHS Trust, for example, administrative activities. The challenges inherent in eliciting particular data led to a discussion of lifeworld and system world dynamics. The inability to evaluate the validity of SPA meeting decisions through quantitative analysis allowed intense focus upon the Basic Social Process (BSP) depicting the internal mechanisms of SPA meetings.

This investigation has both supported and deviated from initial expectations but has been faithful to its early intentions in providing comprehensive, innovative insight into SPA meetings and the related, appropriate processes within the Trust. The study's ending is only such in the context of the thesis; indeed as Chapter 8 demonstrates, this PhD study has bred several new "small steps" that can initiate further journeys of their own.

An overview of the thesis chapters follows:

Chapter 2, "Putting the SPA meetings in context" highlights the necessity in investigating SPA meetings by framing them as part of current strategies to manage people exhibiting problematic behaviours within society. Due to historical practices in Western society, the behaviours now identified as mental health problems have been socially constructed as a form of deviance that need to be dealt with to protect societal "norms". The sociological thesis on deviance is presented and expanded upon. Significantly, this chapter argues that SPA meetings have evolved logically to represent the processes dominating today's society. Increased sociological interest has paved the way to focus upon the agents charged with making decisions about individuals with mental health problems. Thus the chapter identifies the PhD study as timely in providing insight into the current societal practices of managing individuals categorised as deviant, and highlights its relevance to sociological interest in the field.

Chapter 3 provides a full account of the methodological procedures and methods employed to study SPA meetings. There is exploration into the complexities of defining one's research and the crossovers between research and evaluation. Using the constructed term of "mixed methodology" to describe the study design, the chapter explains the twofold rationale behind using qualitative and quantitative data and how these relate to the evaluative intentions. Concepts from Glaserian GT are defined and elaborated upon where necessary.

Chapter 4 encompasses a highly reflexive description of adopting the Glaserian GT procedure (Glaser, 1978; Glaser and Strauss, 1967) and presents early coding attempts. The chapter includes extracts from memos, since a significant element of this methodology is engaging in reflexive notes and recording ideas about emerging categories. The journey from early open coding, progressive categorisation, selective coding, theoretical sampling and development into sophisticated concepts is documented and explained to inform readers of how the GT of Handling Role Boundaries emerged. The chapter ends by presenting the four main phases of this theory with sub-categories defined.

Chapter 5 specifically presents Handling Role Boundaries in detail conveying its allegiance to the concept-indicator model by linking the phases and sub-categories with empirical incidents. The chapter suggests that Handling Role Boundaries is both a linear and cyclic BSP of SPA meeting attendees. Extracts from participant observations and interviews are reflected upon to help explain the theory and diagrams are utilised where appropriate.

Chapter 6 investigates Handling Role Boundaries in relation to other literature and uses the comparative method to consider how extant theories of decision-making, identity, interaction and role relate to it. This focused literature review identifies the gaps within sociological discourses that Handling Role Boundaries is able to fill, as well as ideas it shares with other theories. This chapter endeavours to convey the theoretical contribution that Handling Role Boundaries is able to make.

Chapter 7 proceeds to comment on the difficulties that emerged from the quantitative enquiry. In light of this, commentary is provided relating to how well the bureaucratic procedures in place support the process of SPA meetings and the implications of this. Reference is made to Habermas' (1987) lifeworld and system world concepts. This chapter also explains the opportunity that arose for the project to devote attention to the developing BSP and why this is the prominent focus of this study.

Chapter 8 resumes the discussion on the BSP of Handling Role Boundaries by reflecting on its innovative contribution to several fields and exploring how it can be developed further. The chapter identifies the potentials for future investigation and the study's contribution to micro and macro levels of understanding is described. Plans for practical implementation of Handling Role Boundaries are discussed with reference to the Intervention mode (Artinian *et al.* 2009) and scope for dissemination of findings is explored.

What is important to highlight is that some structure of the thesis, in particular the literature review of Chapter 6, gravitates away from the traditional sociological thesis layout. This was required to abide by the directives established by classical Grounded Theory methodology, where a focused literature review can only be done after categories have been fully developed (Glaser, 1978). The structure is therefore faithful to the highly

inductive nature of this study. This means that the traditional space for a literature review (i.e. preceding the methodology) consists of a literature review devoted to putting SPA meetings in context. This was necessary to identify why the substantive field warranted investigation in the way that this study has conducted.

2) Putting the SPA meetings in context

"A people without the knowledge of their past history, origin and culture is like a tree without roots."

~ Marcus Garvey, Former Jamaican political leader

2.0: <u>Introduction</u>

This chapter locates Single Point of Access (SPA) meetings within a wider context and develops the notion of mental health problems as a social issue requiring management. People in modern western societies who are perceived to have mental health problems undergo a process in which they are labelled as such based on judgements about their behaviour. This identification process is essentially subjective and can be disabling with ramifications on the person's identity and status. The identification process is based on mental health problems being historically recognised and treated as a form of deviance. As such, this chapter draws upon the Sociology of Deviance and related notions of social order. Society has always generated individuals with difficulties we now commonly refer to as mental health problems. I will argue that these individuals' behaviours have always been viewed a focus of deviance, and managed accordingly. Thus here a discussion ensues relating to how this particular form of deviance has been identified and provided for across time. This specifically develops by documenting the perceptions and management of mental health problems during the Renaissance, the Enlightenment and post-World Wars events, including diversification of mental health services with the arrival of AO, CRHT, IAPTs and other service components during the last 20 years.

Approaches to these forms of deviance have altered in response to the changing shape of society and its processes. The 20th century witnessed escalating medical dominance over social issues in western communities and as such, particular forms of deviant behaviour have become constructed as illness to be treated. The current discourse of this deviance continues to use medical labels with a treatment agenda by medical agents, and a heavy reliance on bureaucratic strategies. The approach is reflected in processes employed by mental health services and the related plethora of mental health teams. SPA meetings have evolved out of this medical and bureaucratic approach to provide for people exhibiting mental health problems. Bureaucratic functions are

inherent within health services and specifically, SPA meetings, as provided by mental health services, reflect elements of their operation. Overtly this features as structured meetings with allocated time slots, administrative presence and an established agenda. Moreover, the overall running of SPA meetings depends upon a triaging approach that allocates interventions, following assessments of priorities and judgements relating to which behaviour is best described by medical labels. Drawing upon historical examples of management, this chapter discusses how and why this present strategy of managing people with mental health problems has evolved.

Therefore, this process of identifying those with mental health problems, which has occurred in various ways over time, needs to be understood in both its historical context and its current incarnation. The latter denotes SPA meetings as a key step in the process and is itself a critical social process that is relevant to our understandings of how this form of deviant behaviour is managed. The critical SPA process, which is instituted by bureaucracy, has at its heart a more specific basic social process that emerges in the behaviours and activities of the meeting attendees. This helps one to further understand the dynamics of the larger process of identifying individuals as having mental health problems and thus opens up the rationale for focusing on SPA meetings in this investigation.

Finally, in section 2.10, the design and process of SPA meetings as run by the studied local NHS Trust are set out to provide an outline of how they operate and who attends. The initial evaluative agenda of this study is briefly explored and the rationale for pursuing a Basic Social Process (BSP) is provided. However comprehensive discussion of these two elements is reserved for the next chapter on Methodology and Methods (p 59)

2.1: <u>A critical social process</u>

The identification of individuals as having mental health problems involves a process based on human judgement and subjectivity relating to assessing behaviour. Historically this has materialised as comparisons between ideas about "normal behaviour" and incidents which defy this. This leads to the concept of deviance, which itself is socially constructed to provide rationale for managing particular forms of behaviour in certain ways. The Sociology of Deviance is critiqued in section 2.2 and denotes how mental health problems have been identified under this category. Once constructed as a form of

deviance, provision for these problems are shaped by the processes shaping society at a particular time and management can therefore be perceived as historically contingent. This is demonstrated in the sections that follow from the discussion on deviance.

In subscribing to this outlook regarding management of mental health problems, it is firstly, however, important to lay out my definitions of mental health problems along prevailing discourses in the literature.

The World Health Organisation (WHO) (2013) defines that mental health,

> *"…is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders…"*

My understanding of WHO's stand on mental health and well-being is that it embraces individuals' emotional, cognitive and behavioural functioning. The notion of well-being can take into account one's emotional, cognitive and behavioural functioning. Pilgrim (2006) suggests that mental health is utilised both positively and negatively to denote psychological wellbeing, or the opposite when the term "problems" is added. Regarding aetiology, as discussed in Section 2.10 (ii) this is a contested area and the practice of psychiatric diagnosis is heavily debated. The splitting of mental health problems into functional and organic categories demonstrates the differences in understanding the causes of such problems and the role biology may play (Pilgrim, 2006). Given this heavily research area is yet to settle on a consensus on mental health, I accept that a firmer standing on its aetiology remains aspirational. However, in spite of the contested nature of mental health, I embrace the notion that mental health problems can be understood to be caused by a range of factors including biological, psychological, social and genetic elements. This fits in with my arguments that management of mental health problems represents management of a particular form of deviance. I do not make any claims about the origins and causes of such behaviour labelled as deviant; my point is that such behaviour emerges and is judged to warrant management. In the context of SPA meetings, as discussed further in Section 2.10, this management involves mental health professionals allocating clients to services and interventions deemed most appropriate to handle their problems.

2.2: <u>The Sociology of Deviance</u>

The notion of "normal" behaviour or "norms" remains central to the sociology of deviance. According to Eaton (2001) *"deviance is defined as the breaking of a cultural norm- that is, a shared set of expectations about behaviour…"* (p26). "Norms" are changeable over time and also between and within cultures. Deviance is seen as digression from "norms" and can emerge from individuals and groups (Giddens, 2009; Eaton, 2001). The phenomenon of deviance is discussed as being socially constructed, because behaviour becomes understood as deviant based on subjective definitions by members of society (Eaton, 2001; Erickson, 1966; Becker, 1963). This assertion leads to consideration of notions of power. Cohen (2002) points out that a social construction of deviance raises questions of who labels behaviour as deviant. Scheff (1999) promotes a distinction between the terms of "rule breaking" and "deviance", with the former denoting a breaking of specified rules or "norms". The latter denotes a label assigned to behaviour by members of society, thus deviant individuals are those who have been given a label rather than exerting deviant behaviour. The issue of power in relation to labelling behaviour and sanctioning management will be explored as the chapter ventures into specific historical examples.

Deviance does not necessarily require management because some deviant behaviour is not constructed as problematic to an extent that warrants strategies to deal with them. For example, Giddens (2009) discusses the deviant subculture of the Hare Krishna group whose behaviour departs from the dominant "norms" of society. Though perceived by many to be eccentric, their presence is largely met with tolerance. It then is essential to locate the point and circumstances in which deviant behaviour becomes constructed as problematic by society to the extent that measures are implemented to manage them. This is of particular significance when discussing the history of people with mental health problems. When discussing the historical management of people with mental health problems they are possibly better referred to as "individuals who exhibit bizarre behaviours and provoke anxiety". This description was chosen to reflect that at certain points in history such as the rational era of the Enlightenment of the 17th and 18th centuries, which is often referred to as the "Age of Reason" (Foucault, 1967), medical insights were not always dominant in the management of such individuals and thus terms such as "mental health problems" or any other analogous terminology would not be an ideal way to describe them. Eaton (2001) advocates using a description of this kind, since the term "mental disorder" tends to restrict discourse and would not make for

a realistic historical representation of the phenomenon. Eaton describes "bizarre" as depicting the notions of "odd", "unexpected" "extreme contrasts" and ultimately when applied to behaviours, it presents the idea of something rare and culturally deviant. In addition, the term "madness" will often be referred to because much of the literature delving into the history of this topic refers to such behaviour using this definition.

To return to the notion of deviancy and identifying the conditions that dictate management strategies to deal with such behaviour, the case of individuals who exhibit bizarre behaviour is interesting. Historical writers acknowledge that such behaviour was not always perceived to be problematic by society (Porter, 2002; Foucault, 1967), but seen as an attribute of a creative genius soul, a perception that was present for part of the Renaissance period. Scheff (1999) also suggests that the term "deviance" is misleading because its negative connotations assume that it cannot be met with positive reactions: some incidents of rule-breaking are interpreted as innovative. However, one can see the inconsistent and subjective status and treatment of bizarre behaviour, since periods preceding Renaissance suggested a negative reaction to such individuals. Biblical Scriptures reference madness, which is presented as a phenomenon that defies wisdom and likened to foolishness,

> *Like a madman shooting firebrands or deadly arrows is a man who deceives his neighbour and says, "I was only joking!"* (Proverbs 26:18-19)

It is further depicted as a condition inflicted by evil forces that needs to be drawn out by the Divine One. One example of this is located in the New Testament book of Matthew where Jesus is asked to heal a boy thought to be suffering from madness with symptoms including seizures (Matthew 17:15). Jesus rebuked the demon causing these symptoms to heal. Moreover, the condition of madness was also imposed as a punishment, as in the case of Nebuchadnezzar who was driven away from his home and ended up living among wild animals eating grass (Daniel 4:32-34). Therefore within the construction of deviance, there must be a process or processes present that account for deviant behaviour being perceived as a social problem. Indeed this is why there are examples where individuals who exhibit bizarre behaviour have been treated both negatively and positively within history.

According to Eaton (2001) the theory of functionalism shows how some levels of deviance can be accommodated by society and the way in which it is managed can deliver benefits. In particular, sociological analysis intends to discover latent functions present in a social system, i.e. those functions that are not easily recognised. This is compared to manifest functions which are intentional (Merton, 1956). On a level regarding manifest functions, labelling and managing individuals labelled as deviant allow a process to take place where behaviour is corrected. Concerning latent functions, Eaton (2001) highlights that the labelling procedure allows the "norms" of society to be more overtly pronounced and promoted. Moreover, those individuals who have not been assigned the label of deviance then have their moral solidarity strengthened and a sense of group belonging is generated. The division between in-groups and out-groups is a well-recognised process of society, which enables strategies to protect the interests of the former (Bauman and May, 2001). Marking out behaviours or set of behaviours as deviant out of a range of complex human interactions and processes is inevitably a subjective process, which is influenced by different macro-level factors. Eaton (2001) discusses the notion of legitimating theories so that they unite to construct a powerful symbolic and stable universe. When acts emerge which challenge and threaten to jeopardize this stable framework, whatever that might constitute, their logic is defined as deviant. Consequently society mobilises efforts to deal with those labelled as deviant.

Cohen (2002) discusses the phenomenon of moral panic to explain why certain issues, individuals and/or groups of people become social problems perceived to be exhibiting disapproved behaviour. Such individuals then acquire the position of "folk devils" whose status as such reminds the majority of what depicts undesirable behaviour. The rounding up of folk devils is done by agents of society who have the power to promote convincing messages, such as the press industry. Cohen (2002) focuses on the case of "Mods and Rockers" of the 1960s and argues that the violence attributed to them was highly exaggerated by the mass media to generate moral panic regarding a failing state of society. Moral panic could have been generated in pre-modern times as well through the use of paintings and plays and by a promotion of the idealised "norms" of society.

Deviance is entwined with the idea of social control and conformity. According to Scheff (1999) social control can be seen as a range of *processes that generate conformity in human groups"* (31). The extent of this is wide-ranging even if one should defy expectations, they are unlikely to be immune from the effects of disapproving comments or attitudes of others. Social control can affect decisions regarding which clothes to wear

for particular occasions and exuberates the power to make people conscious about imagined censures as well as real ones. For example, discovering a mark on one's shirt during a posh ceremony can cause embarrassment to the individual even if no one else has noticed because of the etiquette established and expected at such venues. Scheff (1999) suggests that conforming to established shared expectations is met with rewards, whilst departing from such "norms" receives punishment. He adds that social control intends to generate uniformity visually and otherwise,

Systems of social control exert pressure for conformity to social norms through the operations of sanctions: conformity to shared expectations is rewarded, and nonconformity is punished… (1999:35).

Once deviancy is constructed and labelled as something to be punished, the power awarded to those mediating social control and the majority of conformists, perpetuates strategies to deal with such behaviour. The bizarre behaviour labelled mental health problems in 21st century Britain is one example of labelled deviancy that is constructed as warranting management in society. When judgements are applied to the decision making process within SPA meetings and other arenas of diagnostic activity, discussions and thought processes inevitably reflect upon notions of normal behaviour. Deviant behaviours considered mental health problems are then measured against these to ascertain a sense of the extent to which such problem do indeed amount to phenomena that need sanctioning.

Arguably human behaviour is and always has been varied and complex. The system of social control that exists continually defines what constitutes normal and deviant behaviour. Individuals exhibiting bizarre behaviour have received varied attitudes from society over time (Foster, 2007). Various elements and agents of social control throughout history have constructed such behaviour differently, with different management strategies. This has led to the assignment of the deviance label to such behaviour by society, signalling its departure from majority social norms. As society became occupied with an Age of Reason during the Enlightenment period (Foucault, 1967), the constructed deviance applied to individuals exerting bizarre tendencies was perceived to be unacceptable and warranted their removal from the society. Subsequent discussion addresses how the confinement of these individuals progressed. Later, this thesis chapter highlights the eventual arrival of medical dominance from the twentieth

century onwards, to construct this bizarre behaviour as illness to be treated by medical agents in a medical arena. This medical arena is now a dominant social control manager, continuing to implement strategies to deal with the social problem of people with mental health problems, whose behaviour is still regarded as deviant from majority norms. The health system exhibits a range of mental health services which provide bureaucratic procedures such as SPA meetings to provide for people with mental health problems. Particular historical excerpts are now discussed in more detail to demonstrate this historical evolution.

2.3: <u>Pre-mass confinement to asylums</u>

Since people exerting bizarre behaviour have always existed, there have always been formal and informal ways of managing these individuals. According to Porter (2002), there is evidence of trephined skulls, suggesting that madness is a managed phenomenon that dates back to at least 5000 BC. As mentioned earlier, the Holy Bible mentions madness on a number of occasions. Historical accounts of how religion understood and dealt with people exhibiting bizarre behaviour who provoked anxiety demonstrates how managing mentally ill individuals has not always been dominated by the medical field. Indeed, Porter (2002) points out that in Christian Europe, responsibility for those seen as mad remained with the family of these people. Although in domestic care, these individuals were likely to have been kept hidden in cellars, or left for a servant to manage. This treatment was instigated by the shame that mentally ill people were thought to bring to the family. This highlights the stigma of being associated with individuals exhibiting bizarre behaviour and generates some insight into what constituted respectability. In these early periods, respectability was largely defined by Christian standards. Societal responses dictated such treatment of individuals exerting bizarre behaviour and it can be argued that this practice is mirrored in today's British society, when one becomes familiar with the context in which SPA meetings have developed. An example would be the risk assessment agenda that SPA meeting members participate in, as a way of maintaining public safety as well as the individual's. This will be discussed later on in the chapter.

During the Middle Ages (around 500-1500AD) (Smart history website, 2013) management of people with mental health problems continued to be instigated largely by Christian actions seen as part of charitable work (Porter, 2002). The segregation became more formal and would often see individuals who displayed bizarre behaviour

put away in towers and dungeons under public auspices. Furthermore, the London religious house of St Mary of Bethlehem was founded in 1247 and it became known as Bethlem ("Bedlam"). By the later part of the fourteenth century, it was looking after mentally ill people.

2.4: <u>Foucault- Madness and Civilization</u>

This notion of madness as unsanctioned rule breaking is part of the history of managing humans exhibiting bizarre behaviour and provoking anxiety. It is explored by Michel Foucault in "Madness and Civilization" (1967), in which he investigates the modern Western notion of "madness". Foucault's focus is primarily on the "classical period" termed the "Age of Reason" and sometimes referred to by other scholars as the Enlightenment. Foucault's view of the Age of Reason was that rationality was a feature that promoted Christian, capitalist, bourgeois family values. On the other side of reason was behaviour that deviated from the highly esteemed rational values, thus the boundaries between this and reason were subject to careful monitoring. Deviance was recognised among other social groups as well, such as criminal behaviour and moral laxity, but there lacked a clear distinction between these types of deviance and deviance associated with madness. Thus the varying levels of tolerance towards people exhibiting bizarre behaviour before the Age of Reason was substituted for disapproval and along with other social groups perceived to be undesirable, these individuals were seen as a threat to the idealised version of society.

Bolton (2008) agrees that a key point in Foucault's analysis of western modernity and madness is the point in which madness came to be defined as "unreason". This presentation of madness strips it of meaning, truth and voice and reassigns it to being a disorder. Bolton describes it as *"...western modernity's construction of madness..."* (2008: 84). It is likely that Bolton uses the word "construction" because as he points out in Foucault's work, madness was not always perceived to repel reason. Foucault's (1967) description of madness during the Middle Ages highlights the Simpleton in moral fables, characterised as the "madman" and depicted as a guardian of truth, thus representing a significant role. This was also implied in paintings, where the theme of knowledge merged with madness. During the Renaissance (around 1500-1700AD) (Smart history website, 2013), individuals who exhibited bizarre behaviour were sent away on boats, which became known as the "ship of fools". Allegedly seamen were charged with the

responsibility of escorting these individuals out of cities, because they were perceived to be dangerous. Though argued by historians that the Ship of Fools was fictitious, using imagery to convey ideas about bizarre behaviour and dealing with such behaviour is still an important source providing significant insight into societal attitudes. Imagery can be seen to represent ideas and practices of society even if this is not to be taken literally.

In a painting described by Foucault (1967), the ship of fools uses the tree of knowledge as its mast. This conveys the man of unreason, i.e. those on the ship of fools, as in possession of all kinds of knowledge, including the forbidden wisdom and infernal fall of man. In contrast, the man of reason possesses only partial knowledge and is oblivious to many truths of the world. The overall message is that madness reigns over reason. It can afflict any person, because it is the essential feature of all human weaknesses. Further paintings also presented madness in the company of knowledge. Foucault (1967) identifies an engraving in which a Magister wears a doctoral cap and is surrounded by books. However he also wears a fool's cap, which conveys the message that knowledge is in fact absurd and full of ignorant assumptions. People participate in false learning and so madness is inflicted on them as punishment.

However these associations of madness did not remain and the Age of Reason brought with it a *"...rational mind..."* (Bolton, 2008:84). This period in history awarded immense value to rationality and reason and these became associated with the civilized individual. Reason was logical and linked greatly to science and mathematical deductions. In order to distinguish between someone who was rational and someone who was not, people relied on societal norms.

2.5: <u>The Great Confinement</u>

The removal of people with mental health problems from society was another response to the perceived deviance of such individuals by putting them into asylums. The buildings which fulfilled the asylum agenda had previously been used to house individuals suffering from leprosy in the Middle Ages (Foucault, 1967). However, by the 16th Century, leprosy cases had dwindled and thus the buildings were no longer needed for this social group. Their relative success in housing a social group perceived as undesirable is likely to have influenced its evolution into containment for people exhibiting bizarre behaviours to alleviate societal anxiety (Bolton, 2008). This allowed

society outside asylums to maintain a rational mentality, without having to be involved in irrational behaviour. In some ways, we see a pattern emerging throughout history; the mad need to be removed to avoid negative implications on the remaining community, whether this is a family or large society. In the case of the family, Porter (2002) indicated that hiding away family members exerting bizarre behaviour could have been to avoid shame; In the case of society, Foucault (1967) implies that putting mentally ill members of the community into asylums protected against threats to social order.

Foucault (1967) suggests that confinement fulfilled a role that was not to cure illnesses, but to promote the imperative of work. A new work ethic emerged in society that sought to destroy idleness and poverty and promote labour as a moral obligation. Foucault describes confinement as a "*police matter..."* which confirms that it was part of a number of strategies to manage members of society, including those exhibiting bizarre behaviours. Foucault cites confinement as officially beginning in 1656, when the "Hôpital Général" was opened in France. It took a very dim view on idleness, but also provided a new way to deal with it. Before the Hôpital Général opened, extreme and negative actions existed such as excluding unemployed people from cities. The establishment of the Hôpital meant that these exclusions could be replaced by confinement, which had both physical and moral constraints. Similar establishments across England were set up and were known as "Houses of Correction" and like the Hôpital Général, the unemployed, idle and vagabonds were housed there. People suffering from madness were seen to be idle and so were among those confined.

The ethos behind confinement took on a new meaning. The Houses of Correction and the Hôpital Général served to ensure that inmates played a part in contributing to prosperity. In addition, since the Houses of Correction were perceived to be economic institutions, the work that was done within them had to be productive. Foucault (1967) constantly reminds readers of the religious undertones of this dominant work ethic. Idleness was branded as an extreme sin because it defied the premise of working and therefore showed ignorance to the high ethical status of labour. Furthermore, there are suggestions that this work ethic originated from the Bible, becoming instilled in the values of Protestant Christianity. Although labour was seen as a way of resolving poverty, its influence was derived from its moral enhancement rather than any productive achievements. Foucault (1967) also notes that the Hôpital Général forced its younger inmates to read pious books in addition to their work duties. This demonstrates

how Christian values contributed to managing individuals both inside and outside institutions. According to Foucault (1967), the imperative of labour gave an ethical power to the community, which rejected all forms of social uselessness. The work ethic allowed poverty to be viewed negatively, because it demonstrated a weakening of discipline and implied a slackening of morals.

The Age of Reason was thus an era of confinement, the principles of which began to treat those suffering from madness differently from its other inhabitants. Foucault (1967) explains that some criminal behaviour was publicised, because it was believed that this helped suppress the evil associated with that crime and ensured that the individual would receive forgiveness from God. By shaming the person during life on Earth, it was thought that punishment would be less during life after death. However, for people with mental health problems, it was thought that certain acts of evil were so immensely powerful, that any publicity would allow them to be uncontrollably multiplied. Confinement was the only solution, because it ensured protection against scandal, which meant that families could evade any dishonour.

On the other hand, Foucault highlights situations where complete concealment was exchanged for a combination of confinement and exhibition. In the institution of "Narrtumer" in Germany, the windows were designed with bars to allow people on the outside to watch the confined person chained up. Foucault also notes that in France at Bicetre, people with mental health problems were presented in the same way animals are at the circus,

"...One went to see the keeper display the madmen the way the trainer at the Fair of Saint Germain put the monkeys through their tricks..." (1967: 64).

This image was further promoted by the use of whips and the demand for these individuals to engage in dances and acrobatics. It seems clear that this confinement takes on a different nature, whereby the outside society is given an invitation in to view the spectacle of real life madness. This contrasts with the earlier Renaissance where people were invited to see madness displayed on the stage in plays, as well as being able to interact with madness in their everyday life without any confined environments.

Foucault's analysis of madness being treated in this way during the Age of Reason suggests that this arrangement of glorifying scandal was a way of organising madness. People exhibiting bizarre behaviour were viewed as monsters, but the fear associated with madness was alleviated by the reassurance in the arrangement: people could observe madness without having to compromise their safety. People with mental health problems were resigned to the same status as beasts and were seen as the ultimate degeneration of humanity. A man deficient in thought was even less imaginable than a man missing his limbs. Cell conditions where mad individuals stayed conveyed an animalistic environment, filled with straw, sewage and rats. Thus even when not on display for the public, the association with animals was constantly reinforced, e.g. using chains to restrain. Madness was seen as complete resignation of man to his inner animalistic being.

The depiction of individuals who exhibited bizarre behaviours generated a notion that madness was an inevitable consequence of leading an undesirable degenerate lifestyle, reiterating the Bible's representation of it being a punishment. This notion is captured significantly in 18th Century artist William Hogarth's canvases "A Rake's Progress". The paintings depict the experiences of Tom Rakewell, a rich heir, who is unwise with his money and indulges in a lifestyle of debauchery. The final eighth canvas as shown in Figure 2.5 depicts Rakewell's confinement to Bedlam where he is afflicted by madness. According to Pedlar (2006), Hogarth's paintings functioned as a warning of the consequences of leading an undesirable life. However, it is not just madness that is depicted to be the punishment. The whole institution of Bedlam and indeed society is captured within this eighth painting to present a scathing view of the latter in terms of the two well-dressed women who visit the asylum as a social outing. This conveys the notion of madness being a spectacle displayed for the benefit of entertainment.

Figure 2.5 William Hogarth's plate 8 engraving of "A Rake's Progress" (1735)

Bolton (2008) discusses Foucault's (1967) analysis of asylums including the latter's thoughts on life inside and outside the asylum. Foucault suggests a twofold relationship existed between the inmates exhibiting bizarre behaviour and their keepers: social and medical. Being in the asylum meant that people exerting bizarre behaviour who provoked anxiety were excluded from society, thus they became a society of their own within the asylums. These were initially formed as communities that aspired to uphold the norms of society and religious values. The first asylums operated to reverse the negative attributes of the inmates and instead instil sane and "normal" behaviour. Negative attributes to be rectified included irrational, mad, antisocial, uncontrolled and unreligious habits. According to Bolton (2008), Foucault makes clear that in this point in history, any positive associations with madness of the past, such as the mad person being a bringer of truth, were lost. The role of the asylums certainly did not aim to provide a voice for madness and its hidden truth. As Bolton states, *"...There was*

emphasis on silencing mad talk, and on stopping mad behaviour..." (p85). The use of chains was replaced by the use of talk, with psychological inputs designed to instil guilt on the inmates, establish authority over them and maintain their training to ensure they became better people.

This social relationship between keeper and inmate was accompanied by a medical one. Bolton (2008) highlights Foucault's (1967) claims that with increasing asylums came increasing control from the medical profession. The use of medical treatments seemed to verify the notion of madness being an illness. Such medical treatments involved bloodletting, purging and vomiting, immersion and blistering, which all focused on the values of purification and the understanding of spirit and fibres in the body. However, such methods were not strongly evidence-based, and even the justification of taking such measures was not well defined. What was clear though, was that madness no longer possessed any meaningful context. Foucault indicates that it is here that modern psychiatry emerged, where talk about madness was not to install meaning into it, but was restricted to describing it, in terms of symptoms, classification and diagnosis,

> *…the constitution of madness as a mental illness ... thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness has been established only on the basis of that silence".* Foucault, (1967): xiii

According to Porter (2002), Foucault's (1967) work implies that institutionalisation led to the disempowerment of madness, by eliminating free speech and most liberties associated with humanity. Indeed, such individuals were deprived of what was perceived to be the quintessential human feature: reason. On the other hand, Porter (2002) criticises Foucault (1967) for being overgeneralised and simplistic. For example, Porter cites the lack of evidence to support early asylums operating organised labour. Porter suggests that it was more likely that the proprietors of madhouses targeted patients who were rich and genteel and did not expect its patients to work. Thus Porter implies that it is unwise,

> "*...to cast the rise of institutional psychiatry in crudely functional or conspiratorial terms, as a new witch-hunt or a tool of social control designed to smooth the running of emergent industrial society...*"

Porter (2002) adds that one should explore the rise of asylums in terms of varied motives of a mixed consumer society, such as family members, the community, magistrates and superintendents. Porter's suggestions still present asylums as a way of managing people with mental health problems, but encourage us to acknowledge that there may have been different party interests, other than the State, in choosing asylums. Moreover, Porter's (2002) critique of Foucault implies that the work ethic was not necessarily imposed upon inmates in the asylums. This could mean that the perceived idleness of the inmates was further reinforced by their lack of engagement in labour. Asylums were not functioning to correct the lacking work ethic among inmates.

There is criticism of Foucault's (1967) analysis of the history of madness and civilization, with some attacking its over simplistic nature and inaccuracies (Cooper, 2007; Porter, 2002). These criticisms are pertinent because it is unwise to communicate a history that did not exist. However, at the same time Porter (2002) recognises the plausibility in Foucault's (1967) arguments. Moreover, if one is looking for demonstrations that at different points in history, society has had different ways of doing things based on prevailing views, then Foucault makes this point well (Cooper, 2007). To some extent, the inaccuracies in his historical analysis do not affect this point, although this is not to say that these inaccuracies should be ignored. Porter (2002) argues that there was no evidence of a so-called Great Confinement in England in the time period that Foucault refers to. However, one cannot argue that the Elizabethan Poor Law of 1601 *was* passed and led to the confinement of individuals in Houses of Correction (Fraser, 2009). The discourses are identifiable even if not as firmly fixed in time and place as Foucault suggests.

In recognition of the criticism of Foucault's (1967) analysis, it is wise to explore some key dates that will ultimately provide a clearer picture of the management of people with mental health problems throughout history. Shaw's (2007) work provides an opportunity to do this by outlining important policies that have impacted on the management of madness. Shaw agrees that madness was seen to come under the category of unreason and needed to be controlled. The Vagrancy Act of 1744 allowed English counties to

establish asylums where criminal and pauper lunatics could stay. Admissions were the responsibility of the local Justices as opposed to physicians. Indeed the earlier part of the 19th Century saw an absence of medical input in the County asylums and an increasing adoption of "moral treatment". This implied that madness should be dealt with by ensuring that inmates received humane treatment to help them to restore calm and order in their lives. This approach was adopted by Pinel in 1744, which saw the disposal of chains in the Bicetre and Saltpetriere asylums (Shaw, 2007). Later on Tuke was influenced by this process and developed it further by employing kindness and showing respect to inmates at the York Retreat. The aim was to use moral force to enable inmates to achieve a sense of self-control over their animalistic tendencies.

2.6: Pre-1948 developments

The 1845 Lunatics Act made it compulsory for public asylums to be constructed and subject to regulation (Shaw, 2007). This may have been due to the Parliamentary reports of the early 19th Century, which uncovered the huge numbers of private mad-houses in operation. With these new public asylums, approaches changed and medical treatment was favoured over moral treatment. However the mid-19th Century witnessed problems arising, namely issues of overcrowding. The Industrial Revolution had led to an influx of people into towns and cities. There was enormous pressure on the asylums to take in more and more individuals, particularly given their inability to contribute to the economic needs of society outside the asylum. However at the same time, the number of people leaving asylums was compromised by doctors' failings in finding cures for inmates. The reign of public asylums continued in the early 20th Century serving a custodial role reinforced by the processes within the asylums (Shaw, 2007). Routines took on a regimented form and passivity was encouraged among inmates, culminating in a state of strict control being achieved. This is best symbolised by the Panopticon, which was devised by Jeremy Bentham in 1843. The structure of this was arranged in such a way that one person could monitor numerous inmates, and with the strategic placing of screens, inmates had no way of knowing when they were under surveillance. Ultimately a sense of enduring observation was achieved with relatively little effort, since the observer did not actually have to be there. Marshall (1998) highlights Foucault's analysis of the Panopticon, whereby its whole structure implements a functioning of power due to a sense of being watched. The impression of constant surveillance would put inmates in an inferior position by keeping them on edge.

By the end of that century, the therapeutic intentions of the early 19th Century seemed to have become more of a distant memory. Shaw (2007) adds that the 1890 Lunacy Act prioritised the concerns of the public outside the asylums over inmates. The legal issues pertaining to detention into asylums became more rigid. In fact, at this point, the legal world prevailed over the medical and social field when it came to mental health problems. The legal profession sought to manage people with mental health problems in order to satisfy a yearning for safety and reassurance outside the asylum walls. Their tightening of policies also displays a negative disposition towards the issue of mental illness, which suggests individuals with mental health problems threatened a safe and secure society. The fear associated with people with mental health problems is also a dominant issue today. Foster (2007) believes that this fear has increased significantly since 1990. Moreover, this author suggests that there is an overriding belief that mental health facilities lessen the respect of an area, and thus hardening attitudes such as "Not In My Back Yard" (NIMBY). Foster (2007) proceeds to describe how the positioning of asylums had practical and psychological repercussions for inmates. Practically, being positioned separately from the rest of community generated a sense of isolation and segregation from society. This was reinforced by asylums' structure and design, which allowed them to be self-sufficient and thus have no need to interact with wider society. Psychologically, being separated from society contributes to those with mental health problems being perceived as the "Other" or out-group, who must be ostracised from the in-group, for fear of the former contaminating the sane functioning and social order of the latter. A sense of "them" and "us" is generated, whereby the "other" i.e. "them" is seen to hold undesirable characteristics that are incompatible with "us" (Bauman and May, 2001).

However Boardman (2005) argues that the 19th century in Western societies had begun to feature isolated attempts to transfer mental health care from the asylums to the community. On the other hand, he is clear to point out that was not until to Mental Treatment Act 1930 that introduced the potential informal admission and highlighted that support in the community support was vital.

2.7: 1948 and developments after

Much of Britain's current social issues and problems are managed on the basis of values and principles enshrined in the notion of a welfare state (Boardman, 2005). As a term, the welfare state rose to prominence following the 1942 Beveridge Report (Fraser, 2009). This report, conducted by William Beveridge, identified the five so-called giant evils in society: want, disease, ignorance, squalor and idleness. Beveridge advised that the post-war government should aim to provide a comprehensive health service, family allowances and maintain full employment. The government acknowledged its responsibility to cater for individuals from the moment they were born until they died. The Beveridge Report instigated the creation of the National Health Service in 1948, which operated along the principle that healthcare should be free for all (Fraser, 2009; Baldock *et al.* 2007). For people with mental health problems, this new system of welfare support meant that those who did not receive income could benefit from care without needing to be sent into asylums. This was supported by the provision of public housing (Boardman, 2005).

It is important to note that the 1942 Beveridge Report was not the point that British welfare began; rather it was a culmination of a longer process. Britain had previously had systems that could be interpreted as welfare provision, for example the Poor Laws of 1601 and 1834, and Christian charitable practices such as looking after the sick (Fraser, 2009). However, the characteristics of welfare to which our modern society has become accustomed to became more prominent after the Beveridge Report, for example the identification of certain groups as vulnerable, the provision of services for these groups and the protection of their rights. In this sense, the British welfare state became a pertinent feature of society following 1942, and is one that carries on to the present day. The National Health Service (NHS) is one of many examples of state welfare provision, which continues to be a major discussion point in government politics, professionals and lay people. Likewise, the welfare state dominates the discussion and management of other social issues in British society, such as education and minority ethnic groups (Fraser, 2009) with initiative such as the Education Maintenance Allowance (EMA) and Race Relations Acts. This demonstrates the dominance of state interventions in the provision of welfare to organise the management of social problems in 21st Century Britain. The government's commitment to British citizens following the 1942 Beveridge Report has instigated an expectation among the latter for the former to deal with the social issues and problems prevalent in society, with health being a key matter.

Therefore the organisation of managing people with mental health problems is understandably going to involve the state and welfare provision.

The 20th Century also witnessed the move away from asylums to hospitals in Britain, with the Mental Treatment Act of 1930 shifting the focus from detention of those with mental health problems and directing attention towards prevention and treatment (Shaw, 2007). In addition, the situation of "shell-shock" in the First World War had exposed the fact that mental illness could affect the lives of the healthiest people. Rogers and Pilgrim (2005) highlight this and explain that soldiers were considered among the best of England's blood stock, and thus could not be considered as genetically inferior. These authors also cite the occurrence of shell-shock as indicative of a move away from asylums in favour of new approaches. The NHS was founded in 1948 and contributed to the disintegration of Victorian asylums (Killaspy, 2007). Shaw (2007) describes the hospital routine as stable and rigid, which established a hierarchy of power that positioned patients at the bottom. The structure of hospitals by separate sections compromised vital communication, which sometimes led to patients being given contradictory advice. Patients possessed insufficient autonomy, which prevented them from speaking up and challenging such treatment (Cumming and Cumming, 1956).

Ingleby (1983) suggests that medical expertise began to dominate the management of mental health problems within the modern age. "Mental illness" as a concept became an umbrella term for all other forms of insanity. Moreover, medical dominance began to spread its influence beyond the asylum walls,

> *"mental illness" overlaps insanity, to cover deviations not severe enough to call for incarceration. New categories of pathology are devised, notably the concept of "neurosis". New sites of intervention are established in which psychiatry can attack pathology at its very roots- family life, industry and the school system- and new specialities are developed, some relatively autonomous from the medical profession, but all based on the medical model and most under the ultimate jurisdiction of the psychiatrist…* (p161).

Ingleby cites the emergence of the "human sciences" which allowed exploration of all facets of social life. He acknowledges the therapeutic state as described by Kittrie (1971)

as allowing an array of social phenomena to be studied under the realms of the illness thesis and managed by applying treatment. Ingleby's analysis argues that doctors have tremendous power regardless of how the patient came to be in their care, including voluntary visits. The relationship has the dynamics of that present between a parent and child with the client developing a dependence on the doctor. Through its advocacy and utilisation of the medical model, Ingleby claims that taking responsibility over mental health problems turns the medical profession into agencies of social control,

> *The "psy-professions" all achieved their present standing by exploiting the power inherent in the medical model: the power to eliminate moral considerations from their discourse, to make individual patients (rather than their situation in life) the focus of attention, and to subordinate them to their own authority…*(1983:164).

Moreover, according to Ingleby, despite the uncertainty psychiatry faces in relation to their interventions, the industry prevails. The persistence of medical dominance over mental health problems and to some extent, its legitimacy, is due to the nature of such problems being defined by this very field. Thus, practitioners, such as psychiatrists are amongst the few practitioners who can ideally verify or dismiss its claims (Ingleby, 1983).

Several studies concerning fieldwork in psychiatric hospitals, such as Goffman's (1961) work, led to the investigations into the conditions of mental health hospitals. Fear can drive policy changes and influence the management of patients. Not only can it impact on the policy makers and society by motivating the creation of new policies that promote strict, custodial treatment of inmates; it can also impact greatly on the individual with the mental health problem. In Goffman's (1961) seminal work "Asylums", he claimed that mental hospitals were one of four types of total institutions, whereby they take in individuals who are considered a danger to society. He suggests that the process of "mortification of self" occurs once the individual sets foot in the mental hospital. The "self" is constructed as the institutional social control and regimental routines discard any evidence of an old identity, in favour of a new identity. This is achieved by swapping the individual's clothes for hospital attire, and the confiscation of personal items. Moreover, the use of "confessionals" ensured that inmates attached negative attributes to their old lives, whilst everyday life was filled with constant surveillance, thus jeopardising privacy. Goffman's analysis shows how the mentally ill individual embarks

on a "moral career" whereby they transform from humans to inmates. This is a reminder of the past management of the mentally ill, where madness was seen to be the point that humans surrendered to their inner animality, and were treated as such. Goffman's analysis demonstrates the same principle except this time, the individual becomes an inmate.

Subsequent policy took a new direction into that of care in the community. Although the 1930 Mental Treatment Act had charged local authorities with the responsibility of handling the aftercare of discharged patients, Jones' (1975) work suggests that the imminent move into care in the community was only established once the "three revolutions" of the 1950s had taken place. The first revolution involved the emergence of new drugs such as Chlorpromazine, which had a twofold purpose: to alleviate the symptoms of mental illness and to help the individual to participate in daily activities. Such developments are also cited by Ingleby (1983) who perceives this to be part of psychiatry's intention to establish social control. Links with medicine awards the profession some legitimacy when rivalled by other medical areas. Advancements in pharmacology continue to surface with much money and firms investing time and effort into researching the effects of drugs on mental health problems.

The second revolution was an administrative one (Jones, 1975), whereby hospitals were modified and modernised to encompass inpatient and outpatient services, day care services and hostels, thus further developing community care. Administrative activities that permeate health services are reflective of the general shape of all organisations in society. Bureaucratic organisation has seen the rise of specialism such as different classifications of doctors and units in hospitals,

> *…in all countries, medical experts have become the core members of an administrative apparatus that comprises the various levels of staff that run wards, consulting rooms and dispensaries…*(Fulcher and Scott, 2003: 276).

The process of bureaucratization is needed to organise administration of large populations (Weber, 1914). Bureaucracies can be understood as types of organisations that encompass division of labour based on specialism with administrative activities conducted by officials, rule regulation and fulfilment of specified duties (Baldock *et al.*

2007; Fulcher and Scott, 2003). These characteristics are depicted in Figure 2.7. Although bureaucracies can be traced back to ancient civilizations, from the nineteenth century onwards, it became central to most elements of social life. Jones (1975) suggests that in the health context, this came into fruition in the 1950s. Arguably, beyond its status as a revolution, the bureaucratic process continues to reign in most areas of social life. There is much evidence to suggest that today's Britain operates through bureaucratic tendencies, which is quite prominent in public service provision (Baldock *et al*, 2007). Much of the work on bureaucracy is associated with the writings of Weber (Baldock *et al.* 2007; Morrison, 2006; Albrow 1970). Weber's work on bureaucracy is found in his observations about society and authority within his publications "The Protestant Ethic and the Spirit of Capitalism" (1904-5) and "The Theory of Economic and Social Organization" (1910-18). For Weber, authority equates to legitimate power. One aspect of authority is rational-legal authority, which refers to the authority that is associated with the rights and responsibilities of office; thus the authority emerges from the actual position itself along with the related procedures and responsibilities. Weber further believed that in industrial society, rational-legal authority is institutionalised and used the term "bureaucracy" to encompass this notion i.e. government through office. Although Weber never directly defined bureaucracy, commentators surmise certain core characteristics of what constitutes this notion:

Figure 2.7: Core characteristics of bureaucracy, adapted from Baldock et al. (2007) p 252.

These characteristics can be identified fairly easily in British public health services, including mental health services. Working under rules and within a hierarchy, with mandatory training is evident in the health sector whilst there is clear specialisation: GPs receive general training in medical issues, hospital doctors tend to train in specific areas to work in particular departments or attain specialist titles, for example cardiac surgeon. The notion of professionals committing their full working capacities to the health organisation where they work can be demonstrated through doctors' on call status. The process of SPA meetings recognises the specialist nature of the mental health profession and, by being multidisciplinary, the meetings aim to display good representation of the mental health workforce. Furthermore, the team discuss where best to send patients from a variety of mental health services, which also demonstrates this specialisation. Additionally, patient records and case notes are pertinent within the health service and SPA meetings base their discussion entirely on referral letters and case notes. These letters must contain adequate details, otherwise decisions regarding where to direct referrals cannot be made with confidence (Shaw *et al.* (2005).

Finally there is increasing recognition that general practice- the place where the majority of people with mental health problems will initially contact services- is turning into primary care through a process of industrialisation (Iliffe, 2008). This reflects forces standardising healthcare in order to increase productivity. To some extent, the result is that patient individuality is overlooked and the creativity of doctors deteriorates. The SPA meeting was introduced to provide a standard procedure for specialist services to review all in-coming referrals, and by reducing the gatekeeping role of GPs, it could be argued that this stifles GPs' creativity and undermines their knowledge about what is best for their patient. For instance, with a SPA meetings process taking place, the GP no longer selects an individual consultant for their patient. However, bureaucratization can also be understood as a solution to the vast clinical variation between GPs' and consultants' treatment of mental health problems. There is more likely to be inconsistency between GP and consultant judgements about mental health problems than with physical problems (Lucas *et al.*2005). This variation may stem from the under-confidence GPs feel in dealing with mental health problems. The SPA meetings' mechanism, with their bureaucratic structure, could be perceived as a way of reigning in this problem of practice. These industrialisation processes can be viewed as market mechanisms, which are seen as appropriate for the current structure of the NHS: "*...multi-unit enterprises providing multicomponent services, organizationally equivalent to very large, diversified companies...*" (Iliffe, 2008:8).

Jones (1975) then discusses the third revolution, which entailed legal changes instigated by the 1959 Mental Health Act. This moved regular admissions away from compulsory detention, as part of efforts to transform the mental health service away from institutional care and move towards community care. This Mental Health Act materialised from the Royal Commission on Mental Illness and Mental Deficiency and local authorities were encouraged by the recommendations to set up services for those who were unsuitable for inpatient care (Boardman, 2005). However, with the absence of a specified date by which these recommendations had to be met, mental hospital beds continued to be filled during the 1950s. Outpatient facilities did begin to emerge is piecemeal fashion but during this time, financial support and organisation was weak so there was a pessimistic outlook.

As with drug developments and bureaucracy, this third revolution continues to have resonance in the present day, with mental health acts undergoing revision. As the chapter will explore, community care has evolved and now plays a significant part in mental health provision for individuals with mental health problems. Political attention is increasingly being given to mental health issues, such as the efforts to eradicate stigma through government funded campaign "Time to Change" (2013). Moreover, independent bodies and charities now work in this field to advise the government and instigate legal and social changes. Thus the three revolutions acknowledged by Shaw (2007) have been key social developments that continue to progress and contribute to the social environment of Britain today. The following section looks at the 1970s period to understand how community care developed to become what it is today.

2.8: <u>Developments of the 1970s</u>

The attitude towards mental health problems was partly changing by emerging research that highlighted how behaviour and symptoms were influenced by living conditions (Boardman, 2005). A key policy White paper was released in 1975 "Better Services for the Mentally Ill" (DHSS, 1975) and focused on promoting non-hospital community facilities. This included establishing local specialist services, improving staff quality to achieve early intervention and improved organisational links. Day centres were introduced by local authority Social Service Departments and places occupied increased throughout the 1970s. Specifically, the first UK Community Mental Health Teams

(CMHTs) emerged in 1978, however, large hospitals still contained the major resources (Boardman, 2005).

2.9: <u>Developments of the 1980s and 1990s</u>

A significant policy that emerged during the 1980s was the 1983 Mental Health Act. This focused on patients' rights but brought with it perceived bureaucracy (Boardman, 2005). It emerged to provide guidance on the issue of how compulsory action should be taken against certain individuals with mental health problems, if deemed necessary. Safeguarding the individual was addressed and part two documents the civil procedures underlining detainment, which was lacking in prior acts (DH, 1983). The Department of Health directed Regional Health Authorities to close the psychiatric institutions that had dominated mental health in previous decades. This meant that the NHS needed to focus on developing more community services such as CMHTs. Although there is a body of literature on CMHTs, Peck (2003) provides substantive insights on the development of CMHTs, outlining key events from the 1970s onwards. It is necessary to refer to this literature, because the studied SPA meetings were often held at CMHT sites and membership included CMHT workers. Peck (2003) notes that the multidisciplinary team working that is now prominent in the mental health field was developed as part of the evolution of CMHTs.

Policy paper "Better services for the mentally ill" issued by the Department of Health (1975) sets out the concept of integrating health and social care services. Initially led by consultant psychiatrists, the leadership of CMHTs eventually changed to be fulfilled by Community Psychiatric Nurses (CPNs) or social workers and the workforce consisted of these professions and also Occupational Therapists (OTs). There was initial reluctance from many GPs and psychologists, but policy makers pushed forward with their development in the provision of mental health services and interventions. Multi-professional relationships, according to Peck (2003), have enhanced clinical practice, e.g. CPNs were able to integrate social elements in their work by engaging more with social workers.

According to Boardman (2005), the development and progress of CMHTs was stifled by under-funding. Mental health policies began to evolve around those who had severe

mental health problems. This included The Care Programme Approach (CPA) (DH, 1990) came into force in the early 1990s and took into account the complex needs of people with mental health problems by acknowledging the need for multidisciplinary care. According to Bailey (2012), the CPA

"…provides the administrative framework for delivering effective interdisciplinary mental health care and consists of assessment, care plan design and delivery and monitoring review…" (p48).

The early 1990s saw an increase in people with mental health problems treated outside of hospitals, the CPA's approach to care management supported this (Bailey, 2012). However service complexities have arisen, with the collaboration of health and social care services sometimes resulting in a lack of clarity over which agency should take primary responsibility. The collaborative element of the CPA was elaborated and defined more clearly by the policy guidance paper "Refocusing the Care Programme Approach" (DH, 2008). The document aimed to make it clearer about which individuals should be catered for under this premise,

…Individuals with a wide range of needs from a number of services, or who are at most risk, should receive a higher level of care coordination support… (p2).

The document did still prioritise multidisciplinary approaches and advocates the collaborative element of services in achieving integrated care pathways. This requires improvement in information sharing and utilisation of multiple services in catering for those individuals with complex needs.

Difficulties regarding multidisciplinary care have also materialised following the introduction of specialist mental health teams. These were developed following two key policy papers- The National Service Framework for Mental Health (NSFMH, 1999) and the Mental Health Policy Implementation Guide (DH, 2001). Such services have been designed to meet specific needs of specific clients. The papers set out in detail the responsibilities and remits of these teams (DH, 2001; 1999). For example, Crisis Resolution Home Treatment (CRHT) teams that deal with high risk clients who need

immediate interventions. Their aim is to keep the client's problems managed outside of hospital, but should hospital care be deemed necessary, CRHT teams aim to get the client discharged as soon as is possible. The specialist Assertive Outreach teams ensure that clients who have a history or risk of losing contact with services are not lost and intervene to help such clients in the community. In addition, there is also Early Intervention in Psychosis (EIP) catering for clients between the ages of 14 and 35, dealing with early onset of psychosis. These have led to more complexities in the ways that CMHTs work (Bailey, 2012) Furthermore, as Section 2.6 shows, GPs' struggle with lacking knowledge of available services, so even more specialist teams further add to these difficulties. Therefore CMHTs have come to play a role in making decisions regarding allocations to services (Bailey, 2012) and hold a gatekeeping role in access to services.

As is increasingly being recognised, mental health problems are wide-ranging, complex and in efforts to provide more person-centred approaches (DH, 2005) the retention of multidisciplinary working (as present in CMHTs) is embraced. They continue to be at the centre of policy planning for mental health service provision as found in the "New ways of working" report paper (DH, 2005). However, there is increasing recognition of a "risk society" (Section 2.3), it can be argued that this increased specialism are strategies for controlling risk and therefore represent a form of social control (Boardman, 2005). The existence of medium and high-security hospitals could be perceived to be alternative to asylums which fulfil the same purpose as those before 1948.

Shaw (2007) acknowledges that there have been some positive outcomes of community care and therefore CMHTs, such as the ability to treat patients in the community by prescribing drugs, when previously such patients would have been institutionalised. A wider range of treatments are available, such as group therapy and drugs with fewer side effects. On the other hand, there have been negative repercussions for both the patients and the community. There are not always sufficient community services that former patients with mental health problems can access. This results in some of these patients either not being given the right services to cater for their needs or they have zero contact with services. Fear factors have been increased with the implementation of community care, through the media attention given to certain cases that have had tragic consequences. One such case was that of Christopher Clunis who stabbed another man, Jonathan Zito, to death in the London Underground. The publicised nature of such cases means that the government is driven to take measures that reassure the public that care

in the community strategies will not endanger them. This no doubt encompasses further policy changes to establish strict control over people with mental health problems. For example in 1994, supervision registers were created to list those who were identified as a risk to themselves and others. Care staff were given responsibility of monitoring the patients on these lists to ensure their wellbeing. Moreover the Mental Health Bill of 1996 sanctioned patients under supervised discharge, to comply with the terms of their care plan. The "Your Rights"" website (2009), which provides guidance about human rights

> "The patient's RMO may apply for a patient to be made subject to supervised discharge upon his or her discharge from hospital, where the patient is 16 years or over and the patient is liable to be detained in hospital for medical treatment…"

The RMO (Responsible Medical Officer) would apply for supervised discharge if they deemed the detained client to pose a serious risk to themselves or others. It could also ensure that aftercare would be provided appropriately. Additionally, the CPA system introduced in the early 1990s, sees patients designated a key worker (now termed care coordinator) who has the power over several aspects of their life such as where and when they receive treatment. Should the patient defy such conditions, they are subjected to having their case reviewed, where the outcome may involve involuntary hospital admission. The CPA fits in with the bureaucratic tendencies that shape current mental health services.

The Mental Health Act is under constant review to explore its effectiveness in managing those with mental health problems and the community around them. Mental Health Law Online (2009) emphasises the replacement of supervised discharge with the "supervised community treatment" system. Under the Mental Health Act 2007, the motivations and objectives of the supervised community treatment is similar to that of supervised discharge and an emphasis is placed upon achieving safe outcomes is a least restrictive way. However, unlike supervised discharge, patients who are not required to receive continued hospital treatment can be discharged into the community. If deemed appropriate they may be recalled to return to hospital.

One area of care pathway criticised is the primary-secondary care interface, which can be problematic (Slade *et al.* 2008). This regards management, and these authors argue that it should be a priority for policy makers. Whilst mild to moderate mental health problems are treated at a primary care level, more severe presentations are referred onto specialist mental health services. Slade *et al.* (2008) argue that problems arise in ensuring that patients are sent to the appropriate services of the mental health system. The strategies and gatekeeping processes involved at this point are varied and are influenced by multiple factors, which can affect which patients get sent to which services. The management of dangerous people in society here is linked to the notion of risk society (Beck, 1992) and this is addressed in the next section.

2.10: <u>The current context</u>

(i) *Risk* <u>society</u>

Beck (1992) argues that modernity has brought with it a "risk society" which goes beyond the hazards and dangers of pre-modern societies and concerns itself with the distribution of dangers. Rather than seeing the situation as revolving around increased risk, he discusses the notion that the shape and nature of risks have altered due to advancements in science and technology. Risk has become politicised in attempts to pre-empt threats to public security and remedy this with precautions through rational control and decision-making (Elliott, 2006; Beck, 1992). Turner and Colombo (2008) confirm that the 1950s witnessed a cultural revolution where individuals became authors of their own destinies as opposed to subscribing to the fixed narratives like the previous generation. Feminism and civil rights were two sources of this revolution that liberated women and people from minority ethnic groups. At the same time, communities lost their unified structure and neighbours became isolated from one another. Scientific development was partly heralded for its contribution to making risk calculable, but ironically, such advancement generated new hazards.

The repercussions of contemporary dangers are not restricted by what were once seen as traditional static social divisions such as social class. Disasters such as the tragic Chernobyl nuclear power point explosion have embodied this point by shamelessly altering the lives of individuals from all social classes. Moreover, the demarcation of nation states has ruptured through globalisation and an international consciousness to tackle problems such as poverty and terrorism has arisen (Giddens, 2009). Beck (2006) calls this "cosmopolitaniasm" where global risks are tackled on an international level.

Universal responsibility to deal with social issues can be demonstrated through events such as Live Aid and global campaigns to generate peace to warzone nations.

According to Giddens (2009) modern life entails copious amounts of risk assessments in all facets of the everyday, but the calculation of such risks is difficult because of the uncertainty associated with social life e.g. the instability of marriage and traditional life jobs. Nevertheless, the engagement in risk assessment is prevalent and has become a normalised feature of everyday life, particularly boosted by the age of austerity. Giddens (2009) questions whether or not modern times have brought with it more risk or is it a case of society's attitudes to risks changing and manifesting what Beck (1992) calls risk consciousness and risk avoidance. Arguably it is a mixture of both in many areas of social life, none more so in the context of healthcare. Beck (1992) faces critique from claims that evidence does not confidently verify the emergence of a "risk society" (Giddens, 2009) but if one wished to explore the increasing existence of risk preoccupation, one could certainly find convincing validation in the arena of health.

Turner and Colombo (2008) question whether care has been sacrificed for risk in the context of service user contact. These authors suggest that the modern individual is responsible for risk creation in the light of distrust of experts and the fragility of scientific assurances. Moreover, this insecurity infiltrates both micro and macro levels of living. In the context of healthcare, Turner and Colombo (2008) suggest that this paved the way for public and political scrutiny of crime, law and order in the endeavour to control crime. Beck (1992) highlights societal emphasis on risk avoidance to prevent the effects of hazards on society. According to Turner and Colombo (2008), this extended the responsibility of crime control to agencies beyond the police, such as probation and psychiatry. Concerns about public safety and measures that prioritise and promote safety to the public are evident in mental health policy (Hewitt, 2008; Rogers and Pilgrim, 2005). The media's focus on violence by people with mental health problems has intensified the association between dangerousness and mental illness. Turner and Colombo (2008) agree that the media contribute to society's adoption of a risk agenda in their commitment to extensive coverage of high profile cases of homicides by people with mental health problems. It has been argued that they capitalise on the public's vulnerability to fear through selective headlines and portrayals in film and television dramatisations (Henderson, 2008).

Hewitt (2008) reports that there are now expectations upon mental health policies to adopt measures that will ensure protection of the public from the violence of people with mental health problems. The implementation of risk assessment and risk management is encouraged by the belief that dangerousness amongst people with mental health problems can be predicted and therefore avoided. These notions have formed the bulk of criticism towards community care (Rogers and Pilgrim, 2005), with people with mental health problems constructed as a threat to public safety and social order. The NSFMH (DH 1999) aimed to recover the declining public faith in community care (DH, 2001), by widening the diversity of services and utilising the specialisation of different teams. For example, the EIP mental health service works to detect the symptoms of severe mental health problems at its earliest onset, in order to alleviate the risk of illness developing and leading to possible physical, social and legal harm. However, Boardman (2005) implies that specialist mental health services, such as AO have been developed as part of the risk management agenda and represent supervision for clients by staff.

Consequently there is a focus on accountability which is prominent in health care provision (DH 2004; Onyett, 1995). Scrivener *et al.* (2011) highlight the significance of the accountable practitioner in nursing where the whole spectrum of health professionals must weave accountability into all facets of their practice. This involves being able to demonstrate that one is competent in carrying out tasks. These authors also recognise that often accountability is negatively defined as being related to a "blame culture". This can be again linked to the media lavishing attention to high profile cases such as Baby Peter (The Guardian, 2013) Legal obligations are inherent in the practice of health professionals (Scrivener *et al.* (2011) where their planned actions or lack of actions must be considered against the level of harm posed to the patient. The government (DH 2010) elevates the significance of responsibility and accountability in their vision to enhance New Ways of Working within healthcare. This document does not shy away from the issue of risk and advocates a practice that cultivates positive risk taking through professional assessment of responsibilities and competencies.

(ii) *Medicalization*

Strategies to attend to the risk agenda within mental health care have seen medicalization increasingly enter into our social lives. The medicalization thesis postulates how some social issues are labelled and constructed as mental health problems (Conrad, 2005; Rogers and Pilgrim, 2005; Gabe *et al.* 2004; Shaw and

Woodward, 2004; Conrad and Schneider, 1992). There has been considerable expansion in the range and number of conditions identified as "mental illness" namely the Diagnostic and Statistical Manual of mental disorders (DSM-5) and the International Classification of Diseases and Related Health Problems (ICD-10) (Bolton, 2008). These manuals provide standard descriptions, classifications and diagnoses of mental health problems. However, much of the terminology and language of these diagnostic manuals involve references to beliefs, experiences and behaviours, which are subjective and judgemental (Johnstone, 2008). When taking this into account, it could be interpreted that diagnosing mental health problems actually involves making judgements about social and cultural norms that have been made to appear as medical norms. Read (2005) agrees that the twentieth century has harboured copious medicalization increasing the number of diagnosable conditions considerably and leaving general doctors struggling to keep up to date with these advances. Moreover, this author draws attention to the fact that this situation has given rise to increased specialism in the medical arena with specified remits that coordinate professionals to stick to the realms of their areas and thus sacrificing holistic practice among individual practitioners.

A well-documented case of the link between risk and medicalization is situated in the political construction of Dangerous and Severe Personality disorder (DSPD) by the Home Office and DH (1999) which extended the medicalization practice beyond the medical realms (Turner and Colombo, 2008). Its intention was to penalise based on prediction of violence among individuals and thus disrupted the "norm" of punishment *after* crime committed by using risk calculations to determine such action (Turner and Colombo, 2008; Corbett and Westwood, 2005). According to Corbett and Westwood (2005), the Butler Committee's 1975 definition of "dangerousness" sparked risk to become synonymised with danger, relating to violence. Over time, discussions of risk became entwined with notions of dangerousness, which provides some understanding into the construction of DSPD. The label, rather than depicting an actual experience, allows society to specify future hazards (Corbett and Westwood, 2005). Robinson (2004) highlights the dilemma of democratic regimes, which need to balance the rights of the perceived dangerous person with the mental health problem with the rights of the general public who have an entitlement to protection. This author labels such duties belonging to psychiatrists and psychologists as burdensome thus once again exposing the subjective nature of such decisions. Robinson also signifies the stigma inherent in a label such as "dangerous".

Jackson (2012) investigated the American Psychiatric Association (APA)'s revision of the DSM ((DSM- IV) to issue version 5 in 2013. She summarises the criticisms targeting the proposed revision,

> *…it applies psychiatric diagnoses to an even greater number of what might be considered normal ranges of human emotions and behaviours and that it ignores almost completely ay factors that might contribute to mental illness other than biological and neurological…* (Jackson, 2012:4).

The critics argue that the DSM neglects to consider the effects of social and environmental input on mental health problems and maintains an unhelpful practice of medicalizing social problems (Jackson, 2012). Among the mental health problems expected included in DSM-5 is "Oppositional defiant disorder" with symptoms including arguments with adults and being spiteful and vindictive. Although when looking at the British context, the most utilised manual is the ICD-10, it is generally accepted that both manuals share similarities and follow the same practice (Pilgrim, 2006).

The subjectivity of the manuals has, in the past, led to some professionals disagreeing on diagnosis despite using the same criteria (Eaton, 2001). This exposes the fragility in mental health diagnosis and reveals a conflict battling the increasing medical categorisation of a spectrum of social problems against the questionable validity of diagnoses. Medicalization is a by-product of this progression to a risk-dominant society because it transfers social problems to the medical realms and issues management strategies to rectify the problems, often before they advance to a more severe stage. Such strategies come in the shape of agencies that are issued with remits guiding them when to intervene e.g. EIP team as mentioned before and AO service. Thus in this attempt to cater for risks posed by individuals with mental health problems, labels have been extended as part of the medicalization process. However the contestable nature of diagnosis remains (Jackson, 2012) and some question the point and usefulness of such strategies. Nevertheless, it cannot be denied that a medicalization era prevails as part of the management of risk and thus procedures such as SPA meetings take this into account. This is evident when duty workers go through referral letters and vet clients before processing their notes to meetings. They filter out clients who they feel require more urgent attention. Moreover, within meetings, risk is a common discussion point that emerges and relates to the remits of services that have designated "risk levels",

which they deal with. For example, the Improving Access to Psychological Therapies (IAPT) service will only deal with clients with mild mental health problems who have not had recent history of self-harming.

The process of diagnosis itself is criticised in the context of mental health because of its struggle to fulfil the purpose that diagnosis generally serves well for physical ailments e.g. establishing prognosis and providing aetiology (Johnstone, 2008). Moreover in psychiatry, Johnstone (2008) stresses that diagnostic manuals often revolve around symptoms as opposed to signs and attempt to establish "normal" ways of behaving to enable labelling of behaviour that deviate from this. The lack of organic basis only serves to increase the contentious aspect of psychiatric diagnosis. In addition Pilgrim (2006) exposes the circular logic upon which psychiatric diagnoses operate, as demonstrated in Figure 2.10 (ii):

Q- *How do you know this patient has schizophrenia?*

A-Because she lacks insight into her strange beliefs and she experiences auditory hallucinations

Q- *Why does she have strange beliefs and experience hallucinations?*

A- *Because she suffers from schizophrenia*

Figure 2.10 (ii) Circular logic of psychiatric diagnosis as adapted from Pilgrim (2006).

With such logic dominant, it is difficult for psychiatric diagnosis to gain reliability and validity. Aetiology remains ambiguous (Johnstone, 2008) and psychiatric language often involves assumed synonymous terms such as "personality disorder" and "psychopathy" when these differ in reality (Manning, 2001).

(iii) _Sociological input_

With regards to increasing medical dominance and the prevalent use of the medical model to deal with social issues (Ingleby, 1983), the twentieth century paved the way for scrutiny of this model and growing acceptance of sociological input. Many sociologists recognise that the biomedical model is inadequate when explaining mental health problems (Johnstone, 2008; NHS Confederation, 2008; Cockerham, 2006; Rogers and Pilgrim, 2005). The biomedical model, often referred to as simply the medical model, is a framework which takes an anatomo-pathological view of the body and advocates the notion that specific diseases have specific causes. The medical model emerged from the late nineteenth century and has become Western medicine's dominant approach to illness and disease (Gabe *et al.* 2004). Much of its popularity can be attributed to its apparent success in describing, understanding and treating physical illnesses (Cockerham, 2006), however, it is challenged as an approach to mental illnesses.

As documented in this chapter, classifying mental health problems encompasses much subjectivity because judgments need to be made about what constitutes abnormal behaviour, or an irrational belief. Although claims are made about genetic predisposition to some mental health problems, it seems that the illness does not always materialise until there is an external trigger, such as loss or conflict (Trivedi, 2002; Sharpley *et al.* 2001). There has been support for more encompassing approaches, which take into account not only biology, but also psychological and social factors (Cockerham, 2006), for example the biopsychosocial model, which allows consideration to be given to social triggers of mental illness as well as genetic predisposition.

According to Busfield (2001), sociological input into the subject of mental health and illness has not always been granted significant attention and credit. The preference of medical explanations and insights is suggested to be because it validates the use of drugs and the pharmacological industry by identifying biological aetiology. Moreover, for people who have mental health problems, biological explanations also serve to verify the reality of their experiences. Some may be averse to the sociological notion of social constructionism which is perceived to challenge the realities of people's experiences. However, the shortcomings of the medical model and the contentious status of psychiatric diagnosis have paved the way for sociological explanations to be more prominent or at least be considered. Sociological insight has been applied to mental health and illness through history, notably through the work of Durkheim (1964) and his ideas about how and why one defines the "normal" and the "pathological" as a strategy to maintain the status and stability of the former. However, policy responses to social

aspects of mental health and illness emerged significantly in the 20th and 21st centuries. These include the founding of the NHS in 1948, the Mental Health (Patients in the Community) Act (1995) Mental Health Acts (1959, 1983, 2007), and the Mental Health (Discrimination) Act (2013).

According to Busfield (2001), sociological studies began to generate challenges to the genetic outlook on mental health problems and highlighted how factors such as environment, gender, ethnicity and class may play a part. These findings mainly arose from epidemiology studies. The plethora of services that deal with mental health problems following the NSFMH (1999) and the continued policy initiatives to strengthen community care recognises this need for social perspectives and understandings and the notion that medical input is not solely enough. Forums such as SPA meetings allow this collection of expertise and insights to be given a space to consolidate ideas and planning for best treatment. With continued sociological analysis, attention now needs to be given to the organisational context in which activities pertaining to mental health issues are carried out and the agents involved in this. Busfield (2001) confirms the growing field of the Sociology of Professionalism. Thus the defining of mental health problems still remains a crucial area of investigation, but inevitably, scrutiny needs to be applied to the individuals who sanction and authorise such definition. Their decisions affect the careers of individuals who potentially have mental health problems, and such practices are framed within a particular context that represents British society. My stance is that this is a continuation of our history in which certain agents are authorised to manage people who exhibited particular behaviour in ways that did not suit the context in which they lived in.

(iv) *General Practice*

In the light of increased mental health agencies to manage the complexities inherent in the field of mental health problems, General Practitioners (GPs) are perhaps overwhelmed with the plethora of services available. As discussed in Section 2.9, the introduction of a diverse family of specialist CMHTs such as EIP and AO services may have intensified the complexity of the referral procedure for GPs, undermining the execution of competent service provision: there is no guarantee that patients are being transferred to the appropriate mental health service teams if the referral procedure is ambiguous. Primary care is recognised as having a crucial role in the treatment of people with mental health problems (Goldberg and Huxley, 1992). According to Lucas *et al.*

(2005), lack of time, lack of knowledge and inadequate training may hinder GPs' ability to deal with mental health problems efficiently. Moreover, while detection might be a strength for some GPs, management of the clients' problems is not easily handled. Problematic patients that caused problems among GPs were mainly those whose issues did not indicate a clear cut diagnosis (Lucas *et al.* 2005). Read (2005) agrees that increased medicalization has been demanding on GPs and they have struggled to keep up with constant developments.

According to Whitehead and Dowrick (2004), a large proportion of GPs' caseloads are individuals with mental health problems. Primary care may be an ideal environment to deal with such clients given the potential to intervene early and thus withhold a potentially stigmatised mental health career within secondary mental health services. However, these authors recognise that GPs are not always prepared to undergo the emotional input that dealing with such cases requires, and also, in line with Lucas *et al'*s (2005) findings, they are restricted with time and training. Moreover, their links to secondary mental health services are compromised by the changing roles of CPNs who have altered remits regarding what kind of client they will deal with and resources such as up-to-date directories are lacking. In a study looking into the content of referral letters written by GPs, Shaw *et al.* (2005) discovered that GPs deviate from set guidelines intended to aid in the ideal information and structure to include. These authors consider the renowned discrepancy between primary and secondary mental health professionals' perception of mental health problems and highlight that this must be taken into account when developing guidelines. Without such consideration the potential for what is classed as "inappropriate referrals" is exacerbated. Moreover Shaw *et al.* (2005) acknowledge the variations between different GPs who may exert preference and competence for one approach over another. Another issue to be considered is that the writing of a referral letter may also be perceived by GPs to be a surrendering action that indicates their failure to deal with the patient's problems and thus discourages them from committing to a diagnosis.

(v) ***Government responses***

The twentieth century has seen governments playing a central role in developing health services since the conception of the Welfare state in 1945 and NHS in 1946/1948 (Baldock *et al.* 2007). These two features of modern society have aimed to tend to the health and social needs of all British citizens with economist and social reformer William

Beveridge's intention to create a system that would cater for the population with protection *"from the cradle to the grave".* With regards to mental health, the deinstitutionalisation of the mid twentieth century came partly as a result of pharmacological advancement (Rogers and Pilgrim, 2005) which meant mental health problems could have their symptoms manageable in the community. Care in the Community dominated the Conservative government agenda in the 1980s, but so too did the public's increased fear of people with mental health problems which was ignited by high-profile violent cases involving some individuals (Scales and Schneider 2012). This compromised the public's faith in and support for Care in the Community, ultimately contributing to the initiation of the CPA in which strict monitoring and coordinated care would be provided for those discharged into the community. Assignment of a care coordinator enables contact with all relevant agencies to be maintained and reviewed, and care plans to be continually applied (Scales and Schneider, 2012).

Given the increased specialism mentioned earlier, there has been an emphasis in recent government agendas for multidisciplinary team working so that specialist services can work efficiently to provide for the public's complex mental health needs (DH 2005). Moreover, the family of services evident in mental health care were sanctioned as part of the government's NSFMH (DH, 1999) in efforts to reaffirm this faith in community care. This complex network and availability in mental health services has exposed the need to work collaboratively and distributing responsibility is recognised. Increasing use of psychological therapies is advocated and provided as part of a Stepped Care approach (Clark *et al.* 2009; DH, 2008; Bower and Gilbody 2005) which has seen the launch of the IAPT programme. The IAPT Implementation Plan (DH, 2008), highlighted these therapies as a strategy to improve the lives of those affected by depression and anxiety disorders among which only a third of people diagnosed receive treatment. Funding was announced to implement these psychological therapies to comply with the National Institute for Health and Clinical Excellence (NICE) guidelines advising such interventions for individuals with anxiety and depression. NICE issue regular guidelines relating to health matters. The 2008 paper came from recognition that depression and anxiety conditions are debilitating for individuals' wellbeing and cites the WHO study, which revealed that a person's functioning was affected more by these than certain physical conditions. The IAPT programme was conceived to offer those with diagnosed anxiety and depression evidence-based interventions e.g. Cognitive Behavioural Therapy (CBT) as opposed to drug-based treatment. The paper was optimistic about these interventions in preventing relapse and highlighted that in the long run, there would be improvement to the economy since people receiving treatment would not need to take time off work.

The Implementation Plan acknowledges that such funding is paramount since NHS psychological therapies are not easily accessible or produce long waiting lists. Better access to such therapies would mean that visits to GPs regarding such conditions would be reduced and referrals to specialist services would be less.

Access to IAPT interventions is based on the Stepped Care approach (Clark *et al.* 2009), which advises that clients receive the most effective but least invasive approach to deal with their problems, with primary care provision as an option. This takes into account the complexities associated with the fragile prognosis of mental health problems: Mental illnesses have different levels of severity and to all intent and purposes, predictions of the course they may take are futile. This awareness is further demonstrated by the government's continuous liaising with NICE. Their clinical guideline 123 (2011) attempts to offer advice regarding identification and the appropriate pathways for dealing with common mental health problems. Dedicating much discussion to the Stepped Care approach, it specifies where mental health teams should step in and take responsibility by offering ideal level interventions for the client. This can be seen as a triage system, which shows that current approaches need to evolve with regards to the recession era we are living in. Health interventions need to be allocated based on priority (Newdick, 2005).

In addition to all this, the twenty-first century has witnessed several UK campaigns to end the stigma associated with suffering from mental health problems which are increasing in popularity, with famous people offering their support through disclosure of personal accounts. The government's commitment to such approaches is evident in their funding of the "Time to Change" (2013) project. Stigma reduction is also enhanced with the drive towards holism and attempts to erase the mind/body dualism. In the DH's (2011) white paper "No health without mental health", the government makes clear its ambition to promote mental health issues to equate the attention and attitudes that associate with physical health issues. It encourages a holistic outlook of individuals by directing attention to their mental health as well as their physical wellbeing.

2.11: <u>Investigating SPA meetings</u>

Taking all this into account, exploration of SPA meetings reflects the extensive background outlined in this chapter. Primarily, this is captured in the notion that practices are historically and socially contingent and influenced by dominant ideas and processes present at that particular time. Moreover, with specific consideration to SPA meetings, the organisation and procedure of such a forum has evolved in response to the changing context and dominant perspectives inherent in society. Within this, people with mental health problems are labelled as social deviants and depart from social norms of society. SPA meetings, as part of mental health services, are a strategy for dealing with the range of behaviours that are encompassed under the heading of "mental health problems". The plethora of services and teams with different organisational backgrounds and philosophies need to be represented in the SPA environment when decisions are to be made about potential clients, as does the embracing of multidisciplinary team working. The SPA procedure has had to ensure that it deals with the difficulties faced by GPs in managing mental health problems and operate in an environment that supports the risk assessment practice that society has become accustomed to. The allocation of clients to interventions and services can also be interpreted as an allocation of clients to resources. This translates as SPA meeting attendees assuming a gatekeeping role to effectively sanction individuals becoming entrained into specialist mental health services. Understanding these agents as gatekeepers is crucial to study SPA meetings effectively and accessing their social worlds where gatekeeping activity occurs means that conceptualisation develops faithfully.

According to the investigated Trust's website, the SPA process is understood in the following way:

> "…Each locality has a Single Point of Access for all referrals into Secondary Mental Health Services requiring Health & Social Care assessment and interventions (non- crisis). Referrals are received from GPs and also via acute Mental Health Services. Referrals are screened against specific criteria and then offered an appointment for clinical assessment and treatment within the multi-disciplinary team… Service users will receive interventions if they are experiencing moderate to severe mental health problems including anxiety disorders, depressive illness and disorders of personality. Interventions are offered on a one-to-one and/or group therapy basis…" (Trust website, 2013)

Therefore the meetings are part of a wider referral process but are the pivotal point where discussions occur and critical decisions are made. The discussions are around judgements of clients' problems against particular criteria. Meeting with key personnel suggested that this is represented by a social process, which opened the way for Glaserian Grounded Theory methodology to be embraced. This is elaborated upon in Chapter 3, section 3.3.2. Further ascertained from initial meetings with key personnel, it was learned that SPA meetings take place within the context of a large and geographically dispersed organisation. This happens within seven different sites under the authority of the Trust organisation and their characteristics are further defined in Table 2.11.

SPA meeting site	Duration (generally)	Number of districts covered	General professional backgrounds/ representatives	Number of meetings per week
Area 1	2 hours	2	Team lead; Consultant psychiatrist; CPN; EIP rep; Eating Disorders rep; CBT rep; IAPT rep; Administrative staff; students	1
Area 2	1.5 hours	1	Service manager; CPN; Dual Diagnosis rep; CRHT rep; IAPT rep; Social worker; administrative staff	1
Area 3	2 hours	2	Social care team lead; CPN; Consultant psychiatrist; ED rep; Administrative staff	1
Area 4	1.5 hours	1	Team leader; EIP rep; Consultant psychiatrist; CRHT rep; IAPT rep; Administrative staff; medical students	2
Area 5	1 – 2 hours	1	OT; Consultant psychiatrist; Health	1

			manager; Social care manager; CPN; CRHT rep; students	
Area 6	2 x 1 hour meetings	1	Consultant psychiatrist; Social care manager; Health lead; EIP rep; Administrative staff CMHT staff members in latter meeting and CRHT rep	1
Area 7	30 minutes-1 hour	1	Health team lead; Social care team lead; Consultant psychiatrist; CPN; OT; EIP rep; students	1

Table 2.11: SPA meeting characteristics

As Table 2.11 demonstrates, Areas 1 has the largest number of attendees. As Areas 1 and 3 are dealing with two districts, they received the most client case referrals to discuss per meeting. Area 7 tended to receive the lowest amount of referrals. All referrals processed and transferred to the meeting are expected to be discussed and a decision of some kind is required before the meeting's ending.

Through personal communication with administrative staff and CMHT mental health professionals, it was established that in common with other NHS facilities, it has been obliged to place a strong emphasis upon efficiency and firm business management. To support this, the organisation has invested heavily in information services intended to record, track and quantify the activities it provides to clientele.

Personal communication suggested that it could be possible to use information captured in this way to follow clients' progress through care, and thereby ascertain in retrospect

how accurate or appropriate judgments made in SPA meetings had proved to be. This led to plans put in place to evaluate the Trust computer system in supporting, capturing and providing post-SPA meeting details of clients' interactions with services. However, as information held by the organisation's IT system was accessed and considered, it became clear that these expectations would not be fulfilled. This called into question the appropriateness and functionality of these information services in their ability to fulfil their intended purpose. This information system was not as successful as hoped, as a means of collecting, storing and summarising clinical decisions and their consequences including those made by SPA meetings and clients' subsequent progress through care.

In Chapter 7, suggestions for consideration to improve the Trust's information facilities are discussed within the wider thesis on lifeworld and system world concepts as presented by Habermas (1987). This is an appropriate discussion that ensues because it gives attention to the two prominent environments that allow SPA meetings to occur: The shared interaction and membership of the meetings (lifeworld) and the wider bureaucratically run organisation (system world) that it takes place in.

The lacking quantitative data provided an opportunity to focus on pursuing and developing the emerging BSP that represented the behaviour captured through qualitative data instead. Investigating SPA meetings, particularly giving attention to the interactional elements, where a BSP is present, is a continuation of documenting the historically contingent management of individuals. The focus shifts from individuals exhibiting potential mental health problems to explore more prominently the gatekeepers charged with judging and allocating them. This shift is part of intimate sociological attention that needs to be given to human processes inherent in decision making, and contribute to the growing body of knowledge relating to mental health professionals as gatekeeping agents. Such agents use socially constructed categories in the decision-making process as part of the discourse on mental health and the result of their discussions may have significant effects for the mental health career of clients and their social identities. Understanding the behaviour of these agents, who are responsible for the gatekeeping activity is therefore crucial to the wellbeing of clients and also to further one's comprehension into the current management of this form of deviancy. As part of a bureaucratic organisation, SPA meetings are a pertinent strategy that is part of the identification process needed to categorise members of society believed to have a mental health problem. Within the process is a more intimate BSP that emerges and sheds light onto the activities of the gatekeeping agents. In addition, the forum provided

by SPA meetings offers an opportunity to support inter-team working. Complexities arising from a multidisciplinary workforce can be detrimental to successful team working, particularly in CMHTs (West *et al.* 2012). SPA meetings are a central place for managing the consequences of diversification.

2.12: <u>Conclusion</u>

In conclusion, this chapter has established the context within which SPA meetings have evolved, exist and operate within to provide for clients with mental health problems. A series of pertinent points have been made and expanded upon to exposit the rationale behind this study. The need for identifying behaviours currently termed "mental health problems" in western societies has always existed. This process is based on subjective judgements, which assess signs and behaviours. This is reinforced through the practice of measuring socially constructed deviance against social "norms". People with mental health problems have been treated as deviants and historically contingent management strategies have been employed to deal with them. This included relative tolerance during the Renaissance, mass confinement in the Enlightenment period, and construction as an illness in need of treatment, prominently from the 19th century onwards.

Medical agents now are at the forefront of this identification process that operates to recognise and deal with people with mental health problems. The organisations where such activities occur have evolved to cater for a risk society where medicalization is prominent and primary care struggles to handle such individuals. The three revolutions of the 1950s (Jones, 1975) have helped adjust the medical agenda to prioritise Care in the Community. The administrative second revolution has given rise to the health arena as a bureaucratic organisation that still permeates services today. Therefore, current management of people with mental health problems will operate with this in mind. A general promotion of sociological insight into the medically dominant arena of mental health problems has influenced an interest into the agents behind medical decision making processes. This paves the way for a study such as this, to contribute sociological knowledge into how mental health professionals, as gatekeepers, come to categorise those who exhibit bizarre behaviour as having mental health problems or not, and whether their conditions warrant specialised care.

Going back to the original assertion that subjective judgements are involved in the assessment of deviancy, the SPA meeting now represents the identification process in this local NHS Trust with the gatekeeping mental health professionals operationalising this agenda through their meeting activities. Insight into the BSP at the heart of this is crucial since the effects of such action have an impact on clients' wellbeing. Moreover, if management is historically contingent, capturing the current form of dealing with this form of deviance is necessary to continue documenting understandings into the Sociology of Mental Health and Illness. In order to do that, pursuing the BSP at the heart of attendees' decision-making is appropriate. The next chapter discusses the opportunity that arose to do this through Grounded Theory methodology and focuses on the study's chosen methods.

3) Methodology and methods

"There is in the act of preparing, the moment you start caring."

~ Sir Winston Churchill, former Prime Minister of the United Kingdom

3.0: <u>Introduction</u>

This chapter provides an account of the methodological aspects of the study beginning with a debate on defining the study and its confirmation of evaluation status following correspondence from the National Research Ethics Service (NRES). From this, methodology and methods are discussed critically with theoretical and practical implications explored in relation to evaluative intentions. Employing a mixed methodology approach, the aims of the study are presented. A prominent aspect of the study became its use of Grounded Theory (GT); whilst this is discussed more thoroughly in Chapter 4, the basic principles and my use of these are discussed in this current chapter. This chapter provides an opportunity to detail how quantitative and GT methodologies have been applied. In addition, validity issues and my commitment to reflexivity throughout the project are considered.

3.1: <u>Defining the study</u>

Initially perceived to be a research study, a primary aim was to construct a comprehensive protocol document and complete applications for ethical approval. Guidelines from the National Research Ethics Service (NRES) (2009) website state that under Research Governance Framework, if projects are deemed to be research, then there are strict procedures to follow to ensure they are managed as research within the NHS. Such procedures include an ethical review by an NHS Research Ethics Committee (NHS REC); acquiring approval from NHS Research and Development (R&D) department and also gaining approval from the organisation that is hosting the project. After several drafts of the protocol document, and correspondence with the research governance department, it became apparent that the study's intention was in fact to provide an evaluation of the SPA meetings. A letter with details of the planned enquiry was sent to the NRES (Appendix 3), who advised that the project should be treated as a service evaluation and therefore would not require an NHS REC review and approval from the NHS R&D department (Please see Appendix 1). However, the project team members

would be responsible for respecting ethical issues present including the endorsement of basic ethical principles such as informed consent and confidentiality of participants. Please see section 3.4 for discussion of ethical issues.

According to Doherty (2011) distinguishing between research and evaluation is complex and it can be argued that they are part of a continuum. She maintains that they are closely related and should be synergistic but they serve different purposes. One such difference is that research describes how something works whereas evaluation will aim to convey how *well* something works. In the field literature, reference to evaluation still includes the term "research" (Bryman, 2004; Kardorff, 2004; Esterberg, 2002; May, 2001). One such definition exists,

> *…research that is concerned with the evaluation of real-life interventions in the social world* (Bryman, 2004: 539).

Scriven (1991) suggests that evaluation assesses the worth, merit or value of something and empirical investigation is employed using social science techniques. The conclusions can then be integrated with standards to provide evaluation.

With regards to this study, it always made its intentions clear regarding its use of GT methodology, a technique employed largely by research studies (Glaser and Strauss, 1967). The potentials of GT methodology mean that recommendations can be made and findings can be employed in clinical settings to enhance practice when theory is developed in the Intervention mode (Artinian *et al.* 2009). In her efforts to distinguish between research and evaluation, Doherty (2011) suggests that research is generalisable or at least aims to be. However, this is not always the case with qualitative research since the use of smaller samples does not make this possible.

The NHS has offered a system of categorising studies with the terms "research", "audit" and "evaluation" (NRES, 2009) in what is an ambiguous area where crossovers can occur. As such, presentation of this study to the NRES resulted in it adhering to its definitions of "evaluation" rather than "research". However, with critical analysis of the literature on this matter, there is scope for the term "sociological research informed

significantly by GT" to also be applicable. Nevertheless, for practical purposes, the NRES' definition allowed the development of field work to proceed in the right manner by adhering to their guidelines for conducting evaluation studies.

With this NRES' decision to define the PhD study as evaluation, advice was sought from the hosting NHS Trust's research governance department to proceed with the study and commence field work. The project members were advised that authorisation to attend SPA meetings should be gained from service managers for both County and City services (Please see Appendix 2). This gave authority to attend SPA meetings in seven different Trust centres within the locality. In some locations, these SPA meetings were where Community Mental Health teams were based whereas others were provided as part of mental health services and units within hospitals.

Since this Trust provides services with different organisational histories and traditions that provide for different populations, the study investigated the services for seven areas to provide the Trust with a comprehensive evaluation (See Table 3.1). These are subsequently number coded to protect the identity of subjects.

Area	Type of organisation
Area 1	Adult Mental Health unit within hospital
Area 2	Adult Mental Health unit within hospital
Area 3	Adult Mental Health CMHT
Area 4	Adult Mental Health unit within hospital
Area 5	Adult Mental Health CMHT
Area 6	Adult Mental Health CMHT
Area 7	Adult Mental Health CMHT

Table 3.1: Type of organisations

According to the NHS R&D guidelines, service evaluations generate data which can be used to assess whether services and interventions should continue to run. The guidelines acknowledge the judgement element present when assessing the value of the evaluation's focus. Evaluations can utilise both quantitative and qualitative data and

highlight the advantages and disadvantages of the intervention. This is supported by the NHS Direct website (2012),

> *"Service evaluations will often use questionnaires, interviews or focus groups with staff or users to explore opinions of a service. It also monitors how well a service meets its aims and how it might be improved."*

This study's evaluation of SPA meetings used mixed methodology and methods, which are recognised as beneficial (Brannen, 2005; Bryman, 2004; Esterberg 2002; Mason, 2002; May, 2001). Such authors emphasise their ability to provide greater validity, a more complete and comprehensive picture of the study phenomenon, offsetting the weakness of one method, providing stronger inferences and capturing the complex processes that tie with human phenomena. Furthermore, Doyle *et al*. (2009) suggest that such a method suits studies coordinated in the field of healthcare, since healthcare dynamics can often be highly complex. NRES (2009) confirms that it is acceptable for service evaluations to use both existing data and administer interviews.

For this service evaluation the intention in assessing SPA meeting was to develop and improve them, thus specifically offering a formative evaluation (Bowling, 2009). Classical GT methodology has been used to investigate the internal running of the meetings, while quantitative data analysis provides an overview of the SPA meetings' efficiency by looking at post meeting events. This will be discussed further on in the chapter.

Evaluation studies are advocated for projects that take place within healthcare settings, encouraging emphasis on evidence-based decision making (O'Cathain *et al.* 2007; Clarke, 2001; Gray, 1997). Such authors cite that evaluation studies can produce valuable information that can result in better decision making. SPA meetings have not been the subject of close investigation. As a growing feature of mental health service teams working for the Trust, it is therefore wise for an evaluation to take place to decipher whether or not such interventions are beneficial to the patient. In the healthcare literature, promotion for evidence-based practice is often discussed in the context of healthcare professionals making decisions for clients in terms of offering them interventions and/or treatments (Grol and Grimshaw, 2003; Muir Gray, 2001). However, there needs to be attention given to all aspects affecting patient care, including

organisational issues (Newell and Burnard, 2011). This evaluation of SPA meetings is crucial because insight into the decision-making process of attendees can contribute to the evidence of how mental health professionals work together to make decisions which take into account the multidisciplinary environment. Such insight can enhance or modify the process to generate better decisions which have a positive impact on the health career of clients.

In accordance with NRES guidelines, an evaluation of SPA meetings will be useful to the Trust since it will investigate the success of their SPA meetings in the context of current mental health services. The study does the following:

- Provides the findings of an original study that has not been conducted before.
- Offers unique insight into the process inherent in the Trust SPA meetings thus contributing to the fields of sociology, mental health and research methods.
- Conveys merits and drawbacks of the SPA process as a stage in the pathway of patients with mental health problems.
- Generates understanding into the nature of discussions and business of SPA meetings, within a multidisciplinary milieu.
- Offers practical implications for several agents through dissemination of findings and by giving scope for future enquiries.

3.2: <u>Aims</u>

SPA meetings are an opportunity to investigate how professionals representing mental health services operate within the social context of contemporary Britain. The key process taking place within the SPA meeting is crucial to understand how raw case referrals get transformed into recordable decisions (Figure 3.2). Moreover, indications into the validity of these decisions are vital to assess the overall effectiveness of the SPA meeting structure and content.

Figure 3.2: Aims diagram

Therefore the aims of this study were twofold:

1. To investigate the internal mechanisms and nature of business relating to decision-making in SPA meetings and discover the Basic Social Process taking place.

2. To investigate the overall efficiency of SPA meetings.

The next section will offer a discussion into the study's methodologies and methods used to achieve these aims.

3.3: Methodology and methods

3.3.1: Mixed methodology

The study used a mixed methodology approach with both quantitative and qualitative methods being employed. As mentioned earlier mixed methodological approaches are

advocated by writers in the research field (Brannen, 2005; Bryman, 2004; May, 2001) noted for its ability to provide a more complete and comprehensive picture of the study phenomenon and capturing the complex processes that tie with human phenomena. Mixed methodologies are particularly useful when it is difficult to rely on solely qualitative or quantitative approaches (Bryman, 2004). Endorsement of this method also comes from authors and researchers who believe it provides better validity, of course if findings from the two methods are concurrent (O'Cathain *et al.* 2007). This is also suggested by Bryman (2004) who referred to an example of cross-checking results from qualitative enquiry with quantitative enquiry of the same phenomena. Bryman also indicates that qualitative and quantitative research can be used to inform one another e.g. hypotheses derived from the former can be tested using the latter. This would be compatible with a core principle of GT known as theoretical sampling (Glaser, 1978).

However within this study it has not been feasible to employ mixed methodology simultaneously or to use one approach to inform the other approach. It was not possible to collect qualitative and quantitative data simultaneously due to data protection issues and in any case, the two methodologies were employed to investigate different aspects of SPA meetings. This latter motive is a justifiable way to make use of mixed methodology since it can answer different research questions and thus enhance the study's capacity to investigate both micro and macro elements (Giddens, 2009; Bryman 2004; Wajcman and Martin, 2002).

Doyle *et al*. (2009) suggest that mixed methodologies and methods suit studies coordinated in the field of healthcare, since health care dynamics can often be highly complex. This is useful when looking at multidisciplinary mental health care team working. The literature into community mental health teams suggested that some of the negative aspects of working in a team consisting of different roles involved role conflict and different understanding of criteria and team objectives (McAdam and Wright, 2005; Carpenter *et al.* 2003; Lankshear, 2003 and Onyett *et al.* 1997). Some authors also suggested that in situations where the multidisciplinary meeting took place in a predominantly medical setting, it could be intimidating and discouraging for members of social care teams. Ultimately this affected their willingness to partake in discussions and multidisciplinary team collaboration (Lankshear, 2003).

According to O'Cathain *et al.* (2007), mixed methodological approaches are adopted widely in health service research, seen as favourable to funders. This PhD study was designed as an application for funding from the ESRC so to some extent this is true that there are strategic reasons why it uses mixed methodology. However, with regards to projects within a healthcare arena and organisational issues, it is accepted that the complexities warrant mixed methodologies to effectively investigate such phenomena (O'Cathain *et al.* 2007; Johnstone, 2004). These authors also indicate that with evaluation healthcare studies, comprehensiveness is a desired outcome with increased attention being given to both process and outcome of interventions; thus different methodological approaches are needed to achieve this. As identified, this PhD study aimed to focus on two main angles with regards to evaluating SPA meetings: the nature of discussion that takes place within the meetings and the overall efficiency of SPA meetings. The former has been investigated with a GT methodological approach whilst the latter was attempted with quantitative data analysis. O'Cathain *et al.* (2007) confirm that a common reason for utilising mixed methods is to investigate different aspects of research questions.

Although mixed methodology is typically seen as combining qualitative methodology and methods with quantitative methodology and methods (Curry *et al.* 2009; O'Cathain *et al.* 2007; Johnstone, 2004), GT is not a qualitative methodology (Glaser 2004). It is an approach that can deal with qualitative data but qualitative data analysis has different intentions. This is evident in the mixed methodology literature which suggests that qualitative research methodologies are approved for their ability to reflect participant voices and as such ground the data in real life (O'Cathain, 2007). Emancipation of participant voices is not the intention of GT methodology; it is to achieve high level conceptualisation and as such, subjects' actions and behaviours become theoretical products (Glaser, 1978). However this is not intended to be a demeaning depersonalisation of subjects, for to attain this theoretical product, one must initially prioritise subjects' actions, words and interpretation of their social world,

> *"GT generates categories' labelling patterns which is merely about what is going on, not for or against and not for corrective action. People disappear into these patterns which abstract their behaviour. GT is not the participant's voice, it is the patterns of behaviour that the voices of many indicate…"* (Glaser, 2007).

The point being conveyed here is that although GT is not a qualitative methodology, this study can still be seen as using mixed methodology since GT has dealt with qualitative data whilst a separate quantitative agenda has also been undertaken. Curry *et al.* (2009) concur that some organisational phenomena such as social interactions are too complex to be measured quantitatively and thus require an alternative approach.

Mixed methodology is increasingly recognised as a methodological approach in its own right, (Bryman, 2004; O'Cathain *et al.* 2007; Doyle *et al.* 2009) but faces criticism. Some writers argue that it is not possible to combine qualitative and quantitative approaches because they both rest on different epistemological assumptions and sit in possibly different paradigms (Bryman, 2004). However, when taking the technical approach, which looks at how data collection and analysis are done, Bryman suggests that this makes it more acceptable for the two approaches to be combined. The researcher must have a credible understanding of both quantitative and qualitative approaches so that mixture of the two can be fruitful and attain good outcomes for the study (Doyle *et al* 2009). I undertook an ESRC approved Masters in Research Methods course prior to PhD study and therefore have received training in the relative benefits and drawbacks of both quantitative and qualitative methods and how mixed methods may be implemented.

3.3.2: <u>Grounded Theory</u>

Methods should be selected carefully by considering what is most appropriate for the purpose of the evaluation (Ovretveit, 1998). The goal was to uncover social processes pertinent in SPA meeting discussions, particularly when the field of mental health and illness is filled with scientific terminology and insights (Bolton, 2008; Cockerham, 2006). GT focuses on *"…uncovering social phenomena and interaction…by its focus on informants' personal experiences and basic social processes…"* (Maijala *et al.* (2003). This is also supported by Walton and Sullivan (2004) who suggest that the basis of qualitative research is the undeniably complex nature of human realities and experiences. These authors advocate GT since it can help generate knowledge of a phenomenon that has not been thoroughly investigated and developed. As evaluative studies are increasingly contributing to the demand for evidence-based practice, it is reassuring that GT cited as a methodology that develops practice-based knowledge (Elliott and Jordan, 2010).

As an under-studied phenomenon SPA meetings provide an opportunity to be investigated using classical GT principles (Artinian, 2009). Focusing on the nature of discussions in the multidisciplinary environment, a Basic Social Process (BSP) can emerge (Glaser 2007; 2004; 2002; 1996; 1978). This BSP, generated as a rich, multivariate theory, accounts for the behaviours shown by attendees of SPA meetings. This provides insight into the significant and sometimes complex, decision making process that occurs in planning appropriate interventions for clients who may have mental health problems. Emergence of theories means that not only problems, but also the solutions that subjects use to resolve their main concern, can be discovered. Theoretical explanations of behaviour can be enlightening for subjects, guiding them on how to manage their social world (Artinian, 2009). Glaser (1978) maintains that revealing the BSP is useful for subjects because although they are able to describe their social world, they do not possess the theoretical conceptualisation that the BSP can provide. Theories as integrated concepts can aid the subjects in managing their social worlds so could contribute to more efficient decision making practices in future SPA meetings and better service provision for clients. This corresponds with the endeavour of evaluation *"to help people to make better informed decisions"* (Ovretveit, 1998: 13).

The theory-generating element of the GT method is a favourable aspect that distinguishes it from many other qualitative methods (Glaser, 1998). In addition, as well as contributing to the literature on the under-developed topic of SPA meetings, the study's utilisation of GT means that it can also provide useful commentary on the research method aspects. This was viewed as a good opportunity since some writers have highlighted the lack of guidelines in avoiding the potential pitfalls that may arise when carrying out the method (Elliott and Jordan, 2010).

To some extent the decision to use GT methodology to deal with qualitative data was already in place before my ESRC studentship. However, I did have a free rein in terms of my interpretation of what constituted this type of inductive methodology and how to employ it. An inductive approach was favoured because of its ability to contribute to the under-studied field in a unique way i.e. creating theory in a substantive area (Glaser and Strauss 1967; Bryman 2004) that can have prevailing conceptual power. SPA meetings specifically have not been focused on greatly in mental health research and thus an evaluation into this Trust's SPA meetings is particularly unique. This can be appealing (though not completely necessary) to the grounded theorist (Glaser, 1978).

In much of the literature, following Glaser's directives is often described as "Glaserian GT" (Artinian *et al.* 2009). Although Glaser favours the term "classic GT" because it hails the method's origins, I have decided to retain terming my chosen methodology as Glaserian GT, because in the next chapter, there will be a reflection on choosing to follow Glaserian directives over Straussian methods and I deemed it more appropriate to convey that debate with such terms.

It became clear that once one has chosen to comply with Glaserian GT methods, the commitment requires a lot of patience and adherence to directives as stated by Glaser and his supporters (Glaser 1978; Glaser 2002; Glaser 2004; Artinian 2009; Artinian and Giske, 2009). It can be a time-consuming, but according to Glaser (2004) the product is simple,

> *"…a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area."* (p2)

Data must not be moulded to suit preconceived ideas or convenient notions (Glaser, 2004). Treating the data in its original form allows meaningful conceptualization and an honest reflection of behaviours in the substantive area to emerge. The requirements are daunting and one may be tempted to force the data to suit interesting notions. Although the topic of SPA meetings has not been studied extensively and literature remains sparse, multidisciplinary team working is a phenomenon that has been investigated in numerous ways. Moreover, there is much theorisation of this in the field of mental health. I will now take the opportunity to discuss literature in Glaserian GT methods, and how I have used it in a way that abides by Glaser's directives. I also highlight its usefulness in the substantive area of SPA meetings.

In terms of evidence-based practice, although evidence may be available, clinicians use of this may be jeopardised by lack of time (Newell and Burnard, 2011). Thus this study endeavoured to generate insight that is comprehensive, comprehendible and accessible. Theoretical interpretations when done well can be much easier to grasp and remember than qualitative descriptions by capturing many incidences under few concepts (Glaser,

1978). They also have a transcending potential in which they can go beyond the substantive area of study and find relevance elsewhere thus developing into a general formal theory (Glaser, 2010; Glaser, 1978).

According to Bowling (2009), when evaluating health services, data should explore their structure, processes, outputs and outcomes. Data on structure includes details about staff numbers, buildings in which intervention takes place and overall framework for activities to occur. Process relates to the actual activities and may investigate interactions and relationships between staff. Discovering the BSP achieves thorough exploration of the structure and process of SPA meetings through the use of participant observation and interviews. By attending the SPA meetings, I got an idea of the environment and conduct of business of SPA meetings. Interviews then explored and expand on initial ideas and categories. Using different methods for collecting data is advocated by grounded theorists (Glaser and Strauss, 1967; Chenitz and Swanson, 1986; Charmaz, 2000) because they offer multiple ways of studying the investigated phenomenon.

Observations and interviews are often combined since observations may produce questions that cannot be answered through continued observation (Esterberg, 2001; Patton, 1990). A semi-structured interview guide was prepared, meaning that there was a loose structure of questions to follow, whilst leaving scope to let participants guide the interview (Bryman, 2004; May, 2001; Esterberg, 2002). This endorsed the principles of GT by keeping investigator's pre-conceived ideas to a minimum.

The study adheres to the common characteristics of Glaser and Strauss' approach to GT, inherent in their original text outlining the method (Cooney 2010; Bryant and Charmaz 2010; McCann and Clarke 2003; Glaser and Strauss, 1967). These characteristics include

- **Theoretical sensitivity**

- **Theoretical sampling and theoretical saturation**

- **Coding and constant comparative analysis**

- **Memoing**

- **Literature as a source of data**

3.3.3: <u>Theoretical sensitivity</u>

Theoretical sensitivity is a skill that is developed throughout the GT process (Glaser, 1978). It refers to the investigator's ability to conceptualise from the data using theoretical terms, through the method of constant comparison (Kelle, 2010). A big debate within GT is the question of how much literature one should read before entering the field (Wiener, 2010; Cone and Artinian, 2009; Heath, 2006; Glaser, 1978). Many take Glaser's directives (Glaser and Strauss, 1967; Glaser, 1978) to mean abandoning literature reviews until much later in the process and favour a *tabula rasa* approach. I believe that this is a misconception of Glaser's instructions: As Strübing (2010) emphasises, in their original writings, Glaser and Strauss (1967) did not endorse a *tabula rasa* attitude,

> (researcher) *must have a perspective that will help him see relevant data and abstract significant categories from his scrutiny of the data* (p3)

Prior literature reviews often need to be done because funding bodies and progress panels are eager to see that the investigator has identified gaps in the field and can justify where their own studies fit into this (Walls *et al.* 2010; Cone and Artinian, 2009; McCann and Clark, 2003). Early literature reviews, when done broadly, can help investigators to hone their sensitising skills by making them aware of what possibilities may arise in the data (Heath, 2006; Glaser, 1978). Specific and relevant literature cannot be known in advance, which is why a more focused literature review occurs when the theory is more developed. Heath (2006) advises that those less experienced often struggle to recognise the bigger picture and take a more narrow perspective. On a personal level, I consulted the literature broadly in the areas of multidisciplinary team working and Community Mental Health Teams (CMHT) in my first year of PhD study. The upgrade panel did comment that I had barely consulted the literature on decision making. As my field work commenced, I started to look at decision making literature but the temptation to apply preconceived notions to the data was justified by the fact that specific SPA meeting literature is scarce. Moreover, many of the themes prevalent in the literature such as power and rank were not dominant in my early analyses. I found that consulting the literature was particularly helpful in finding suitable names for my

categories, even if my use of the name differed from the meaning intended by other authors. Conceptual grab is another aspect hoped to be achieved in GT methodology (Artinian *et al.* 2009; Glaser, 1978).

Some writers point out that Glaser and Strauss themselves were knowledgeable in the field of dying prior to entering the field (Walls *et al.* 2010; Carson and Coviello, 1995), stemming from personal bereavement. Thus literature can guide the investigator to hone the skill of theoretical sensitivity. Moreover, experience can be fruitful when undertaking a GT study. Giske points out that her background as a nurse and knowledge of Norwegian culture enhanced her awareness that patients are not necessarily comfortable with disclosing their thoughts on spiritual aspects of life (Giske and Artinian, 2009). Thus this guided her to formulate questions more openly in a way that accommodated this.

In addition, the risk of forcing ideas on data can be remedied by the constant comparative method inherent in this methodology: if such ideas are indeed appropriate to the substantive area, they will earn their way into the theory (Glaser, 1978; Giske and Artinian, 2009). The prominent aim of GT is to remain open in discovering the main concern of participants (Cone and Artinian, 2009; Giske and Artinian, 2009; Glaser, 1978; Glaser and Strauss, 1967). This depicts the "mover" that motivates behaviour in the field that resolves this main concern. The resolving of the main concern is expressed as a GT with a high level core category and related categories (Artinian, 2009). My personal experience of using Glaserian GT is discussed in the following chapter.

3.3.4: <u>Theoretical sampling and theoretical saturation</u>

Theoretical sampling is based on using developing categories to direct the investigator to further sources of data e.g. which subjects to interview and areas of exploration (Giske and Artinian, 2009; Glaser, 1978; Glaser and Strauss, 1967). This guides the investigator to further establish and/or discard categories and their properties (Bryant and Charmaz, 2010). It is integral in the journey of theory development (Morse, 2010; Sterne, 2010).

My discussion of theoretical sampling can best be tackled through acknowledgement of my data collection methods relating to qualitative data. Two main data collection methods were applied: participant observation and interviews. According to Maijala *et al.* (2003), several data collection methods are often used with GT. In addition, it became quite clear from the literature on GT studies that multiple data collection methods were favoured (Moore, 2010; Coyne and Cowley, 2006; Walton and Sullivan, 2004). Although, as Moore (2010) highlights, Glaser and Strauss (1967) did not directly state which source of data to be collected was best, there are reasons why observations, interviews and document data are suitable for this study.

Participant observation was chosen as the initial data collection to precede interviews because it does assume that the researcher knows what is important (May, 2001). Interviews may well do the opposite, which is not something that I wanted to achieve given the endorsement of GT principles. In addition, May (2001) highlights that observations promote an inductive approach to data collection, by allowing for ideas to develop as opposed to ideas being tested. This is supported by other writers in the research field (Mason, 2002; Esterberg, 2001) who suggest that participant observation is a way of allowing the subject's voice to be heard and giving attention to their experiences. Although ultimately the GT product is not concerned with emancipating participants' voices, one must begin with the participant's point of view in order to produce a conceptual theory that is true to the substantive area.

Access to the field and participants can be a challenge in projects and careful consideration needs to be given to this part of the process (Esterberg, 2002). However, in this particular study access and identifying subjects was less problematic given that selection was simply based on who attended the meeting. These attendees were "experts" in the phenomenon that I wished to study. After gaining the necessary authorisation from managers and team leaders, I was able to attend the meetings.

It was important to establish the extent to which I would be participating within the observation and more specifically what participating would involve. It was agreed that at the very least, participating could be understood as being present within the meeting setting. If the opportunity arose, I could read a letter out, but it was advised by supervisors that I should not partake in discussions and decision making, since I am not a mental health professional. This approach is supported by Esterberg (2002) who also

highlights that the notion of "participant" observation is ambiguous. However this author suggests that such observations can be conducted with the observational side being more primary.

Three participant observations were completed at each of the seven different sites with varied levels of participation. In one location it was quite easy to take a chair and sit in the corner of the room; in another, there was no table as chairs were arranged into a circle around the room, so I sat with the rest of the attendees. In this particular location, I was automatically handed a letter to read on all three occasions. In other centres, although sitting with the rest of the group I was asked if I would like to read a letter. On the first observation, I agreed, but in subsequent observations, I declined because I felt it was important to focus on note-taking. It became apparent that in these observations, making decisions as and when they arose, as opposed to pre-determining actions, was much more feasible and beneficial. The approaches to note taking and building rapport with subjects cannot be standardised given the complexities that arise (Esterberg, 2002). Even intricacies such as where to position oneself can be difficult to establish. In most places, I sat close to administrative members of the team because I deemed this to be a suitable place to take notes comfortably without drawing my subjects' attention. The administrative attendees were also responsible for writing and recording, so I felt less conscious when doing so alongside them.

Observational field notes were open coded and memoing, helping to narrow down categories. This gave me a basis for proceeding to interviews. From my categories (developed out of initial codes), I identified areas for exploration and attendees which would be best to encourage this exploration. At this stage, there were some indications as to what the main concern and BSP were. This is a core example of theoretical sampling and can be seen as the deductive side of what is a predominantly inductive methodology (Glaser, 1978). The prime intent is not to test out hypotheses, though this might occur as a by-product. Its aim is to aid the development of categories and concepts to support endeavour for a relevant theory. On a personal level, I hoped that interviews would verify the main concern and BSP.

The use of interviews was laid out in original plans, but I endorsed them because I felt it would be useful to engage in one-to-one conversation with key personnel identified through the observations. The two are often combined since observations may produce

questions that cannot be answered through continued observation (Esterberg, 2002; Patton, 1990). Specifically, a semi-structured interview guide meant that there was a loose structure of questions to follow, whilst leaving scope to let the participants guide the interview (Bryman, 2004; Esterberg, 2002; Mason, 2002; May, 2001). Semi-structured interviews enabled a focus on participants' perspectives and equipped me with a format to guide and prompt, while their less rigid nature ensured that the participant led their progress. This adhered to principles of GT by keeping pre-conceived ideas to a minimum. Such strategies were crucial in promoting a data analysis that allows the participants' main concern to emerge and a core category to be identified (Glaser, 2001; 1998). Continually selecting participants for the interviews depended on how the data itself evolved in terms of patterns, categories and dimensions. Participants for the interviews were selected based on their ability to offer deeper insights that emerged. Iterative analysis was used in the collected data from interviews to compare and establish the emerging patterns, concepts, categories, properties and dimensions of SPA meetings. I used the data to guide me on what the next actions should be: to choose more participants if data is not theoretically saturated or to stop interviewing if it was.

Theoretical saturation depicts the point in which collecting data about a category or concept uncovers no new properties or theoretical insights relating to the emerging theory (Bryant and Charmaz 2010). It signals the significant development of the GT and indicates that data collection can be suspended. It should never be falsely "achieved": The nature of Glaserian GT means that patience and time are necessary to successfully allow emergence to take place (Artinian, 2009; Glaser, 1998). Premature ending of data collection could result in forcing the data and incorrect establishment of categories. For my study, once the main concern and BSP was identified, verification was not claimed until further interviews had taken place and properties of categories explored. Moreover, memos enabled me to revisit observational data to selectively code based on these developments.

3.3.5: <u>Coding and constant comparative analysis</u>

Three types of coding are pertinent to the Glaserian GT process (See Table 3.3.5). Their differences relate to their application, but all should be discovered as opposed to forced.

Coding type	What is involved
OPEN	Coding freely and openly for anything of interest. I used the highlight feature in Microsoft Office Work to pick out aspects of observational and interview data. Memoing explored these codes even further and enabled the consolidation of several codes into fewer categories.
SELECTIVE	Once the main concern and BSP is discovered, the analyst codes the data for things that relate to these only. My selective coding took place following analysis of interview data and was done with a different colour highlight.
THEORETICAL	In order for one's theory to be of a high conceptual level, the substantive codes are linked with an emerging theoretical code. These theoretical codes derive from the eighteen coding families identified by Glaser, 1978. Although theoretical codes do not have to be discovered, they raise the conceptual status of the GT.

Table 3.3.5: The coding process, adapted from the Bryant and Charmaz 2010; Artinian *et al.* 2009 and Glaser, 1978

Constant comparative analysis is the integral method applied in Glaserian GT (Artinian, 2009; Glaser, 1978; Glaser and Strauss 1967). Incidents are compared to one another and once categories emerge, incidents are compared to these. Eventually categories are compared to other categories and relationships are established. This is greatly enhanced by the use of memos where one can record their ideas about developing categories, including thoughts about the comparisons (Glaser, 1978).

3.3.6: <u>Memoing</u>

According to Bryant and Charmaz, memoing denotes,

> *"…the pivotal immediate step in GT between data collection and writing drafts of papers. When grounded theorists write memos, they stop and analyze their ideas about their codes and emerging categories in whatever way that occurs to them"* (2010:608).

The content of memos varies to include thoughts, reflections, questions, emerging themes, and references to wider literature (Giske and Artinian 2009). They are dated

and organised systematically with one memo designated to one code or category at a time. Memoing should be prioritised over transcription of field notes given the fragility of ideas, which reiterates their significance and priority in the GT process (Glaser, 1978). Memos bridge the gap between description and conceptualisation (Montgomery and Bailey 2007) and distinguish GT from qualitative data analysis. Memos should not be restricted to a set criteria, rather the analyst has freedom in what they record (Glaser, 1998). My use of memos is demonstrated in the next chapter and proved crucial to the theory development.

3.3.7: <u>Literature as a source of data</u>

A focused literature review is undertaken once conceptual development has progressed to a more advanced stage (Heath, 2006; Glaser, 1978). One cannot know beforehand which literature will be significant and my own experiences saw me consulting areas that I did not know would be pertinent. Using extant literature is never done to verify one's GT or even synthesise one's findings with these texts. Rather one treats literature as data and weaves it into the constant comparative method in the same way one would compare and contrast a new interview transcription. Relevant ideas from extant literature can earn its way into one's theory and thus integration takes place that essentially transcends what has been done before (Glaser, 1978). Holton (2010) confirms that the grounded theorist has a responsibility to go beyond people, time and place and in order to achieve transcending abstraction, one must analyse all sources of data available. Moreover, Glaser (2007) continually asserts that data to be compared with the emerging theory comes in all shapes and form. It is important to know where one's theory fits in relation to the general body of knowledge to prevent it from becoming isolated and consulting the literature supports this (Heath, 2006; Glaser, 1978). A focused literature review in relation to my BSP Handling Role Boundaries forms Chapter 6.

Thus, taking into account the advice of Glaser (2007; 1998; 1978) and his proponents (Artinian *et al.* 2009), the general shape of the Glaserian GT methodology can be seen as follows:

Aim: To develop a theory which demonstrates understanding of the subjects' behaviours used to resolve their main concern.

Action: To find the main concern of participants. This "concern" is seen as motivating certain behaviours that are carried out to try to resolve the main concern. One should discover the core category, which along with its variables provides explanation of how subjects resolve their main concern. The core category is seen as the "*…highest-level concept of the theory…*" (Giske and Artinian, 2009: 50). When developed in the gerund mode, the core category is known as the Basic Social Process (BSP).

Product: An "*integrated set of hypotheses which account for much of the behaviour seen in the substantive area…*" (Glaser, 1998: 3).

3.4: <u>Qualitative data ethical issues</u>

When a reply was gained from the NRES relating to the study status, one key point in their letter was that although application to official ethical boards was not necessary, adherence and respect for core ethical principles took place (See Appendix 1). Ethical issues are a key discussion point in sociological studies (May, 2001) and are of particular pertinence in the healthcare field because of past abuses which jeopardised such principles (Newell and Burnard, (2011). According to Bryman (2004), there are four broad areas that need consideration: harm to participants, lack of informed consent, invasion of privacy and finally deception. As this author points out, it can be difficult to establish what exactly constitutes harm since it encompasses more than physical effects. However, I feel confident that my study and personal actions did not open subjects up to any harm or risk. This was aided by the fact that SPA meetings would occur regardless of whether I came along to discover the BSP within them. I built up amiable rapport with subjects which led to comfortable invitation of their participation for interviews. All subjects who were asked agreed to partake and were always reminded of their right to withdraw from the study at any time without negative ramifications.

The issue of informed consent is something that is awarded much attention in the British Sociological Association's Statement of Ethical Practice (2002). Three statements in particular are of interest as shown in Table 3.4.

BSA statement	My handling of the issue
As far as possible participation in sociological research should be based on freely given informed consent of those studied. This implies a	A planned enquiry document was sent to local managers of the services and correspondence also provided explanation of the study. This was

responsibility on the sociologist to explain in appropriate detail, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken and how it is to be disseminated and used (2002:3)	also sent to team leaders and/ or chairs of SPA meetings and verbal explanations were always offered and supplied when asked. Granted authorisation was carried at all times during field work and introductions were always made so attendees knew who I was and what my study was about. With the study being evaluative, no formal document was drawn up for interviewees, but consent was indicated on the digital recording and prior correspondence.
Research participants should be made aware of their right to refuse participation whenever and for whatever reason they wish (2002:3)	Attendees of SPA meetings were aware of who I was and what my study was about. As an evaluation study, I was investigating meetings that would have occurred regardless of my presence so formal issuing of rights to withdraw was not required. For the interview stages, however, I corresponded with subjects to inform them of their right to reject participation or withdraw at any time. This was reiterated on the digital recorder at the start of the interview.
Research participants should understand how far they will be afforded anonymity and confidentiality can should be able to reject the use of data-gathering devices such as tape recorders and video cameras.	Anonymity was granted to all subjects through the careful storage of field notes, memos and any other identifiable sources of information. Paper forms were locked safely and computer files were securely encrypted and password protected. References to subjects in transcripts and the thesis have been and will continue to be allocated codes (as have the seven areas of SPA meetings). Prior to interviews, subjects were asked if they were happy for the interview to be recorded and the file has been encrypted and password protected. The fact that quotes will be used as part of writing up was disclosed to subjects, but so was the assurance that their

	identities would be protected.

Table 3.4: BSA statements

Esterberg (2002) highlights that allocated codes may not be enough to protect the identity of participants particularly with studies taking place in small communities. Many of the mental health professionals being studied did know each other even if they did not attend the same SPA meeting. The coding of identities has been simplified and standardised as much as possible and consists of an abbreviated profession, gender and area of SPA meeting. Some professions were too identifiable so alternative ways of describing what these individuals do was found and abbreviated.

In terms of invasion of privacy and deception (Bryman, 2004), the study was always conducted in an overt manner. I was happy to discuss the project and what I was investigating. Moreover, access to SPA meetings were granted based on a fair and thorough assessment of my study plans by the relevant organisations and as far as possible within the remits of a service evaluation agenda, privacy of subjects was not compromised given my authorisation to attend the meetings. In addition, interviews with selected subjects were designed and conducted largely according to their availabilities and schedules.

According to Northway (2002) and Maijala *et al.* (2002), ethical implications go beyond the issues of confidentiality and informed consent. May (2001) claims that when one considers what constitutes moral behaviour, one enters the realms of ethical debates. I made efforts to be ethically sensitive throughout the process of conducting the study. Throughout the observational period, I thought about where I could sit that would cause the least discomfort and disruption to the meeting. I often came to meetings early and was able to converse with many of the members beforehand which gave the opportunity for me to explain my project in informal terms. Many displayed interest in seeing how the study would progress. I got to know the administrative staff very well, and this meant that I could comfortably seek guidance on issues that needed clarifying and gain help when it came to the quantitative data collection. Maijala *et al.* (2002) emphasise that fairness, truthfulness and avoiding harm are pertinent features of ethical considerations and I feel that my attitude and actions upheld them.

Maijala *et al.* (2002) also suggest that when choosing a topic to investigate with participants, one must have clarity relating to the reasons why one is doing what they are doing. The rigour of GT is such that everything has a justification. For example, I had specific aims to theoretically sample when deciding to move on from observations to interviews. This influenced my selection of interviewees, but when writing to them, I made sure that they knew there would be no negative consequences deriving from not wanting to participate. Times, dates and location were decided based on the schedules of subjects working primarily with their availabilities and preferences. When it came to the actual interviews, I ensured that subjects were happy for digital recording to take place and took my cues from them: if I felt they were reluctant to respond to a line of enquiry, I moved on to another question. I was happy to clarify things that they were not sure of and strived to be courteous and remind them that I was grateful for their participation and time. I emphasised that the interview was about me learning from them as much as I could about SPA meetings in an effort to remedy the possible power imbalance between interviewer and interviewee (Esterberg, 2002). These sorts of attitudes also increase autonomy of subjects, which is another key value that Maijala *et al.* (2002) endorse. The subject of mental health problems is undoubtedly filled with sensitive issues (Cockerham, 2006; Rogers and Pilgrim, 2005), and care was taken when choosing terms to use and the manner in which topics were introduced.

I was also very aware during both observations and interviews that my overt agenda in conducting a service evaluation may present the notion of me scrutinising and assessing attendees. I did not want to deter subjects from acting as natural as possible. As research writers indicate (Bryman, 2004; Esterberg, 2002) this perhaps did happen, particularly in the early stages of observation. However, I always tried to maintain a friendly manner and refrain from bearing an "official" presence, as reflected in my casual attire, mannerisms, gestures and my willingness to discuss my investigation with anyone who wanted to. Moreover, I affiliated myself with the administrative staff and other students which helped in my integration within the SPA meetings and to generate a comfortable atmosphere despite being a newcomer. Many attendees and interviewees expressed interest in the study findings and as Chapter 8 shows, they will have the opportunity to access these. This demonstrates respect for them beyond the field work stage.

3.5: <u>Quantitative data</u>

Bowling (2009) suggests that output refers to productivity issues and outcome focuses on how the intervention affects the individuals/ patients. In terms of SPA meetings, evaluative intentions were framed around exploring whether decisions made in SPA meetings, correspond to what actually happens to the client. This intended to provide indications into the efficiency of SPA meeting decisions and their overall capability to be efficient in dealing with case referrals. Part of outcomes is the notion of appropriateness (Bowling, 2009), which can include organisational factors (Houghton *et al.* 1997). These factors can assess whether the SPA meeting is an appropriate forum for organising the allocation of referrals, paving the way for quantitative collection and statistical analysis (Field, 2009). What was of main interest was generating a picture of the overall flow of clients through each of the seven SPA meetings, looking at their subsequent referral journey and career with mental health services.

Analysis was conducted using the Statistical Package for the Social Sciences (SPSS) software. The details of statistical tests can only be known at the time of dealing with data, because they have certain criteria to be met before conducting them (Field, 2009; Pallant, 2007). A time period of three months (1st December 2010 – 28th February 2011) was selected and collection of client numbers of individuals who were discussed in the seven SPA meetings during this time period was planned. Adherence to data protection guidelines and the Caldecott principles (DH 2003) prohibited me from having access to computer held records. After advice from the Trust's Health Informatics department and contact with the Trust's Caldecott Guardian, it was found that as non-employee of the NHS, I would not be allowed to trace client information on the RIO computer system (Please see Appendix 4).   However, as indicated, I could liaise with a member of the Trust IT department who could then obtain the data that I needed using client numbers. A meeting with said member was arranged and discussion ensued as to what would be feasible for both this member and I to do. Once this plan of action was established, I proceeded with liaising with administrative teams of the seven SPA meetings. They provided me with the client numbers of individuals who had been discussed within SPA meetings that took place within the three months of interest and the SPA meeting decision. Paper sources were stored securely and computerised to send to the Trust information officer to find out subsequent information. Table 3.5 shows the information that was gained from the initial client numbers.

Information elicited from initial client numbers
• Gender
• Ethnicity
• Referral history
• Date referred
• Referral source
• Where client was referred to
• Urgency rating
• Reason for referral
• Discharge date
• Reason for discharge
• Internal referrals and details

Table 3.5: Information elicited from Trust IT team member

A sensitive and secure approach was taken to data handling as part of ethical priorities. Given that the documents and files needed for quantitative data analysis consisted of patient identifiable information, the Trust's *"Safe and secure handling of confidential information"* document (2011) was consulted for advice. When dealing with the confidential data, all email correspondence with the Trust IT member was done via my primary supervisor's email account, who as an NHS employee, has a Trust email account. Documents were securely encrypted and the passwords were disclosed separately. Unfortunately, the nature of data provided limited the use of statistical testing and unfortunately, evaluating the overall validity of SPA meetings could not be fulfilled. This is expanded upon in Chapter 7 and methodologically, the study proceeded to focus on discovering the BSP through Glaserian Grounded Theory procedures.

3.6: <u>Time line</u>

The relative time period of study activities was as follows:
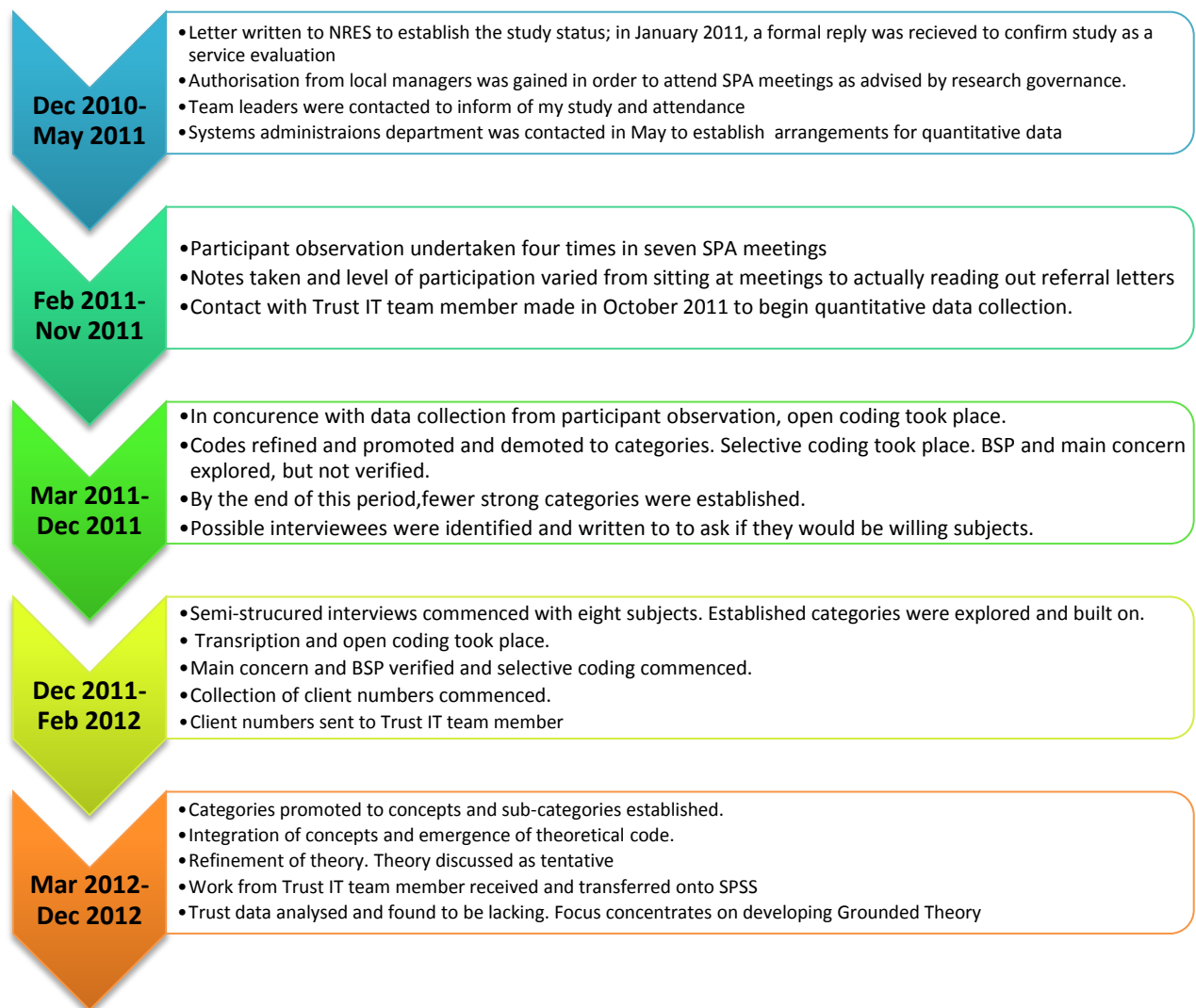
Figure 3.6 Time line of study activities

3.7: <u>Findings</u>

Chapter 7 discusses the challenges that met the endeavour to assess the flow of client referrals through SPA meeting. This unexpectedly delivered insight into tensions between administrative systems and the real life mechanisms of SPA meetings. This situation means that the PhD study focuses more on the successful BSP that has emerged through Handling Role Boundaries and much can be said concerning the internal mechanisms of SPA meetings and nature of discussions. These key aspects are discussed in Chapters 5,6, and 8. Chapter 8 also discusses planned dissemination strategies for Handling Role Boundaries and development of the theory in the Intervention mode.

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3.8: <u>Validity issues</u>

Since qualitative research is perceived to be very subjective in nature compared to quantitative research, it is important to find methods of exploring the validity of such data. There are a range of validity issues to consider in qualitative research (Maxwell 1992). However Glaser and Strauss (1967) do not consider validity in its traditional sense, as a pertinent issue for GT. For the sake of this PhD I identified internal validity as significant, exploring the credibility of the study findings and how well categories have been established (Pandit, 1996). In particular, it considers the rationale behind which categories are established and how they link to one another. This is a key characteristic of GT and therefore justifies a focus on internal validity. More specifically, the following four criteria are used to assess the emerging theory, as depicted from Glaserian GT texts (Giske and Artinian, 2009; Glaser 1978; Glaser and Strauss, 1967):

Criterion	Meaning
Fit	Categories must not be forced: they should emerge systematically and be continually validated by fitting and re-fitting them to the data. The resultant GT should consist of these categories as concepts, integrated in a parsimonious way and fit the substantive area.
Work	How the theory explains how subjects resolve their main concern. Should explain what is happening, interpret what is happening and predict what will happen in the substantive area
Relevance	The GT should have relevance for subjects by having good grab. Core processes need to emerge and be discovered.
Modifiability	All grounded theories need to be seen as having partial closure: good grounded theories have the potential to be modified should new data indicate different categories and/ or properties.

Table 3.8 Criteria for validity

3.9: <u>Respondent validation</u>

Respondent validation is a one method of validity testing that can be used in research (Bryman, 2004). It aims to involve participants in the process by giving them access to findings which they can then comment on. Discrepancies between the investigator's interpretation and the participant's intentions can be brought to the surface and discussed. I decided not to engage in this form of validation after participant observation because it did not seem to be accommodated by the Glaserian GT methodology I was

adopting. The emerging theory at that stage was still under-developed and was not at a stage that I felt confident in disseminating: I felt there was still much to discover. Moreover, I wondered about the extent to which respondent validation could be trusted. Bryman (2004) confirms that it does harbour practical difficulties in the light of defensive responses from subjects. Alternatively, the rapport might have been built to such an extent that the subjects do not want to criticise the investigator's findings.

With specific regard to Glaserian GT, it is agreed that the best form of validation for the emerging theory is if the subject – also referred to as the knowledgeable person- can relate to it because it provides theoretical expertise into their social world, helping them to manage their milieu. Artinian (1998) recounts her experiences of providing theoretical expertise into subjects' social worlds as positive. It signals the ultimate mastery of the data: being able to provide subjects with a different type of expertise that they can transfer to new situations. However, Artinian's (1998) discussion relates to theories that have been substantially developed after theoretical saturation. It is not the same as respondent validation because GT analysis is not the same as qualitative data analysis. Respondent validation aims to ensure that the participant's voice is heard and correctly interpreted. It can be a positive method for rebalancing the power differences between researcher and participant. In contrast, GT, as discussed before, is not concerned with prioritising participants' voices: conceptualisation is the goal. Forms of respondent validation and its related goals are warned against by Glaser (2002),

> *"Inviting participants to review the theory for whether or not it is their voice is wrong as a "check" or "test" on validity. They may or may not understand the theory, or even like the theory if they do understand it. Many do not understand the summary benefit of concepts that go beyond description to a transcending bigger picture"* (p5).

As with Artinian (1998), when an opportunity arises, I will relish the chance to present my GT to subjects and would welcome comments and questions. Moreover, the engagement I have had with the data and my presence in its journey of evolution will put me in good stead to answer any enquiries and provide clarifications of the theory.

3.10: <u>Reflexivity</u>

According to Boud *et al.* (1985), reflecting through learning involves exploring one's experiences to pave the way for new understandings. There are likely to be values present that are taken for granted when undertaking studies so it is vital that these are acknowledged and discussed in terms of their effect (Pellatt, 2003). Neill (2006) confirms that there exists an array of ways in which reflexivity can be defined, and so it is a concept that may be difficult to grasp and effectively put into practice. Therefore it is useful that Pellatt (2003) advises asking three questions when tackling the task of addressing reflexivity,

1) How have I affected the process and outcome of the research?

2) How has the research affected me?

3) Where am I now?

Bryant and Charmaz (2010) describe reflexivity in the following way,

> *"…the researcher's scrutiny of his or her research experience, decisions, and interpretations in ways that bring the researcher into the process…A reflexive stance informs how the researcher conducts his or her research, relates to the research participants, and represents them in written reports"* (p609).

Although this is not a research project in the traditional sense, the fact that it is a study that closely adheres to the processes inherent in research means that such questions and aspects of reflexivity are significant and appropriate. Moreover, in a GT study, it is useful to be aware of how the investigator's values are affecting all aspects of the study in order to develop theory successfully. In addition, reflexivity is pertinent since participant observation is being used. Acknowledgement of the investigator as an instrument of data collection needs to be addressed since there are certain aspects of the field that will be set aside in favour of focusing on others (Esterberg, 2002).

Reflexivity has been addressed through the use of field notes and memoing, the latter being a clearly defined constituent of GT methodology (Glaser, 1998). Within field notes, I made space to record personal reflections and feelings at the time of experiencing them to convey the authenticity of such feelings. Dedication to this enabled the effects of

such feelings to be discussed and critical discussion took place regarding the nature of observations and interviews. It was useful for me to see how the experience of being in the field had affected me. Moreover, the inclusion of memos aided in theory development, and used my wider knowledge accumulated through being a student. My personal reflections and use of memos are discussed in the following chapter. The whole process of GT detracts the theorist from pursuing their own ideas and influences because everything is treated as empirical, even existing data (Glaser, 2007). Relevant categories and concepts are only included in the final theory if they have earned their way there. Extracts from field notes and memos are included in the following chapter as a more intimate look at the theory development is provided. Although Neill (2006) points out Glaser's (2001) rejection of reflexivity due to its distraction from the data, she also highlights that he acknowledged personal experience as part of theoretical sensitivity.

3.11: <u>Conclusion</u>

In conclusion, this chapter has been exhaustive in providing an account of the ethical and methodological aspects of the evaluative study including the methods utilised. The contentious nature of defining one's study has been discussed and how the NRES has offered an interpretation into categorising projects. Discussion ensued relating to the study's official status designated by the NRES as evaluation and provided understanding into the reasons why the study has been conducted as it has. Initially, two broad evaluative intentions of the study were pursued, but operationalisation of the internal mechanisms of the meetings proved more successful. The ethical aspects have been explored to demonstrate how these are pertinent throughout the whole duration of study. Findings are discussed in more detail in subsequent chapters to give them the attention that they require. The next chapter looks at my personal journey using Glaserian GT methodology and the development of early codes into the substantive theory of Handling Role Boundaries.

4) Glaserian Grounded Theory Methodology

"Growth demands a temporary surrender of security".

~ Gail Sheehy, American author

4.0: <u>Introduction</u>

Chapter 4 provides an account of my experiences of using the Glaserian GT methodology to discover the substantive theory of Handling Role Boundaries. In doing so, this chapter reports findings from the early stages of coding, categorising and eventual conceptualisation of higher level variables. It explains the rationale behind utilising the Glaserian classical methodology over Straussian procedures and key ideas inherent in the former. Subsequent extracts from observation and interview data are provided to demonstrate open coding techniques and how these initial codes developed into the final concepts of the theory. My adherence to the Glaserian principles and the management of practical challenges is explored. The chapter defines the stages that led to Handling Role Boundaries and ends with its core phases of Recognising, Positioning, Weighing up and Balancing.

4.1: <u>Glaserian Grounded Theory</u>

This section sets out the rationale for why a Glaserian approach was favoured over Straussian. It is well documented that Glaser and Strauss went their separate ways and both attempted to clarify the GT methodology in their own way (Cooney, 2010; Kelle, 2010; Heath and Cowley, 2004; McCann and Clark, 2003). In particular, it was the attempts to create better understanding of the concept of "theoretical sensitivity" that revealed differences in Glaser and Strauss' methods (Glaser, 1978; Strauss, 1987). Several explorations of Glaser and Strauss' separate writings, including Strauss' collaboration with Corbin (Strauss and Corbin, 1990) suggest that Glaser's approach is more faithful to the original premise (Cooney, 2010; Heath and Cowley, 2004; Glaser, 1978). Hence I adopted Glaserian approach because the principles of the original concept were relevant to this study. However it is important to discuss the decision making process that informed this choice.

Glaserian and Straussian approaches can be summarised in terms of loose stages depicted in Table 4.1 and are viewed as iterative and used in a cyclic way. The table derives from understandings of different authors' attempts to depict the main similarities and differences between Glaser's (1978) and Strauss and Corbin's (1990) method. It particularly draws upon Walker and Myrick's (2006) useful discussion on the main differences.

"Stage"	Glaser	Strauss
1	Substantive: Open coding -This is the first part of Substantive coding - The first part of comparative analysis- comparing the data in every way possible e.g. line by line, incident by incident - Memos are written outlining the researcher's ideas about developing concepts and themes. - Requires patience and persistence to ensure that categories emerge and this will eventually lead to verification - This helps achieve theoretical sensitivity - Stage ends when the researcher starts to notice a theory that is relevant and that relates to all the data - This marks the movement to the next stage- Substantive- selective coding.	Open coding - The first of three stages - Concepts are identified and their properties and dimensions are established. - Dimensionalizing of categories is crucial at this stage. - Theoretical sensitivity is achieved by using the analytic tools that Strauss and Corbin provide e.g. questioning; analysis of word, phrases, or sentences; making close-in and far-out comparisons.
2	Substantive coding: Selective Coding - The second part of substantive coding - The coding process is delimited and focuses on the core category and categories and concepts related to this core category	Axial coding -The data is fractured from open coding and is so put back together in new ways - This involves establishing links between categories and their sub-categories - It often means that amount of categories produced from open coding get reduced - A coding paradigm is used where

		three aspects of the phenomenon are considered: 1) The context/ situation of the phenomenon 2) The subjects' interactions, actions and responses to what is occurring in the situation 3) What happens after the action (or inaction) occurs - Key purpose of this stage is to establish understanding of categories and their relationship with other categories.
3	Theoretical coding - The data is integrated around a central theme or hypothesis so that a theory can be generated - This is done with theoretical codes- such codes materialise from the data - The role of theoretical codes is to use concepts to show how substantive codes can link with each other as hypotheses - These are then integrated into a theory - It is a matter of bringing back together the fractured story (similar in principal to Strauss and Corbin's axial coding)	Selective coding - This stage is about integrating and refining the theory - A core category is selected by the analyst and then links this to the other categories. - General categories are related to other categories as well. - Should not be confused with Glaser's stage of "selective coding".

Table 4.1: Comparison of Glaserian and Straussian methods adapted from Walker and Myrick (2006) article

On closer reflection of the original methodology in *"The Discovery of Grounded Theory"* (Glaser and Strauss, 1967), Glaser's independent writings adhere to this more than Strauss's collaborative work with Corbin. Several writers highlight analytic tools that Strauss and Corbin's (1990) lay out as instructions for carrying out data analysis e.g. the paradigm model (Kelle, 2010; Cooney, 2010; Melia, 1996; Glaser, 1992). They suggest

that the main criticism facing Strauss and Corbin's version of GT is that it risks being construed as forcing the data rather than allowing concepts to emerge. This defies the core principle of GT methodology where emergence is to be trusted and given time. Glaser (1992) claimed that Strauss and Corbin are no longer talking about GT but a new form of qualitative methodology.

More specifically, Walker and Myrick (2006) imply that Strauss and Corbin's inclusion of dimensionalizing (establishing dimensions and properties of categories) during the stage of open coding should be reserved for a later stage. Evidence suggests that deduction and verification dominate the analysis stages of Strauss and Corbin's version because they believe that induction has been exaggerated in the original GT methodology (Heath and Cowley, 2004; Strauss and Corbin, 1994). According to Heath and Cowey (2004), Glaser disapproves of deduction being favoured over induction because it may lead to speculation arising over the data. The emphasis on induction element of GT further swayed towards Glaserian thinking. Moreover, the various rules and formulaic nature of Strauss and Corbin's (1998; 1990) method with the inclusion of the Paradigm model seemed too prescriptive to allow the data to speak for itself. At this early stage of study I was worried about the risk of forcing the data with preconceived ideas as opposed to being sensitive to the people whose social worlds were being investigated. This could compromise the developing substantive theory.

One concept present in both Glaserian and Straussian versions of GT was "theoretical sensitivity". As mentioned in Chapter 3, theoretical sensitivity is the ability to conceptualise from the data by understanding that the data is subtle and requires the investigator to recognise what is relevant and what is not (Strauss and Corbin, 1990; Glaser, 1978). The difficulty is how to find the correct balance of identifying sensitising concepts without risking forcing certain frameworks onto the data (McCann and Clark, 2003). Strauss and Corbin (1990) suggest that asking questions through analytic tools is the best way of achieving this whereas Glaser (1992) insists on full immersion in the data using the constant comparative method - searching line by line and incident by incident. In some ways Strauss and Corbin's (1990) methods seemed appealing where the prescriptive rules became welcomed aids to use in the daunting nature of data analysis. Indeed, some researchers have commended and adopted Strauss and Corbin's version over Glaser's (Cooney, 2010; Maijala *et al.* 2003; McCann and Baker, 2001). Furthermore, it could be argued that Strauss and Corbin are merely putting into writing the cognitive processes that take place (Walker and Myrick, 2006).

However, my review of critical texts on both versions of GT (Kelle, 2010; Cooney, 2010; Artinian (2009; Walker and Myrick, 2006; Heath and Cowley, 2004; Strauss and Corbin, 1998; Strauss and Corbin, 1990; Glaser, 1978), informed me that Strauss and Corbin's methods could increase the risk of imposing preconceived ideas on the data, particularly when using analytic tools to ask questions. My academic background in the Sociology of Mental Health and Illness means that I am conversant with various texts and standpoints in the field and beyond the discipline. Thus, asking questions as guided by the analytic tools could have resulted in some questions being influenced by topics that were of interest to me. There is a huge risk of overlooking what is actually happening in the data. Glaser and those supporting or using a Glaserian methodology advise that although time consuming, through constant comparative methods and the use of neutral questions, concepts will emerge (Artinian, 2009). In fact amid my commitment to adhere to Glaserian GT, I discovered useful papers that recognise that individuals operate using different cognitive processes and therefore will vary in how they use the methodology (Heath and Cowley, 2004). This literature advises that commitment to the key principles of constant comparative methods, theoretical sampling and emergence, will help strike a "*…balance between interpretation and data that produces a grounded theory…"* (p149). Therefore, although this flexible approach is less prescriptive it does not fall short of guidance.

Embracing Glaserian commitment to classical values of emergence through the constant comparative methods enabled me to achieve the aims of this study. Strauss and Corbin have modified their approaches in later publications (Corbin and Strauss, 2008; Strauss and Corbin, 1998) insisting that their methods are flexible. However, such modifications compared with Glaser's consistent ideas compelled me to commit to the latter.

4.2: <u>Early consultation of the literature</u>

As mentioned in Chapter 3, progression to the second year of PhD study relied on assessment by an Upgrade panel. Therefore it was crucial to undertake a literature review to demonstrate my grasp of the field. Academic competence is often measured by one's ability to identify gaps in the field and pertinent debates. Consultation of the literature is a dilemma faced by the Glaserian grounded theorist who is anxious not to equip oneself with too many preconceived ideas (Walls *et al.* 2010). Reading in related areas can be beneficial in enhancing theoretical sensitivity (Glaser, 1978) and is necessary for offering initial direction (Walls *et al.* 2010). Moreover, to fulfil an interest

in the field, one would want to read around the topic. Indeed, Carson and Coviello (1995) argue that Glaser and Strauss were knowledgeable in the area of dying, the focus of their research. According to Glaser, (1996), GT dissertations tend to be *"motivated by studying the life cycle interests of the authors"* (xi) fuelling their hunger for discovering theory in that particular substantive area. It was necessary to undertake a literature review of the historical treatment of people exerting behaviour that caused anxiety to others (e.g. people we may refer to contemporarily as having mental health problems). The literature enabled me to structure a rationale as to why SPA meetings have evolved to deal with people with mental health problems in contemporary Britain. This review formed the bulk of my document for the Upgrade panel and was broad enough to avoid venturing too close to the substantive area since specific literature on SPA meetings is sparse. Reading scholarly texts also gave me a sense of the standard of language and shape of debates that I would need to utilise to disseminate findings and survive in the academic realms. This is endorsed by Glaser (1978) who implies

…the analyst's theoretical sensitivity, which is developed by intensive reading in sociology and other fields is also not only sharpened by learning what kinds of categories to generate, but also by learning a multitude of extant categories that could possibly fit on an emergent basis (p4).

Rather than possible categories, I saw this more as relating to appropriate language and ways of communicating ideas. This is testament to the fact that SPA meetings have not been tackled extensively by research and certainly not as a GT study which endeavours to perpetuate conceptualisation. However, non-specific literature and wider sociological reading advocated by Glaser sensitised me to the general themes that eventually earned their way into the developing theory. This is the point Glaser (1978) continually strives to impart: relevant ideas will earn their way into the theory through the constant comparative technique. When adhering to the principles of Glaserian GT, one is trained to avoid allowing ideas to be forced upon one's data.

4.3: <u>The Gerund mode</u>

Grounded theories can be developed in different modes depending on how the theory is emerging (Artinian *et al.* 2009). Initially, it is important to know what approach one is taking in terms of the project itself. The study was initiated in the discovery mode as

opposed to the emergent fit mode since no existing theory was guiding the current theory development (Artinian, 2009). Within this discovery mode, early coding and analysis revealed that the theory was emerging as part of the Gerund mode. The Gerund mode signals the emergence of a Basic Social Process (BSP) as the core category and indicates that there are more than two emerging phases (Artinian, 2009; Pash and Artinian, 2009; Sircar Osuri and Artinian, 2009). Gerund is named as such because of its use of predominantly gerund verbs to describe the theory as demonstrated by Glaser (1996). According to Artinian (2009), BSPs tend to emerge in substantive areas where the subject moves through a situation, for example, going through an illness and,

> *"…is ideally suited to a study that continues over time so that stages of a BSP can emerge and demonstrate changes that occur over time…"* (p107).

The Gerund mode was emerging as relevant given the nature of what I was studying: a substantive area in which subjects move through a decision-making period. Moreover, it soon became clear that at the very least, two phases were emerging. This is discussed in more detail in section 4.6.2.

4.4: <u>The core category and the BSP</u>

The BSP, as with all core categories, is the highest level concept in the GT (Giske and Artinian, 2009) and should link to all the other categories and explain how subjects resolve their main concern. Some studies may have a core category that is not a BSP but the core category in this study did emerge as a BSP. Emergence of the core category is a revolutionary moment for grounded theorists because it enables the theory to be integrated and provides clarity and explanation into the behaviours observed in the substantive area (Giske and Artinian, 2009). Core categories embrace the grounded theorist's goal *"to generate a theory that accounts for a pattern of behaviour which is relevant and problematic for those involved"* (Glaser, 1978:93). The core category elevates the theory to a dense and saturated level by integrating the theory's variables and should account for variations in behaviours. Emergence of the core category is essential to delimit the theory and develop it into its desired and parsimonious form. According to Glaser (1978), three key factors are pertinent in relation to the emerging core category:

1. Only one core category should be focused on and developed at a time.

2. The theory consists only of variables that are related to the core category

3. The core category explains how the subjects' main concern is resolved

Searching for the core category requires the analyst to be alert. Where a BSP is concerned, this involves looking for gerund verbs which describe the process that accounts for the behaviour and main theme (Glaser, 1978). When a core category emerges as a process, it is referred to as a BSP and their potential for general implications are evident in their labelling,

> *BSP's such as cultivating, defaulting, centering, highlighting or becoming give the feeling of process, change and movement over time* (Glaser, 1978: 97).

BSPs consist of two or more different stages that explain variations in emerging behaviour as an overall process. In addition to occurring over time, BSPs account for behaviour changing over time (Artinian, 2009; Glaser, 1978). The relative lengths of each phase that is part of the BSP, vary from process to process; moreover, within the same process they can vary from person to person. The phases in this study's BSP are explored in Chapter 5 and each phase is broken up into theoretical units that are discussed. This does not mean that there cannot be crossovers, however, separate discernible stages that have emerged allow the BSP to be presented clearly. Transferring from one phase is not always straightforward, since social problems vary and are complex (Glaser, 1978). However despite variations in experiences, the pervasive nature of BSPs means that they account for such variations by establishing the conditions and variables that contribute. As such they are a useful theoretical reflection of social life. Glaser's directives for BSPs are as follows,

> *…When the stages and their properties, conditions, consequences, and so forth are integrated into the "whole" process, when each stage's relationship to the process and to the other stages- how they affect it, shape it, and so forth- are*

integrated, then the process can be conceptually followed from stage to stage,
the change over time being theoretically accounted for, without the imagery of
the overall process being lost… (1978:99).

Thus it is important to present each phase in relation to the process as a whole as well as establishing the links between the phases to demonstrate the theory's integrative element. The shape of experience inherent in one phase influences the shape of experience in the following phase and inevitably how the process is experienced as a whole. This is demonstrated in the presentation of Handling Role Boundaries in Chapter 5.

In GT literature, the discovery of BSPs is presented as a desired goal in capturing the observed experiences of subjects (Wiener, 2010). They are revered for their transcending potential (Glaser, 1978) and for the practical transformations that they can help generate in the lives of subjects,

The practical implications of a BSP give a transcending picture that helps
practitioners access, evaluate and develop desirable goals in a substantive area…
(Glaser, 1996: xv).

As an evaluative study, this is pertinent and could help enhance attendees' decision making activities by generating a framework that scrutinises their current practices of resolving their main concern. This gives a base from which modifications can be implemented to improve and/or alter the situation.

4.5: <u>**Memos and conceptual maps**</u>

Category and eventual conceptual development relies on the consistent use and commitment to memoing (Bryant and Charmaz 2010; Artinian *et al.* 2009; Montgomery and Bailey, 2007; Glaser, 1978; Glaser and Strauss 1967). These authors advise that memoing enables the analyst to record their ideas about categories, establish their properties and investigate their relationship with one another. Moreover, memos can be used to establish links beyond the data that revolve around key themes in extant

literature (Glaser, 1978). The content and length of memos are not restricted by rigid rules and specifications (Lempert, 2010; Montgomery and Bailey, 2007) allowing freedom in terms of structure and treatment. The emphasis is on ensuring that capturing fragile ideas and thoughts is prioritised over any other aspects of the analysis process (Glaser, 1978). During my GT experience, I related to the fragility of ideas and constantly engaged in memoing to capture valuable reflections which contributed to the theory development. Lempert (2010) concurs that memos bridge the gap between data and theory.

In addition to memos, the expression of ideas and eventual theory can be aided by the use of conceptual maps (Artinian and West, 2009). These authors suggest that translating memos into a more cohesive developing theory is through conceptual mapping. In essence, conceptual maps are diagrams which indicate the relationships between variables. Section 4.6.2 of this chapter shows that using conceptual maps was a useful implement even before the final presentation of Handling Role Boundaries. Artinian and West (2009) confirm that conceptual maps are useful when attempting to organise ideas, particularly when one cannot detect a relationship between variables. Moreover Glaser (1996) identifies that illustrations can enhance presentations of concepts when space allows.

4.6: <u>My journey</u>

Qualitative data collection from participant observation began in February 2011 and my raw field notes were mainly recorded into a notebook. On rare occasions, field notes were recorded after the meeting because I was involved in reading letters and I found that my anxiety over getting this task right overwhelmed my ability to record concurrently. Field notes were typed up at the earliest availability and coded immediately. My translation of the open coding strategy involved me using the Microsoft Word 2007 program to highlight in yellow anything of interest. Green highlights were then allocated by summing up the general idea with a word or phrase. Blue highlights represented mini-memo thoughts that struck me while coding. Box 4.6. demonstrates an example of this format. Each new case is indicated by a hyphen while conversation corresponding to this case is indicated by what can be described as the "greater than" symbol (>).

3rd meeting; April 2011; Area 3

Present: R&R Team Leader/ SPA Chair; Consultant Psychiatrist M; Social Care team leader M; CPN Special Registered F); Personality Disorder F; Admin F; me

- SCTL M: comments that this is a "thin" meeting, not many present ==Opinion about meeting attendance==

*Clock is in the centre of the table ==Time; Awareness of time==

- One case, met with the response "Give him a chance" ==Giving a chance==

> Admin F: checks that it's for screening and not outpatients ==Checking== ==Admin support== ==Record keeping== ==Checking decision==

> CPN F: "Where does he live?" ==Question about where patient case lives==

- CPN F's letter is written by CP M so agrees to read it out > CPN F checks with him first ==Reader== ==Changing reader== ==Teamwork== ==Checking== ==Flexibility==

> CP M: addresses SCTL M , doesn't read letter > directly talking to him ==Reader approach== ==Addressing team member==

>CP M: suggests that part of the case's problem is not having enough money ==Speculation about patient case's problem==

> CP M: informs everyone that the case's medication has changed and that he is not responding brilliantly. ==Informing== ==Sharing information== ==Knowledge of patient Providing own experience==

> SCTL asks if CP has spoken to Step 4 (Psychology) ==Enquiring== ==Establishing== ==Liaising== ==Interacting with other MH teams==

> CP says that the case has no history of mental health problems so this is where the embarrassment is. ==History of patient case== ==No mental health problems previously==

> SCTL– "If you feel psychology is the best way forward" "not sure" (name of service) ==Recognising people's opinion==

> CP – "Almost 65" (age) ==Sharing knowledge; Age==

> CP > "Signpost to psychology" ==Signposting== ==Decision reached after discussion==

- Chair: says "go on" indicating that the next person should read out ==Role of==

Chair **Indicating/ directing**

> Quite a lot of laughing **Laughing**

> Case has no RIO history – "strange" **No RIO history- strange**

> Last discharged in 2003- reader suggests this might be why (case has no RIO history) "out of area"- maybe **Reader- offering reasons** **Speculating**

> Letter "grateful" **Feelings of referrer**

> IAPT? **Suggestion offered as Question**

>CPN- interfering in his life too much for IAPT **Disagreement** **Justification**

> Chair- Medical? **Suggestion offered as Question**

> CPN –Maybe **Considering**

> CPN- Turns to CP **Non verbal seeking of opinion**

> CP pauses and suggests screening might be better initially, then he will be happy to see him after. He says that people don't always respond well to medical. **Pausing** **Suggestion** **Justification**

> CP earlier suggested that cancer could be a problem too. **Speculation into cause of problem**

- Letter is addressed to a CP F (not present at the meeting) **Letter content- Adressing specific member**

> CPN> "That actually does need to go to Dr *****" **Agreement with referrer** **Appropriate**

- Letter suggests that post-traumatic stress disorder/ personality could be a problem **Letter content- speculating MH problem diagnosis**

> Only had one overdose, but has had crisis intervention ? (CPN) **Stating history and interaction with MH team**

>CPN: Screening?

>SCTL: Should have been screened by crisis, worried **Indicating/ pointing out/ stating what should have been done** **Worried**

- Another case

 >SCTL Step 4? *Informal terms- demonstrating familiarity/ comfort with team Team will know what he is referring to*

> CPN- Think it will have to, because it can't go to IAPT if (he/she) has already

had psychotherapy **Agreement**   **Stating that it is the best decision overall** **Justification**   **Stating MH team remit**

- **CPN reads next; CP leans over to read to himself** **Reading- approaches Members other than reader reading** **Non-verbal**

> **CPN reads sections in case notes e.g. outpatients letter (reads to herself first)** **Presenting letter content to the team**

> SCTL- **any physical conditions**? **Want to know about physical health**

>CPN –No **Responding**

> SCTL- Reads pink social care sheet relating to the case **Reading- choosing something to read**   **Admin support- during meeting (has been organised)**

> SCTL is curious as to why there is nothing on past physical- checks to confirm date of birth. **Curiosity**   **Checking**

> Admin- R&R, doesn't have to go on waiting list with Admin; Chair will take it (he is R&R team leader) **Admin support** **Checking procedures** **Informal**

> Admin checks if he wants notes as well; Chair/R&R leader says it will be "useful" **Checking**   **Admin support**   **Case notes- useful**

- Another case

> CP says that if you had ADHD it would be difficult to do online gambling (this is what the case does) because online gambling requires concentration. **Speculation**   **Sharing knowledge**

> Anger Management- this team don't do it; IAPT might cater **Base team- capabilities MH team remit**   **Sharing knowledge**

> PD F- Two young children involved **Highlighting-concerns and factors**

> CP What are we doing? **Question – pushing for team decision**

> SCTL "Rittalin ?" In the history makes it medicalised; difficult case **Establishing medication**   **Medicalised**

> SCTL is surprised that the GP sent in to Learning Disabilities **Surprised at GP approach Opinion given**

> CP suggests that this was because the case has dyslexia **Suggestion Speculation**

> Chair -IAPT him just to see? **Suggestion**

> CPN – <mark>Good luck</mark> **Opinion** **Sarcasm**

> Chair <mark>Nothing we can offer him, but IAPT may be able to keep him as much out of the mental health system as possible.</mark> **Justification for decision Stating base team remit Suggesting capabilities of IAPT**

Box 4.6: Coded transcript example

4.6.1: Observations

All my coded observational transcripts were conducted in the same manner as displayed in Box 4.6 and I found myself feeling quite overwhelmed with the variety and yield of open codes that were generated. Moreover, I was not quite sure what I was to do with them. This led to a significant memo being written to ascertain some sense of organisation and see if some of the codes could be reduced. This memo is shown in Box 4.6.1.

Memo July 2011

SOME IDEAS FOLLOWING INITIAL OPEN CODING (JULY 2011)
A very rough draft of possible categories that seem to be emerging.

Two modes so far:
-I am initiating the study in the Discovery mode (since there is no pre-existing theory I am using)
-I am possibly developing the theory (initially) in the Gerund mode by letting a Basic Social Process (BSP) emerge.
- A theoretical code has not emerged yet.

GERUND MODE... Describing the action of moving through a situation e.g. moving through the meeting to reach a decision
Main concern of subjects: <mark>To appropriately plan the next steps in the care pathway of all the people on the referral list, preferably during the current SPA meeting</mark>
Core category: BSP?: <mark>**REACHING A DECISION**</mark>: decision- making strategies and actions taken by attendees of Single Point of Access meetings, in order to reach a decision about what the most appropriate next steps should be in the care pathway for the referred patients on the list (preferably within the current meeting time)
– Various stages are followed that make up this Basic Social Process of "Reaching a Decision". The steps are not always in order.

> Administrative support and/or knowledge
~ pre meeting
~during meeting

~ post meeting

> Reading
~ Reader reads out letter and case notes–elicits information
 ~ Re-read quietly or aloud
~ Passing it to a person they feel it is appropriate for (before reading)
~ Choosing a section to read out (either after the main letter, or instead of)
~ Highlighting
~ Summarising
~ Searching (for something in case notes or letter)
~ Discovering

> Chair person input and support
~ Inviting feedback
~ Time checking/ reminding/ Awareness of the clock
~ Adhering to meeting structure and agenda
~ Indicating (when next person should read)
~ Instructing
~ Advising

> Questions/ Enquiring from reader and/ or attendees
  ~ Clarifying points read in the letter
    ~ History/ age
~ Asking to see the letter themselves/ case notes
~ Other e.g. "What should we/ are we going to do?"

> Establishing/ Checking
~   what the letter (writer) is seeking/ Referrer request
~ Understanding of letter- legibility/ letter content
~ What the patient wants
~ Needs- what the team needs to do; What the patient needs ; What others need to be doing (e.g. the GP should have…)
~ History- either through letter and/or verbally by team member
 ~ if diagnosis is present
  ~ capacity of self as mental health professional
~ criteria/ remit of proposed mental health team/ professional
~ risk
~ if this is the first presentation

> Reading between the lines and/or Speculation
~ Assumptions/ guessing- beyond what the letter says or in the absence of information

> Seeking opinions/ suggestions and knowledge of team members
~ From different team members
~ Confirm or disagree with
~ "What do you think?"

> Team members Giving opinions/ suggestions/ statements and sharing knowledge
~ Personal – professional's past interaction with person or if person is looking to come their way
~ Uncertainty/ reservations stated
~ Statements with confidence E.G. It is ****** team
~ Humour/ Banter

Box 4.6.1: Early memo to organise ideas

The memo in Box 4.6.1 was useful in grouping some of the open codes into discernible themes that could then be viewed as possible categories. However, my anxiety is evident in the fact that I have attempted to work out what the main concern and BSP was at this early stage. This could have risked forcing the data, but my use of question marks shows that I was not committing to this line of thinking. Glaser (1978) acknowledges that one has to be alert to look for core categories and may have to take a chance when it comes to pursuing one; however caution should be applied. Relevant ideas earn their way into the theory. My understanding, appreciation and abilities at using GT were developed through the practical implementation of the procedures involved. Much of my wisdom about the GT experience came from actually doing it and could have not been learnt beforehand. This is something that resonates with fellow Glaserian grounded theorists (Giske and Artinian 2009; Giske and Artinian, 2007). Thus, the content of memos subsequently began to treat and reflect on the data for what it was, rather than a pressure pot for establishing a theory of some sort. Lembert (2010) confirms that early memos do not need to follow a coherent form, but they must make sense to the analyst. This led me to suspend the notion of "reaching a decision" as the BSP, though the elements of the main concern prevailed as shown in section 4.6.2.

4.6.2: <u>Categorising</u>

The practice of encompassing codes under smaller categories is something that I continued to do to ensure that the data was manageable. Moreover it was good training to learn what it meant to be parsimonious which is what I hoped my final theory would be. I began to search for further commonalities between the codes and establish where they could be separated. Box 4.6.2a explores the generation of an early category called "Establishing what is known" and how this arose from some of the open codes featured in Box 4.6.1.

Memo October 2011

Reading- letters, re-reading, reading aloud, choosing certain sections, summarising, reiterating -why? To establish points and understand whay is going on, Assessing information available, analysing letter content

Chair person- role of the chair inviting feedback, leading questions, advising e.g. which sections to read, asking for opinions

ESTABLISHING WHAT IS KNOWN

Questions/ enquiring- Usually from listeners and attendees e.g. what does the referrer want, asking to see the letter themselves, specific information wanted such as history, age of client , what it is the client wants, is there a diagnosis- finding out what they can.

Speculation- Not everything can be known from letters and case notes- sometimes one needs to read between the lines, dealing with the absense of information, personal experience can be brought in.

Box 4.6.2a: Categorising example- Establishing what is known

This category seemed to be an important stage in an unknown process that was identifiable in the SPA meetings. It encompassed many procedures relating to dealing with information e.g. taking into account the role of chair, the different methods of reading and the rationale behind this. I conducted a more detailed memo to begin exploring further possible properties of this category and relate it back to some of my experiences from being in the field. This reiterated the whole premise of grounding one's theory in the data. Box 4.6.2b provides an extract of this memo.

Memo 4th October 2011

"Establishing what is known"

- This category has come to encompass several other codes which were previously separate.

Reading:

> Reader reading out letter and case notes- which was the most popular way of eliciting information.

> Even during times when subjects had an inkling that they knew the client, it was only through reading that this was confirmed.

> Reading was usually a mixture between doing it aloud and quietly. The letter was usually read loudly with the reader then reading case notes to themselves before choosing what to read aloud.

> Sometimes, because letters and case notes are distributed early on during SPA meetings, subjects read quietly through theirs before it is their turn to read>> This could be to get an early establishment of significant points>>> could also link in with time factors of SPA meeting and assuming responsibility for the clients you are reading out.

> *Reflection: I myself did this at one location when I had to read out. For me, it was part of an anxiety to get things right such as pronunciation.*

> In some locations letters were intentionally distributed in a certain way as opposed to the random manner in other place.

> One reader in Area 3 found that the writer of the letter was someone present at the meeting. She then asked if he wanted to read it out, which he did. This could be because she judged this method to be the best way of establishing what was known about the client.

> In Area 2, the Chair tends to distribute letters based on who the letter is addressed to –**role of chair**

> Sometimes the reader either chose, were told to or were advised what sections should be read out- **role of chair.** This sometimes resulted in a section of the main letter being read out or another letter in case notes being read out.

> Summarising was a big part of reading- sometimes this was done by the reader, and in other SPA meetings, the chair did it- **role of chair/ chair responsibility.**

> Summarising was crucial when it came to lengthy case notes.

> Searching for specific information was another aspect of reading, closely linked with discovering.

> In some SPA meetings, someone would make a statement and it would be corrected by the reader based on something in the letters/notes.

> Sometimes there was a need to clarify what had been read such as "*Did you say he was…?"*

> Similarly questions from subjects prompted the reader to find out something that they had not read.

> Reading prompted other actions e.g. leaving the room to make a telephone call and find out further information.

Box 4.6.2b: Memo exploring the properties of "Establishing what is known"

I began to do this for other categories that appeared to be emerging and used conceptual mapping to explore a possible linear pattern. This was tentatively called "provisional diagnosing" and a brief description and the conceptual map has been inserted into Box 4.6.2c.

"PROVISIONAL DIAGNOSING"

- Possibly a BSP that describes behaviours shown by attendees/subjects of SPA meetings.

Possible main concern: Reaching a decision that can be recorded within the meeting time about what next steps should be in the care pathway of individuals on the referral list.

* Diagnosis meaning in this context: Not relating to identifying a specific mental health problem. It is about attendees naming what they feel is the right pathway for clients, which can then be recorded. E.g. "Let's Talk Wellbeing" or "Get more notes" is the "diagnosis" in the context of decision making.

Conceptual map of PROVISIONAL DIAGNOSING:

> 1) *Establishing what is known*
>
> **> Reading**
>
> **> Listening**
>
> **> Sharing accounts**
>
> **> Asking questions/ enquiring**
>
> **> Identifying**
>
> **> Making judgements**
>
> **> Writing things down**
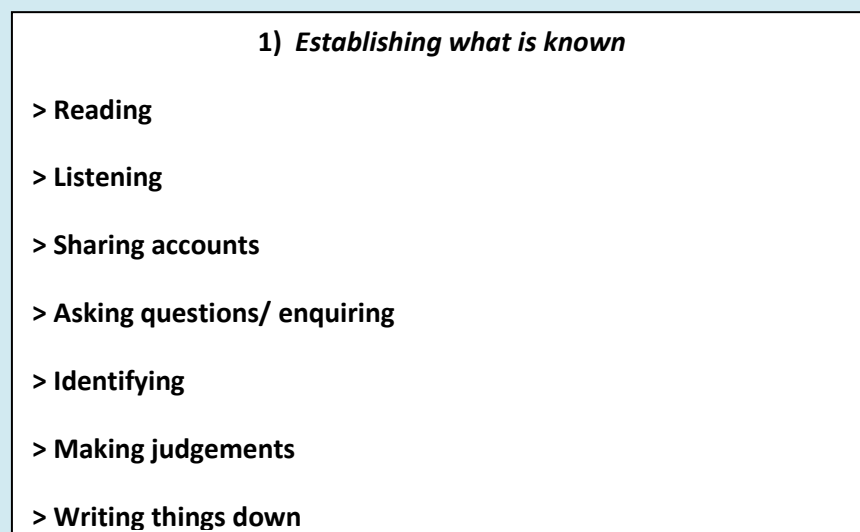
2) *Assessment practices*

>Analysis

>Evaluation   ASSESSING WHAT HAS BEEN PRESENTED

> Speculation

> Self assessment   ATTENDEE ASSESSMENT

> Seeking assessment

> Meeting agenda assessment – AGENDA ASSESSMENT

3) *Naming the "diagnosis"*

- Subjects' main concern (reaching a decision that can be recorded within the meeting time about what the next steps should be in the care pathway of individuals on the referral list) is resolved during this stage.

- It systematically follows the stages 1 and 2, because it is a result of the assessment of available information that has been presented.

Acceptance of "diagnosis" (e.g. the suggestion of sending client to IAPT) happens when the decision is officially recorded either on paper notes or a laptop computer. Acceptance does not always indicate agreement, but in most cases, acceptance allows a decision to be made regarding the care pathway of referral cases. This resolves the main concern at least.

If acceptance does not happen when a "diagnosis" is named, then subjects will go through previous stages again until they can name a "diagnosis" that is accepted by recording it.

Box 4.6.2c: Provisional Diagnosis memo

After discussion with my supervisors, it became apparent that the term "diagnosing" as I was employing it, would be problematic. Diagnosing as an everyday term has a predominantly medical meaning. Marry that with the fact that the substantive field has a medical context, the potential for misunderstanding was great. It was likely that my interpretation of "diagnosing" would not be successful in accurately representing the process I suspected of occurring. I tentatively renamed the BSP "Systematic Selecting" to give it a "grabbing" element (Glaser, 1978) and the stage of "naming the diagnosis" was taken out. During this time, I was due to complete the fourth round of observations for each SPA meeting site. I decided to focus on individual categories rather than get tied down to producing a theory since putting myself under pressure was likely to generate forced concepts. Glaser (1978) warns that it is vital that one paces oneself carefully and sensibly to progress through theory development. Thus my task was designated to focusing on and developing the two remaining categories that had emerged from the data- "Establishing" and "Assessment practices". Observations were not producing any new codes that could be assigned to the two categories so my agenda transferred to interviews. Since no clear process had emerged, the feeling was that interviews should be conducted with members who had a good overall understanding and knowledge of SPA meetings. Thus attendees with experience of chairing SPA meetings were chosen. A semi-structured interview guide was devised as advised by research writers in the field (Bryman, 2004; Esterberg, 2002). The decision to move onto interviews represents the deductive element of GT and the principles of theoretical sampling (Glaser, 1978). I could no longer ascertain new insights from observational data and thus decided that interviews would be an ideal data source. My deductive agenda was to find out more about two categories I had and also to learn more about the SPA process from subjects. With this in mind, as well as the evaluative aims of the overall study the interview guide was constructed as shown in Box 4.6.2d.

Questions that are asked during interviews have evolved out of observational findings. I have produced an interview guide that can be referred to, but questioning will be predominantly guided by interviewee responses.

Questions written in RED are linked to ideas from the memo of the category "*Establishing what is known*" and these are intended to explore the properties of this category.

Questions written in BLUE are linked to ideas from the memo of the category "*Assessment practices*" and these are intended to explore the properties of this category.

* Some questions link to both categories #R #B

Questions written in BLACK are linked to the overall evaluation intentions of the project and don't specifically link to categories.

Interview guide/ aide memoir

- What do you see as the purpose of Single Point of Access meetings? *Is it about ascribing a (tentative diagnosis) (~attribute behaviour to a cause) or directing client to a service?*

Definition as provided by the Trust's website:

> Each locality has a Single Point of Access for all referrals into Secondary Mental Health Services requiring Health & Social Care assessment and interventions (non crisis).
> Referrals are screened against specific criteria and then offered an appointment for clinical assessment and treatment within the multi-disciplinary team.
> Service users will receive interventions if they are experiencing moderate to severe mental health problems including anxiety disorders, depressive illness and disorders of personality

- What is your opinion about the above description?
- What are your thoughts and feelings about the meeting in terms of its organisation and structure? *No. of cases discussed >>To see if time is a factor.*
- How do you feel about the distribution of letters?
- What do you feel is important when reading a referral letter? When you read a letter, what is your intention?
- What do you think makes a good referral letter? *Details/ content;* What do you expect to find in a referral letter? #B
- How do you feel about the referrers and the quality of letters? Any issues?
- What do you do when you are not reading a letter? What are your aims?
- How do you decide what else to read apart from the main referral letter?
- How would you describe the role and responsibilities of Chairperson during SPA meetings? > *In terms of interactions with other attendees; readers/ what has been read* #B
- How would you describe your relationship/ interactions with the rest of the team?

#B #R

- What do you think it is important to base decisions on? What factors do you think is important? …> *subjective, clinical judgement, letter, speculation, remit#*

- What do you think the threshold (entry) /**criteria** are for specialized services to deem client as appropriate for management? Same for recurring or first presentation? And is this judged by letter content alone? *Terms, expressions in letter?* What is criteria based on?

- How do you feel the team arrive at a decision?

- What do you see as your role in the decision making process? *Linked to being Chair or role (consultant)?*

- Can you think of any problems and issues that arise in regards to remits of services? And services taking on cases? *>>>E.g. IAPTs ; Risk management*

- How do you feel things pan out if consensus isn't reached?

- Are there ever situations where the appropriate treatment would be out-of-area? What happens in the meeting?

- What do you think about the attendees who come to SPA meetings? Representation *Anyone who you feel should be there who doesn't come ?…* Speaking – are some more vocal? Would you like certain members to be more vocal? *Do you think role has anything to do with this?*

- Generally, do you think the right referrals come through to SPA meeting? *>>perhaps explore in terms of resources + options available to team.*

- What do you like about SPA meetings? Why?

- What do you dislike about SPA meetings? Why?

- What makes a good SPA meeting? Why?

- Do you feel SPA meetings can be improved? How?

Box 4.6.2d: Initial interview guide

4.6.3: Interviews

Interviews took place over a three month period with eight different mental health professionals. The details of the interviewees are shown in Table 4.6.3a.

Area	Gender	Role	Code for anonymity
1	Male	Consultant psychiatrist	CP M: A1
2	Female	Service team leader	STL F: A2
3	Male	Team leader	TL M: A3
4	Female	Nurse	Nurse F: A4
5	Female	Consultant psychiatrist	CP F: A5
6	Male	Consultant psychiatrist	CP M: A6
7	Male	Team leader	TL M: A7
1	Male	Team leader	TL M: A8

Table 4.6.3a: Details of interviewees

As shown in Box 4.6.2d, initially the interview agenda was to explore the categories of "Establishing what is known" and "Assessment practices" and further questions were structured as such. As with observational notes, interview data were transcribed and open coded at the earliest opportunity, with the same coding system applied. Semi-structured interviewing complemented the theoretical sampling aspect of GT: by listening to the reflections of interview subjects, I was able to alter and modify my questioning to investigate their disclosures and possible new categories further. Moreover, theoretical sampling meant that by listening to the pattern of answers, I was prompted to alter the interview guide in terms of the order and manner of questions. The questions generated accounts that fell into five broad categories: presenting, making sense, personable, assessing and laying out the plans. Box 4.6.3b provides the revised version of the interview guide.

Interview guide/ aide memoir

GENERAL

- What do you see as the purpose of Single Point of Access meetings? *Is it about ascribing a (tentative diagnosis) (~attribute behaviour to a cause) or directing client to a service?*

Definition as provided by the Trust's website:

> Each locality has a Single Point of Access for all referrals into Secondary Mental Health Services requiring Health & Social Care assessment and interventions (non crisis).

> Referrals are screened against specific criteria and then offered an appointment for clinical assessment and treatment within the multi-disciplinary team.

> Service users will receive interventions if they are experiencing moderate to severe mental health problems including anxiety disorders, depressive illness and disorders of personality

- What is your opinion about the above description?
- What are your thoughts and feelings about the meeting in terms of its organisation and structure? *No. of cases discussed >>To see if time is a factor.*

PRESENTING

- How do you feel about the distribution of letters? Manner in which it is done?
- What do you feel is important when reading a referral letter? When you read a letter, what is your intention?
- How do you decide what else to read apart from the main referral letter? Navigating
- What qualities do you think listeners should bring?

MAKING SENSE

- What do you think makes a good referral letter? *Details/ content;* What do you expect to find in a referral letter?
- How do you feel about the referrers and the quality of letters? Any issues?
- What effect does little information have on discussions? Is decision-making still possible? What do you do within SPA meeting?

- How do you know when to class a case as a bring back or a case that can still be decided upon in the absence of adequate information?
- How do you feel you make sense of letters and cases- particularly with complex cases?

PERSONABLE

- How would you describe the role and responsibilities of Chairperson during SPA meetings > *In terms of interactions with other attendees; readers/ what has been read*
- How do you feel about your relationship/ interactions with the rest of the team during SPA meetings?

ASSESSING

- How would you describe the nature of discussion during SPA meetings?
- What do you think it is important to base decisions on? What factors do you think is important? …> *subjective, clinical judgement, letter, speculation, remit#*
- Do you think that who is present has an effect on discussion? What qualities of SPA meetings ensure the best discussions?
- What do you think the threshold (entry) /**criteria** are for specialized services to deem client as appropriate for management? Same for recurring or first presentation? And is this judged by letter content alone? *Terms, expressions in letter?* Are there criteria? What are criteria based on?
- How do you feel the team arrive at a decision? Is there a process present?
- What do you see as your role in the decision making process? *Linked to being Chair or role (consultant)?*
- Can you think of any problems and issues that arise in regards to remits of services? And services taking on cases? >>>*E.g. IAPTs ; Risk management*
- If, for example, there is a case that seems well matched to the IAPTs service, bar a history of self harm, and then IAPT can't take it, what are your thoughts and feelings about this? What happens to the case/ where is it sent to? How do you

come to that decision?

- Are there occasions where consensus is not reached? Or lengthy discussions take place before consensus isn't reached?

- What do you feel the reasons are for times when consensus is not easily reached/ lengthy discussions etc.

- How do you feel things pan out if consensus isn't reached?

- Are there ever situations where the appropriate treatment would be out-of-area? What happens in the meeting?

LAYING OUT THE PLANS

- What do you think it is important to do once consensus is reached and a decision is made? *Recording, repeating, re-iterating decision, summarising, justifying; allocation of tasks*

- Are you happy with the administrative support of SPA meetings?

GENERAL

- What do you think about the attendees who come to SPA meetings? Representation *Anyone who you feel should be there who doesn't come ?…* Speaking – are some more vocal? Would you like certain members to be more vocal? *Do you think role has anything to do with this?*

- Generally, do you think the right referrals come through to SPA meeting? Is it manageable? *>>perhaps explore in terms of resources + options available to team.*

- What do you like about SPA meetings? Why?

- What do you dislike about SPA meetings? Why?

- What makes a good SPA meeting? Why?

- Do you feel SPA meetings can be improved? How?

Box 4.6.3b: Revised interview guide as part of theoretical sampling

The procedure of memoing continued to be conducted to ensure that categories were investigated appropriately and adequately. After four interviews were completed, I sought advice from an expert Glaserian grounded theorist and she suggested that I complete mini-memos after each interview to gain a sense of the main concern and BSP for each individual interview. I could then assess these and identify any cross-overs, similarities and variations. Boxes 4.6.3c, d, e and f are the mini-memos completed with the main concern, BSP, related categories identified and conditions affecting the process. I completed these for all eight interviews.

Friday 16/12/11 CP M Area 1

Main concern: Responding appropriately to the request for help

Core category: Communicating professionalised locations/ (Contributing in a way that reflects one's own particular professionalised location within the organisation)

Related categories: Building a clinical case (placing bits of information around a person); Looking through the clinical lens; TRANSLATING -Understanding the client from a clinical perspective; Responding to cues and clues; Developing one's own conception; Scrutinising (nots); Contributing; Engaging; Compromising; Accommodating client; Discussion; Playing one's hand; Fitting clients and problems

Conditions: Reading style; Informal authority (of consultant psychiatrist) – affects meeting (subject tries to "duck it"; Services not accepting responsibility (so team have to accommodate case elsewhere); Attendees engaging and building their own clinical view; Who is asking for what? (is it patient, relatives, professional); Clarity of request (is referrer being clear in what they are asking for, or does team need to interpret); The context of the problem; Information provided; Attendees present; Who the referrer is; Urgency of the situation (can have an effect on whether to defer decisions); State of membership (so the people who have been there longer might contribute more, more free in their contributions)

Box 4.6.3c: Mini memo from interview 1

Wednesday 11/01/12 CP F Area 5

Main concern: Working out where the primary responsibility for the client lies

Core category: Recognising one's role remit/ Recognising the remits of one's role/ Recognising role remits (i.e. others as well as one's own) > Role- Chair, professional, person?

Related categories: "Zoning" in- on certain things mentioned in the letter- expectation that social workers pick up on social aspects e.g.; Expectations

Conditions: Time (one might volunteer in order for things to move on quickly; personalities of attendees and GPs (e.g. it might be decided that a consultant would be better to talk to certain GPs –Area 5); Resources available –access to services; Policies/ national guidelines- working within rigid or flexible guidelines; Reading style to encourage engagement; Chair/ leader - encourage engagement- the manner of meeting they encourage

Box 4.6.3d: Mini memo from interview 2

Friday 20/01/12 TL Area 3

Main concern: Putting clients in the right place/ placing clients correctly/ pointing clients in the right direction.

Core category: Recognising/ being aware of role remits/ boundaries- Recognising limits/ strengths/ weaknesses

Related categories: Getting the gist; Picking the bones out; Picking up (clients); Signposting; Risk assessment; Being in tune with your own strengths; Team working; Discussion Compromising; Giving credit; Not stepping on anyone's toes

Conditions: Time (needing to move decision on if it goes off on a tangent); Personalities/perspective of GPs (understanding why they have referred and why they need help in directing client); Attendee personality/ knowledge (knowledge of services out there); Attendance (some attendees could offer advice about where to signpost)

Box 4.6.3e: Mini memo from interview 3

Main concern: Working out what is right for the patient

Core category: Recognising individual remits/ Recognising remits

Related categories: Knowing colleagues (knowing your immediate colleagues + distant colleagues e.g. GPs- who they are, personality; knowing services- their rationale, habits.) Knowing oneself; Being at ease; Bowing down; Backing down; Compromising; Wearing one's cap; Communicating; Knowing personality traits; Picking up (certain elements); Merging (personality traits with professional role responsibility); Awareness of responsibilities; Sharing responsibility; Knowing which hat to wear (balancing between different roles); Staying in role; Trusting one another; Discuss and decide; Patient-centred; Awareness of weaknesses; Awareness of strengths; Tradition; Liaising; Guiding; Knowing where each other is coming from; Understanding assessment processes; Awareness of what works; Awareness of who should be there; Understanding the GP's perspective; Understanding other perspectives; Stepping up; Speculating; Adapting one's role (changing habits, stop doing things); Knowing the system; Seeing the wider picture; Playing it safe; Drawing one's own clinical formulation

Conditions: Individuals; Closeness of individual's present; Clarity and availability of information; GP; Resources; Developments in service

Box 4.6.3f: Mini memo from interview 6

From these memos, it is clear that the notion of "roles" and their associated strength and limitations were emerging as a dominant category. Subjects talked about their own roles and responsibilities but also highlighted the importance of awareness of colleagues and what they can be relied on to do. Taking into account the assessment of the main concerns that were being captured, work was done to assemble these ideas into one clear and accurate overriding one. Eventually the settlement revolved around the idea of finding an ideal place for the client. I began to see how earlier significant categories such as "Establishing what is known" and the later "Presenting the client" were all linked to attendees' roles and what they felt they needed to do as part of that role. Moreover, from the interview data, I discovered the complexities attached to "roles"; subjects were not always attending SPA meetings with one role, but several. Additionally as well as discussing roles as a professionalised concept, the notion of personality became entwined with discussions about fellow colleagues and the idea of "knowing one's colleagues" became prominent. I felt I was getting much closer to capturing the BSP and

tried to find a term that summed up the handling of these different roles. This was tentatively named "balancing role remits" with the main concepts of "recognising role remits"; "zoning in"; "getting the gist" and "applying oneself".

4.6.4: <u>The challenges</u>

Trying to communicate my ideas of "balancing role remits" became very difficult. My initial confidence in the various phases I believed to be inherent suddenly became vague and difficult to distinguish. I became dismayed at this and decided to reassess the situation. I looked at the things that I was certain of: I was confident that the main concern could be verified because it was consistent and applicable to all the observational and interview data, however not enough emphasis was put on the fact that decisions had to be made within the meeting time and that to all intents and purposes, it had to be a group decision as had been disclosed by interviewees. Thus, I re-phrased the main concern to encompass all these elements and presented it as "working together within the meeting environment to find a place for the client". This satisfied all the elements contributing to the concern of attendees and was what motivated their actions within SPA meetings. I was clear that the notions of recognising roles was an important part of the process and that there was some element of balancing. I realised that I was so attached to the category of "zoning in" that I had elevated it to a much higher status than it should have been. It simply was not appropriate to make it a stand-alone category when there was something else prominent that I was restricted from seeing because of misguided attention. "Zoning in" was a term used by one of my subjects to describe how she felt compelled to focus on certain parts of letters as influenced by her professional role. As I began to let go of this "concept", I scrutinised my treatment of other concepts. I found that I could not find adequate ways of defending "getting the gist" as a standalone category. Moreover, the more I wrote about "applying oneself", the more I realised that I was actually describing what I understood to be the "balancing" process. I realised that rather than being the whole process, "balancing" was likely to be the last phase of a process yet to be named. I was disheartened and critical of myself when this came to light and anxious that much time had been wasted. Once again I consulted the expert Glaserian grounded theorist to "sound off" somewhat and gain some clarity. She advised me that fitting and re-fitting categories and concepts to the data is not an easy task, but eventually it does lead to one getting most of it right and that will be the reward.

After taking some time off from the data and developing theory, I came back to it and began drawing flow charts on scraps of paper. My two categories of "recognising" and "balancing" were placed at the beginning and end respectively and an empty space remained in the middle. I reflected on what the effects of "recognising" had been for the subjects by looking at the interview transcripts and referring to the observational notes I had made. I could see that the idea of making expectations on others and being aware of expectations of others was also important to subjects. I selected the term "positioning" to capture the notion of subjects setting expectations on others and also placing themselves to fulfil expectations e.g. the subject who "zoned in" to certain aspects of letters. Further memoing and conceptual mapping confirmed that positioning was a pertinent concept in the process. Thus the result was three high level categories that could be seen as concepts: "Recognising", "Positioning" and "Balancing". These phases clearly revolved around subjects' various roles and I identified three main ways of describing the process reflecting these ideas: Managing, Dealing and Handling. I repeated them out loud assessing the "grab" factor that they had i.e. which term invited the most attention? I opted for "Handling" and putting my work together, I tentatively wrote the theory up as "Handling Role Remits".

Therefore, the willingness to surrender revered terms and categories liberated me from the restrictions of moving forward and letting the true theory emerge. As difficult as letting go was, it was necessary so as not to compromise the overall GT and stunt my development. Another difficulty that I faced was the temptation to "tell the whole story", which is constantly warned against by Glaserian grounded theorists (Artinian 2009; Glaser, 2004; Glaser 1978). This was compromised by the relative ease in which storytelling could be done within the context of SPA meetings: each discussion revolving around a client case had a beginning, middle and end and thus this made the discovery of a process and one core category difficult. I found writing highlighted messages saying "don't tell the whole story" every time I coded was crucial to dissuade me from falling into this practice. I learned to appreciate the fact that my theory should not explain everything- it should focus on describing the process in conceptual terms that resolves the particular main concern that had emerged.

This commitment to finding a process that resolved one main concern was challenged during a presentation that I conducted for the fourth qualitative research on mental health conference (QRMH4 July 2012), in which I discussed my experiences of using Glaserian GT to study SPA meetings (please see Appendix 5 for the slides of this

presentation). As conference attendees all had an interest in mental health matters, some were mental health professionals themselves. After briefly presenting my developing theory a couple of members of conference attendees revealed their thoughts that the process seemed too harmonious given the nature of multidisciplinary team working. I think given more time, I would have been able to demonstrate that the concepts should not be taken at face value and can account for disagreements between SPA meeting attendees. Moreover, given the main concern that is being investigated, which revolves around a decision being made within the meeting time, the process is relevant. If the main concern was about achieving harmonious relationships or full agreement, then no doubt a different BSP is present which considers actions and conversations outside the meeting as well.

However, the criticism did encourage me to think about the clarity of my theory and how it came across. Laying out the theory once more in diagram form, I assessed whether or not "Balancing" consecutively followed on from "Positioning". The comments about the theory coming across as too harmonious alerted me to the possibility that it might not be received well by subjects in the substantive area. I knew that I had followed the GT procedures correctly to develop three concepts. However, I became open to the possibility that an extra stage was present that took into account the complexities of discussions in the decision making process experienced by SPA meeting attendees. I engaged in memo-sorting, which can be a hands-on process of filing memos, integrating categories and inserting them if and where they fit into the process (Noerager Stern 2010; Glaser 2003; Glaser 1978). I returned to my former dominant category of "assessment practices" and realised that the essence of this was what was missing in the theoretical process because it captured a huge part of the discussion element of decision making. My preoccupation with the other concepts had meant that I had overlooked this. Box 4.6.4 contains a memo outlining my thought process concerning this issue and the eventual naming of this missing category. Through selective coding, "Weighing Up" earned its way to becoming a concept.

MEMO : A possible extra stage in the process?

Main concern :Working together within the meeting environment to find a place for the client

BSP: HANDLING ROLE REMITS
- Recognising
- Positioning (which includes getting the gist/ negotiating conception of the case and communicating this).
- WEIGHING UP? In relation to role remits. Assessing the contributions (derived from positioning stage)- Weighing up – involving discussions, questioning, challenging, , defending, justifying (?) Is it a way of verifying contributions e.g. assessing points of view, justifying, questioning. Understanding where these contributions come from e.g. from certain role remits

- Balancing- Perfect balance not necessarily achieved. Negotiating a balance, attempting to strike a balance, but how do they attempt to strike a balance? Trying to find the best solution in the realms of all those remits, because for this particular main concern, a decision must be made and recorded. Balancing role remits in relation to contribution and assessment of contributions. Trying to strike a balance of the various role remits present e.g. prioritising one role function over another; holding back (e.g. prioritising the team remits over personal beliefs); Bowing down; Volunteering.

TOO HARMONIOUS? – Questioned at QRMH4 conference-
- Perhaps this indicted that an extra stage was present that was not accounted for.
- The main concern of working together involves meeting activities only, because it revolves around a decision needing to be recorded. To resolve this particular main concern (working together to find a place for client), handling role remits is what they need to do.
- If the main concern was something else, e.g. Being heard, another BSP would be present that probably took into account subjects' behaviours outside the meeting/ incidents. E.g. taking into account informal discussions between staff members.

Box 4.6.4: Memo- an extra stage

Another challenge occurred quite early on in the analysis of observational data and it involved contending with the threat of forcing the data. My supervisors commented that it seemed quite unusual not to have the theme of power and rank emerging given the context of the SPA meetings in a multidisciplinary environment. I was adamant that this theme was not evident in an obvious way and felt worried about forcing the data to include this merely because it is expected in that context. According to Glaser (1996), when studying an area of interest, one may be faced with the temptation of pet categories. However when the data deviates from these expectations, new insights offered by the deviation should be embraced for its ability to enhance one's drive and excitement. In his earlier work, Glaser (1978) offers useful advice regarding this dilemma which I subsequently followed and reaped the benefits of. Offerings of potential categories can be viewed as whims or sources of wisdom: with the former, these may be attempts to indeed force the data to ensure the resultant theory encompasses a standard and expected concept; with the latter, such suggestions can be viewed as opportunities to allow the theory to grow. Without a doubt, my supervisors' intentions were to facilitate theory growth and thus the suggestion of power and rank could be viewed as wisdom. Glaser (1978) reassures that through the constant comparative method, such suggestions will either earn their way into the theory or can be left out. Advancing with this guidance, I noticed some subtle hints of power and rank evident in the data, particularly in terms of management of the meetings and some incidents in which decisions were deferred to consultant psychiatrists. Moreover, the Handling Role Remits BSP accommodated variations in power and rank levels i.e. SPA meeting occasions when it was very prominent and ones where it was less so.

4.6.5: <u>Handling Role Boundaries</u>

With the main concern and phases of the BSP verified, I became aware that the term "remits" may not be appropriate. Researching the term, I found that its connotations were largely attached to legal implications e.g. according to Oxford dictionaries (2012), as a noun in a British context, the term can be defined,

…the task or area of activity officially assigned to an individual or organization…

I could see the risk of "remit" giving an impression of "roles" being associated with the professional realm rather than being able to encompass personality traits as I had

intended (since the data indicated this). Moreover, Glaser (2006; 1996, 1978) points out grounded theories' enduring qualities and their ability to prevail and transcend beyond time, place and people. Since "remit" as a noun is used mainly in the British context, I could see the limitations of its resonance within other societies. Furthermore, I was constantly having to define what I meant by the term "remit" rather than generating instant understanding. This compromised its grabbing power. Searching for an alternative, I inspected my own definition of "remit" and realised that a term I had been employing to demonstrate its meaning was "boundaries". This was a less problematic term that effortlessly captured the process in relation to the notion of roles and so I adopted it into the theory. Thus the BSP was named "Handling Role Boundaries" and is demonstrated in Figure 4.6.5.
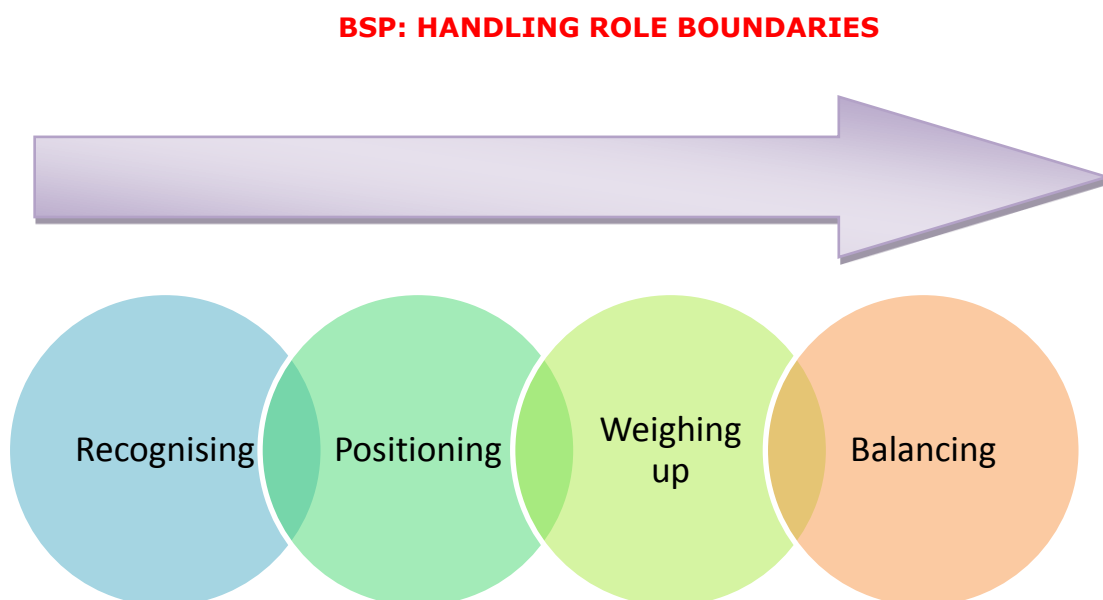
BSP: HANDLING ROLE BOUNDARIES

Main concern: Working together in the meeting environment to find a place for the client

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Figure 4.6.5: Handling Role Boundaries short diagram

The concepts which form the phases of Handling Role Boundaries are discussed fully in Chapter 5 with identification of the sub-categories. Sub-categories were identified through the use of memos and selective coding based on the verified BSP and main concern. These allowed the properties of the four main phases to be established. Such properties were best communicated as lower level categories to capture the variation of experience within the substantive area.

4.7: <u>Conclusion</u>

To conclude Chapter 4, I have sought to generate insight into initial choices that informed my utilisation of GT methodology and my understanding of the key principles theoretically and practically. I have included various extracts of my memos and transcripts with reflection and commentary to demonstrate my journey and the challenges inherent. I have showed how the BSP of Handling Role Boundaries evolved from initial open codes derived from observational data and I have adhered to the premise of grounding the theory in the data. My intentions for this chapter were to give insight into the hard work and commitment one has to employ when engaging in Glaserian GT methodology. This insight highlights some key aspects of my journey and implementation of the methodology. Furthermore, I ensured that the chapter ended with the core phases of Handling Role Boundaries to give Chapter 5 an ideal starting point.

5) Findings: Handling Role Boundaries

"The lotus is the most beautiful flower, whose petals open one by one. But it will only grow in the mud. In order to grow and gain wisdom, first you must have the mud."

~ Goldie Hawn, American actress; Received from the Venerable Thupten Ngodrup, Nechung Oracle of the Nechung Dorje Drayang Ling Monastery in Dharamsala, India

5.0: <u>Introduction</u>

The primary aim of this chapter is to present "Handling Role Boundaries" as a substantive GT of subjects attending SPA meetings across the Trust sites. The previous chapter documented theory development by presenting early results from open coding of observational data, theoretical sampling, open coding of interview data, verification of the main concern and Basic Social Process (BSP), and selective coding. The constant comparative method has been employed thoroughly and has led to the reduction of codes and promotion of concepts. This chapter focuses specifically on the main concern and BSP as well as the sophisticated integration of substantive categories through the theoretical code of strategizing. The integration of the variables to produce an inductive hypothesis is discussed with related empirical evidence. As discussed before, these are principal elements of the GT methodology (Holton, 2010; Glaser, 2004; Glaser, 1978; Glaser and Strauss 1967). The BSP and overall GT called "Handling Role Boundaries" is presented in Figure 5.1 and each phase of the process is discussed at length to describe their properties.

5.1: <u>Handling Role Boundaries</u>

Handling Role Boundaries describes the BSP that SPA meeting attendees perform in their endeavour to work together within the meeting and make decisions regarding clients. Each meeting focuses on a list of clients who need to be discussed in the multidisciplinary environment of mental health professionals. For each client, a recordable decision needs to be made and by the end of the meeting, all clients on the list will have had some level of discussion.

Handling Role Boundaries takes into account the range of roles present within SPA meetings. On first impressions, this might present itself in the form of different professional backgrounds for example the social worker, the consultant psychiatrist, the medical student. However, the BSP takes into account the multiple roles inherent in one person i.e. their allegiance to a CMHT (thus group identity), their personality traits as well as their professional identity. All these roles have associated boundaries that revolve around the most one will do and the limits e.g. strengths and capabilities, limitations, role "norms" and tendencies. Attendees of SPA meetings need to employ strategies for dealing with these different roles and their related boundaries so that they can make a decision for all clients that have been processed for discussion.

Here I present the four key variables of the Handling Role Boundaries process. These derived as a result of elevating and demoting the categories presented in Chapter 4 to higher and lower levels respectively and have emerged in both a linear manner (Figure 5.1) and a cyclic form (Figure 5.2a). The four main variables are the most pertinent concepts of the theory and have sub-categories as well. These phases will be discussed to show how they have emerged through the concept-indicator model (Holton, 2010) reiterating my commitment to ground the theory in the data. The concept-indicator model ensures that all concepts have empirical evidence to support them (Bryant and Charmaz, 2010) and also means that concepts have earned their way into the theory (Holton, 2010). This is because concepts are derived from emerging codes which themselves arise from many incidents that have been analysed through the constant comparative method as discussed in Chapter 4.

HANDLING ROLE BOUNDARIES
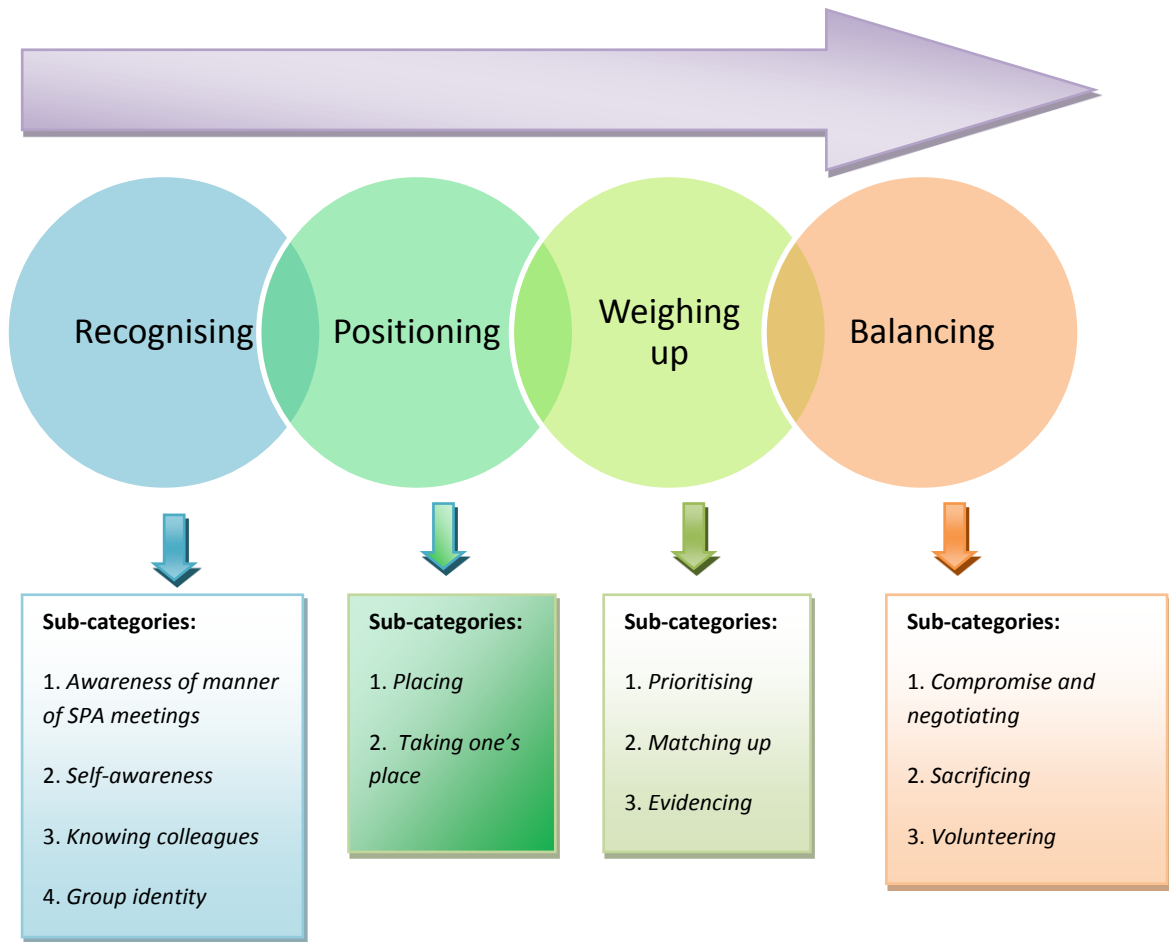
Main concern: Working together within the meeting environment to find a place for the client

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Figure 5.1: Handling Role Boundaries diagram

5.1.1: Handling Role Boundaries as the BSP

As Figure 5.1 shows, the main concern of subjects is their need to work together during the SPA meeting in order to find a place for each client. This main concern prompts the behaviours shown by subjects, which were recorded as "incidents" during participant observation and interview disclosures. The BSP of Handling Role Boundaries collects and accounts for these behaviours and incidents by fitting categories to them. Such categories are developed, promoted and demoted eventually leading to fewer high level

concepts integrated and expressed as a parsimonious theory. The diagram shows that each phase is closely integrated with the next and this demonstrates the swift movement SPA meeting attendees make between each. This is likely to be accounted for because SPA meetings are primarily based on verbal discussion which proved to be complex. The BSP needed to accommodate such complexities in a parsimonious way as well as taking into account the whole length and elements of discussion and thought relating to each client and the overall meeting structure and length.

Thus far, the four phases of Recognising, Positioning, Weighing Up and Balancing form the Handling Role Boundaries process in a consecutive pattern. Each phase leads to the next in a systematic, consecutive and necessary manner e.g. Positioning cannot happen if Recognising does not take place. As documented in the previous chapter, these consecutive stages are indicative of why the study's substantive GT was developed in the gerund mode with an emerging BSP - a pattern was discovered that explained behaviours occurring over a time period i.e. the duration of the meeting.

Beginning with Recognising, SPA meeting attendees establish awareness of their present colleagues, the SPA meeting atmosphere and also their own multiple roles. In addition, there is also awareness of newcomers to the meetings such as students. Likewise, newcomers will reciprocate this with recognition of the more stable members of the group. Attendees also recognise the role boundaries of those not present within meetings but who are pertinent to discussions e.g. GPs and other referring agents; teams that SPA liaise with. With recognition of roles comes recognition of boundaries. As mentioned above the role boundaries revolve around professional identity, personality and group/team identity. The Recognising phase consists of four sub-categories: *Awareness of the manner of SPA meetings; self-awareness; knowing colleagues and group identity.* This establishing of role boundaries gives subjects a sense of direction when it comes to letter reading, listening and discussion of case notes.

This leads to the next phase- Positioning. Attendees place themselves to behave in certain ways during the meeting based on their establishment of role boundaries from the recognising phase. Two sub-categories are present; *placing* and *taking one's place. Placing* involves attendees positioning themselves and others in terms of expectations e.g. what they expect themselves to do, what others might expect them to do and what they expect others to do. Thus an attendee who is a consultant psychiatrist might place

themselves to focus on the medical aspects of the client whilst expecting a social worker to pick up on anything to do with safeguarding. *Taking one's place* is the personal response to these expectations and how each attendee actually does position themselves during the SPA meetings relating to tasks and behaviour. For example, regarding letters and case notes, this might lead to attendees "zoning into" and focusing on elements that relate to their role boundaries (thus a consultant psychiatrist might zone in on medication details of letters and pick up anything pertinent). As part of *taking one's place,* attendees might negotiate their own conception of the case and communicate this. Conception is done against the background of their various roles and associated boundaries that they have during the meeting. This might be linked to personality traits as opposed to, or as well as, professional roles. Positioning is about making expectations on others and oneself. Just because someone is positioned to do something, that particular "something" is not necessarily fulfilled, because expectations of this kind are rarely verbalised during the meetings. For example, the social worker is not told he has to pick up on certain issues at the start of the meeting. However the mental process of having expectations (*placing*) and *taking one's place* to do certain tasks is one that all attendees go through. Moreover, it is always guided by awareness of roles and boundaries.

After Positioning, the SPA meeting attendees enter a phase which sees them Weigh Up the contributions and conceptions derived from positioning. Attendees assess contributions and consider these in relation to people's roles and boundaries. Weighing Up consists of three sub-categories: *prioritising* in which options are narrowed down and one or two are singled out as the "front-runners"; *matching up* where the teams/ members associated with each option are linked together; *evidencing* which involves justification of why one option might be better than the other. Effects of taking certain options and responses from discussion are weighed up and assessed. This is made possible by the clinical conceptions and contributions that came from the previous Positioning phase. With client cases which are less complex, attendees will find that their main concern is resolved after weighing up. However for more complex cases, a further phase is needed and this is where weighing up leaves attendees with the necessary components to enter the final phase of Balancing.

Balancing is not intent on achieving a perfect balance of role boundaries i.e. it is not about finding a way for everybody to have an equal contribution. With cases that require more discussion, Balancing involves subjects negotiating a balance that takes into

account the main roles and boundaries at play. One must not forget that the main concern that is being investigated here revolves around the meeting environment – an environment which requires a recordable decision to be made. The Balancing stage finalises the overall decision making business of the meeting and allows the subjects to resolve this particular main concern of working together to find a place for the client. Whilst trying to strike a balance of the various role boundaries present, subjects may go through one or more sub-categories: *compromise and negotiating* where attendees will use forms of discussion to help finalise the decision e.g. reassuring, adjusting and modifying questioning style, offering a safety net; *sacrificing* which involves attendees suspending or limiting one role in favour of prioritising another (either within their own multiple roles or someone else's role over your primary one) and may also involve holding back a particular view; *volunteering* where attendees step up and verbally offer to do a task. Balancing takes into account the realms of role boundaries which have been established and developed through previous phases.

5.1.2: <u>Theoretical coding.</u>

According to Kelle (2010) theoretical codes elevate the substantive codes to a higher conceptual level by describing their relationship in abstract ways. This promotes the conceptual power of the theory by transforming it into a theoretical model. Stern (2010) also highlights that theoretical codes involve employing an abstract approach to the variables rather than looking at them in a substantive way. Glaser (2005) advises that the more respected grounded theories are those where theoretical codes have emerged to relate the substantive codes as this increases the theory's plausibility and relevance. Artinian (2009) highlights Glaser's guidance of various theoretical codes that can explain how substantive codes interrelate. As with much of the GT methodology, theoretical codes need to emerge as opposed to being forced on the data variables. According to Glaser (1978), there are 18 different coding families. Transforming data into theory is achieved by identifying the conceptual code which captures the underlying pattern present in the substantive area. The role of theoretical codes is to *"conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory"* (Glaser 1978: 55).

One such family of theoretical codes is known as *The Strategy Family* which encompasses the notions of dealing with or managing a situation. Glaser (1978) cautions the grounded theorist to use the strategizing theoretical code in the right way and not to

claim it has emerged in situations where subjects are not consciously managing others. To put another way, he distinguishes between situations where behaviour is a *consequence* of another's behaviour and those where an act was done consciously. Through my iterative data collection and analysis, I was constantly faced with emerging terms such as *managing, tactics, placing, planning,* which suggests a conscious manner in the way actions are executed. Moreover, on reading Glaser's (1978) writings on theoretical coding, I found the term *strategies* captured the emerging process that I had previously been trying to express to no avail. Subjects were employing various strategies to try and deal with the different role boundaries that they were faced with, and have to consciously adopt strategies in the face of new or unexpected role boundaries, e.g. placing attendees in different ways (see section 5.1.4). The purpose of these strategies is to achieve a goal i.e. ensure a decision is made for each client within the meeting.

Thus because the BSP explains the strategies employed by subjects of SPA meetings, Handling Role Boundaries and its substantive variables (concepts) are integrated by the emerging theoretical code of "strategizing". The BSP and its composition of four main phases are best explained by presenting examples from the data as part of adhering to the concept-indicator model. Each phase of the Handling Role Boundaries BSP and their properties are now discussed.

5.1.3: Phase 1- Recognising

Recognising the different role boundaries is important for attendees in their endeavour to plan for each client during the meeting. It is the key to everything else and materialises in four different ways (Figure 5.1.3). *Self-awareness* and *knowing colleagues* are two sub-categories of Recognising. Attendees need to be aware of what parts of themselves and others will be dominant and more obscure during each particular meeting. The Recognition phase helps them to establish awareness of the positive and negative aspects of their roles and the associated strengths and limitations. This awareness can give them direction about how to shape the meeting's progress and what level of contributions they make and overall input in decisions. Recognising referrers' role boundaries also takes place despite their absence at the meetings because one gets a sense of them from the letters that they write and through past dealings with them. *Awareness of the conventions of SPA meeting* e.g. knowing how things work in the SPA meeting is also part of Recognising and contributes to the expectations formed as part of Positioning phase e.g. whether or not one will be expected to read out. Additionally,

there are times when attendees *identify with a group* rather than their self as an individual and thus have awareness of their role as part of a wider group and the group's boundary e.g. as part of a Community Mental Health Team (CMHT).

Figure 5.1.3: Recognising and its four sub-categories.

The sub-categories are discussed with extracts from the empirical field. Although for the sake of clarity, these sub-categories have been tackled separately, there is much opportunity for cross over, which is expected given the complexities inherent in human nature and interaction (Walton and Sullivan, 2004).

Awareness of the manner of SPA meeting

A persistent theme that emerged as part of the Recognising phase was an understanding of the way the SPA meetings work. Knowing the conventions of SPA meetings - which were often described as unspoken - was mentioned several times by subjects during interviews. All subjects were regular members of SPA meetings and had substantial knowledge of how the meetings worked. This facet of Recognising contributes to the later Positioning phase of the BSP, since it helps attendees to specify what they will be

expected to do in order to adhere to the conventions of the meetings. For example, recognising that everybody takes it in turns to read referral letters positions attendees to prepare themselves to read. Moreover, recognising the style that people read in can also help attendees to plan how they might read.

Awareness of the manner of SPA meetings involved the recognition of diversity of professional backgrounds which was appreciated,

> *Yeah, I think it's, it's a good make up of a good good spectrum of people there, good broad, broad span of skills and er you know it's it's good, it's good we have, you know medics, social workers, specialists, psychologist, CBT, IAPT, the Eating Disorders, i-it's, it's a really sort of good mix really.* (TL M: A3, p17)

This diversity and range of professionals and associated skills was celebrated and viewed as a positive element of SPA meetings. For much of the attendees, the spectrum of professionals was deemed as the whole point of SPA meetings. It was viewed as being advantageous to the quality of case discussions because of its ability to provide joint input. This had further implications relating to the notion of responsibility,

> *that's comforting in that respect, you're not making a decision about what might be a difficult er, referral on your own, you're actually making it on the basis of the consensus and the decision of the meeting.* (TL M: A3, p19)

This is crucial point in recognising that responsibility is not exclusive to one person; decisions are made against the backdrop of consensus. This may be influenced by foci of accountability and responsibility as driven by government agendas, clinical guidelines and the wider sociological attention given to risk (DH 2012; Arnoldi, 2009; Onyett, 1995).

Subjects were also able to identify and get a sense of the unspoken conventions of the SPA meeting that had become accepted as stable features,

> *"Certainly we do operate by consensus here so there's no question of voting counting votes…"* (CP M: A1, p11)

Having a clear grasp of the tendencies of how the SPA meeting operates may be a result of CP M: A1's stable membership which he spoke about in the interview. A newcomer may not possess this recognition and thus there may be different levels of recognition based on different members.

Consensus was also identified as an aspect of SPA meeting by Nurse F: A4. To begin with, the notion of "consensus" seemed to be tallied with the idea of clearly allocating clients to a service or intervention. However, with further questioning, this changed,

MN: Do you feel that consensus, is well is it always reached in these meetings?

> *Er, not always because sometimes people want to get the notes and then and then have another look at them.* (p16)

MN: Is that the only sort of thing that would happen where consensus isn't reached or is there other examples?

> *Erm, I think on the whole, you know it it it or other information gathering to bring back, you know there's specific questions which are unclear but erm, there's usually a consensus that that needs to be what happens you see what I mean, it's not somebody saying "Oh well I think they need, they should definitely go there" and somebody else saying "Well no I don't think so", it's you know, everyone will say well "we'll get the notes… bring it back and then we'll be on to make a decision" so I suppose in a way that's consensus in itself that.*(p16)

Thus even when a decision cannot be made about what interventions or service will be appropriate for the client, consensus is not necessarily eluded since there will be consensus about getting more information, for example.

Consensus was recognised as the feature of SPA meetings that maintained the democratic environment,

> *It's not as though anyone ultimately has the final say, we will discuss and decide what needs to be done and hopefully come to a consensus on that, so there's no sense of medically you kind of steamroll over and say "this is what will happen" yeah?... (CP M: A6, p14).*

General attitudes about the SPA meetings and the manner in which it is treated was also discussed by another subject,

> *I think on the whole people give it the respect and attendance it requires, er and are very good at sending representatives er, and if a team can't attend, they're very good at letting us know and happy for referrals to be kept or sent down to them (STL F: A2, p3).*

This too can be seen as an unspoken convention which has become a normalised feature of the meetings; the notion of good representation and assurance of courteous tendencies if one cannot make the meeting. Furthermore, STL F: A2's account also reveals the impact of knowing each other well - i.e. even in someone's absence, they are still able to refer to that person.

Likewise, the workability of SPA meetings was also mentioned by CP M: A6,

> *so as a system, of dealing with incoming referrals, quite effectively, I think it works. I think the size of it means it works, having experienced bigger meetings where there's lots of people having their say you tended to end up with far more, erm, uncertainty about what you were going to do. (p2).*

This reveals a respect for the process and CP M: A6's advocacy of the meeting is further enhanced by comparing it to his experience of other meetings and their drawbacks.

There were further incidences which demonstrated subjects' recognition what the SPA meetings' functions were and what the types of clientele they should be dealing with.

> *Single Point of Access meeting should be receiving and processing, to use a word, all referrals anyway* (CP M: A1, p19).

There are clear beliefs about what the function of the meeting is and what should be achieved. Moreover, there is also recognition as to the limits of the meeting in its inability to determine verification of decisions,

> *So we conduct this, you know what can be seen as a triage or a sorting process, but we never find out, or we rarely find out whether in fact we're getting, we're getting it right…and so, it could be that we're simply conducting a fairly passive sorting process, the consequences of which are picked up further downstream"* (CP M: A1, p20).

This was further hinted at through acknowledgement of what decisions are actually based on.

> *…because all we're doing is looking at bits of paper. We're not actually interacting with people…But clearly we're making decisions which have quite a…powerful effect upon which clinicians see which clients when* (CP M: A1, p20)

CP M:A1 recognises the limitations of SPA meetings and as a SPA team member, he is aware of his and indeed other team members' role boundaries (e.g. huge decision making responsibility but only looking at paper). This can help determine behaviour in the Positioning stage in the endeavour to attach functions and aims realistically e.g.

maybe to not refer externally if there are unclear aspects; to play it safe by offering the person a screening with the mental health unit in order to get a better picture. Alternatively, the proposal may be to wait to get more information, thus deferring.

Notions about the realities of SPA meetings were disclosed by other subjects also,

> *…ideally the Single Point of Access meeting is the first forum through which referrals to the CMHT are discussed…the process is to just find the best pathway for each individual referral"* (TL M: A3, p1)

Here TL M: A3 describes the ideal notion of what SPA meetings should be about and also provided indications about what the process should be achieving.

STL F: A2 describes the actual actions that take place,

> *…we just screen on the letter, we don't have any formal screening document or tool* (STL F: A2, p1)

This draws similarities with CP M: A1's awareness of the limitations of basing decisions on paper sources. Likewise, STL F: A2's highlights the most that the attendees do within SPA meetings and also reveals the limited resources.

Subjects continued to be forthcoming with their descriptions and accounts of the general manner of SPA meetings, which is also a form of recognition.

> *It's not one of those rigidly agenda'd and structured meetings … it's sometimes quite, you know free flowing and emotive and er erm, it wonders off onto tracks that sort of you won't you didn't envisage from looking at the original referral really, I mean a referral coming in and say well you start off looking for a an*

outpatients with a doctor and end up in PD network's er referral tray so I mean it's just like tending on … where the discussion takes it really yeah… (TL M: A3, p9)

The unpredictable nature of SPA meetings is captured here which, paved the way for further interesting insights into what goes on to contribute to decision outcomes within this environment. The significance and value of the discussion element is also emphasised because it is this that enables the shape of decisions to evolve. Although I am reluctant to divulge into the elements of the Positioning phase too early on in this section, it is difficult to refrain from emphasising the links between Recognising and Positioning. In the case of the quote above from TLM: A3, it is implied that knowing how the SPA meeting works, including the uncertainties inherent and the unexpected turns it takes would position the attendees to be vigilant. This is likely to involve them being focused in order not to become complacent and go along with initial requests. Being familiar with the path that discussions can take positions attendees to be cautious to the fact that initial requests in letters may not in fact be appropriate at all.

Moreover, TL M: A3 demonstrated his knowledge of the general nature and journey of discussions,

*…usually ok, usually very professional and sort of er…and business like, erm sometimes they get a little bit emotive, I think that's based on er on the history of the the person who's been referred into services and er, not emotive as in sort of people are weeping and gnashing their teeth but actually sort of er you know, "Oh dear this is this is this could be a problematic person, this case has been known to have difficult- you know create difficulties in the past" and that sort of, that sort of level of emotion really but I think usually quite professional … (*TL M: A3, 11)

He concedes that on the whole, the SPA meetings generate a professional environment which accommodates sensitivity and space for emotions.

Awareness about the limitations of the SPA meeting attendees as a team was captured with quotes such as the following,

> *… we can't catch everything, we can't do everything for everybody so, you know. But if there's elements of risk and it's rated a mental health problem, then we'd pick it up* (TL M: A3, p14)

TL M: A3 is based at a Community Mental Health Team (CMHT) and his disclosure here, as well as outlining limitations, also demonstrates clarity in knowing what the team should be taking on. His account developed further to document how he viewed the environment of SPA meetings,

> *you're going to get people who aren't comfortable in actually sort of vocalising things in in in a meeting, er in an open forum like that really, cause that's what it is, it's not like I say, it's not a structured hierarchical meeting, it's it's a forum where people can discuss things, discuss a referral so, some people aren't comfortable in that, but they do offer opinion and thoughts and er, input in the meeting* (TL M: A3, p17).

This is similar to CP M: A1's desire to generate a democratic atmosphere where all attendees feel able to contribute. However, as is indicated here, not everyone does feel comfortable in doing that or at least in being vocal. TL M: A3's recognition of this is important, because he is aware of who is more likely to be speaking and have vocal input. This then determines his behaviour and attitudes within the meeting.

Subjects reflected on the fact that people complimented each other to provide an environment that was not extensively dominated by one profession,

> *I feel quite on a par with others, …I like it, because it's not so medically driven, erm and that we work on that…* (CP F: A5).

There was also recognition of the evolutionary elements of SPA meetings coupled with personality and how the dynamics had changed over time,

> *…other members of the group, have become progressively more comfortable with being assertive, erm, and playing their own hands."* (CP M: A1, p12).

This is interesting because it combines one aspect of Recognising with another, i.e. the materialisation of personality traits; assertiveness has become more comfortably employed as the SPA meeting has grown and developed over time. This then allows certain attendees to be recognised as assertive and confident.

Recognising the evolution of SPA meetings was also discussed by another subject, which led to an awareness of how it currently works with respect to improvements,

> *It constantly comes up as, for like, can we do this better (laughs). It's always one of those meetings where you'll kind of sit and you'll think Oh, are we really are we doing what we think we're supposed to be doing, are we doing it in the right way, can we do it any differently… you know, why don't people like coming and … we changed ours a bit because our previous one was too long, so there's issues about making sure that it's er it's doing what it's says on the box if you like so we have a clear structure in terms of what we do first and then and then and then, so that everybody knows at the beginning of the meeting is feedback, bringbacks, then we discuss the referrals, then we do crisis referrals and then we give space if anybody wants to talk about anything that's difficult, there's a bit of space… and ours has been shortened because previously what people said was that it's too long, erm, people who weren't actively involved in the talking and the thinking and the doing…* (CP F: A5, pp5-6).

CP F: A5's account shows the extensive work and modifications that have been employed, fuelled by the endeavour to get it right. Talking through the evolution, the subject shows that she recognises its current incarnation and the reasons behind that way of doing things, e.g. having a space for airing concerns.

Moreover, Nurse, F: A4 also discussed the evolution of the SPA meeting she is part of and spoke with pride,

> I've never been to any others apart from the ones that we run but I think it's quite a good system, it's pretty clear, erm and we've, we've kind of built that system up over the years since we started and erm, I think it works pretty well. (p4).

Likewise, the SPA attended by CP M: A6 had also undergone changes to bring it to its current form,

> I think we picked up on the fact that the bigger the meeting, the less efficient it was and as well as it being less efficient it took a lot of the other members of the team away from what they could be doing for an hour, if they're all sitting around for an hour with limited amount of input it does seem quite a waste, and as long as you've got the the leaders for that particular professional group there to represent them, they're probably not necessary… it led to decisions being made snappier…

The subject provides justification for the changes and relates this directly to the decision-making aspect of the meetings. By highlighting its evolution, he recognises the importance of the meetings to generate rapid decisions, which suggests that this feature has become an aim of current SPA meetings.

Furthermore CP M: A6 spoke about how SPA priorities had changed. When I asked if the purpose of SPA meetings was to keep clients out of secondary mental health services, he responded,

> *I wouldn't say it's the purpose, but it's become a necessity yeah, of our Single Point of Access, yeah. Because we just don't have the the space and resources to do what we once did…*(p8).

Thus resource availability has also contributed to how SPA meetings have evolved and it has had to respond by refocusing its priorities and the approach it takes to clients.

Self-awareness

As data collection proceeded, it became apparent that the Recognition phase encompassed a strong sense of self-awareness for subjects. This covered acknowledgement of professional identity and also extended to personality traits, thus indicating that personality was another role that they brought into the SPA meetings. This was supported by CP M: A1, who asserted that "*… you can never get away from personality*" (p5). Being aware of one's personality was disclosed liberally during interviews,

> *…I'm incredibly obsessional … I generally keep to time and there's something about if I know if I'm in that allocation meeting, it's done, yeah? And when I'm not around and someone else sort of covers it, it tends to be not, I hate to say it, but it tends not to be done … it tends to drag on, the following week when I'm back, it's a bit of a shambles, so the fact that I know every **** within five minutes of the allocation meeting I'll come through, I dictate the letters, I just, it feels better me, in an obsessional way that it's done. Basically I trust me more than I trust anyone else, that's that's (laughs) the bottom line! (CP M:A6, p4).*

Knowing this about himself, CP M: A6 recognises his tendencies and also the reasons why he does things. Part of his recognition about his personality is discussed in relation to his colleagues' manner of doing things, which demonstrates that *knowing one's colleagues* is also part of Recognising and can help *self-awareness*. Moreover, CP M: A6 demonstrated that knowing himself led to understanding as to why he does not want to do certain things,

I don't like reading because as a bloke I can only single task and if I read, I can't actually concentrate on what the letter's saying (p13).

Further evidence emerged that showed how awareness of roles (including personality traits) encompassed recognition of strengths and limitations,

"I think everybody is guilty at some stage at not er, of not having er, eye wholly on the ball and probably I'm as guilty as anybody at that" (TL M: A3, p5).

Thus this shows TL M: A3 accepting that sometimes, subjects do not maintain attention and can lose focus which can be identified as one limitation.

Closely related to personality and personal traits was where subjects showed awareness of their own personal beliefs,

"…can't box people with mental health problems up in in clear categories really…" (TL M: A3, p12)

The above quote demonstrates TL M: A3's attitudes towards classifying people with mental health problems and the management of this. This will have an effect on how he positions himself with regards to specific tasks in the meeting e.g. how he handles the information elicited from letters. More personal beliefs were derived from interviews from other subjects,

I'm very much in favour of you know if it looks like a secondary mental care, health care and there's issues we can help with, that we need to assess before we can say yes or no (STL F: A2, p2)

This self-awareness is on a very personal level as identified by using "I'm" and can be juxtaposed to the times when subjects refer to themselves as "we" when talking about team identity. Here, STL F: A2's philosophy is revealed in terms of how she likes things to be run. She continued to deliver the notion of recognising one's own personal beliefs,

> *..and certain things like if it were, an example would be a straightforward bereavement er would be most appropriate to me to go to bereavement services, er instead of bringing somebody into secondary care services that were already you know very busy, er not bringing clients in that don't need to be there…"* (STL F: A2, p2).

Thus along with recognising and knowing how secondary care works and the pressure they are under, STL F: A2 acknowledges what personally makes sense to her. Her personal beliefs later extended to relationships with GPs,

> *…how I like to tend to manage it is because we have CPNs still based in all the GP surgeries, er the CPN that knows the GP and works out of that surgery would tend to take the letter and have a face-to-face discussion because I think that's a much better quality of service for the GP and for client rather than me writing a letter saying "sorry we're not seeing clients because of such and such", I think it's much better if the CPN goes and says to the GP "Can I just discuss this with you, we can't see any mental health needs, we just wondered, you know, is there anything we've missed or anything else you'd like to add to this referral" … so there's a, a dialogue and a discussion.* (STL F: A2, p3)

I asked STL F: A2 why she felt this approach was important to her and what instigated it:

> *…I think it's professional relationships with the GP who's also having more and more influence over our funding and services we deliver, er and I just think it's the the the professional way to go about things. And I think it helps the client get to the right service and team as well* (STL F: A2, p3)

Her response indicates recognition of the wider picture and implications of maintaining good professional relationships and alliance with GPs who will hold future funding responsibilities. Generally STL F: A2 indicates that she believes this approach has better implications for client care.

Awareness of one's professional identity provided a big contribution to the *self-awareness* sub-category. During an interview with CP F: A5, after a lengthy discussion on her experiences as a chair person, I asked her about how she felt as an attendee of meetings. Her response was,

> *You mean as a, as a medic or as a…just…* (CP F: A5, p20)

Here, the subject wants to clarify exactly what I meant and she considers her professional role to be a possible line of exploration. It emphasises the notion of subjects bringing several roles to the meeting. In relation to her specific role of being a consultant psychiatrist in the SPA meeting, CP F: A5 said the following,

> *I feel I have a certain area where I might be more expert that others and I try to offer that advice, but I try not to, er, impose it.* (CP F: A5, p20).

CP F: A5 indicated that she recognised that she was naturally drawn to particular aspects of the letter,

> *…like I will, if I hear something about a medication in a history, and I think ooooh, I'm much more zoned into that… it might not be the most, the issue that's needs the highest priority for that person, that referral, but erm, that's where my brain goes.* (CP F: A5, p18).

This self-recognition is intriguing because the subject has come to realise that this behaviour is a natural tendency implying that it is not necessarily planned. However an awareness of it, as shown here, will position her to do this more intentionally in the next phase of the Handling Role Boundaries process. When she focuses on her role as consultant psychiatrist, she will place herself with the task of picking up medically relevant information. Positioning is discussed in more detail in section 5.1.4.

Similarly, Nurse F: A4 had become aware that her motivation was much different to other attendees,

> *I always conscious of the fact that I perhaps have more interest in the referrals than other people that are at the meeting … I'm dealing with with them in a more … in depth way and I I think it's not uncommon for the odd person to be er nodding off in the corner especially the medical students who perhaps are not, erm, you know who are just passing through so they don't have the same interest.* (p5).

This subject, as part of her role, invests a lot of time and commitment to dealing with case referrals before the meeting and thus can contribute a wealth of knowledge relating to each client during the meetings. Other attendees do not share this investment of interest because they are not necessarily a "core member" of the meetings or it is not part of their role.

Recognising specific tasks and interests that had become part of one's role was also indicated by subject CP M: A6,

> *And that writing back to the GP has over the years been landed on my door…* (p2)

This quote refers to situations in the meeting where it is deemed inappropriate for any team or individual to take on the client and thus somebody has to let the GP know. The subject acknowledges that this task has gradually become attached to his role.

This was similar to the reflections of subject TL M: A7

> *…always feel that I get the lion's share of ones to do because I'm here full time, erm, because I'm usually quite willing to do it in that I don't moan that much so. Whereas I think other people could do it but choose not to, I think the doctors get unfairly put upon sometimes …*(p22)

For TL M: A7 his self-awareness reveals that he recognises that the bulk of tasks go to him, but he does not resent this. Moreover he recognises the capabilities of others but accepts that they do not volunteer and also acknowledges that doctors often get tasked with more than they should. Thus, the implications are that TL M: A7 volunteers because he does not want doctors to be continually put upon. The notion of *volunteering* is part of the Balancing phase of Handling Role Boundaries, but because it has become a part of TL M: A7's role, it is now something that is recognised as part of his character.

The fact that attributes arise out of Balancing (the last phase of Handling Role Boundaries) and over time become part of the Recognising phase show that Handling Role Boundaries can be a cyclic process as well. This is further discussed in 5.2.

Nurse F: A4 was also aware of how she coped in the face of difficulties,

> *Erm…I think if you've got some if you've got somebody who's very opinionated obviously that's a bit of a… difficult, but because I've been doing it now for four years I can usually, erm, handle that ok* (p11).

She recognises that she has honed the skill of dealing with colleagues who were more challenging and notes that experience has aided this management. At the start of her chairing experience all those years ago, her attributes would have been different. Thus the Recognising phase is ever evolving and dependent on many factors such as experience.

There were clear notions about what one's professional role involved, as was the case of Nurse F: A4,

> *…work to get more information regarding referrals, erm because it means that not as many if if that wasn't carried out, there would be more assessment, but by erm, investigating whether or not somebody's been seen, assessed by a different service within the Trust erm, recently that the GP may not be aware of you know that's very important and also getting the information prior to the referral meetings and screening the referrals when they first come in to get any information that might contribute to making a quick decision at that meeting…* (p3).

Here Nurse F: A4 highlights the significant duties that she carries out and accentuates the difference that her role makes. As part of this she demonstrates awareness of what would happen if she did not fulfil these tasks. What Nurse F: A4 describes is her duties pre SPA- meeting and thus she feels that the effects of her doing her role properly include rapid decisions being made. In this form of self-awareness regarding professional role, Nurse F: A4 also shows that she recognises the limitations of GPs who may not possess rich knowledge about the client's history. Thus GPs' limitations contribute to what she does as part of her role. This is an interesting point to highlight, because again it shows how the Handling Role Boundaries process can be cyclic as well as linear.

Interestingly, Nurse F: A4 did not always feel that her role was fully appreciated,

> *It's very time consuming, and it's something which isn't really taken into account…* (p4).

The implication here could be that other people's recognition of Nurse F: A4's role does not match her own self-awareness. This will lead to different expectations as part of the Positioning phase. This was intimated later on in the interview,

And the other thing is that all the other part of the…team don't come to the meeting apart from the consultant, but they don't have a clue how much work we're actually keeping out…a lot of the the referrals aren't for people who've actually got mental illness and I don't think the team realise how much goes into those meetings to prevent inappropriate referrals coming into secondary care… (Nurse F: A4).

Nurse F: A4 feels that many key facets of her professional role and duties go unrecognised by others when in fact these actions are beneficial for the team as a whole. She identifies her functional input in preventing inappropriate referrals from coming into the SPA meeting so that discussion can be allocated to those who actually might need secondary mental health attention. Moreover, she emphasises her commitment to regular attendance at the meeting which is not the case for everyone. Lack of regular attendance is another factor contributing to the perceived ignorance of Nurse F: A4's work. Clearly she would like more recognition and appreciation for the work she does primarily because it contributes to a smoother running of the SPA meetings and ensures that cases being discussed are largely appropriate. Nurse F: A4 talks for the profession as a whole rather than individualising her role. However, there was one occasion during the interview where she talked about her professional role in a personal manner,

… I do sometimes get a bit frustrated because sometimes it's very obvious the GP's asking for CBT or some kind of… referral, erm and I've been told that they still need to be read out in the meetings…it's time consuming, and I think probably as Band 6, I would, I should be able to make that decision and send it directly… (p7)

Here, Nurse F: A4 takes issue with not being able to fulfil her full potential and not being awarded with the authority that validates her decision. She mentions the rank of her nursing role and the expectations she has relating to this and describes her emotion at still having to process certain cases to the SPA meeting rather than being able to use her judgement.

When discussing approaches to SPA meetings, CP M: A6 suggested the need to prioritise which "hat" to wear,

It is, and I think it's something we actually encourage, hence why the multidisciplinary – it's on that sheet isn't it, the thing about multidisciplinary- I think within that setting, I mean as a clinician, I'm obviously a doctor, but most of what I do is sort of a holistic approach to mental health, for me it's a holistic approach, but in that meeting, when we have got multidisciplinary, it's about us trying to stay in role if we can…I think within the Single Point of Access it's the one time when we try and wear a cap otherwise why bother having it multidisciplinary? You know when I see patients I do a holistic job of assessment so why don't I just do it on my own? Yeah…and it's the only time really when you feel able to think "Right ok, this is now about medic", hence why I write back to the GPs afterwards, cause I do it with a medical hat on, not with my kind of soft and fluffy assess everything kind of hat on (pp15-16).

Choosing to push forward one professional approach over another, gives interesting insight into this level of self-awareness. It is an awareness that shows consciousness of multiple professional approaches and the need to promote one over the other in the meetings. In this case, CP M: A6's focuses on implementing his medical perspectives while diluting the holistic approach that he is capable of applying.

The notion of wearing different hats was also evident in TL M: A7's account,

I've got two hats here because I work in a CMHT but also my primary function is social care manager and sometimes we have people that certainly come through the system, you look at it and you think "Well there's no point in involving a doctor in this, because a doctor won't be able to do anything about that" it's about we need to look at it from a different angle… (p3)

In a similar way to CP M: A6's self awareness revealing the need to push forward with one role over another, TL M: A7 also notes the importance in looking at things from different angles when faced with multiple roles.

Coping with multiple roles manifested in other ways as well. TL M: A7 discussed the informal nature of the SPA meetings he attends and the times in which he has chairing duties,

> *I think the one thing that concerns me … is that sometimes we can appear quite irreverent about things and I'm really conscious when new people come to the meeting that sometimes, cause I tend to, er, I'm not overly serious all of the time, sometimes I will kind of try and make it a bit more light-hearted and sometimes, considering the si, the the subject matter that we're dealing with, I sometimes wonder that we can be a bit irreverent sometimes, that worries me a bit and I sometimes, when I'm chairing it have to just kind of keep my eyes focused a bit to make sure that we don't become a bit sometimes…* (p14).

This subject has awareness of the manner of discussions that take place but is conscious that it might be insensitive to generate too much levity given that the focal point is people's mental health problems. TL M: A7 admitted later on that light-heartedness was part of his personality stating that he is *"not a humourless person"* (p15), but within the above indented quote, he implies that he is cautious when chairing. This is another example of having to prioritise between multiple roles (personality and role of Chair) and change approaches to adhere to which role has been levelled higher. TL M: A7 feels a responsibility to distil excessive humour when he has the role of Chair and is particularly cautious following awareness of new attendees and how the manner of discussions may come across. He later said in the interview,

> *I do know that sometimes you know, people sometimes have to have a bit more gravity so so but I'm very conscious not to allow that to get out of hand really…* (TL M: A7, p15).

The merging of professional role and personality was further evident in other subjects' accounts,

> *I think my kind of obsessionality and enthusiasm for detail helps in terms of the letters and it helps in terms of me making sure that what I'm going to be putting*

to the GP does reflect what the multidisciplinary team felt rather than what I feel as a medic…in my letters to the GP, I will always say, "Following our multidisciplinary team meeting, the discussion of the team suggested that this is what needs to be done", so although I am writing the letter, I'm making it absolutely clear that I'm basing it on the multidisciplinary discussion, which I think is important, so it doesn't look like I've just gone off on one and decided this is how it will be, so in the discussions, I'm always quite keen to make sure that I've got it right, one I'm going to be encouraging the GP to do you know, so if I'm not sure, I'll say "Now hold on a minute, get this right we're talking about the Women's Centre, you know, we've got a number for the women's centre " and ***** (social care lead) may give me the number. So I am actually reflecting back to the GP the multidisciplinary team and I think my, my personality comes across in that, because I'm quite obsessional about getting that right, yeah? …I'm just obsessionally trying to find out what exactly it is that they said (laughs) so I can tell the GP… (CP M: A6, pp16-17).

This quote again reveals the dynamics of the Recognising phase and specifically increases understanding into the properties of *self-awareness*. Before, CP M: A6 had suggested that the SPA meeting provided attendees with justified opportunity to wear and promote professional caps. Here he intimates that his personality trait of being "obsessional" directs him to ensure that he has adequately understood what all the SPA attendees have said and reflect this back to the GP. Thus at different times in the meeting, different approaches to roles are used to achieve certain goals. This commitment to promoting the thoughts of the whole multidisciplinary team is driven by CP M: A6's personality role and he clearly says that he is conscious not to express solely his medical input in the letters written to GPs. However, when it comes to directing attention to the letters, this is when he would focus on wearing his medical "cap" and pick up on medical aspect of the referral letters. This will be further discussed in section 5.1.4.

In addition to professional identity and personality, one subject also revealed awareness of another influential aspect of the self

Mine's an interesting one I think for a number of reasons…yes I, I'm a consultant psychiatrist, I've also been here longer than most, practically everybody

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> *else…those two together confer considerable amount of informal authority"* (CP M: A1, p12)

Thus CP M: A1 discloses the notion of membership stability and links this to *informal authority* suggesting that beyond awareness, there is also consideration of the influences that these facets of the person have. The implication is that being a stable member of SPA meetings and professional identification as a consultant psychiatrist bestows elements of power, suggesting that there is a hierarchy present. CP M: A1 later confided that he did not support this and preferred the promotion of a democratic environment but conceded that elements of hierarchy were present nevertheless. This also displays recognition of the wider meeting environment as well as the dynamics of individual members.

Subjects disclosed their thoughts and feelings about their chairing role during SPA meetings, demonstrating an awareness of this particular role,

> *…you also have to know about what your- what are your personal traits … and it's terrible isn't it, you have to constantly like be aware of what you are like yourself in a group, what you're like as a leader, you need to know your own leadership style, because it may not suit the group, and as the Chair, I think you'd have to adjust that (laughs), and er, cos I know sometimes I'm quite keen on time management of chairing meetings, but for me then I'd have to remember, I can't time manage so severely that I prevent people talking and actually doing, I can't you know, squash them by time, over time management, do you know what I mean, er, so I need to allow discussion but I also know that I get extremely irritated if time management isn't a factor for other Chairs… (Laughs)* (CP F: A5, p16)

This provided a lot of insight into the sub-category of *self-awareness*; here the subject is talking about personality filtering into chairing duties which can contribute to a leadership style. Thus she presents the notion that there is no one consistent way to "chair" a meeting, rather it is affected and implemented according to the individual in that role. This supports the idea that attendees of SPA meetings have multiple roles and boundaries that need consideration even before action has taken place. The subject

mentions adjusting her style when considering her attention to time management and also in relation to other members of the group. This would suggest that early on in the meeting, she recognises the need to allow one role to dominate over the other – in this case the Chair leader role over personality, in order to work with other members and contribute to the smooth running of the meeting. In addition, there must be recognition of her colleagues which informs the decision about which aspect of herself to promote.

CP F: A5 also discussed her awareness of her weaknesses and how she manages this in terms of her dominant role in the meetings,

> *… I'm really peed off if meetings go on and on and on a but- after the time when they said they'd stop. But I just, I can't, I know that about myself. I also know that erm, I can rabbit on like I do so as the Chair, I have to watch myself, and not start rabbiting on but actually that's not my role then. I can do that if, when somebody else has to chair me, in other meetings, but erm, er… like in small meetings, I'll be quite talkative, but in larger meetings I won't and it's quite interesting, you just have to know what your strength and weaknesses are in terms of as a Chair, maybe as a leader and as a manager.* (CP F: A5, p6).

This sheds further light on how Recognising phase influences the Positioning phase; as a leader/ chair, CP F: A5 recognises that her leadership needs to be dominant in the Recognising phase and then positions herself to be less talkative when discussion commences. When she is an attendee, her personality role (which includes being talkative) can be dominant because she recognises that it is somebody else's role to chair and manage her and so she can position herself to be free flowing with her verbal input.

Therefore, one can see how prioritising one role out of multiple roles happens during the Recognising phase and this incidence provides significant insight into this element. Prioritising is clearly a key aspect in strategies to manage multiple roles.

Nurse F: A4 had clear ideas about what chairing duties should involve,

I think it's important that any new people that are just passing through … are introduced and so that everybody is aware of who's in the meeting. Obviously you need to make sure that confidentiality erm, is looked at if there's any erm staff members or students or medical students who are being referred in you know that's very important to make sure that that's taken into account. Erm, I think it's important to keep keep the meeting moving on quickly because you sometimes get people in there who are a bit waffly and they like the sound of their own voices and you know to spend a lot of time analysing things which is very time consuming unnecessarily and unnecessarily really because we're doing, I think that's one thing that has changed since we started the meetings, we know (makes sounds) where people need to go fairly swiftly and we don't need to pontificate for a long time so I think that's a very important role of the Chair… (pp 10- 11).*

For this subject, chairing encompasses a lot of responsibility with respect to fellow attendees – particularly students- and also clients. It also involves an awareness of colleagues as well who may refrain from the time limitations and expand on points etc. Nurse F: A4 believes that as a chair, she needs to rein such discussions in to adhere to the smooth running of the meetings.

This mirrored CP M: A1's notion of chairing,

Oh sort of saying stop and start, erm, a bit of timekeeping, in other words, if the discussion seems to be going on unhelpfully longer than it should do, erm looking after junior members, students and trainees, so enabling them to feel welcomed, erm…and yes, just to generally keep order. There isn't an agenda to set, because that's a very clear one and it's already set, erm. Certainly we do operate by consensus here so there's no question of voting, counting votes, erm, so it's really just acting as a figure head for meeting, a sort of kindly person who makes the whole thing run along. (p11)

Again, the time keeping element is highlighted as well as the general responsibility aspect.

Aside from chairing duties, subjects also had clear ideas about what their professional duties were,

> *if it isn't clear cut and it's not certain where the person needs to be sent then that's when we would do the, the …assessment …because then it it nearly always becomes much clearer where they need to go next* (Nurse F: A4, p13)

This is a great demonstration of the notion of "boundaries" because it shows awareness of knowing when to step in i.e. being aware of the boundaries of one's role.

For CP M: A6, recognition of his professional role involved understanding how things have changed in his clinical practice over time,

> *So I now see someone with moderate to severe depressive disorder and I write back to the GP and say "This is what you do to the antidepressant- increase it to this dose, if that doesn't work change it to this dose, try that, add in this, and if there is no improvement in six months time re-refer", whereas five years ago I would have done that. I would have kept them in service, I would have changed the antidepressants and I would have managed that. Now it's far more consultation exercise because I haven't got the space that keeps in that person and that's come about because of the change in the resources that we've got* (p7).

Thus changing professional capacity has meant altering extent of responsibilities and thus the role boundaries of him and GPs have been modified. The fact that five years ago the role boundaries were different could be a product of the recession and demonstrates to a certain extent the fickle nature of role boundaries themselves.

Knowing colleagues

Knowing one's colleagues as part of the initial phase of Recognising is important because it allows attendees to understand where everyone is coming from and expectations can be formed realistically. It also guides attendees to position themselves in terms of self-expectations from initial awareness about what their colleagues may and may not do. CP M: A6 spoke about the benefits of knowing his immediate colleagues,

> *By working closely … kind of know where we're all coming from … from my point of aspect, it's actually very helpful because you do get a sense of where the team are at as well in terms of how many people they can see…You also get an understanding of the social care assessment process which is a mystery to most medics I have to say…* (p2)

This subject shows that knowing colleagues can give insight into their capacity and also enhances his awareness into the type of thinking that goes on against a certain professional background, which suggests an educational component. This also sheds further light onto the Recognising phase as a whole by suggesting that the attributes one associates with colleagues are not necessarily applied out of pre-conceived ideas; they can also arise through learning directly from those colleagues.

TL M: A3 further hinted at elements of personality of colleagues and having awareness of this

> *…even if you know, you're the most er, intransigent consultant that we don't really have here, you know they make a decision they're often, I mean they're open to persuasion anyway.* (TL M: A3)

Awareness of both professional identity and personality emerged as part of the Recognising phase with a sense of respect for attendees' ability to bring varied contributions to discussions,

"I think that there is…a sense of…equity and yet at the same time there is also a respect for the different skills and backgrounds that the different people bring to the table, which is again, healthy and appropriate" (CP M: A1, p5).

CP M: A1 continued to highlight this recognition of both personal traits and the beneficial elements of professional backgrounds.

"We respect one another as equals in one sense, but we also respect one another's individualities as far as professional organisational backgrounds is concerned as well" (CP M: A1, p5)

Whist respect for professional backgrounds and the benefits of this were outlined, subjects also acknowledged the limitations associated with professional role,

"…they (IAPT) *have a responsibility to their home team, so you know, they won't be popular in their home team if they come back with a handful of referrals that the home team aren't happy with"* (CP M: A1, p10)

Referring to the IAPT service, CP M: A1 recognises the restrictions that they operate under and their rationale. Here, it is demonstrated how recognising roles takes into account the boundaries of those roles which encompass both strengths and limitations. This is needed in order to determine behaviour associated with the next phase of Positioning as part of the overall Handling Role Boundaries BSP.

On the other hand, although another subject questioned the success of the IAPT service, he also acknowledged the possible positive effects of being able to liaise with them,

… we seem to get an awful lot of people six months down the line who have been through Let' s Talk Wellbeing still coming into secondary care, but I don't know

how many we're not seeing who we'd have otherwise had to see- that's the bit…(CP M: A6, p8).

Limitations of other services also came to light,

Forensic services locally…seem to be causing us increasingly…higher levels of frustrations (CP M: A1)

CP M: A1 has a picture in his mind about the forensic service conjured up through experience of dealings with them. Thus recognition is fed by past experience and there is a current awareness of the problems the service is causing.

The limitations of forensic services were also indicated by another subject, however, in this case, it had a slightly different slant,

Erm, well i– it's sometimes it's difficult to actually signpost people to say Forensic services because they don't hit their their service threshold but we know they've got, we know they've got a problem- (TL M: A3, p21)

It appears that TL M: A3 accepts this as a difficulty of the service that is based on their threshold as opposed to deliberate awkwardness.

Regarding forensic services, CP M: A1 established a distinction between how he and others perceive them and how they see themselves

…from the outside they're regarded as…an outfit that's there to provide for people who are particularly troublesome. They're more interested in people who are particularly complex from a legal point of view, which isn't quite the same thing… (CP M: A1, p16).

This implies consequent tension due to this discrepancy. It also highlights the fact that services may not view themselves in the same way as others regard them. This will have an effect on subsequent phases in the Handling Role Boundaries process and how management of case referrals is executed.

Identification of professional identity was often matched to specific functions that particular professionals engage in or withdraw from,

> " *…level of complexity, level of risk, for instance, which as everybody knows, as it were, IAPT don't deal with…"* (CP M: A1, p10)

The notion of "everybody knowing" suggests that this is a well-recognised feature of IAPT and gives some indications as to what the service will exclude from their caseloads. Knowing what clients different teams deal with is a significant property of the Recognising phase of Handling Role Boundaries and links to having an awareness of the purposes of the teams,

> *"…for Assertive Outreach, it tends to be that erm, the referral is from secondary services anyway…if it's that element of disengagement and or don't comply with treatment programmes or whatever…"* (TL M: A3, p4).

TL: A3 discussed the locations of several services,

> *No no I mean PD Network now is based in ****** so they go there. Erm, this the **** **** place I mentioned that's based in **** itself…I mean Eating Disorders, there's obviously, there's a representative from Eating Disorders services, comes there. Not that often, but fairly frequently to the botto- but there's er an agency based at **** who send the, a lot of people with eating disorders to called **** **** Erm I mean … the Community Alcohol team,*

there's Dual Diagnosis services which, they do have links here but they're based elsewhere so yeah. (TL M: A3, p11)

Recognising usually encompassed details about where teams were based so knowledge about one's working area and the local vicinity is also important. However, this sort of knowledge was not always a given, as some subjects were not always clear about specific locations and sought clarification from the colleagues. In Area 6: Observation 1, there was an enquiry from one attendee who wanted to know the name of a service on a street. Even though this particular attendee did not know the service's name, this incident is part of the recognising stage since the attendee identifies that others are likely to possess this information.

At the Recognising phase, knowledge about teams and their functions are at a general level; specific expectations relating to the meeting are left to the Positioning phase.

if it's not a serious mental health problem then we'd utilise IAPT or something else, I know they are attached to mental health services but they're more sort of general practice focused than than from ourselves (TL M:A3,p12)

This shows TL M: A3's ability to see how certain teams differ from the CMHT he is part of i.e. what distinguishes them, what their purpose is and where they sit in the wider mental health/health service context. Similar disclosures came from other subjects,

…but make sure that they get the best advice and support and other referrals that we don't take on unless there's significant mental health is er domestic abuse because we've got a very good centre, the **** Centre where these women can access all the support they need from housing benefits, you know outreach workers and people that were, are experts in working in this field all the time. (STL F: A2, p2)

This is an example of recognising the experts who deal with the issue of domestic abuse and acknowledging this expertise. This helps STL F: A2 and the team to later position

themselves as only needing to offer advice rather than commit to taking the client on, since they have already recognised the experts in this area. However it also shows that should a significant mental health issue arise, STL F: A2's team would endeavour to step in. This emphasises the notion of role boundaries – knowing the capacity of one's role (in this case as a team member of a mental health service) and being alert to situations that one would need to step in and ones in which it will be acceptable to hand over to someone else.

Nurse F: A4 discussed the changing criteria of the IAPT service,

> *Let's Talk Wellbeing now will only take people that are appropriate for CBT, so they're very focused and when they, the referral comes in for them, erm, I think they tend to do more telephone screening. If it doesn't meet the criteria and they know that this person isn't definitely going to move on because they get, they got all these outcomes to achieve and that's how they get the funding I believe so if the person when they first look at the referral doesn't look like they're going to achieve outcomes therefore they're not going to get a a good outcome you know twelve weeks down the line, they won't take them on. And they only offer erm treatment for people with depression anxiety now* (p16).

Thus, the way in which this service is recognised is altered based on the effects of funding on its boundaries. The subject's assessment of this service suggests that it has become more rigid and difficult to refer into.

CP M: A6 also gave an account of some of the teams the SPA attendees liaise with,

> *I know colleagues have made to like for CBT can't go to psychotherapy, again getting bounced back …but it just feels as though people who you think are appropriate aren't, with a fairly weak reason why not, and I think ultimately it's about this struggling with waiting lists, yeah? But it does feel slightly false to me and…because of that I generally don't refer there now and I think patients kind of miss out, we don't have particularly CBT or psychodynamic psychotherapy. It's there but it's very difficult to get referrals through. I think I've had one referral to*

CBT accepted in the last year and none to psychodynamic. Not that I've made many but I don't because they seem to get knocked back. Psychological services are slightly different in that we don't have problems … Alcohol service just brilliant, they just pick up anything that goes their way. Erm, same with Mother and Baby unit, EI, erm…we have no problem with assertive outreach, so it tends to be the psycho- psychological services, including Let's Talk Wellbeing, cos we have a little bit of a banter with them as well in terms of their criteria, cos one of our on-going festering source is that they seem not to take anyone who have self-harmed (pp17-18).

Experience with these teams has affected the way in which CP M: A6 recognises them and ultimately how he makes decisions. These result in both positive and negative perceptions of the services and by his own admission, he refrains from referring to certain teams.

CP M: A1 recognised the less frequently-attending members of the group,

I see the, the meetings as actually quite an important training experience for medical students, trainee doctors, nursing students all alike… enabling people to feel included in the process is a useful part of enhancing its values as a training experience (CP M: A1, p4).

This subject differentiates between the less regular attendees of the meetings and once again alludes to awareness of the wider elements of SPA meetings, in this case, its educational potential.

CP M: A1 later continued to demonstrate a tendency to identify stability of SPA meeting attendees when reflecting on a meeting he had just attended,

the people who were there, who weren't students or recently arrived trainee doctors, er, and therefore were if you like regular attendees of the group (CP M: A1).

In the light of self-awareness, individual identity and then group identity, subjects also showed that knowing one's colleagues was important as well.

…Sometimes there's, there's erm significant cogs in the wheel missing …sometimes the consultant isn't there, but I think because everybody knows the way that those particular services work and the type of work they pick up… (TL M: A3, p12)

Thus despite absence, the awareness of how these colleagues work enables the meeting to consider their service during decision making. TL M: A3 offers a sense of respect for such colleagues as consultants by referring to them as "significant cogs", which also demonstrates recognition. Positive attitudes towards colleagues and their skills continued to be disclosed,

(on admin) *It couldn't be better in all honesty. I think **** has got er real sort of experience and knowledge and awareness of wha, of what goes, how to keep the meeting sort of flowing, all the, all the sort of the administrative support, the templates, all the, all the sort of support and help she gives, we couldn't do without the admin support we've got and it's fine at the moment…*(TL M: A3, p16)

TL M: A3 reiterated this by praising administrative staff in general and giving recognition to the skill they offer and appreciating their place on the team,

… well I mean, at the end of the day Mel, I think you get receptionists, admin workers, they're often on the frontline of services…it's not the CPN that has first contact with er, you know people with problems and concerns, it's the receptionist staff that deal with stuff, in the absence of clinicians sometimes, so they are, they are skilled and they are aware of the type of issues and concerns we have so (TL M: A3, p16)

There is a sense of everyone being on the same wavelength and sharing the same intentions. This notion also entered in an interview with STL F: A2,

… there's regular people that deputise for me, er, and they very much know my philosophy is as you know if we're not sure assess, then bring back, so they wouldn't, they carry on that, cause they know that that's what I would expect them and want them to to say and do, so I don't go on holiday and find out that twenty referrals have been sent back to the GP without being seen…

STL F: A2's philosophy that she recognises as a significant part of her and her approach to health care is maintained by people she can trust in her absence.

Clearly many of the subjects retain a great respect for their colleagues and are open about this. Not only was this the case for CP M: A6 but he identified that perceptions of colleagues were a factor in deciding whether the CMHT would see the referred client or signpost them on to another service,

… you'll often find that in notes, a respected colleague, and it would need to be someone who we know or a reasonably senior medic or senior nurse or social worker has written something down the notes about such an intervention not being helpful or maybe the secondary psychiatric care services aren't for them, so decent quality information from the records would certainly influence us to whether we took someone on or not… (p21)

This respect seems associated with rank as indicated by the mention of "senior" which would be given consideration. The notion of power is implied here where level of professional identity bears some weight in judging referral letters and case note content.

In the light of this positive respect for colleagues, there was however an incident where one subject highlighted the differing philosophies between her colleagues and herself,

I know the system in secondary care so that's not such a big issue. But it's educating other people about what's out there…there's still a lot of workers within

secondary care that still have this philosophy that you know, all all people with mental health problems need to be nurtured and, and then of course it it breeds this sort of dependency … before they even come in, they need to be shown "look you know, you're going through a difficult time at the moment, we can help you, but there's these other places out here that can help you to get back to work" and…back to running a normal life again… (Nurse F: A4, p19)

Nurse F: A4 believes that her philosophy is the appropriate way forward, but again the recognition that not everybody thinks along these lines is also part of the Recognising phase. Not being on the same wavelength is not detrimental to the Handling Role Boundaries process because as shall be demonstrated, the BSP encompasses a range of behaviours that deal with situations such as differing philosophies and disagreements.

Understanding of the boundaries of mental health teams was also gained through experience, which helped to establish a deeper knowledge of such teams' processes.

…personally I worked in the crisis team before …I understand how they work anyway… (Nurse F: A4, p4).

STL F: A2 also reflected on her experiences as a nurse,

…because nurses can't diagnose, we can give an impression but not a, a diagnosis… (STL F: A2, p1).

Here STL F recognises generally the limitations of nurses in that they cannot diagnose due to legal constraints. Thus this helps position them in the meeting to avoid ascribing diagnoses when it comes to clients. This helps them to determine what sort of a contribution to make as part of their nursing identity.

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Acknowledging limitations as part of self-awareness was also captured by another subject whose reflections encompassed personal beliefs as well,

> *I don't think there's any practical sort of erm peer type interventions where you know, people are actually being given the information about what we expect the referrals, erm to contain and I I'd like to get involved with that but because of the lack of time really…er…it's it's not possible to kind of network better, but I think that is very important that we should be networking better…* (Nurse, F: A4, p3).

Nurse, F: A4 would like to see primary care workers better informed about the components of a satisfactory referral letter; moreover, she expresses a personal desire to be part of that but is aware of time constraints that come with her role.

Awareness of colleagues in the meeting was deemed important by one subject in particular, specifically with regards to her chairing role,

> *well if you're not connected to the meeting that must be more difficult… you have to be careful who characters are in any meeting don't you in a group, so you have to make sure there isn't one or two people who are kind of always, you know, and that, that's the purpose being a Chair, so we talk about that and that's why our chair role is rota'd around. The chair is rota'd around erm between health, social and medic…and our OT. The chair is mostly taken up by the senior members of the team... I've often thought it would be nice for other members of the team to give it a go and sit and but they don't, they don't feel they want to…* (CP F: A5, p6)

CP F: A5 suggests that it is imperative to be cautious about attendees- her use of the term "characters" suggesting that personalities are again a key aspect for consideration. Once again, we can see how this element of the Recognising phase can impact on her positioning experiences as Chair; awareness of difficult attendees helps her to position herself to ensure that everybody is given the opportunity to air their views.

CP F: A5 further discussed fellow attendees and mentioned the effect that their presence has on meetings,

> *…so it's a business meeting, you know, and it has to be seen as that and and it has to be run, you know to time, it has to cover what it's supposed to cover, erm it's got to be efficient… but it also has to be open and welcoming and it used to feel here, well the view from the team members was that it wasn't open enough. And it was interesting, because if we analysed that, my own opinion is that depends on who's in the meeting …* (CP F: A5, p6).

Thus, even in the midst of the SPA meeting's clearly recognised agenda and desired environment, which individuals attend has an impact on how it progresses.

This idea was also alluded to by Nurse F: A4, who discussed the different approaches taken to reading out letters,

> *… personally think it's good to read word for word because by summarising, you might miss something. Erm, I've noticed some of the SHOs sometimes will try to summarise, who are there, you know with just a few visits and I think they tend to get themselves a bit, bit mixed up because they've, you know, I just think it's, yes, easier to read straight from the, the whole thing. Even though it takes longer…* (p4).

She discussed SHOs collectively as a group and recognises a tendency for them to fall into confusion resulting from their summarising approaches. This has an effect on the conduct of discussions in the meeting because confusion will need to be cleared up for clarity to descend and a decision to be made. For her own approach, she does acknowledge that this is time-consuming but ultimately more effective.

Recognising limitations among colleagues is interesting in the way it is done: sometimes in relation to a group collectively taking into account professions and status e.g. with Nurse F; A4 discussing SHOs, and at other times on an individual level capturing

personality traits and character as with CP F: A5's reflections. As has been documented within this chapter, this is much the same for *self-awareness* sub-category of Recognising as well.

In addition to SHOs, Nurse F: A4 also spoke about consultants as a group but acknowledged that they varied in approaches, thus recognising them individually as well.

> *I think sometimes there's a difference between the consultants and some will are not very good at therapeutic risk taking and will basically say "yes you need to see everybody" you know even if the risks are very slight but I think that's you know probably due to past experiences you know if they've had a lot of suicide and things like that so…* (p11).

Recognising that some consultants would prefer the team to capture all potentially risky clients again denotes the commitment to "playing it safe". However, while presenting this as a negative practice of consultants, the subject does signify that she understands the motivations behind it.

CP F: A5 discussed the rotational chair feature of this SPA meeting and highlights the exclusion of some attendees from the role. I explored the types of attendees who she was referring to,

MN: Is that sort of like students and things?

> *Well no, other band 5s, CPNs, or other social workers and and, you know, erm just in terms of erm, just in terms of having that experience and chairing a meeting, because I think that gives a really good viewpoint on what it's like to chair a meeting, what are the kind of things you need to be aware of…* (CP F: A5, p6)

By acknowledging these particular attendees' lack of experience of chairing, CP F: A5 reveals her awareness of the qualities and skills that being a Chair provides- ones that these attendees not be able to hone.

For some subjects, knowing colleagues highlighted areas in which they felt needed improvement,

> *…think the people who come to the meetings probably have a good idea of of the criteria, although some of the people in Primary Care perhaps…need a little bit more training regarding the criteria for Secondary mental health services …sometimes I think they, they don't look at specifically at whether or not a person has a mental illness* (Nurse F: A4, p2).

Nurse F: A4 identifies what she sees as the shortfalls of the IAPT service (Through further questioning I established that this service was what she was referring to). Her critique pinpoints a specific area where she feels that they fail i.e. establishing the person's mental health capacity. The suggestion is that identifying mental health problems within a person should be prioritised and could aid the subsequent discussions taking place within the meetings. There were occasions during my participant observation, where Nurse F: A4 and attendees in other areas had enquired as to what the client's mental health problem was, immediately after the letter had been read. Nurse F: A4 above account suggests that mental health professionals are not always on the same wavelength as each other. It makes sense that for the SPA meeting to be efficient in dealing with each case referral, there needs to be a process present that takes this into account.

Knowing colleagues included subjects' recognition of dwindling resources and cutbacks and how this has affected service availability,

> *not with all the funding cuts, it's become a lot less, there's a lot less things available and there used to be a lot more erm, support services out there* (Nurse F: A4, p13).

Recognising the effects of cut backs and what services have been eradicated helps subjects in the later Positioning stage by guiding them to form expectations in the face of certain services' absence.

When the opportunity arose in interviews, I explored whether subjects felt that discussions were influenced by professional role,

> *Definitely yeah… Well we we quite often have a psychologist in there who is very erm, anti any kind of diagnosis so that sometimes causes issues around somebody who's had a difficult life experience who maybe is labelled within the meeting as having Personality Disorder- they don't like that.* (Nurse F: A4, p14).

The principles of the psychologist are recognised in relation to past experience and thus Nurse F: A4 was able to generate a picture of them in answer to my enquiry. She identifies the psychologist who comes to the SPA meeting that she attends as being averse to allocating labels to clients. This subject also recognised the tendencies of social workers,

> *Erm, social workers will be looking much more at all social aspects of the person's life obviously, erm much more than the, erm, the sort of medical model so there are differences yeah.* (p14)

This time, she does not overtly demonstrate that this recognition has arisen out of experience- rather it is a general awareness of what will happen. This highlights the varied ways in which perceptions are informed.

There was also recognition of the strengths of particular colleagues and how they had come to be relied on to undertake specific tasks,

*…she's good at going through the notes and screening things… we all do specific things. ***** will read and take lead on the social care, *****'s worried about the waiting list…* (CP M: A6, p13).

Thus far, Recognising's sub-category of *knowing one's colleagues* has dealt with immediate colleagues and teams that are liaised with. Another key awareness revolved around being able to recognise GPs, who form the bulk of referring agents of SPA meetings but do not attend the meetings. Nevertheless, attendees still acknowledge their attributes during the Recognising stage. Sometimes GPs were talked about individually and at other times as a professional group. With the former, issues of personal traits emerged. One gets a sense of the GP from letter i.e. their strengths and limitations and their character. Knowing GPs is also informed by past dealings with them and liaising.

Subjects often understood the motives of GPs by providing explanations of their reasons for writing the referral letters,

there's quite a lot of GPs that refer to Crisis because they, because of their anxieties when actually, the client isn't actually any more risky or unwell (Nurse F: A4, p4).

This suggests that GPs often err on the side of caution in a bid to deal with any threat of risk. This apprehension is understood and accepted by Nurse: F, A4 as something that she needs to manage. Thus the GPs' role boundaries are considered alongside her own role boundaries during the Recognising phase.

Consideration of GPs' role boundaries was also demonstrated by subject CP M: A6 after I explored his decision to include advice in letters he wrote back to them,

Because when a GP's made a referral, yeah, GPs are very much aware of resource provision, and I think when they're making referral it's normally because they have either run out of ideas or they think it is then appropriate for them to

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be seen in secondary care. And most of those will be appropriate in secondary care, but some won't but it's still- th-the issue still remains that the GP didn't know what to do next otherwise they would have done it, yeah? (p3)

Thus CP M: A6 considers the GPs' perspectives and that their motivations for referring to the SPA meetings are because they do not know what to do with clients. Therefore regardless of whether the client is appropriate or not for specialist services, that issue still needs addressing. The subject feels a responsibility to use the strength of his professional role (knowledge of what might be appropriate) to deal with the weakness of the GP's professional role (lack of knowledge about what to do). This is also enhanced by CP M: A6 personality role in liking things to be done (as he mentioned in the interview) and so does not mind writing letters in such a manner. Moreover, CP M: A6 also mentions why it makes sense for him to take the responsibility of writing letters,

I mean doctors when they refer in, still primarily see us as being a medical service and I think they do like to have… a medic writing back with recommendations and I think it probably helps them when the patient comes back next time to say well they have made the referral, they've communicated with Dr **** at ***** and what he's recommending is the following. It gives them something, perhaps something a bit more significant than passing back to the patient. (p4).

Thus not only is the GP's professional weakness considered, but also her/his preference in corresponding with fellow medics. This gives an understanding of the range of role boundaries that arise and their subsequent need to be handled. There is also the theme of power coming into play in relation to these role boundaries; the notion of a GP preferring to correspond with a fellow medic and the latter accepting this preference reveals the hierarchical nature of healthcare. A letter from a doctor holds more resonance than a letter from another mental health professional despite the decision being made through the contributions of a multidisciplinary team. Thus the thinking processes of the GP are recognised as part of the hierarchical nature of the system and are handled partly by CP M: A6 volunteering to write back. At the level of the Recognising phase, this is about being aware that such differences in roles exist. Actions in response to this come in later phases.

On the other hand, power and hierarchy are not always constructed along the lines of medical profession,

> *I think it's cos I volunteer, I think it's a fault on my part in the sense that sometimes I'd rather take the responsibility myself than delegate it. Because I feel that I delegate enough other things that, you know I'm often putting on staff …sometimes it does need a manager to do it, sometimes. I think it holds a bit more resonance…* (TL M: A7, p23).

This describes the task of writing letters to GPs. TL M: A7 recognises his knack for volunteering. One senses a personal desire to employ fairness and not delegate excessively. However he also justifies this partly by his belief that a letter from a manager holds more resonance. Thus while still indicative of the identity of the writer needing to hold weight in terms of the GP's perspective, this time it is felt that a manager as opposed to a fellow medic is what will achieve this. Thus we have two different CMHTs employing different methods to handle a role boundary based on GPs preferring to correspond with someone high in the hierarchy. In the examples above the ability to employ such methods utilises certain role boundaries of these subjects (CP M: A6's personal desire to get things done and TL M: A7's personal desire for fairness and not wanting to put upon others). In addition both CP M: A6 and TL M: A7 have an awareness of how their role as medic and manager respectively holds weight.

Later on in the interview, subject Nurse F: A4 further elaborated on her opinions of GPs,

> *Yeah, and it-it's very obvious the GPs sort of had specific mental health training, they…write excellent letters and will go through you know, most of the the areas that we would in, you know doing the assessment ourselves…some some GPs will just say "Please can you see this gentleman who has been depressed for several months, you know, you don't know what, why what you know whether there's any children in the family, whether they've erm, what the symptoms are, what medication they're on, you know all those things are very important.* (p9).

Thus whether the GPs are on the same wavelength as the SPA team would depend on their familiarity with the mental health field, accessed through training. According to Nurse F: A4, this is often identifiable through studying the letters.

Conception of GPs through letters was also mentioned by CP M: A6,

> we've got GPs who will make cracking referrals and we've got others that routinely send three, three lines and we write back and ask for more information which we rarely get and I think what you tend to do is the more information you get, the less likely you are to see them. Because you can make that decision. The less information you get, the more likely you are to see them, because you don't know what you're missing if that makes sense. Somebody who puts a brief letter in and we can't get any more information but it's kee- the doc is keen for us to see them, you kind of have to go and assess them… (p8).

A couple of things are revealed here- the variety of GPs that CP M: A6 and his team deal with, as demonstrated in the letters that they wrote, and also how this influences the latters' decision to see the client or not. There are elements of "playing it safe" because there is a preoccupation with not wanting to miss anything. Considering that the option of "Bring Back" exists (where the team seek more information from the GP or referrer and then bring back the case to re-discuss in another SPA meeting), this perhaps sheds some light on the philosophy on the team that CP M: A6 is part of- i.e. give the benefit of the doubt and assess even in the absence of information.

For subjects, knowing GPs included an understanding into the way in which they work and their mentalities and tendencies,

> **(on GPs)** because of the legalities round that, that tend to fortunately or unfortunately stay with the medical model of diagnosis (STL F: A2, p1)

The subject is unsure about the relative merits and drawbacks of GPs focusing on the medical model, but she does recognise that this is what they do and thus accepts that

this is a part of their culture. Acceptance of GP's practice even if it is not completely met with wholesome approval was also shown by CP M: A6,

> *we used to be, is come up with a referral letter effectively that kind of standardizes the sort of information we want and it just didn't get used. Yeah, GPs will do their own thing… And I can understand that, because when I make referrals here I'd far rather just write a referral letter than fill in a referral form. One, I can't find the referral form and two I can never get the right information for the right boxes so…* (p9).

For CP M: A6, understanding GPs' approaches is further enhanced by relating it to his own thinking processes and thus empathising to recognise where they are coming from.

Sometimes, impressions and perceptions of GPs were not always primarily from letter content,

> *…you're very much aware there are certain GPs when they refer and you just, your heart sinks, you think "Oh my goodness" …whereas some GPs you would be saying well, although I think this referral, I'm not sure whether we need to see them or not, they're asking us to see them and they're a good GP, they don't often ask us to see them, let's see them…Because we get some referrals, you know some GPs refer in one or two a week and you're thinking they can't be seeing that many people with legitimate need for secondary psychiatric services, and they don't, you see them and they're not actually that unwell whereas some GPs refer three through a year and you just know you've got to see them. So draw on the GP, it's not just letter, contact letter, it's who the GP is…* (CP M :A6, p15).

Thus, judgements about GPs are often based on their referral rates including the assessment of the legitimacy of their requests. The response that this subject gives was in response to a question about what factors he feels decisions are based on. Clearly the identity of the GP plays a big part in influencing decisions which again reiterates the significance of knowing GPs as a basis for further actions in the meeting. Thus even

though the GP is physically absent during SPA meetings, recognising them and their boundaries is as important as recognising the boundaries of colleagues who do attend.

This is something that also emerged from my interview with TL M: A7,

> *I think another thing that comes into play here and with the greatest of respect is we know the GP's quite well and often what you'll hear somebody say is "Doctor ***** in *****, he's a really good GP and he usually writes very good referrals" so if he writes a referral that doesn't give all that information, then chances are, it's because for one reason or another, he hasn't got that information and I think you tend to, whereas there's another doctor who I won't mention who who historically, … when he sends referrals, they're always two or three lines, they always do not give a great deal of information and it's always like "off you go" so, so what would dictate whether we decide to get more information is who's written it…* (p24).

Clearly TL M: A7 recognises that he and other members of the CMHT he works for have come to recognise the GPs that they liaise with and are able to differentiate between those who genuinely have no more capacity to deal with the client and those who may be able to provide more than they have. This will lead to positioning these two types of GPs in different ways and will also direct the attendees on how to respond to such GPs.

Group identity

From much of the empirical evidence we have seen, there are many different aspects of recognising that relate to the attendee as an individual, a professional being and a SPA member. However there was another way in which they demonstrated awareness of themselves and that related to their identification with the base team that they belonged to e.g. a CMHT team member. Recognising aspects of themselves in a collective sense as part of a wider team generated interesting understanding into group identity.

As expected, the use of "we" and "us" featured prominently. Subjects revealed insight into how outsiders perceived them and their roles,

(describing referral letters) *it's pretty clear what we're being asked to do here"* (CP M: A1, p13)

By having an awareness of how others perceive them, subjects get a sense of what they might be expected to do in relation to functions. The use of "*we're*" demonstrates a group identity that is sometimes alluded to, as well as other instances where individual traits are discussed.

As discussed in Chapter 3, four of the seven sites that were studied were identified as CMHTs; three were named as general mental health services. Interviewees spoke about the general role of their base teams, be that a CMHT or general mental health service,

> *I think because, people perceive this as a Community Mental Health Team they just see the word "mental health team" and they don't see the fact that er, they they they, sometimes the perception is that it's a generic service that will take anybody whereas you know we're really sort of at the higher end of people with mental illness with you know moderate to severe depression and psychosis. We're not really for the worried, we're not really for the people with, you know with social problems which can be addressed elsewhere so I mean it's you know it's think there are people out there with genuine worries, concerns, anxieties but they don't need us, they need they need something else sometimes* (TL M: A3, p20).

This level of recognition regarding the function of CMHTs in some ways creates a "check list" approach relating to the types of client that they should and should not be dealing with. It also involves recognising the other services that would be more appropriate to deal with the problems that the CMHT is not designed to manage. In some ways, it is a "not wanting to step on anyone's toes" philosophy in that teams need to deal with what is relevant for them.

As with awareness of the manner of SPA meetings, group identity had undergone evolution as well,

> *yes we are still multidisciplinary in that there are doctors, there are nurses and we have an OT, but we don't actually have social workers within our team, they're a separate team that happen to attend our allocation meeting, yeah? And that's one of the big bugbears that I have in terms of mental health services, that we no longer have integration with social care* (CP M: A6, p5).

CP M: A6 discussed the group identity of his membership of the CMHT and its evolvement in relation to dwindling resources,

> *So in terms of team assessments or care coordinators, we've now got less care coordinators and less team than we had for the same referrals, the same community mental health team, we've got less bodies than we had, yeah? We've now got specific personality disorder unit, we have other developments in the service, so I think we do do things differently now because of the nature of the resources, so the criteria that I have, when I started sixteen years ago, about seventy-five to eighty percent of referrals at our allocation meeting we would assess, of which most of those would be medically- that's very very different now, because a lot of the referrals that we would have assessed even ten years ago now go to the Primary Care Let's Talk Wellbeing service… which wasn't around then, so our criteria over the years changed as services have developed.*

Clearly resource availability dictates the shape of the CMHT and its approach to clients and criteria need to be modified to accommodate such changes. The development of new services such as IAPTs has allowed the CMHT to pass on certain clients that would have been their responsibility before. Changing times and diminishing resources has also had an effect on the responsibility they allocate to GPs,

> *…and there's nothing more that we can offer… And I think we do that more than we perhaps used to. In the past we may have seen them- seen someone for a one off, confirmed there was nothing more to do but we would have had that*

conversation with the patient, whereas now we're asking the GP to have that conversation with the patient, which I don't think that's necessarily a bad thing… (CP M: A6, p7).

This is about recognising that GPs have the capability to do this and must take on that task because it is can no longer be the duty of the CMHT role. It is also about CP M :A6 acknowledging where his role ends and where the GP takes over.

Clarity over the types of problems that their home teams should deal with was also shown by STL F: A2,

"service users will receive interventions if they're experiencing moderate to severe mental health problems including anxiety" (reading statement from Trust website)*, yeah …that statement's correct.* (STL F: A2, p1)

STL F: A2 highlighted the developed strength of her team in identifying appropriate clients,

And even though we I think are much better at saying well, identifying what is the mental health issues, er, we haven't actually got a, a tool or a document that actually says "Well they don't score this so we're not seeing them, er and I know I think some SPA's er were using the PHQ-9 and that sort of thing, but as I say as you know we don't currently do anything like that. (STL F:A2, p2).

This recognition of what her team does well is coupled with the awareness of the lack of resources and how this limits them. The team have honed their skills in the absence of these aiding tools and this strong ability to pick up relevant cases has become a feature of this particular team and is recognised as such by STL F: A2. Knowing what is and is not accessible in the working environment is a key part of this phase as well. Lack of resources was also emphasised by another subject,

yes I think in the in the ideals and like what I was saying in terms of what you might want to do in a service, because erm, er, because I have a different view about what I would like our service, I'd love our service to be doing X, Y, Z, for instance, but we can't, because we don't have the resource… somehow you have to start doing some kind of resource allocation, even though it's really difficult to think about (CP F: A5)

This quote reveals somewhat of a conflict between personal beliefs and the reality as dictated by resources and the fact that the latter needs to be prioritised. Recognising this demonstrates limitations of the CMHT that need to be taken into account, and in relation to the Handling Role Boundaries process, this will affect behaviour in subsequent stages.

Subject TL M: A7 too brought in the issue of resources when discussing group identity,

…with the resources that we've got to our hand, we have to judge it by specific criteria to decide who's going to come to us and I think that's what we do. (p6).

According to TL M: A7, resources dictate the criteria that the CMHT use and in a sense determine their clientele. He continued to reveal aspects about the CMHT he works for,

… sometimes there will be a patient who has gone to see the GP with a multitude of things but actually the CMHT isn't the right place to deal with it and sometimes I think it's better for the patient to know that as well. Then I advise them where, you know there might be, now if it's financial issues, then really we're not always the best people to deal with that, we can deal with the distress but really you're probably better doing something else… (p4).

TL M: A7 is aware that sometimes the CMHT is not best placed with all clients' problems and at the same time has a good idea about the nature of problems they are capable of dealing with. Therefore his recognition of the CMHT group's role boundaries are grasped to enable attendees to move on to further phases in the Handling Role Boundaries process. TL M: A7 later gave indications about what has contributed to this recognition,

…that's what we do, we measure them against specific criteria, what we feel is secondary care and what we feel is social care, because there are NICE guidelines that suggest where we should become involved… (p5).

Clinical guidelines are utilised and direct this CMHT in deciding what their responsibilities and what problems they need to respond to. The development of these guidelines is such that they are constantly modified, evolving and issues (NICE, 2012) and that potentially means that recognising is also subject to these same conditions. At different time points, if role boundaries change, attendees may recognise different things relating to the four sub-categories mentioned.

Lack of resources was a recurrent theme arising from the data in relation to group identity and it was something also mentioned by CP M: A6. However, his reflection was also encompassing of pride,

We do what works works for us and…I think it's quite notorious for this team as well, we we've always kind, try to take, it's a massively clinical team, we haven't got academics, we haven't got management particularly working in this team, and we're all patient centred, so what we tend to do is what works ultimately right for the patient, which means we do tend to fall foul of kind of senior management that don't like the way we do it, we've never got HoNOS on time and our RIO entries are probably not up to date, but the patients get seen, the patients get a really good service I think. (p12).

Thus in the face of flaws and limiting resources, this team pride themselves on their endeavour and success in putting patients first and ensuring that the patients receive a good service. CP M: A6 continued to highlight his endorsement of the team as a whole,

As a team we work well together…Total trust in each other, absolutely and that's, as I say that goes back to patient centredness and the way this team works and

got a real sense of what we're about is delivering a service to the patient…(pp13-14)

The *group identity* sub-category of the recognising phase was interesting in its comparison to the *self-awareness* element. With the latter, subjects would compare themselves to other attendees of the SPA meeting. Regarding the former, the subjects spoke with a collaborative emphasis such as using terms such as "we" and "us". One subject even compared the CMHT where she was based to other CMHTs,

… we were talking about recently here that different community teams take in different types of referrals and others don't so there is a varied ability across even within our Trust and there will be and I'd there isn't any, and what you'll find is the teams with a bit more capacity will take more because actually people want to help and people, you know, want to look at things, you know, cos part of what we would do is preventative strategies, so you could take somebody into service, erm, even, you know even if we're saying "Mmm, is that a bit borderline for us?" But somebody might say "Do you know what, I have a bit of time and I have a bit of space, I could do 6-8 sessions with that person on such and such and that might help them stop coming in again and again and again, which is good, but if you have a team which has one CPN, they'll actually say, "Can't do", you'll have to look elsewhere… (CP F: A5).*

This demonstrates the complexities of roles that subjects possess- sometimes talking with an emphasis on individuality and sometimes prioritising their allegiance to a team and being a team member. Once again, the limitations of resources emerge as a huge factor.

Recognising the shortfalls of one's team was also an important part of the group identity sub-category phase,

…but it just wasn't documented anywhere, er, and that's why I think we sometimes fall down, because we're not quite as explicit as how we should be, and I think that's just our practice. Maybe at the end of every referral we should

actually have somebody to write a letter, erm, to the GP saying "yes we are taking this person" which is what ordinarily we will do… (TL M: A7, p22)

Having awareness of how one's practice differs from others allows attendees to get a sense of their limitations and also identify areas for improvements to instigate better practice.

The four sub-categories which contribute to the recognising phase provide a baseline for subsequent behaviour. Recognising establishes awareness of oneself, one's colleagues, one's group and the SPA meeting process and tendencies, which guides attendees on the best approaches to follow subsequently. Without this initial phase of recognising with its sub-categories, attendees could not establish expectations on themselves and others in the multidisciplinary environment hosted by the SPA meeting. For example by recognising that a SPA meeting works with everyone reading letters, attendees are able to enter the Positioning phase knowing that they will need to read a letter and that this will be done in a certain order. Essentially the Positioning phase relies on awareness acquired from Recognising. Positioning will now be discussed in the following section.

5.1.4: **Phase 2- Positioning**

Positioning is the second phase in the Handling Role Boundaries process and pertains to the attendees placing themselves and others in the context of the meeting. It helps attendees to establish expectations they have of themselves and others and also sees them taking their place to behave in certain ways during the meeting. This behaviour stems from the role boundaries that were established from the Recognising phase. Expectations may include negotiating conceptions of clients based on professional background. This mental process of having expectations and placing oneself is something that all attendees go through. Positioning has two sub-categories; *Placing* and *Taking one's place. Placing* involves attendees establishing expectations with regards to meeting duties and behaviours e.g. expecting oneself to read after someone else, expecting a social worker to pick up on safeguarding issues, expecting the IAPT service representative to be more cautious than others about taking on clients. *Placing* can also relate to personality issues since this has role boundaries as well. For instance one might expect an organised person to take charge of time keeping in the meeting. *Taking one's place* involves actively behaving in the way you have placed yourself e.g. "zoning" into a

certain area when it comes to listening to letters being read and subsequently communicating this; or listening to fellow attendees who are reading and making contributions. Positioning and its two sub-categories are represented in Figure 5.1.4.
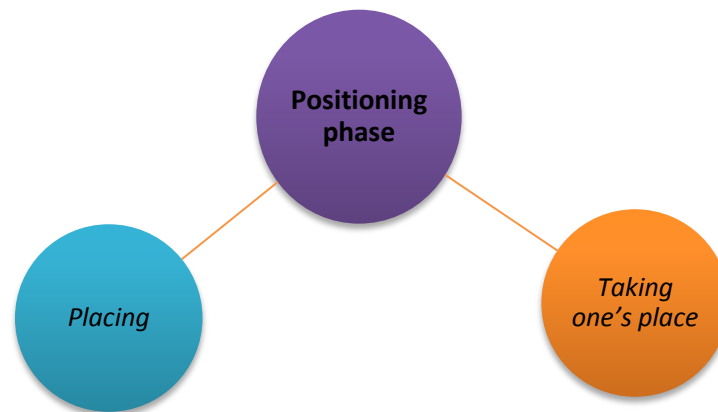
Figure 5.1.4: Positioning and its two sub-categories.

Placing

After recognising various role boundaries, attendees of SPA meetings are able to place themselves and others as part of Positioning. They form expectations upon themselves and others derived from the established role boundaries. Placing is often a mental process but can be verbally done as well e.g. an attendee might directly ask what the consultant psychiatrist felt about the medical risks of a client.

Placing as a sub-category of positioning involves attendees attaching responsibilities to people that they expect them to fulfil,

> *…the person who reads the letter can, if they try, influence the outcome of the discussion by the way that they read the letter, by the way that they present the findings from the case notes…* (CP M: A1, p3)

The above quote demonstrates clear expectations on readers. This subject elaborated further on what attendees as readers should achieve,

> *it's sometimes important to maintain people's attention, erm… particularly if the letter is a long one. Er, it can be frustrating for the meeting if a relatively inexperienced person starts reading a long letter without being able to grasp the main issues and perhaps summarise it because not all letters are written, not all letters are read out completely verbatim. If it's clear that there is an issue that can be communicated from the letter to the group by summary, then that's a perfectly permissible way of doing it. Dealing with, or presenting a case to the group also can require a search through the case notes, and searching our case notes is an acquired skill, which not everybody has because not everybody's been in the business long enough to know to use it, to acquire it…* (p4)

Being a reader seemed to require an execution of certain skills and this left me intrigued as to whether or not CP M: A1 felt that it should be left to the more experienced attendees. His response was as follows,

> *… I don't like that. I, I see the, the meetings as actually quite an important training experience for medical students, trainee doctors, nursing students all alike. Erm, and… enabling people to feel included in the process is a useful part of enhancing its values as a training experience, so…I wouldn't choose to do that.* (p4)

Thus, the subject has placed all attendees as being capable of reading and further places the less experienced attendees as being in a position to be trained in such skills. There were however expectations that were reserved for the more experienced attendees,

> *I would say that everybody who was there had an opportunity to contribute, not necessarily in relation to every case… it might not be relevant with every single case, but I, if I just sort of run my head round the, the people who were there,*

who weren't students or recently arrived trainee doctors, er, and therefore were if you like regular attendees of the group, everybody had an opportunity to contribute in a way that reflected their own particular professionalised location within the organisation. (p5)

Thus, CP M: A1 bases some of his expectations of what regular attendees should be doing in the meeting, on the expertise associated with their professional roles. As the quote reflects, this is not an expectation that he feels is appropriate for the less regular members of the meeting. More specifically, this subject was clear about the purpose of using one's professional background,

…looking at the individual or the individuals one by one, through the lens, through the clinical lens, erm, and so attempting to elaborate a perspective of the individual based upon the information that's provided, through the particular lens or from the particular position that each of us is sitting in... (p10)

Thus, creating one's own clinical conception of each client is viewed as an important element of SPA meetings as part of this Positioning phase. Forming a conception means that contributions are delivered which develops discussion.

Placing the more experienced attendees in different ways to lesser experienced attendees was common for subjects,

Lack of agreement…is rare, because what actually happens is if there is a real er…uncertainty about what to do, I think it people start to look towards the senior members of the team and you're looking towards three or four people in the, in the, in that team. And usually there's some agreement made between those three or four about what should happen, erm, so I think it goes to the more senior experienced members and I think that's probably right…but ultimately it's the Chair…the Chair decides what to do, erm whether it's, they have to come back next week to re- discuss it or whether so and so should take the decision or whether they take the decisions, so the Chair has that really important role of…saying, and I've often said, "Look guys, come on, we've talked about this for

> *ten minutes, we need to come to a consensus at least, at least have a plan. You*
> *can't A B C in a plan but at least have the plan.* (CP F: A5, p27).

Thus this is an example of *placing* the senior members (after initially recognising that there are senior members and the experience they possess) to step in and take control of the discussion. This a practice advocated by CP F: A5 and suggests that a hierarchical power structure exists which influences the Positioning process. Moreover, CP F: A5 reveals her expectations of the Chair person by specifying how their role should be implemented in certain situations. CP F: A5 *places* the chair person in a very senior position based on expectations and this stems from her initial recognition of the chair's role boundaries. Thus she expects the chair to intervene in order to direct the discussion to reach an actual decision. I asked the subject if she thought it was acceptable for Chair to act in this way and she responded,

> *I do! But they need the, to be able to do it and be experienced to do it… The*
> *Chair mustn't just say for every referral, "Well this is what's going to*
> *happen…tough" you know, yeah.* (p27)

Thus *placing* is done within the established role boundaries; although the Chair has significant authority within SPA meetings, he/ she cannot impose a decision that overrides all other members' contributions. This is why CP F: A5's expectation is such that she attributes *some* responsibility to the chair, but not an amount that would go beyond their role; expectations are moulded by the already established role boundaries of a Chair person. Attendees' expectations are conveyed through their *placing* of fellow attendees. For example CP F: A5 implicitly believes that the Chair is capable of intervening and directing discussion because she holds an awareness of what the boundaries of the Chair role are i.e. it is within their responsibility to keep general control of discussions. This helps her to *place* the Chair accordingly by expecting them to step in should discussions stray from topic. Attributes from Recognising inform expectations to be fulfilled in Positioning.

There were more examples showing that *placing* involves utilising the skills of attendees that have been established from the Recognising phase,

Yes, and you rely on somebody like our senior OT is really good at remembering as well as somebody else, and if they're there, they'll say, "Oh yeah, that was read out and it was this that and the other" so that person has a really good skill of picking up the ins and outs of referrals, yeah… (CP F: A5, p24)

Thus the Positioning phase is a step further from Recognising because it is about what one does with the recognition; in this example above, it revolves around how that skill informs the expectations of CP F: A5 and how it can be applied in the meeting. The subject relies on the OT to apply their memory when it comes to clients who have been discussed before and contributing the result of this memory to the rest of the team. CP F: A5 *places* the OT in this way because she recognised that the OT has this skill.

This reliance on attendees' skills was also mentioned by another subject,

I think the admin support we get is very very important as well and the, the knowledge of when somebody's got an an appointment coming up, what the waiting lists are like and if there's a query, going back to the SPA sheets and being able to identify, yes this referral was discussed on this day, here was the outcome (STL F: A2, p3)

STL F: A2 *places* administrative attendees in the meeting based on the merits of their skills in record-keeping and knowledge of several aspects of clients and their referral journey. She has awareness of their capabilities and this is likely to have been built up over time. From this she is able to have a sense of what they should be doing in meetings, which is communicated as expectations.

Taking one's place

This sub-category relates to the personal responses to having placed oneself and concerns the actual behaviours and actions that attendees exhibit as a result of placing themselves.

CP M: A1 described his approach to looking at case notes and what he did with them,

So if I open a set of case notes and I see a letter that I've written and it reminds me of my encounter or encounters with that particular patient, I can then conjure up…yeah… that person to a level of detail, it may not be with a level of accuracy, but to a level of detail anyway, that I wouldn't be able to achieve just by reading from the notes totally uninformed. So the notes cue my recollections of the person (p9).

Thus his clinical conception of the client is created and fuelled by the marriage of case note content *and* reflecting on his experiences with that client. So through *taking one's place* he sets himself the task of having a specific purpose for looking through case notes (thus seeing them as functional) and also keeps in mind that he may have to employ his memory as well. As with *placing*, this concerns meeting activities.

Likewise, CP F: A5 had clear notions about how information should be treated and discussed,

I-I think there's a, there's a place for my opinion, my subjective opinion, but not for that to be the basis of the decision. Decision-making needs to be across the board, erm, but also there has to be some objectivity, if you're looking at subjective, objective, it does need to be clinically based though and if you don't feel you have enough information, the purpose of the meeting is to go and seek it,you know, so you know, you don't go and make decisions ono information, because what's that got to do with anything? Erm, mmm, you know evidence-based…interventions really, so if you've got a set of problems and you know that the evidence says a certain intervene- intervention is good for that set of problems, you go and you say can we offer that intervention, how do we go about doing that, because there's good evidence that that works, so obviously you know, you-you do that. Erm, if you don't know, you make a plan… (pp20-21).

CP F: A5 is clear to point out that she can offer her opinion but decisions should not derive from this; rather she promotes evidence-based practice to guide the discussion so that decisions adhere more strongly to clinical validity. In situations of uncertainty she *places herself* with being prepared to make a plan.

Furthermore as mentioned earlier, CP F: A5 *takes her place* by "zoning into" medical aspects of the letter and contributes to the meeting in this way.From the Recognising phase, CP F: A5 has an awareness that she is drawn to certain aspects of letters as informed by her professional training, and this part of Positioning means that she tasks herself with focusing her attention on the parts that are relevant to her professional background.

Moreover, CP F: A5 had notions about *taking her place* when she took on an occasional role as chair,

> *sometimes when I chair, I think I might go back to keeping them all on my lap and just se- putting the one out that's about to be read, because sometimes, I have concerns that everyone is is, that people might lose er, the focus on one referral, because they're busy trying to organise their own referral and "(gasps) What's the issue here? Wha wha what" and you know, it's a bit as a chair I notice it can sometimes be a little bit distracting if somebody's flicking through a set of notes when somebody else is trying to read out a referral, so erm...* (p9).

She plans to act in this way because she expects a chair to have a modest amount of autonomy in how the meeting is organised and this action fits in within those boundaries. Moreover as well as arising out of this recognition of what a chair role involves, it also stems from recognising the shortfalls of attendees who are preoccupied with their own referrals and their tendency to get distracted.

The plans that formed part of *taking one's place* described approaches that subjects believed were important during SPA meetings,

> *…but the final decision is regards of criteria and difficulties that can be helped are met with the assessment team, er and I think that is appropriate that they should make that decision, er for example I wouldn't feel happy SPA making a decision of whether somebody got or didn't get an assessment from the Early Intervention service I feel it's the Early Intervention's role to say that…* (STL F: A2, p2).

STL F: A2's approach is motivated by her personal beliefs about responsibility attribution. She sees specific teams as having the capabilities and authority in making decisions about what clients they take on and does not feel that the general mental health service that she is part of should make that decision on their behalf. She builds her expectations on herself and the Early Intervention team to fit in with the role boundaries that she understands. She provided further insight into her own actions,

> *…and personally er, unless it's something really clear cut on paper, I don't believe we should be sending referrals back without seeing the client. I'm very much in favour of you know if it looks like a secondary mental care, health care and there's issues we can help with that we need to assess before we can say yes or no because sometimes the information you get on paper from the referrer is quite inaccurate or there's minimal information and we actually sit with the client and it can be a whole different presentation and a lot more serious…* (STL F: A2, p2).

She *takes her place* in preparing to accommodate for a range of clients and will be vigilant to identify anything that clearly suggests her team do not need to get involved. *Taking her place* to treat the clients in this way through going through letters and case notes fits in with her personal beliefs that it is important to "play it safe" with regards to possible risks. Through the previous Recognising phase, she also established the fact that referrers do not always provide a complete picture, which is where assessment can be beneficial in filling in any gaps.

As all the interviewees had experience of chairing SPA meetings, there was discussion about how one *takes their place* as Chair,

sometimes, when I'm chairing it have to just kind of keep my eyes focused a bit to make sure that we don't become a bit sometimes… (TL M: A7, p14).

This came from a discussion about times when he felt conscious that discussions were verging on too much levity. Thus if he was chairing at this time, he positioned himself to be more cautious and alert to ensure he could *take his place* and step in to re-direct the manner.

There are links that explain how the Recognising phase influences the Positioning phase. The following example shows in particular how recognising impacts the *placing* and *taking one's place* subcategories of Positioning,

… there's a long, there's a long running issue with Learning Disabilities services, who…are actually occupied mainly in looking after people who are very seriously disabled... so when a more modest degree of learning disabilities part of the patient's presentation, there's a temptation to feel that learning disability services should take responsibility for this…but they don't because they're busy doing other things with much more disabled people, erm, and so one questions the validity of even entering the presence of a learning disability into the whole way of talking about that particular patient (CP M: A1, p15).

CP M: A1 has built up an impression of the Learning Disabilities service through experience over time, and as part of the recognising phase, he identifies that they only take on clients who have severe disabilities. Thus this association and awareness of their reluctance to take on clients with lesser disabilities means that CP M: A1 *places* the Learning Disability service as only appropriate for certain clients and thus suspends his previous expectations for them to take on all clients with any degree of learning disabilities. Moreover, he *takes his place* by feeling it may make better sense when reading, not to disclose information about learning disabilities if it is of a smaller degree since the Learning Disabilities service will not take the client on.

The Positioning phase is an important part of the Handling Role Boundaries process because it signals the start of attendees working with the role boundaries they have

become aware of and gives them direction. Forming expectations is important because in this multidisciplinary atmosphere, no one person can do everything, so they learn to rely on people's skills and strengths. Moreover, it helps them on a personal level to determine what they need to do within the meeting and what they can leave for other people. In terms of discussion development, the Positioning phase gives the opportunity for conceptions of clients to be formed and contributions to be made. This paves the way for the next phase of the process called Weighing Up.

5.1.5: <u>Phase 3- Weighing Up</u>

This third phase in the Handling Role Boundaries process works with the results of Positioning. Attendees Weigh Up the contributions and conceptions that came as a consequence of the Positioning sub-stages. As well as assessing contributions, consideration is given to the motivations behind them and the role boundaries from which they derived. There are three sub-categories of Weighing Up as demonstrated by Figure 5.1.5. *Prioritising* involves options being narrowed down to fewer "front runners" which then become the target of discussion. In order to single out fewer options, the needs of the client are prioritised to establish what needs to be tackled first. *Matching up* sees the options linked with corresponding professionals (who may or may not be attendees at the meeting). If such professionals are present in the meeting, they are likely to become dominant in the discussion. *Evidencing* sees attendees providing justification for their advocacy of one option over another. This may involve referring to past success associated with that option or reiterate parts of the letter and/ or case notes to highlight their points.

Weighing Up as with all the other phases depicts exactly what it does; attendees weigh up the possible effects of taking certain options as well as responses from discussion. Options and responses are assessed and there may be much speculation involved. With clients who require less discussion, weighing up may be a mental process that is not verbally demonstrated. It may be clear that one service in particular will be ideal so in one's mind, the effects of the option(s) will be conjured up and *evidencing* will be based on that service's past success with dealing with the issue. It may be a case of "everybody knows" and thus just a simple mention of the service is enough. However in all cases, some level of weighing up will take place.
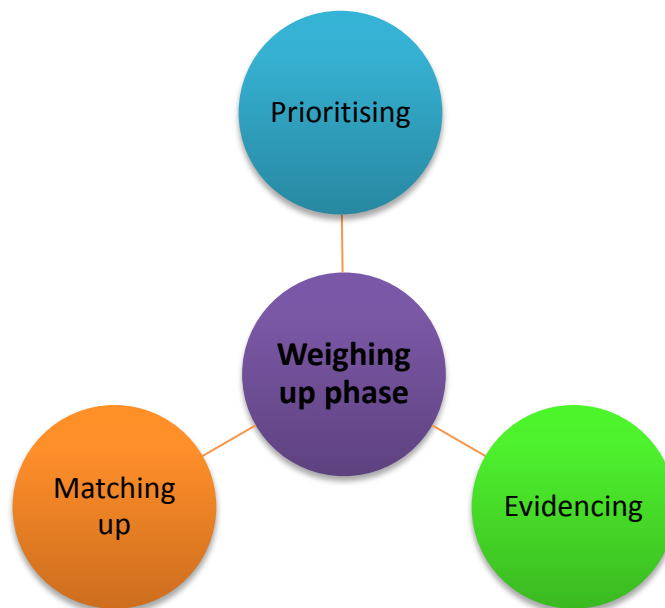
Figure 5.1.5: Weighing up and its three sub-categories.

With regards to relevant quotations from the interview data, the nature of verbal disclosures meant that the three sub-categories of weighing up often merged; thus it makes more sense to discuss them collectively rather than individually as has been done with other phases. However, what the discussion should demonstrate is that they can be understood as three separate sub-categories of the Weighing Up phase.

Prioritising, Matching up, Evidencing

The Weighing Up stage can lead to bulky discussion through attendees' going through the sub-categories,

> *…it's a question of actually taking it on face value and actually saying "Well yeah, it's been referred to Dr *******but it it's more appropriate to go to IAPT because you know the, because that's the nature of the issue that's in the letter... some, some come through to er the the medical lead I mean the the the local consultant either Doctor **** or Doctor ****or sometimes Doctor ****, some come through to erm… CPNs who've seen the person in the past, but it, they all get sort of erm the same sort of er, same discussion and the same thought put to them.* (TL M: A3, p5).

In some cases as with above, *prioritising*, *matching up* and *evidencing* is done verbally and this is common for clients whose cases are not as clear cut as others. Thus TL M: A3 discusses the notion of referral letters being addressed to certain individuals, but some attendees do not concur with the referrer's thinking. Reflecting on the letter, the client's issues are *prioritised* and *matched up* to the IAPT service. *Evidencing* may not be disclosed verbally; it might be assumed that all the attendees are aware of what the IAPT service provides and thus can think about how the client's problems are relevant for them to deal with. Moreover, it is likely that attendees would reflect on how IAPT have effectively dealt with similar problems in the past.

The three sub-categories cannot always be done effectively if referral information is lacking,

> *…depends on whether, you know how risky the client sounds really and erm, whether you know, there's specific concerns which could be erm risky or whether i-it's more that we probably think that they could go to* (IAPT service) *erm, and the GPs not quite sure which, you know sometimes I'll ring up and say "D-d-do you feel this patient needs* (IAPT service) *or do you think they need secondary care because it's not clear from the letter* (Nurse F: A4, p10).

Therefore attendees are often faced with such challenges as the subject above. However despite the referral information not always being helpful, there are still attempts to *prioritise*, *match up* and *evidence*. The subject above demonstrates this by reflecting on how the team need to assess the risk element of clients and whether specific concerns are identifiable. If *prioritising*, *matching up* and *evidencing* fail within the meeting, a decision will need to be made as to whether or not see the client anyway or seek more information. This side of decision making will be discussed in section 5.1.6 on Balancing.

There may be some cases where evidencing is done out loud,

Practices don't allow that appointment system so what you often see is a GP that perhaps has only met a patient once or twice referring them through even though they've been seen psychiatrically before and nothing's really changed and what we'll then often have to do is write back and say on the basis of information nothing seems to have changed, there was a full assessment eighteen months ago that suggested the following and try and highlight to the GP what was recommended then, because from the GP's referral it's clear that that wasn't actually done, yeah? Or it was done and there's still no improvement and occasionally we just have to write back and this is one of the most difficult letters to write back and say "although the patient clearly remains quite distressed with on-going symptoms they've actually had all the treatment options that are available and there's nothing more that we can offer". And I think we do that more than we perhaps used to. In the past we may have seen them- seen someone for a one off, confirmed there was nothing more to do but we would have had that conversation with the patient, whereas now we're asking the GP to have that conversation with the patient (CP M: A6, p7).

Within the meeting, CP M: A6's account of the above would have manifested verbally where the CMHT's past dealings with the client would have been reflected upon, with *evidencing* showing that interventions were not successful. This demonstrates how *evidencing* is not always done to justify the decision to offer clients a particular service or intervention, but can also be used to demonstrate why a service or intervention is not suitable. *Prioritising* is done once again, but the client's issues cannot be *matched up* to anyone in secondary mental health care or the IAPT service. Another interesting point is that *matching up* has changed to keep in line with evolving services and approaches. For example when resources were better, the CMHT would have been in a position to offer the client an appointment to make sure that there was nothing more that they could offer; now they need to make this decision based on letter content and are no longer *matched up* to the client in this way.

The notion of the Weighing Up phase being affected by changing times and resources was also discussed by TL M: A7,

Historically again everything used to come to Community Mental Health teams before the primary care service was set up, so therefore this was oh, I'm trying to

think, eight years ago probably. Possibly a bit longer. Everything used to come to the CMHT anyway. Obviously now that there's a primary care team then then the focus has slightly shifted. However in answer to your question, I still think what the the referral meeting does is both of those functions, I think it does signpost, but also I do think it also decides the best course of of response to people who are actually going to come into service as well, I don't think it's one or the other. I think we do both. I think, and I think fundamentally before other services like Primary Care existed, it was very much the former that we decided what to do whereas now I think it's just because services have become so erm, widespread really, but also I think there's the other thing where you've got to bear in mind is that changes in provision mean that it's not just the NHS that's providing services, I think there's also a lot of stuff in the voluntary sector that erm, has to be born in mind that they sometimes provide a better service for certain aspects of of of an illness or symptoms than than we ever could do (p2).

TL M: A7's account followed my question about whether he felt the purpose of SPA meetings as signposting clients onto other services or the CMHT taking them on. The introduction of services has seen options far more widespread, which gives the team more scope for *matching up*. Moreover, these options transcend the boundaries of NHS provision to take into account what the voluntary sector have to offer. *Prioritising* is done to establish that the CMHT themselves are not the appropriate team to deal with the nature of the clients' problems. The above quote also reminds one that the different phases of the Handling Role Boundaries BSP are all integrated together to work as a whole since initial recognition of what the CMHT is designed to deal with needs to be known in order for subsequent phases such as Weighing Up to take place. Thus recognising enables *matching up* to be done more accurately.

The ways in which Weighing Up and its sub-categories are employed varies from client to client because of the different levels of complexities of problems,

Well I think it is matter of arriving at consensus erm, which can be very quick and easy if there's an obvious message in the information, you know, young person, psychotic, you don't even have to talk about it, everybody agrees, including the Early Interventions team so that's it, job done. Erm, a person who has been referred with a complex mixture of, a history of domestic disturbances and drug

and alcohol problems and, erm, a history of, I don't know…residential uncertainties or moving about, you know, it's not quite clear what's going on here, then, it might take time to come to a conclusion, or the conclusion might be as you well know we don't have enough evidence to come to a conclusion and we want more, and we want more. (CP M: A1, p15).

The elements of Weighing Up depend very much on the quality of information in the referral letter and case notes. Moreover CP M: A1 brings in the notion of consensus as well. *Prioritising*, *matching up* and *evidencing* can be done swiftly if there is clarity in letters and it is likely that in such situations, there will be consensus among attendees since there is nothing that appears to dispute the clarity. However, some clients have very complex, multi-faceted problems and *prioritising* can take more time. This has an effect on *matching up* and *evidencing* since there may be competing options available. As the subject above suggests, the result of *prioritising*, *matching up* and *evidencing* may not lead to settlement on one particular option and instead reveal the need for more information.

Observational data revealed some interesting insight into the three sub-categories of weighing up. The following field note extract shows how the team attempt to *prioritise*, find *evidence* to deter from a certain option and *match up* to a mental health professional and how this is done through verbal and non-verbal indications.

TL- *Go on* – indicating next person should read out

> Case has no RIO history- comments come that this is "strange"

> Last discharged in 2003- reader suggests that this might be the reason why there's no history

> Suggestion of IAPT.

> CPN- Too much interfering in his life for IAPT

> TL- *Medical?*

> CPN – *Maybe.* She turns to CP M

> CP M pauses and suggests screening might be better initially, then he will be happy to see the client after.

(Area 3: 3rd observation)

Prioritising is initially done through thinking and options are narrowed down to IAPT. The CPN does not think that this will be suitable and takes part in *evidencing* by suggesting that there has been too much going on in the client's life for IAPT to intervene. The fact that the client has a complex history prompts the team lead to *prioritise* a medical appointment intervention. The CPN then *matches up* this to a particular consultant psychiatrist who is present and indicates this by turning to him. He offers his own suggestion where he *prioritises* an initial screening first.

The Weighing Up phase continued to be evident through analysis of further observational data,

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- CP F reads main referral letter and then reads dates, symptoms, treatment

> Summarises "*psychiatric stuff*"

> Chair F – *tricky isn't it? Sounds not very well*

> Nurse- *When you read out, sounds like she's heading for Mental Health Act again*

> CP F - *We need the notes so that we can look at risk…see how she came to the service last.*

> Chair- *No correspondence, but two Mental Health Acts in 2009*

> Nurse- *How did this referral come through?*

> CP F- *Just thinking, is it Crisis?*

> Nurse agrees

> Chair- *Put her on alert until next *******

> CP F – *It needs dealing with soon if we are involving crisis. To be honest, she might be more appropriate for recovery but we need to know risks…I would have thought that they* (Crisis) *can run with this one.*

> Chair- *Yes, we don't give them much*

> CP F – *Needs dealing with now*

(Area 4: 3rd observation)

This field note extract also demonstrates the silent and verbal examples of *prioritising, matching up* and *evidencing.* It is one of the higher end complex cases that was discussed in SPA meetings that I attended and this particular SPA team had to contend with the fact that the client had been sectioned under the Mental Health Act twice before. It is clear that this led them to *prioritise* the client's risk factor, in the absence of any other guiding information. *Matching up* was verbally suggested twice- the Crisis Resolution and Home Treatment (CRHT) team and the Recovery team, but the team collectively swayed towards the former. Moreover, *evidencing* enhanced this advocacy for Crisis intervention; the comment about them being able to run with it shows that CP F had thought about the clients that this team are capable of dealing with. Moreover the Chair uses *evidencing* to justify her support for Crisis involvement by emphasising that the team rarely refer to them.

Weighing Up and its three sub-categories are integral to moving on the decision making process. The quantities and manner in which the sub-categories are employed are inconsistent but it is clear to see that they do take place to some extent for each client. For the clients whose problems are complex, discussions are longer and the phase of Weighing Up provides a very accurate way of explaining the conversation content of attendees and motivations behind this that go on. As has been demonstrated, the three sub-categories can be employed to justify why a certain intervention may be appropriate or to provide a reason why it may not be. Narrowing down the options makes the elements that decisions are based on more manageable, which works with the time constraints of SPA meetings. Moreover, the effects of Weighing Up allow attendees to move onto the Balancing phase which completes decision making for clients in the context of the meeting. For clients with less complex problems, the main concern is often resolved through the Weighing Up phase. However with cases which require longer discussion and have less clarity, the Balancing phase becomes crucial.

5.1.6: Balancing

Balancing is the final phase that completes the decision making activities and behaviour within the meeting and is more pertinent when there are complex cases to be discussed. With this phase, the agenda is not to achieve a perfect balance in which everybody has an equal contribution in terms of their role boundaries. Rather, this phase involves subjects negotiating a balance which takes into account the main role boundaries. This is to ensure that a recordable decision can be made within the meeting; I reiterate that the main concern being investigated here is attendees working together *in the meeting*

environment to find a place for the client. Thus in situations where clients with complex problems are being discussed, the Balancing phase moves attendees to the point of resolving their main concern but can only do so by following on from previous phases. Attendees strategically consider what action will work best with regards to the role boundaries present in the meeting. There are three sub-categories of the Balancing phase that attendees may go through as reflected in Figure 5.1.6. *Compromise and negotiating* which sees attendees find ways in which to work with anxieties and misgivings. Typical *compromise and negotiating* behaviour involves reassurance and offering a safety net. *Sacrificing* relates to the main role boundaries that have been established and developed through previous phases. Attendees often find themselves suspending one role to prioritise another. The prioritised role may be one of their own roles out of multiple ones e.g. prioritising one's Chair role over their role as social worker; or may be another attendee's role e.g. prioritising the consultant psychiatrist's suggestion over one's personal beliefs. *Volunteering* involves attendees stepping forward to offer to do tasks and this is prompted by different role boundaries. During Balancing, it is possible for all, some or just one sub-category to materialise.
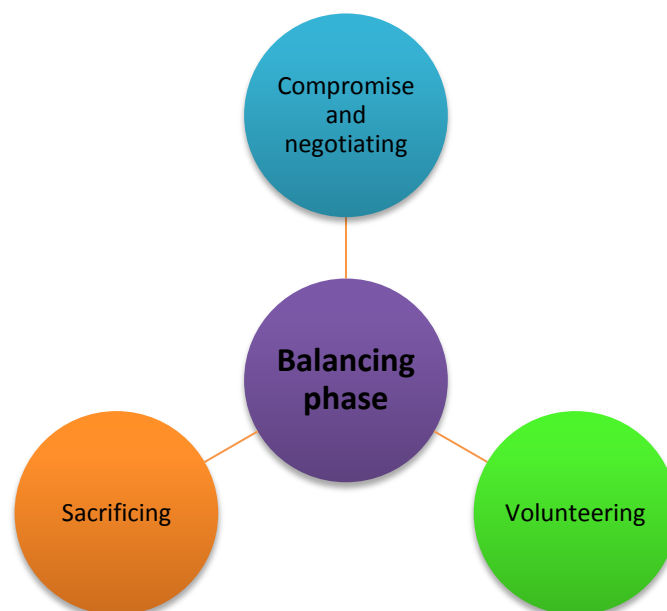
Figure 5.1.6: Balancing and its three sub-categories.

Compromise and negotiating

Compromise and negotiation is particularly prevalent during times when there is reluctance and doubt about taking on clients,

> (On conflicts)… *but you just have to manage it really. And it's much better to have the dialogue. Erm, sometimes we'll try and have the discussion before that, but we'll say "Look ok, we'll assess, as a secondary care service, but if we think it should come back to you, would you accept it at that point?" And they might say, "Well ok, but we're worried about the long term nature" and we'll say "Yeah, but look why don't you focus on your six to eight sessions on such and such a problem". At least that's work that they've got done, they've had that input, it's been positive, you know, they might not need us then, they might go back to the GP, or if they need us, they can come to us. So you know, erm, all of that depends on the individuals doing the negotiating and chatting…* (CP F: A5, p25).

CP F: A5 ultimately refers to offering colleagues a "safety net" whereby she reassures them that they can refer back to the team after trying their intervention. She specifically highlights the significance of negotiation and the integral part it plays for some discussions. In order to conjure up this compromise, CP F: A5 has had to consider the role boundaries that have been established and developed from the previous stages e.g. what service her colleagues actually provide and whether they are usually open to negotiation (Recognising); listen to their contributions to the discussion about the client including any doubts and worries they have (Positioning); and assessing whether their worries warrant somebody else taking on the client or whether it makes sense for them to take on the client (Weighing Up).

STL F: A2 deemed the ability to negotiate and compromise as part of the success of SPA meetings in her area,

> *I'm sure you've heard me say it, when somebody's said "well I'll take, I'm not sure but I'll take it", then I always say "that's fine, thank you very much, assess and bring back if there's any issues or you feel it's, it's not for your service… and I think that helps and I think it works well because people then don't go away worried or resentful, "well I've been lumbered with this, no matter what I've got to see it", yeah and I think the SPA here and and services here are very very*

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open, very good at doing that and I think it's been one of the reasons that IAPT has worked so well … I think that really works well because for me the priority is getting the assessment, then you know any renegotiations take place from there but till somebody's sat face-to-face with the client, you're never going to be a hundred percent sure. (p11).

Again, STL F: A2 describes offering a safety net where the particular team have the reassurance that they can bring the client case back if they find that they cannot deal with it. For the purposes of that particular meeting, attendees have then found a place for the client, however temporary that may be. Offering negotiations and compromise mean that STL F: A2's personal principles of granting clients an assessment are more likely to be fulfilled.

For another subject, the compromise of offering an initial screening assessment for clients before an appointment with a consultant psychiatrist was a strategy for efficiency,

…it's multiple reasons why they go through screening, erm, sometimes it- a consultant would say "yes- a- it probably will be me, to see them eventually but can you just screen them first just to confirm what's happening," cause I mean sometimes a screening appointment's for a lot sooner than a than a consultant outpatient's appointment, so we can get, cause it's, what tends to happen is if they're screened in a, the CPN or the social worker sees that there's a you know, a serious mental illness or a serious problem actually there that need a consultant input then if we've seen it and assessed it then that gets through quicker than waiting and waiting for a consultation… (TL M: A3, pp7-8).

Thus, as well as giving consultant psychiatrists a better picture of clients before an outpatient's appointment, screening assessments also worked with the current state and limitations of waiting lists. Then should the screening assessment pick up on anything of significance, the client can be processed quickly to progress to a consultant's appointment. Like STL F: A2, this subject also agreed that this was boosted by amicable relations,

…there's usually sort of erm, a- a get out clause as it were in that sort of if a consultant's not willing to pick up a person then you know we probably offer them a screening and take it back to the consultant with further information or get further information from the referrer. I mean it's it's, you know things aren't insurmountable, I think that's the point of having good relationships with the people… (pp 13-14).

The description of this arrangement being a *get out clause* reminds one of the notion of offering a safety net and reassurance. The sub-category of *compromise and negotiating* offers a way of working in difficult circumstances where attendees do not always agree. I asked TL M: A3 about times when consensus was not easily reached,

Er, well (sighs) it's it's obviously a clinical issue really that if dif different professionals' perspectives on a on a problem, erm but like I say, it's never usually a major concern within that meeting that I-I've come across really. No it's not, it's not anything that I've come across very often in there, I think there's usually sort of movement, even if you know, you're the most er, intransigent consultant that we don't really have here, you know they make a decision they're often, I mean they're open to persuasion anyway   Not sort of looking at sort of using er, you know medieval torture devices on them, you know it's just really rationalised discussion and you know reasoning really, so yeah, they're usually very er, they're usually not very, they're usually amenable to sort of er…to looking at things in a different way, I mean everybody is really I think… (p15).

Therefore knowing that colleagues are open to altering their perspectives provides the possibility and opportunity for negotiation and allows the main concern to be resolved. This is part of abiding by the meeting conventions to promote rational discussion and reasoning.

Sacrificing

Sacrificing is often made possible as a result of trust in fellow attendees and thus arises in a willing manner,

…it's knowing what is needed, it's respecting each other's professional viewpoints … and working with each other for so long that you're prepared to actually agree if someone else has got a reasonably strong viewpoint that they're right and no one is going to do anything that's actually going to harm a patient...we've got so much respect for each other that we know where we're coming from. (CP M: A6, p20).

Understanding that there are good intentions behind motivations makes CP M: A6 trust his colleagues' perspective to the point that he is willing to suspend his own views. In this case, respecting fellow colleagues makes sacrificing a personal role easier because there is faith in a common goal of doing what is best for the client. This subject gave more specific examples of how this might come about,

*So even if I thought to myself "Well I actually think I could see with, see that person" if if *****'s telling me "Well, I think it'd be not a" I think medically you keep away because it would cause problems, yeah? I'd bow down to her, if she had a really strong view about that, there's no question. Even if I had quite a strong view, I would kind of go with her…*(CP M: A6, p20).

Bowing down to his fellow colleague, CP M: A6 sacrifices his medical role to adhere to another point of view. This is likely to be an effect of working together for so long with developed appreciation and respect for one another's role boundaries. *Sacrificing* did however come about in different ways also, for example, as part of strategies to manage one's own multiple roles,

I think we're very careful to try and make sure that we don't take anything that we don't think fairly confidently is ours… but with my social care head on, everybody's entitled to a community care assessment …we should still be doing the social care intervention, but again that is dictated with resources really because sometimes I will deliberately not say something because that's not been what they've been referred into because again I've not got that many staff I can, I'm not looking for work, I'm trying to push work (laughs) away if anything. If I was being equitable I think sometimes we would automatically take that referral and run with it. We do occasionally… but sometimes it's easier just to not,

because it's a referral into the mental health team, to not do anything sometimes. (TL M: A7, p32).

What is demonstrated in TL M: A7's account is his allegiance to the CMHT as a team member, clashing with his beliefs stemming from being a social worker. Ultimately, he describes his experiences of suspending the latter to abide by the limitations of resources affecting the CMHT. This is established by his holding back from saying something from the point of view of being a social worker. Moreover, he talks about it being *easier* which may be as a result of time constraints of SPA meetings. This was something that became evident in other subjects' reflections as well,

Yeah, but usually they (consultant psychiatrists) *end up erm winning the argument because you know it's quite difficult to draw the line sometimes I think as as Chair person as as a as a nurse and so it's easier to say ok we'll we'll see them.* (Nurse F: A4, p11).

Nurse F: A4 mentions that it is *easier* to go along with consultant psychiatrists sometimes and this is likely to be because of the SPA meeting time pressure of having to get through a certain amount of cases in a certain amount of time. The subject further implies this by emphasising both her Chair role and her nursing role, which reiterates that Balancing and its subcategories are influenced by role boundaries. Sacrificing her personal beliefs, Nurse F: A4 abides by her chairing responsibility to adhere to the best decision within the time available. With further questioning in the interview, Nurse F: A4 admitted that such situations frustrated her because of the amount of work that would then create. However one must remember that this particular main concern being resolved is not about ensuring satisfaction among all attendees or something of a similar manner; it is to work together during the meeting environment (thus within the meeting time as well) to find a place for clients. Sometimes, *sacrificing* as part of the Balancing phase of Handling Role Boundaries is needed in order for this particular main concern to be resolved. Other main concerns within this substantive area (which are very likely to exist) would warrant another BSP being implemented.

Nurse F: A4 also demonstrated that she considered the role boundaries of her colleagues before the decision to sacrifice,

> *...if people are under pressure it's easier just to say "Oh yeah we'll see them, we'll see them if you see what I mean rather than, yeah...* (p11).

Thus as well as bearing in mind the constraints of time, sacrificing often stems from understanding the work pressures of specific teams and colleagues and considering one's own capacity; sacrificing works with all of these role boundaries and strategically offers the best course of action within the meeting for that particular client.

Volunteering

There are different motivations that instigate volunteering and this demonstrates the SPA meeting attendees' different ways of Handling Role Boundaries. We can be reminded of the quote on page 137, where CP M: A6 speaks about doing tasks himself. This works with his own personal and professional boundaries e.g. his desire to get things done and the rank that his medical identity offers. Moreover he considers GP boundaries in their preference to correspond with fellow medics and also the limitations of his immediate colleagues who tend to delay the task of writing back to GPs. In exploring the situations of writing back to GPs, CP M: A6 emphasised his professional role further,

> *...but I think once you're looking at junior medics, it starts to fall apart, like it needs to be a fairly senior doc that does it.* (p5).

This once again reiterates the strength and power of rank as a senior medic and gives further understanding as to why the subject volunteers for this task. Thus volunteering offers a balance between these various role boundaries and helps to resolve the main concern that preoccupies the meeting attendees.

CP M: A1 also revealed similar notions in his account about task allocation,

If I take one of those away, it's usually because I volunteered to do so yeah?...It's usually a sense of feeling that I would like to tell this GP something… I would, you know, I think they got it wrong, erm and it's again, it's almost like something hierarchical within the profession. I would like to enlighten or educate my colleague yeah? (p22).

Here CP M: A1's willingness to volunteer comes from both his position as a medic and his desire to educate and inform the GP. He emphasises the hierarchical manner present in the system and identifies himself as being the appropriate person to take responsibility for the task.

In terms of corresponding with GPs, STL F: A2, p3, discussed why she felt direct contact was important, as shown in a quote on page 138 of this chapter. She considered the wider picture and the future role boundaries of GP; their power and influence will be extended with the government's planned reforms for health care. She feels professional courtesy is important with regards to these future changes and also holds a personal belief that this is the right way to do things in this situation. Moreover, the overall aim of finding the right service for the client is also emphasised which reminds one of how the Balancing phase is sometimes needed to fully resolve the main concern of attendees in this context.

CP M: A6's reason for volunteering partly stemmed from the influence of his rank as a medic. Another subject implied the same process but this time arising from the rank associated with being a manager,

…I think it's cos I volunteer, I think it's a fault on my part in the sense that sometimes I'd rather take the responsibility myself than delegate it. Because I feel that I delegate enough other things that, you know I'm often putting on staff and I think sometimes well that's and that's, probably sometimes it does need a manager to do it, sometimes. I think it holds a bit more resonance so… (TL M: A7, pp 22-23).

As with CP M: A6 and STL F: A2, as well as one's own role boundaries, the role boundaries of one's colleagues are also considered. TL M: A7 accepts that he gets the bulk of tasks but also admits that this derived from volunteering. He does not like to delegate because he feels that it is not fair to always do this, particularly with his earlier recognition that doctors are often expected to take responsibility for many tasks. Moreover, TL M: A7 believes that some tasks do come under a manager's responsibility and also has recognised the effects of a manager's intervention. These factors contribute to his willingness to volunteer.

Balancing is most pertinent when clients' problems are complex and there may be several or no ideal indications as to what might be best for them. When one considers the main concern being investigated and its need to be resolved within the meeting, it is clear to see why the Balancing phase may be needed and why it is executed through the three sub-categories discussed. Balancing logically follows the previous phases and takes into account what has emerged from them. It demonstrates the last stage of strategies that attendees employ to work together, taking on board all contributions to balance the role boundaries in order to reach a decision together about where to place the client. Moreover, there are indications that over time, the Balancing phase contributes to the Recognising phase, which promotes the likelihood of Handling Role Boundaries occurring in a cyclic pattern as well as linear. This will now be discussed in the following section.

5.2: <u>**Handling Role Boundaries as a cyclic process**</u>

As analysis proceeded, there were incidents recorded and investigated as emerging categories that showed how Balancing contributed to the first phase of Recognising. This opened me up to the Handling Role Boundaries process being a cycle as well as a linear phenomenon.

HANDLING ROLE BOUNDARIES: CYCLIC

Resolving the main concern of working together in the meeting environment to find a place for the client

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Figure 5.2a: Handling Role Boundaries cyclic diagram

There may be discoveries during the Balancing phase that then contribute to new attributes of the attendees, which are subsequently recognised as being part of that person. These attributes and features have been initially discovered from the Balancing phase but have become regular recognisable traits over time. As an example, we can be reminded of incidents discussed already in this chapter:

Example	Balancing/ Recognising link
I just think it's the the the professional way to go about things. And I think it helps the client get to the right service and team	STL F: A2 recognises that the team prefer direct correspondence with GPs. However this promotion of professional courtesy has been

as well. (STL F: A2, p3)	influenced by changing times and the fact that GPs will have influence and power over funding services. These changes would have been considered and have made support for such professional courtesy more prominent and regular. The reasons behind this professional courtesy have partly arisen out of Balancing.
I think one of the- I'm I'm happy to do it, because I think GPs like to talk here from medics (CP M: A6, p4).	A recognisable feature as part of *self-awareness.* However this was born out of *volunteering* as part of the Balancing phase. It made sense for CP M: A6 to do this because took into account his beliefs about GPs preferring to correspond with fellow medics and also his own personality trait of being obsessional and knowing that things will get done.
I always feel that I get the lion's share of ones to do because I'm here full time, erm, because I'm usually quite willing to do it in that I don't moan that much so. (TL M: A7, p22).	This is a part of TL M: A7's *self-awareness*, recognising that the bulk of workload gets allocated to him. However, by his own admission, he *volunteers* for these tasks believing it to be better than delegating. *Volunteering* arose from consideration of other role boundaries and attempts to balance these. So what was once done as part of the Balancing phase has become regular enough to be a pertinent feature of TL M: A7 and is now recognised as part of him through *self-awareness.*
I think we do that more than we perhaps used to. In the past we may have seen them- seen someone for a one off, confirmed there was nothing more to do but we would have had that conversation with the patient, whereas now we're asking the GP to have that conversation with the patient, which I don't think that's necessarily a bad thing... (CP M: A6, p6)	At some point, these changes in how the team deals with certain clients would have been discussed in the Balancing phase. There is a suggestion that this CMHT's remit has altered and they now have to pass on more responsibility to GPs. It is likely that the stages in Weighing Up would have at some point identified that in the current climate, GPs are more appropriate to deal with the client. Balancing would then have helped established how the GP should be informed of this. Now the fact that this has become a regular practice in dealing with particular clients, it becomes part of the Recognising phase, i.e. as part of *group*

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	identity, where the CMHT is recognised as inappropriate to take on this particular type of client since the GP has the ability to deal with them.
…and what you'll find is the teams with a bit more capacity will take more because actually people want to help and people, you know, want to look at things, you know, cos part of what we would do is preventative strategies, so you could take somebody into service, erm, even, you know even if we're saying "Mmm, is that a bit borderline for us?" But somebody might say "Do you know what, I have a bit of time and I have a bit of space, I could do 6-8 sessions with that person on such and such and that might help them stop coming in again and again and again, which is good…*(CP F: A5)	Learning about fellow teams happens a lot during Balancing e.g. the willingness to help out. *Negotiating and compromise* not only helps decisions to be completed, but also informs attendees about which members and teams are more likely to participate in negotiation. This then becomes a recognisable attribute of some members, as CP F: A5 reveals, "*people want to help*".

Table 5.2: Balancing and Recognising link.

This gives insight into how the intricacies of Handling Role Boundaries can change over time:

Behaviours and attributes that are associated with attendees as part of the recognising phase may change over time based on what happens in the balancing phase. New attributes may be added and/ or old attributes may be discarded depending on how people and/or the manner of SPA changes. Role boundaries are not static.

Through behaviours of the balancing phase (*compromise and negotiating; sacrificing; volunteering),* when these become regular, they then become part of the recognising phase as recognised and established attributes of attendees

When new attributes/ features of roles and associated boundaries are recognised, there will be new ways of *placing* oneself and other attendees. T*aking one's place* may also mean acting in a different way to before in the light of new expectations made by oneself and/or others

Contributions arising out of the positioning stage need to be considered and weighed up. *Prioritising; matching up; and evidencing take place.*

Recognising

Positioning

Weighing up

Balancing

HANDLING ROLE BOUNDARIES

Figure 5.2b: Cyclic diagram with explanations

New developments such as the discovery of a cyclic pattern demonstrate that Handling Role Boundaries is modifiable and continues to increase its conceptual power. The theory has emerged from following the directives of Glaser (1978) and his advocates (Holton, 2010; Artinian *et al.* 2009) and can be seen as providing conceptualisation in this

substantive area. In the next chapter, Handling Role Boundaries will be discussed in relation to relevant literature in the field, applying the constant comparative method.

5.3: <u>Conditions</u>

As implied throughout the chapter, the specific actions and behaviours that are part of Handling Role Boundaries process are subject to change over time. However there are other variables other than time that influence attendees' behaviour. Such variables can be seen as conditions, which have an effect on the process as demonstrated by Table 5.3.

CONDITIONS AFFECTING HANDLING ROLE BOUNDARIES PROCESS
- **Who is present** - **Era** - **National and/or local guidelines** - **Resources** - **Who is chairing** - **Time left in the meeting** - **What role boundaries are prominent in the meeting** - **Who the referrer is** - **How many referrals need to be discussed** - **Nature of clients' problems**

Table 5.3: Conditions affecting Handling Role Boundaries

5.4: <u>Conclusion</u>

In conclusion, this chapter has presented the GT of Handling Role Boundaries to conceptualise the strategizing behaviours present in the substantive area of SPA meetings. Concepts and sub-categories have been discussed in relation to empirical evidence to demonstrate how their properties have been sharpened and developed and reiterate my commitment to grounding the theory in data. Moreover, this approach means that one can see how the concepts have evolved and earned their way into the theory. Diagrams have been created and presented to communicate the theory of Handling Role Boundaries with more clarity and demonstrate its existence as both a

linear and cyclic process. The conditions affecting Handling Role Boundaries have briefly been explored. Handling Role Boundaries can be seen to offer useful conceptualisation in the substantive area. It is the aim of the next chapter to discuss Handling Role Boundaries in relation to extant literature and explain its contribution to several fields. This should demonstrate its validity with regards to the criteria of fit, work, relevance and modifiability (Glaser, 1978; Artinian *et al.* 2009) and draws upon my own reflections on the BSP as a participant observer.

6) Handling Role Boundaries: Literature review

> *"Many men go fishing all their lives without knowing it is not fish they are after."*
>
> ~ Henry David Thoreau, American Essayist, Poet and Philosopher

6.0: <u>Introduction</u>

Chapter 5 presented the substantive GT of Handling Role Boundaries (BSP) relating to empirical evidence thus adhering to the concept-indicator model. The four main phases and sub-categories were elaborated upon to determine their elements. The theory of SPA meeting attendees' decision making process will now be discussed with relevant literature. Handling Role Boundaries offers relevance at micro, meso and macro levels of understanding self, identity, interaction and role theory. The Glaserian GT approach indicates that once one's theory has been sufficiently developed, a focused literature review can proceed, revolving around the core and related categories of the theory (Artinian *et al.* 2009; Glaser, 2007; Heath, 2006; Glaser, 1978). The extant literature consulted is treated like other data which can be woven into the constant comparative method. Relevant literature is integrated with the GT to achieve a transcending quality. Unlike traditional deductive approaches where comprehensive literature review is undertaken early, the Glaserian procedure postulates that one cannot know beforehand the appropriate areas to delve into. Thus a literature review relating to Handling Role Boundaries follows, exploring the theory in light of assessment of the extant literature. Through constant comparative methods, this chapter demonstrates the theory's validity relating to fit, work, relevance and modifiability. This is enhanced by my occasional personal reflections from participant observations. The theory of Handling Role Boundaries has relevance in multidisciplinary team working within health arenas, but also contributes to the general role theory thesis.

6.1: <u>The literature</u>

Chapter 5's presentation of Handling Role Boundaries highlights key sociological themes that can be explored to assess their relevance to the BSP. These revolved broadly

around theories of multidisciplinary teams' decision making and themes of self, identity, interaction and role theory. The purpose of a literature review here is not to validate the BSP (Glaser, 1978), but to identify opportunities for collaboration and integration, enhancing Handling Role Boundaries. Guidance was sought from other Glaserian grounded theorists about how their treatment of the literature emerged (Lison- Pick, 2011; Giske and Artinian, 2009).

Key themes were identified through coding and memo notes and recorded in a file to preserve their relevance. Relevant words were grouped into broader areas of decision making in multidisciplinary teams, themes of self, identity, interaction and roles to identify their sociological relevance. A focused literature review ensued as the development of Handling Role Boundaries gathered momentum. Box 6.1 shows the key stages emerging from the literature search and review and identifies the resources used to complete this process.

Decision making and interaction

- Databases: Swetswise; CINAHL; OvidSP; Google; Google Scholar. In addition, my knowledge as derived from my student career was employed to explore this theme.

- Key words used in database, search engines and detected in contents pages and index of books *Sociology of decision-making; Decision making in multidisciplinary teams; Decision making- social interaction; Decision making- the group leader; Group decision making; Group decisions- status; Multidisciplinary group decision making; Team decision making; Role status in group decision making; The decision making process.*

- Searches were altered and modified based on success in finding articles and texts.

- Articles and texts were saved into relevant folders.

- Identification of related themes that materialised from the decision-making literature.

- Exploration of these themes was conducted in the same manner as above

Box 6.1: The main stages and procedures taking place for literature search and review

6.2: <u>Decision making in multidisciplinary teams</u>

The conceptual and empirical healthcare literature examining decision making in clinical settings predominantly focuses on nurses' perspectives, indicating a gap in the attention given to other professionals. Handling Role Boundaries offers fresh insight into the decision making practices of other multidisciplinary workers. Team working and decision making is crucial to promote efficiency in health and social care (Kane and Luz, 2011; Wood *et al.* 2007; Walker *et al.* 2003; Cook *et al* 2001). This often revolves around case management, allocation and prioritising resources (Eagle and de Vries, 2005; Kee *et al.* 2004; Walker *et al.* 2003). Working together was more successful when members focused on shared goals and values to establish their team ethos (Cook *et al.* 2001).

West *et al.* (2012) identified principal factors that ensured multi-professional team working (MPTW) was effective in delivering mental health care for service users. Organisations studied included some generic adult CMHTs and qualitative aspects involved observations of weekly team meetings and interviews. The findings revealed that team meetings generate mutual understanding between team members regarding meeting agendas. Role interdependence and willingness to engage in discussions was pertinent. This reflects my findings of Handling Role Boundaries with the Recognising phase encompassing the notion of familiarising oneself with meeting conventions. West *et al.* (2012) identified that aspects of referral processes contributed to poor working relationships based on disagreement about responsibility, restrictive service criteria, team inflexibility and receipt of inappropriate referrals. The reorganisation of certain services was also challenging. Strategies to rectify such issues included mutual understanding, negotiation and reciprocity. The ability to deal with the expectations of other teams was also highlighted. These themes were prevalent in my study and resulted in the emergence of the key stages of Handling Role Boundaries. Disagreements, rigid criteria and inflexibilities associated with team liaison were pertinent factors affecting teams in SPA meetings. Moreover, strategies including negotiation were used to deal with such issues. Team inflexibilities and rigid criteria were known and understood in the Recognising phase where characteristics of individuals and/or teams are acknowledged as the "norm". When disagreements persisted, actions in the Balancing phase such as negotiation, backing down and submitting to someone else's point of view would come into fruition. West *et al.*'s (2012) participants found that negotiation strategies included changing one's practice style to accommodate another professional's way of working. They also mention the term "bargaining" where teams would accept a particular client if the referrer took on some of their clients in return. This

was not particularly evident in the SPA meetings I attended, nor did it emerge in interviews. However, some subjects in participant observations felt their decision to refer to a particular team was justified when they had not previously sent many clients their way. West *et al.* (2012) also include extracts from transcripts where participants talk about "stepping in" when it comes to client care. This is similar to the sub-stage of *volunteering* within the larger stage of Balancing in Handling Role Boundaries.

As with this PhD study, West *et al* (2012) identified inter-professional and general professional respect among team members, where opportunities emerged to use individuals' specialist and general skills. My participants revealed that SPA meetings were one of the few environments that differed from the usual emphasis on holistic perspectives. Attendees were encouraged to stay within their professional domains and "wear one's hat". Such specialist perspectives also emerged as expectations upon oneself and fellow attendees, as indicated in the Positioning phase of Handling Role Boundaries. However expectations were not limited to professional roles and included leadership and personality. West *et al.* (2012) found that sometimes team managers were pro-active in referral discussions if decisions were not going to be easily reached. This notion of re-focusing the discussion was also identified in my study on SPA meetings and could be captured in Positioning where individuals *take their place* i.e. leaders see it as their duty to focus on the relevant discussion and step in when necessary.

Two main models are referred to within literature in the context of clinical decision making: Information-processing hypothetico-deductive approach and the intuitive humanist model (Banning, 2007; Elliott, 2007; Buckingham and Adams, 2000; Elstein *et al.* 1978). The information-processing model employs a hypothetico-deductive approach where practitioners collect cues to form hypotheses. Further cue acquisition validates or challenges such hypotheses resulting in a sole diagnosis (Banning, 2007; Elliott, 2007). Figure 6.2a displays the main stages inherent in this approach to clinical decision making.
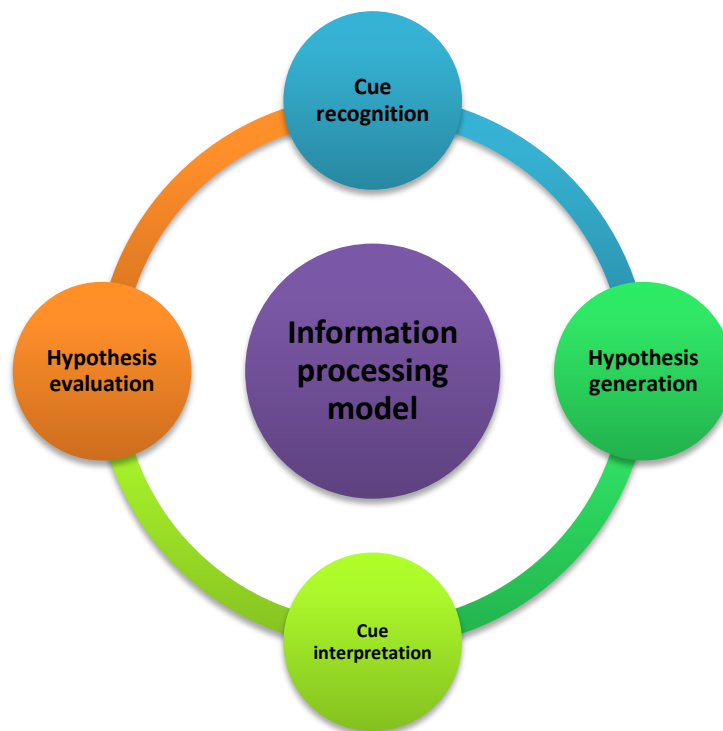
Figure 6.2a: The information-processing model adapted from Banning (2007)

The information-processing model is generally employed during encounters with clients with cue recognition occurring when the nurse begins assessment. Hypotheses are strengthened or modified depending on collection of further cues (Banning, 2007). This prevalent model is deemed as useful for aiding nurses' decision making to ascertain correct diagnoses (O'Neill *et al.* 2005; Manias *et al.* 2004). Buckingham and Adams (2000) claim that this model uses decision trees, comprising of different decision points to record the relative probabilities and effects of decisions. Banning (2007) reveals that these decision trees can be problematic because potential errors might occur in the structures and in establishing probabilities. Moreover, the formation of hypotheses may be compromised by misunderstanding or generalisations (Elliott, 2007). This does not cater for patients who exhibit symptoms that are not contained within normative structures of diagnoses.

The information-processing model may be relevant for SPA meeting attendees, particularly since much of the behaviour it describes relates to assessment and first impressions of clients. Within SPA meetings, assessment of the client is largely achieved from reviews of referral letters and case notes without the client being present. However, subjects revealed that they picked up on cues and clues to build a picture of

the client and their problems. Further discussion, particularly with complex cases, served to verify these clues and discover the client's overall picture. This suggests that there are some elements of inductive and deductive practices in the attendees decision-making, which are integral to the information-processing model. Within Handling Role Boundaries, such behaviour would be captured through the Positioning and Weighing Up phases. Expectations are often made on attendees through *placing* to pick up on particular aspects of letters and case notes and reflect on these as part of *taking one's place*. The Weighing Up phase is where the attendees contribute these reflections and the discussions here would result in the team narrowing down options. It may not result in a firm diagnosis but in terms of relevant professionals, it might reveal who the main members are. Thus, the behaviour that occurs in Positioning and Weighing up could also be described through the stages of the information-processing concept. However, the information-processing model would be insufficient to explain absent attendees' behaviours alone since paper sources are not always generous in supplying cues. Subjects discussed the occasions when referral letters contained sparse information. Shaw *et al.* (2005) acknowledge the lack of compliance among GPs in writing ideal referral letters. In the absence of cue acquisition, attendees depend on other tactics to ascertain an understanding of the client. Furthermore as explored in Chapter Two of the thesis, within the field of mental health and illness, diagnosis is recognised as a contentious and complex issue. Cue acquisition will be based on assessment of behaviour rather than physical signs and this will always involve subjective judgement.

The intuitive-humanist model offers another way of conceptualising the decision-making process in clinical settings, revealing the value of experience and intuition. Intuition refers to the situation of knowing something without reason (Banning, 2007; Rew, 2000; Hammond, 1996; Gerrity, 1987; Schrader and Fischer, 1987). Banning (2007) stresses the value of this knowledge acquisition in clinical settings. Furthermore Elliott (2007) discusses the notion of pattern recognition, a cognitive process that deals with cue interpretation by employing knowledge gained from experience. Cues are matched to those experienced in former patients (Banning, 2007). Buckingham and Adams (2000) add that intuition and pattern recognition are associated with gut feelings and hunches, as opposed to scientific fact, suggesting that if such intuitive approach is dominant in nursing professions, it may reinforce the perceived lower status of nurses.

SPA meetings' attendees recounted times when cues were absent and speculations were made, thus the experience of more "stable" members was used. Although intuition was

not directly mentioned, the fact that attendees do not always possess tangible cues suggests that they use this approach. During participant observations, some subjects made comments including "sounds like he's depressed" or "I have a feeling…". Moreover attendees shared their past clinical encounters with clients demonstrating the value of personal experiences in forming clinical conceptions. Eagle and de Vries (2005) also discuss prior knowledge and personal involvement when deciding which patients should become entrained into their hospice. In some SPA meetings, letter reading sometimes ended with an attendee naming a service, e.g. "IAPT" and nods verified this as the accepted decision. This suggests that attendees used their experience to build up a reference of what clientele are associated with each service and use pattern recognition to match services up to clients. This has relevance for three particular phases of Handling Role Boundaries: Recognising, Positioning and Weighing Up. Recognising can involve increased awareness of what each service deals with relating to criteria and client e.g. *knowing one's colleagues.* Positioning might see attendees *taking their place* by speaking up when they have knowledge about the client, whilst within Weighing Up, the *matching up* sub-stage guides attendees to single out certain teams as appropriate.

The intuitive-humanistic model acknowledges useful processes employed by SPA meeting attendees as reflected above. However, like the information processing model, it seems unlikely to explain all facets of decision making because reflecting on past experiences may be inaccurate (Banning, 2007). Clients' mental health careers can change and their past problems may not apply anymore. Memory may sometimes be unreliable leading to inaccurate reflections. Although attendees valued experience, many prioritised establishing clients' mental health problem during discussions. They actively sought evidence in letters and case notes to identify diagnosis. This suggests that gut feelings and speculations were not solely trusted and needed verification through evidence based practice. Eagle and de Vries (2005) add that one cannot clearly explain how they reached a decision using intuition. There were examples where my study subjects employed intuition, and the BSP accommodates this aspect of the decision-making process. The nature of SPA meetings, with referral letters of variable content meant that there was a need for some speculation and looking beyond the information available, allowing intuition to emerge. However it was not the sole contributing factor of discussions, with the Weighing Up phase encompassing sub-categories of *evidencing,* where attendees attempted to validate their input and ideas by referring to case notes, past examples and success rates.

The general decision-making literature offered elements of decision making practices of SPA meeting attendees but failed to provide a wholesome model that accounted for the resolution of their main concern.

Cook *et al.* (2001) found that when looking at information transaction, certain team members were seen as fulfilling a function e.g.

> *The role of the CSW* (Community Support Worker) *was instrumental in providing detailed information about clients. They developed close working relationships with clients enabling them to acquire a very intimate knowledge of them…* (p145).

This demonstrates that team members' strengths were used to form expectations about them. Kane and Luz's (2011) findings support this and found that multidisciplinary meetings had people who contributed and those who did not e.g. junior members who treated the meeting as educational. The Recognising phase of Handling Role Boundaries reiterates this with subjects distinguishing between stable and junior members of the group e.g. students. Interviewees revealed that they did not expect students to contribute extensively to discussions and did not deem this as detrimental to the decision making process. My entry into SPA meetings saw me engage in the Recognising phase to ascertain a sense of levels of prominence among members and where I fitted. I positioned myself lower than junior members because initially I was not familiar with the group and meeting conventions. As I attended more meetings my *self-awareness,* recognition of others and *placing* myself changed because I became confident to talk to others and engage in reading letters. Thus Recognising captures the diversity in functions and as Chapter 5 revealed, what attendees recognise as part of someone's character may alter over time. This was supported by participants in Cook *et al*'s (2001) study who discussed knowing who to talk to when it concerned certain issues. Getting to know one another was deemed crucial to ascertain a sense of expertise, perspectives and trust. Furthermore, the notion of role boundaries was specifically mentioned by a participant,

> *…there is a boundary between health and social care…there's a boundary between decisions (a CPN manager) can make and the decisions (a) SW manager can*

make…there are boundaries the agencies put on you (Participant from Study A in Cook *et al*, 2001).

Thus, as with the Recognising phase of Handling Role Boundaries, awareness revolved around strengths *and* limitations. Walker *et al* (2003) highlighted that members of a community learning disabilities team demonstrated awareness about lack of other community services within the region. Therefore as a team, decisions can involve knowing when to intervene and manage the client and when to hand over the client to another service. For some health teams this was complicated by the changing remits of their service dictated by clinical guidelines and decreasing resources (Eagle and de Vries, 2005). Handling Role Boundaries theory accommodates such complexities inherent in team decision-making.

One particular study that has resonance with this PhD study is that of Griffiths (2001) who studied allocation meetings run by Community Mental Health Teams (CMHTs). Griffiths argued that these teams operate by applying implicit categorising, where referral letters are re-formulated within discussions to challenge referrers' accounts and effectively "buffer" caseloads. This manifested in the construction of clients as not fulfilling the "serious mental illness" criteria and justification for them falling outside of the CMHT's remit. Out of the two CMHTs investigated, one had psychiatrist referrers present, whilst the other did not. Implicit categorising occurred in both with variations in the process to account for these different circumstances. Griffiths highlights that the CMHT remit has altered significantly which leads to confusion about which clients they are authorised to cater for. Moreover the pressures of workload impinge on the discussions with professionals reluctant to take on cases,

> *Rationing becomes entwined with concerns about workload pressures and funding, as well as ongoing negotiations about the nature of CMHTs, teamwork and occupational identities* (Griffiths, 2001:679).

Clients as cases become defined with alternative discursive terms that challenge the referrer's conception and transform the case into an inappropriate referral. The motive for this implicit categorisation is influenced largely by depleting resources.

The notion of case construction that Griffiths discusses has resonance with Handling Role Boundaries because building a clinical picture often occurs as part of the Positioning phase. Subjects from this PhD study expressed their expectations of attendees forming their own clinical conception of cases as translated from the referral letters and case notes. However, whilst Griffiths argues that this is done discursively with the intention of rejecting cases, the Handling Role Boundaries theory implies that case construction is not always a verbal process. Moreover, the intention is not explicitly to reject the client; criteria for rejection can only be applied once a conception of the case is in place. Subjects highlighted their responsibility to think of clients in these terms and draw upon their clinical background and expertise to contribute different aspects of the client. There are ways in which Griffiths' findings relate to this PhD study. Concerning CMHT criteria and job roles altering in response to dwindling resource availabilities, one consultant psychiatrist from this PhD study revealed that the CMHT's function had changed. Tasks that he once took responsibility for now needed to be transferred to GPs. However my findings indicated a very strong inclination to "play it safe" among subjects and to offer the referrer some form of intervention, even if this took the form of a leaflet giving information of available services. Moreover many of the sites studied offered screening assessment appointments for many cases where subjects were unsure about which interventions would be appropriate.

Griffiths refers to the CMHT staff who participate in referral meetings as gatekeepers and this is something that Handling Role Boundaries takes into account when highlighting the significance of multiple roles. As well as formal professional backgrounds such as social worker and CPN, each attendee has an overall responsibility to fulfil the meeting agenda- indeed, the main concern being investigated was the attendees' need to work together to find a place for clients. This undoubtedly involves them engaging with gatekeeping strategies to decide who does and who does not become entrained into specialised mental health services and who can be allocated to less intensive interventions.

Griffiths' (2001) data captured the conflicts that afflicted participants relating to their different professional backgrounds and the way this shaped their perspectives of clients' problems,

> *…psychiatrists, operating with relatively inclusive nosologies of psychopathology, and social workers, who see many presenting problems as "a normal reaction to life events"…* (p682).

In one of the CMHTs studied (Team A), psychiatrists were absent from the referral meeting, whereas in Team B they attended and chaired the meeting. For both teams, the referring agent was the psychiatrist. Griffiths found that acceptance of clients would mean that largely staff of lower professional status would be left with a heavier workload. This made them even more averse to accepting clients from referring psychiatrists. The study suggests that these differences lead to the practice of implicit categorising to deal with these conflicting agendas. Handling Role Boundaries also accepts that differences exist among professionals but argues that such differences need to be managed and dealt with to avoid jeopardizing client discussion and decisions. Moreover, the differences are often celebrated to promote diversity within SPA meetings. In the context of needing to use the meeting to work together to find a place for the client, one can understand why such differences need to be handled.

When it came to task allocation, Griffiths (2001) discovered that team members received a mixture of case loads, but clients who needed drug injections, were assigned to CPNs. Moreover, Team A believed that the psychiatrist was responsible for gatekeeping and was failing to accomplish this efficiently. Likewise, the Handling Role Boundaries theory suggests that through the positioning phase, attendees of SPA meetings *place* fellow attendees and colleagues through expectations that they feel they should fulfil. They themselves *take their place* which might include listening out for areas of their expertise and make a contribution based on this. Thus this may result in a certain task or type of client being assigned to certain members of the team. Fulfilling expectations was implied to be a pressure for some members of multidisciplinary teams within meetings (Kane and Luz, 2011) with some suggesting that more time was needed to prepare for presenting information. In this PhD study during participant observation I noted that once referral letters were distributed, some attendees began reading to themselves whilst another client was being discussed. I speculated that this might be because of the pressure to provide a satisfactory presentation of the case with coherence and clarity. This was later confirmed in interviews. Thus *taking one's place* is not necessarily a straightforward step.

Categorisation within CMHTs, according to Griffiths (2001) rests on two classifications: the "seriously mentally ill" and the "worried well" with the former falling in CMHTs' remit. This implies that for categorisation to take place, staff need to be aware of the overall aims and responsibilities of the CMHT. Within the process of Handling Role Boundaries, awareness of group identity plays a big part in the recognising phase, where attendees acquire a sense of what the team's capabilities and target group are. Eagle and de Vries (2005) agree that understanding the group's cultural beliefs regarding the service they feel they should be providing is important, sometimes even more so than the problems afflicting the referred client. Griffiths' study showed that participants often re-formulated the referrer's letter through the construction of the client as not seriously mentally ill. Categorisation certainly occurs in the Handling Role Boundaries process as it does in most avenues of social life (Hutchinson, 1979). Within the Handling Role Boundaries process, categorisation of clients is likely to happen during the positioning phase where attendees may be forming their clinical conceptions and attempting to contribute to the overall picture of the client. This is likely to lead to attendees ascertaining whether or not clients have a serious mental health problem.

However, Handling Role Boundaries proposes that categorisation is done with different intentions. As part of case construction, categorisation may fulfil one's professional role and contribute in a multi-role climate where decision making occurs. During the following phase of Weighing Up, these contributions and reflections are considered with respect to the attendees that generated them. As with Griffiths' study, there may be times when attendees wish to displace responsibility to alleviate heavy workloads but reformulating cases that clearly are appropriate for a particular team or attendee is likely to fail because of the sub-categories of Weighing Up such as *matching up* and *evidencing*. Moreover, the final phase of Balancing, in which negotiating is prominent, attendees have the security and reassurance of sharing responsibility. For example, when the IAPT team were dubious about certain clients and demonstrated reluctance to accept the case because of possible risk factors, team leaders sometimes suggested that the CMHT would do an initial screening assessment and if risk factors were assessed to be low, the IAPT team could take the client on. Details of such arrangements were established during SPA meeting discussions and such compromise was integral to working together and achieving the task of finding a place for the client.

Categorising failed to be promoted to a significant stage within Handling Role Boundaries because the prominent concepts revolved around broad processes, which depicted more

intimate behaviours relating to attendees' roles rather than specific treatment of the client. Thus Handling Role Boundaries does not dismiss categorisation; it accommodates it under Positioning but within the context of this study, it was not strong enough to make a significant contribution to the theory. In relation to specific categories of level of mental health problems, many subjects often talked about the limitations of assessing clients based on paper sources. Furthermore, the diagnosis process holds a contentious status within the arena of mental health. Thus within SPA meetings, categorising to the extent of identifying specific mental health problems may prove difficult. Even if the referrer has identified the client's problem or established past diagnosis, people's mental health careers can alter over time. Indeed, there were times in the field when I witnessed SPA meeting attendees assessing referrers' letters and drawing alternative conclusions.

However, aspects of Griffith's (2001) process of categorising shares similarities with the Handling Role Boundaries process. There were indications that some forms of *matching up* and *evidencing* take place as identified in the following extract from Griffiths:

Nurse Manager (NM): I know you're quite heavy but would you mind taking this on Derek?

Social Worker1 (SW1): Would I what?

NM: Would you take this one on?

SW1: What as a case?

NM: Yeah

SW1: Well, no. I think it's known at the area office. I think it's probably been dealt with. Christine Baker was actually dealing with this at one time.

NM: What's her name?

SW1: Christine Baker, but she's moved on. Somebody…I'm pretty sure somebody in child care or it could be the disabled children, you know, the team. There's a child abuse thing hanging over this and…I think some years ago…

Box 6.2a: Extract taken and adapted from Griffiths (2001)

Thus, NM in the above extract demonstrates an initial attempt to *match up* the client to SW1 who subsequently disagrees and provides *evidence* as to why somebody else might

be suitable. Griffiths also included extract examples in which disagreements over clients led to different interpretations arising,

> *We can describe these different formulations of the patient's condition as competing versions. Acceptance of one version implies acceptance of a particular definition of CMHT work and appropriate service users…* (2001:694).

This understanding partially represents the intention of the weighing up phase of Handling Role Boundaries in which attendees' conception of clients are considered and reflected upon.

In addition to *matching up* and *evidencing*, Griffiths (2001) acknowledges that negotiating was a strong element present. She identifies that in Team B when the referring psychiatrist was present, negotiations were more common because the referrer's presence allowed them to justify their reasons for referring the client. In this PhD study of SPA meetings, GP referrers were never present. However, occasionally, if an internal referral was being made, the internal Trust referrer was present. In Griffith's (2001) study, having these referrers present meant that, from a manager's perspective, the psychiatrist could convey the agenda more sympathetically and demonstrate understanding of other members' burden of heavy caseloads. This sort of negotiating made work relationships harmonious and fruitful whilst dealing with case referrals. Similarly, the Handling Role Boundaries process occurs in attempts for team members to work effectively and efficiently together and this involves managing conflicts and disagreements. *Compromise and negotiating* occurred as part of the Balancing phase and in contrast to Griffiths (2001) study, they emerged in the absence of the referrer. Most subjects discussed why they felt compelled to give the referrer some form of advice even if the referral was inappropriate for any team members to take on. Such reasons, as seen in Chapter 5, included professional courtesy and identifying the limitations of referrers such as GPs whose referral was interpreted as a call for help. Subjects agreed that even when clients were deemed inappropriate, this did not mean that the GP stopped needing help and therefore required their input. This emphasises the fact that SPA meeting attendees need to handle the role boundaries of GPs as well as those present in the meeting. *Compromise* and *negotiation* helps them to identify where they can step in and offer some assistance even for clients that are not appropriate for the level of service that they provide. As discussed before, another form of negotiation for

the SPA meeting attendees was when there were uncertainties regarding risk factors. Moreover, when it transpired that two mental health care professionals could offer appropriate input, the option of joint assessment was favoured in some SPA meeting sites. Looking at caseload management in community learning disability teams, Walker *et al.* (2003) discuss the notion of joint working between health and social care members.

Indications of what I termed Balancing can be found in Griffiths' reflections of the categorising process,

> *While expert psychiatric categorisations have a central place, they are put forward in case discussions that typically involve the narrative/descriptive mode of presentation. The Team B psychiatrist appears to adapt his practice to for this mode…"* (2001: 696).

This is reminiscent of the *sacrificing* stage of the Balancing phase, where some attendees withheld certain viewpoints to submit to the overall thinking of the wider group, rather than prioritising personal agendas. This has been termed groupthink by writers in the field (Cook *et al.* 2001).

Griffiths' (2001) conceptualisation of categorising invites some crossover with the theory of Handling Role Boundaries and recognises the effects of differing organisational backgrounds,

> *…they have differing degrees of power to refer, to prescribe, to section, and to make other decisions…in crude terms doctors diagnose, while social workers and nurses assemble the clinical and social information that will assist in the diagnostic process…* (p697).

Griffiths (2001) explains that implicit categorisation allows CMHT members to enter realms beyond their working remit. Similarly SPA meetings allow collaboration and insight into diverse professional perspectives and can be educational. One consultant

psychiatrist highlighted that he had become more accustomed to the elements pertinent to social care assessment which he had not previously been acquainted with. Moreover, the various roles within SPA meetings require attendees to remain within and venture out of professional stances. Although seemingly contradictory, this is captured realistically by the Handling Role Boundaries process. Griffiths suggests that implicit categorisation enables nurses and social workers to access a legitimate approach to challenging psychiatrists' views and conceptions including contesting diagnosis. Within SPA meetings, the Handling Role Boundaries process identifies that within the different professional perspectives, everyone is entitled to contribute to discussion including challenging diagnoses. Indeed, this may even be encouraged as part of employing their expertise to interpret the case. When competing views arise, further phases of Handling Role Boundaries shape the discussion to reach a decision.

One difference between the implicit categorisation and Handling Role Boundaries theory involves the consideration of individuals participating in referral discussion. Both take into account professional roles, but the Handling Role Boundaries process demonstrates how other roles are pertinent as well, for example being the chair person and personality traits. This is highlighted by Eagle and de Vries (2005) who suggest that nurses and doctors at a hospice had to take on the roles of gatekeepers. Likewise, when discussing findings from multidisciplinary team meetings, Kane and Luz (2011) refer to some participants as "presenters of information". Subjects in this PhD study demonstrated awareness about how their personality was implicated in discussions and affected their approaches in meetings. Handling Role Boundaries is not only a theory that discusses the complexities in managing varying professional roles between individuals, but also multiple roles within one person. There are often numerous professional roles allocated to one person. Professional roles can be complex particularly in the arena of CMHTs and can lead to conflict (Peck, 2003). This is relevant to discuss, since most of the SPA meeting centres are located within CMHTs and thus their members account for much of the attendees. According to Hannigan and Allen (2011), the policy endorsement of increased multidisciplinary working, as proposed by the "New ways of working" paper (DH, 2007) has led to anxiety amongst some health care professionals relating to perceived threats to their professional identity and distinct perspectives. These authors suggest that this can lead to professionals asserting their identities. The SPA meeting professes to be a milieu where assertion of professional discipline is encouraged, since the collection of multiple disciplines was intended as part of its conception. However, this does not mean that conflicts relating to diverse disciplines do not arise and such situations give rise to the Balancing phase of the BSP.

Peck (2003) discusses the complexities of competing professional roles within one person highlighting the issue of loyalty, where members may find it difficult to decide whether to commit to the overall CMHT, or to one's immediate profession. This was also evident in this PhD study and in the context of SPA meetings having a clear agenda, faithfulness to the team seemed to prevail over one's professional beliefs. Moreover one's professional role "ethos", including nursing values may change over time and varies depending on the context within which one is working in (Hannigan and Allen, 2011; Peck, 2003). For example, Peck (2003) notes that with the introduction of functional teams designed to tend to specific client needs following the NSFMH (DH 1999) mean that nurses work in an environment that best suits their interests. CPNs who favour social aspects of mental health may find AO services appropriate, whereas CPNs who enjoy looking at psychological elements may prefer to work in primary care liaison teams. Regarding SPA meetings, where such functional teams are represented, this can impact how one nurse perceives a client's problems and the intervention they feel is best.

In this PhD study, further complexities in varied professional roles included being responsible for chairing/ leadership duties as well as attending meetings within one's professional "cap". Each role generated certain expectations that needed to be considered and sometimes prioritised to participate effectively in the meetings. Handling Role Boundaries as a BSP captures these complexities well, including the process that sees one professional role sometimes promoted over the other. This is most apparent in the Positioning phase. Furthermore the BSP gives attention to the impact of personality roles, something that is scarce in the multidisciplinary literature. According to Peck (2003) CMHT conflicts often revolve around competing disciplines in one physical space and sometimes these professional boundaries can translate into barriers to effective working,

> ... boundaries come into being through differences in organisational structures and values...they are inculcated into individuals through training regimes and sustained patterns of socialisation...

Handling Role Boundaries rests on the assumption that personality boundaries also evolve in the way that Peck (2003) describes for professional boundaries, which is why they need to be given as much attention. This PhD study does not dismiss that conflicts

arise from the amalgamation of these various boundaries within the SPA meeting, but argues that attendees need to find resolution because they have a specific task assigned to them. This is where the BSP comes into fruition. Peck (2003) agrees that when teams have shared aims, they work more effectively together.

Recently further theories into multidisciplinary team working and the decision-making process have materialised. McCallin (2007) conducted a GT study into interdisciplinary team working to discover the main process in team members' practice. Deriving data from two teaching hospitals in New Zealand, the study explored how health care professionals dealt with practice concerns. McCallin argues that Pluralistic Dialoguing is key to overcoming the challenges in working collectively with individuals from different backgrounds. Looking beyond professional disciplines and refocusing on client care was essential to allow new ways of thinking to surface. Interdisciplinary teams consisted of medical, nursing, occupational therapy, physiotherapy and social work disciplines. Engaging in dialogue was the underlying activity that depicted team members' behaviour. A diagram of McCallin's theory is demonstrated in Figure 6.2b.

DECONSTRUCTING THINKING		**RESYNTHESISING THINKING**
Rethinking Professional Responsibility		*Reframing Team Responsibility*
- Breaking Stereotypical Images - Grappling with Different Mind-Sets		- Negotiating Service Provision - Engaging in the Dialogic Culture
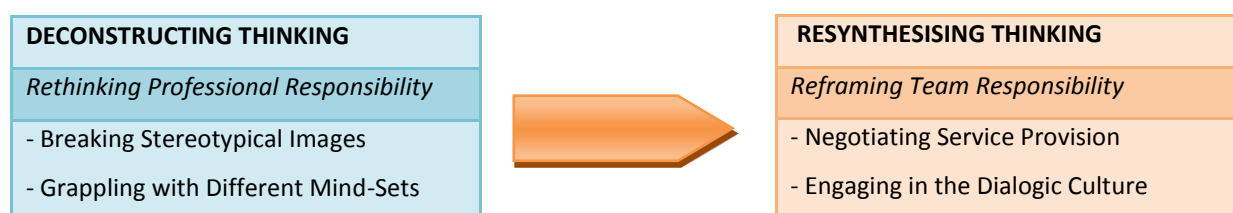
Figure 6.2b: Pluralistic Dialoguing theory as adapted from McCallin (2007)

Pluralistic Dialoguing revolves around health professionals talking in formal and informal spaces within the health environment. It gives attention to the specialist knowledge associated with different expertise but discusses the sacrificial element that occurs where health professionals do not allow these to be dominant. They show willingness to share ideas and see things from other perspectives to provide efficient services for clients. Talking was integral in the form of questions, debates, explanations, negotiations, exploration and other elements. McCallin (2007) argues that Pluralistic Dialoguing, is necessary for efficient teamwork in interdisciplinary environments and involves finding shared meanings in practice. Traditional rigid thinking is restructured to embrace team agendas through a dialogic culture. The motivation for this transformation

of thinking is prioritising clients and constructing a service that considers their needs. The aim is to work effectively together by,

> …*rethinking professional responsibility and reframing team responsibility…team members grappled with different mind-sets when they examined alternative worldviews in team learning situations…* (McCallin, 2007:40).

This breaking of stereotypical perceptions of different health professionals initially involves identifying routine images to ascertain what attributes they associated with these professions. This allows them to enter the realms of conventional thinking to transform their interactions and behaviour. This is aided by focusing on a common ground goal, which in this particular substantive area was investing attention into client-focused care to enhance service delivery. McCallin (2007) acknowledges that as part of rethinking professional responsibility, there is a stage where learning to grapple with different mind-sets is vital. Conversing was a successful aid in this task and practice ultimately becomes less fragmented. Rigid allegiance to one's discipline jeopardised the ability to compromise and negotiate, so the emphasis needed to be on the common goal and prioritising the relevant perspectives.

These early phases of Pluralistic Dialoguing partially relate to Handling Role Boundaries in their endeavour to focus on the goal of a client-centred approach. This instigates compromise, providing an exit from rigid non-negotiable mind-sets. The initial awareness of stereotyped views can be likened to the Recognising phase of Handling Role Boundaries as SPA meeting attendees identify their role boundaries and their colleagues' to ascertain the foundations for basing future behaviour and progression to further phases in the process. Awareness of one's own character and knowing colleagues was important for SPA meeting attendees because it influenced their approaches to the decision making process and as with Pluralistic Dialoguing, paved the way for compromise. The premise that there needs to be an initial recognition phase is reiterated throughout McCallin's presentation of the theory,

> *I think you need to get to know each other and get on with each other and understand each other before you can challenge each other and be open for the*

better…Team building happens as the team works together day by day by day…
(2007:48- Extract).

In multidisciplinary working, McCallin's (2007) acknowledgement that there are different mind-sets to be grappled with, reiterates the principles of Handling Role Boundaries i.e. there needs to be management of role diversity and the capabilities and limitations that are intrinsic to these. Moreover, Pluralistic Dialoguing accommodates a prioritising activity where different perspectives are promoted or demoted depending on their relevance to the context. This is also the case in Handling Role Boundaries where *prioritising* within the Weighing Up phase assesses clients' needs and individuals' capabilities of dealing with them. Debates and contributions are prioritised according to their perceived applicability to the case. Another study into multidisciplinary team meetings (Kane and Luz, 2011) acknowledged a stage where treatment options are appraised and provide a space for specialists to offer input, which can be considered.

Furthermore like McCallin's (2007) theory, early phases within Handling Role Boundaries led to behaviours of compromise and negotiation. Drawing on Bohm's (1996) theory of the dialogue process, McCallin presents this aspect of multidisciplinary working as a delicate feature. McCallin reflects on Bohm's work in clarifying the Pluralistic Dialoguing theory. In Box 6.2b contains a quote from McCallin's work, which offers insight into effective team working,

> *A team that works well has a collective responsibility for the patient. I would never talk about anyone else's work. Although I might know what should be done I am not the practitioner registered to give that information. I am very careful there. I have been in the team a long time and I know how far to go and what appropriate dialogue is in relation to patients and our roles…I leave the (discussion) to the other professionals but at the same time I have to have a good understanding of what the other team members do and what they might say*

Box 6.2b: Extract from McCallin (2007)

When developing Handling Role Boundaries, this was evident in subjects who realised that they sometimes needed to hold back certain views to allow other perspectives to materialise without limitations and objections. It was important to recognise whose sphere the client was falling into and assess the extent to which one's persona could contribute to that case. For example, one attendee identified that in some situations he needed to apply his input as a CMHT team member and inhibit his personal opinion whilst in other situations he projected his viewpoints from his social worker role perspective. Through the Balancing phase, *sacrificing* heralded attendees' recognition that they needed to allow others to dominate discussion for the sake of the group's ultimate aim.

Pluralistic Dialoguing does not explicitly apply the term "boundaries", but it certainly alludes to knowing one's margins and being able to recognise the applicability of colleagues' capabilities to remedy one's own limitations,

> *Now we work as a group and the consultants are listening and prepared to admit that they don't know what is the best type of treatment for this patient. But perhaps the physio knows? Or, perhaps the OT? Or, perhaps today it's the nurse who's doing the transferring. Ten years ago the House Surgeon would have been doing that…* (Extract from McCallin 2007)

Therefore this implies that McCallin saw a Handling Role Boundary process emerging in an arena of multidisciplinary working. It also emphasises that processes including Pluralistic Dialoguing and Handling Role Boundaries have evolved and transformed working practices where multidisciplinary environments now dominate healthcare. Previous approaches to working in healthcare may no longer be relevant and new processes have had to develop to achieve satisfactory health services in light of these modified working relationships and environments.

Pluralistic Dialoguing is certainly a process that SPA meeting attendees are likely to relate to. However, McCallin's (2007) emphasis on breaking stereotypical images is not wholly representative of attendees' experiences since many maintained that the SPA meeting was the one environment where they felt authorised to remain within their professional arenas. They suggested that the multidisciplinary nature of SPA meetings

invited and encouraged promotion of professional perspectives so that case discussion has a balanced contribution from different areas of specialism. On the other hand, it would be unfair to say that Pluralistic Dialoguing completely refutes this: McCallin's (2007) reflections demonstrate that one should step up and promote their viewpoints when appropriate but at the same time avoid ignorance towards the diversity of roles and contributions. This is also inherent in the promoted principles of SPA meetings.

These important themes from Pluralistic Dialoguing relating to negotiation are worth exploring. In the context of multidisciplinary working, and specifically in SPA meetings where there is a particular task to achieve, negotiation and compromise emerge to deal with one's own competing role boundaries and the role boundaries between one another. Hannigan and Allen (2011) draw upon Abbott (1988) to suggest that the negotiation process that occurs within these multidisciplinary milieux may eventually lead to a departure from official job descriptions of that profession. This implies that something other than professional role emerges during interactions, with this most likely being aspects of personality. In this PhD study, in order to negotiate and compromise, volunteer and sacrifice as part of the Balancing phase, attendees employed aspects of their personality such as care and empathy towards others.

Another useful theory that has emerged relating to clinical judgement is that of Elliott's (2007) Mutual Intacting. This is a process describing the ways where health professionals resolve concerns relating to clinical practice. This study investigated advanced practitioners' experiences in mental health and accident and emergency environments. The theory emphasises the strategies used by practitioners to maintain relationships with clients. Mutual Intacting is a three phase process, but examination of phase one called Situated Patterning (See Figure 6.2c) invites reflection since it can be compared to some of the attributes of Handling Role Boundaries.
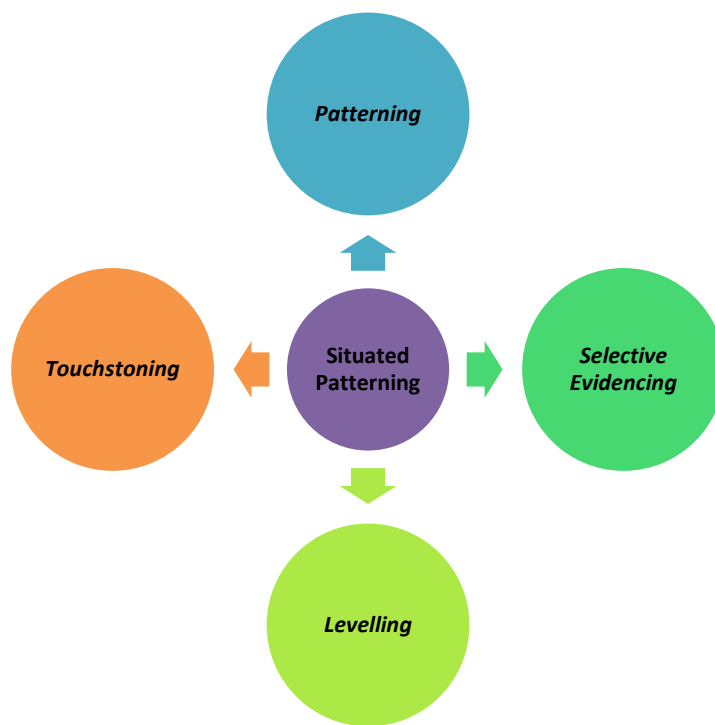
Figure 6.2c: Situated Patterning phase of Mutual Intacting process, adapted from Elliott (2007).

In Situated Patterning the health professional needs to ascertain a sense of the client's problem before engaging further in the decision-making process. According to Elliott (2007),

> *…they work at achieving this by taking pieces of information during patient assessment and constructing them into recognisable patterns…* (p206).

This can involve reflecting on dealings with past clients who were afflicted in similar ways and also approaching clients with the context in mind. This general intention of Situated Patterning can be compared with the Positioning phase of Handling Role Boundaries where the meeting attendees need to gain a sense of what the client's problems entail particularly in relation to professional interpretations. The four sub-stages that contribute to Situated Patterning are also relevant.

In *Patterning* the strategy of exampling is employed where past experiences are drawn upon to offer insight into present client concerns. This is more likely to occur with practitioners with more clinical experience and a bigger reference point. Thus diagnosis and treatment options run on a "tried and tested" basis. Handling Role Boundaries does not explicitly outline how clinical pictures of clients are formed, but by including the phases of Positioning and Weighing up, it acknowledges that specific processes such as *patterning* may take place. For example, as part of Positioning, one attendee may *place* an experienced practitioner attendee in a position which sees the latter expected to draw upon former clinical encounters when assessing the referral letter. Moreover in the Weighing Up phase, there is a sub-stage known as *evidencing* where attendees justify their suggestions. Part of *evidencing* might involve *patterning* in which the argument that "it has worked before" is proposed.

The second sub-stage of the phase Situated Patterning is called *Selective Evidencing* where practitioners gather evidence to validate their initial clinical judgements. This might involve checking client's history with their relatives. *Selective evidencing* is useful for more complex clients with a higher level of risk and thus jeopardise the stability of clinical judgement. High levels of detection are employed to gain insights into clients' problems. Levels of questioning are modified depending on the state of practitioner-patient relationship. Despite the similarities in name, *Selective Evidencing* as part of the Situated Patterning phase of Mutual Intacting is different to *evidencing* as part of the Weighing Up phase of Handling Role Boundaries. The environment is different because attendees of SPA meetings do not see the actual client there. However, Handling Role Boundaries' use of *evidencing* has similar intentions to Mutual Intacting's *Selective Evidencing* as it can be used to verify clinical judgements. For example, if a SPA meeting attendee felt that the Eating Disorders service would be most appropriate, this would indicate that the client's main problem was something that the Eating Disorders team could deal with. To justify this reasoning, the attendee may find and convey *evidence* in the form of a line from the referral letter to demonstrate their point. Moreover, similar modification of questioning employed in *Selective Evidencing* may be used in the Weighing Up phase to ascertain a more accurate picture of the client.

The third sub-category of Situated Patterning is known as *Levelling*, which practitioners employ to,

> *…calculate what are the treatment priorities, risk of consequences and level of organisational support…*(Elliott, 2007: 207).

This detail relating to assessment of information is not identified within the Handling Role Boundaries theory because the main concern being studied largely related to working relationships, not relationships with clients. Handling Role Boundaries is however extensive enough to accommodate intricate details relating to assessment practices such as *Levelling* as founded by Elliott (2007). Risk assessment certainly occurs in SPA meetings as reflected in participant observation and interviews and is to some extent reflected in the sub-categories of Weighing Up. Prioritising, particularly with complex cases, involves attendees assigning some order to the plethora of problems that need to be dealt with. *Matching up* also aids in narrowing down the potential teams/individuals who may be appropriate for the client. These aspects of behaviour relate to what Elliott's (2007) labels *Levelling* and demonstrate the integral role that prioritising actions play in areas of clinical judgement.

The final sub-category that Elliott discusses relating to Situated Patterning is known as *Touchstoning* and describes how practitioners identify the clinical guidelines that motivate their actions. As explained,

> *In most situations the level of touchstoning is low insofar as practitioners just briefly refer to the guiding principles and are aware that they set the parameters for their scope of clinical practice…* (2007:208).

This acknowledgement bears resemblance with the Recognising phase of Handling Role Boundaries and its sub-category of *self-awareness*. Attendees develop their self-awareness in relation to the realms of their professional role and the limitations and capabilities of their personality. The Recognising phase also highlights the importance of *group identity* and the boundaries associated with being part of a wider team. Such recognition is often informed by clinical guidelines such as NICE. This takes into account the team's remit in terms of being a CMHT for example, which may clash with personal values. This is why the plethora of roles needs to be handled. Moreover, clinical guidelines may be drawn upon in the later Weighing Up phase of Handling Role Boundaries when discussions sometimes turn to who should step up or back away from a

case. In particular, clinical guidelines are most likely to be referenced as part of *evidencing.*

Decision-making beyond the realms of multidisciplinary working are also found in the literature. A key theory looking at the experiences of rescue workers responding to individuals in emergency situations is called Covering, developed by Hutchinson (1979) (see Figure 6.2d). This author explains that this process protects those who work in publically scrutinised environments.
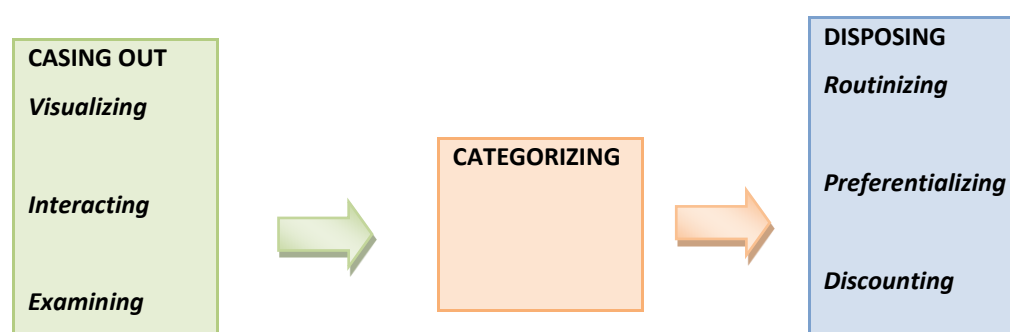
Figure 6.2d: The theory of Covering as adapted from Hutchinson (1979)

According to Hutchinson (1979), Covering is a necessary process for rescue workers who need to make decisions without facing negative repercussions. The two factors that challenge their working environment are uncertainty of the situation and their high visibility to the public. The first phase of Casing Out represents the initial assessment of the patient in the context of initial viewing. Information is gained from the patient and the nearby public. The workers then move onto to Categorizing the patient regarding their illness and behaviour. With social evaluation, values are attributed based on the patient's appearance, ethnicity and apparent socio-economic status. Categorizing involves a prioritizing process where workers evaluate the issues at hand and focus on the most significant ones. The level of emergency dictates how quickly workers can move on to the Disposing phase. This final phase consists of three sub-stages which reflect the final actions of dealing with the patient. Routinizing involves routine care which can be seen as safe, preferentializing equates special care and discounting refers to less than humane care. Ultimately this results in the patient either being transferred or remaining where they are.

The work of rescue workers and the environment of SPA meetings share some characteristics regarding the rapid decision-making element inherent in both. Additionally, for SPA meeting attendees, although public scrutiny is not as immediate as with the work of rescue employees, with media, technology and official standard and assessment bodies, the pressure of making good decisions is present. Casing Out bears similarities with the Recognising phase and the Positioning phase of Handling Role Boundaries. Not only does some form of assessment occur with clients, but it is also important when gaining a sense of each other and wider colleagues. Assessing the manner of SPA meetings familiarises attendees with how things operate and the general order of things, whilst assessing others in relation to their professional roles and personality traits is helpful to navigate through decision-making. Client assessment is done through written accounts based on other people's perspective e.g. the referrer and other agents who have encountered the client. This means that with the Positioning stage, it is likely that attendees will be placed based on their professional backgrounds to pick up on things relevant to their expertise. Reflections of the client are based on attendees' making some form of assessment and offering opinions. Thus the Positioning phase may carry some level of Categorizing (as mentioned when discussing Griffiths' 2001 study). As with Hutchinson's Covering process, essentially, SPA meetings need to operate a triage process so that pertinent issues can be addressed first and Handling Role Boundaries accommodates this. Through Weighing Up, attendees' contributions (ascertained by Positioning) can be considered and prioritised before identifying which professional/ agent will be appropriate as part of *matching up*. Decisions relating to discerning between who to treat and not treat are a dominant focus in healthcare (Newdick, 2005).

Hutchinson's (1979) final phase of disposing reflects on the actions rescue workers take to deal with clients. This is perhaps where Handling Role Boundaries differs; there is a sense that clients are dealt with through a decision that is made, but this comes as a result of how the attendees respond to *each other* and their handling of their diverse roles. Therefore in the final phase of Balancing, the sub-categories of *compromise and negotiating; sacrificing* and *volunteering* all revolve around how attendees react based on the role boundaries that have been circulating within the meeting. This in turn affects how the client is dealt with. Thus there are some shared elements inherent in Covering and Handling Role Boundaries but differences are to be expected given the different social aspects that they are dealing with.

Thus far, the chapter has drawn upon studies that explore the micro-level of interaction linked to decision-making strategies in healthcare teams. These empirical studies allow opportunity for comparisons to see how elements of Handling Role Boundaries may emerge in other contexts, particularly in milieux where team work and decision- making within and beyond the mental health arena takes place. Moreover, what is demonstrated is that several theories offer useful categories that Handling Role Boundaries finds resonance with, such as Categorising (Griffiths, 2001), Pluralistic Dialoguing (McCallin, 2007), Situated Patterning as part of Mutual Intacting (Elliott, 2007) and Covering (Hutchinson, 1979). However, Handling Role Boundaries reveals that personality traits contribute significantly to interactions within professional realms such as multidisciplinary team working. This has not been given copious attention in the empirical studies reviewed with an emphasis being placed on professional roles.

With this in mind this chapter now seeks to develop the issue and importance of personality further. In order to do this, it is necessary to engage with the literature on central themes of self, identity, interaction and role. Reference to Handling Role Boundaries is made to find common ground and points of departure from extant theories. Additionally other aspects of identity that Handling Role Boundaries covers, such as the notion of handling multiple roles is relevant to these wider macro level concepts.

6.3: <u>Self, identity, interaction and role theory</u>

Facets of identity including personality and professional identity described by Handling Role Boundaries need to be understood within the larger concept of identity. Exploration of identity then generates further related themes of self, interaction and roles. The literature on the macro level concepts self, identity, interaction and role theory is plentiful and established within the field of Sociology. This section of the chapter endeavours to review the extant sociological work that has explored these macro-level themes before drawing attention to the notion of multiple roles. Handling multiple roles contributes to understanding more about how personality is active besides other aspects of identity, an issue that is crucial to Handling Role Boundaries BSP that underlines SPA meeting attendee behaviour. The discourse that ensues considers the work of prominent writers in this field and how Handling Role Boundaries relates to such work, whilst also identifying its original contributions to these sociological arenas.

According to Stryker and Burke (2000), sociological concern with identity can be categorised in three ways

1. The culture of people
2. The common identification with a social category
3. Parts of the self that individuals attach to the multiple roles they play in highly differentiated contemporary society.

It is with the third usage of the term identity that Handling Role Boundaries finds resonance. This particular usage can be traced back to Mead's (1934) work which culminates in the theory of symbolic interactionism. Mead suggests that humans make sense of the world by using symbols to attach meaning to social life through interaction. Such meanings are socially constructed and must be shared to make sense and prevail. Thus following Mead's (1934) work, one must engage in understanding society in order to fathom any understanding of the self.

Stets and Burke (2005) offer a useful review of the sociological literature of self and identity. They endorse Mead's (1934) strategy when looking at identity, suggesting that it is important to begin with discussion of the notion of "self" before tackling the issue of identity. Exploration of the self-thesis requires investigation into society. These authors present Stryker's (1980) work which utilises a structural approach to the symbolic interactionist perspective. This is where his perspectives depart from Mead's situational approach. Stryker suggests that societies are actually stable as opposed to being in a constant flux. It challenges the traditional symbolic interactionist approach (Mead, 1934) by opposing the notion of individuals being free to define situations in any way they wish. According to the structural symbolic interactionist thesis, there are patterned "norms" which represent regular ways of doing things through human action (Stryker, 1980). Stets and Burke (2005) support this standpoint claiming that,

> *Individuals act, but those actions exist within the context of the full set of patterns of action, interaction, and resource transfers among all persons all of which constitute the structure of society…* (p3).

This does not support a notion that structure accounts for all human agency; rather self and society are reciprocal. Thus social structures are generated from human agency (such actions become patterns over time), but individual actions need to be understood in the context of the social structures where such actions take place (Stets and Burke, 2005). With regards to the Handling Role Boundaries theory, this would account for behaviours of SPA meeting attendees by justifying the Balancing phase. There are choices available to attendees as they embark on acting in certain ways, but this choice is limited within the context of the meeting and maintains established ways of doing things. Moreover, the attendees are primarily motivated by the need to make decisions together about clients that can be recorded. Thus, individual action in SPA meetings reflect the context within which they take place and beyond this, the wider context of the NHS organisation.

Stets and Burke (2005) suggest that reflexivity is a key element of selfhood and is made possible through the mind and language with the latter providing the ability to point out meanings. Interaction allows one to ascertain a sense of how others see us and therefore the self is *"…a merger of perspectives of the self and others, and a becoming as one with the others with whom one interacts"* (p4). The notion of humans as processual entities relies on shared meanings of the objects and symbols that are reflected through interaction (Mead, 1934). Self-concept allows individuals to present themselves to others and have a clear conception of who they are. This resonates with the Recognising phase of Handling Role Boundaries theory, which highlights the idea of attendees needing to have an essence of their own roles and also those of others. The cyclic presentation of Handling Role Boundaries indicates that the recognising phase is evolving and relies upon what happens in the Balancing phase to determine whether new elements of the individuals are recognised or not. Being able to recognise attributes of attendees relies on attendees presenting themselves during the meeting and this relates to Stets and Burke's (2005) discussion on self-concept.

Further defining self-concept, the authors imply that it materialises from our observations of ourselves, our understandings of who we are as determined by how others act towards us, our desires, and our self-evaluations (Stets and Burke, 2005; Burke, 1980). It encompasses our idealized views, which generally remain stable, and also our working copy which may change depending on how the situation evolves. This working copy, also known as self-image, helps us in moment-to-moment interaction. This is evident in the Handling Role Boundaries theory where the Balancing phase signals

actions from attendees that might step outside their patterned "norms" as motivated by various factors. The sub-stage of negotiating and compromising acknowledges that sometimes, these processes are needed to deal with the interaction taking place. According to Gecas and Burke, (1995), self-concept derives from the reflected appraisal process, which claims that our perceptions of ourselves are influenced by others' appraisals of us. Essentially, self-concepts are filtered through our perceptions and convey how we believe others to see us. We tend to be more in tune with how groups see us rather than individuals since group standards may be more clearly reflected (Stets and Burke, 2005). In my semi-structured interviews, I found that generally, subjects had clear notions of what they were expected to do in their professional capacity at the meetings. They rarely talked of conflicts in this sense and it seemed that all attendees had a general understanding of group expectations. However, when it came to elements of personal traits, some subjects revealed that these were understood adequately by all attendees. For example, one consultant psychiatrist revealed that she got annoyed when attendees would begin reading referral letters to themselves when the group were meant to be collectively engaging in one at a time. The fact that attendees continued to do this, suggests that the attendees possibly did not know that the consultant psychiatrist viewed their actions as unreasonable and would prefer them not to do this. Thus did not comply with her expectations. They were more likely to fulfil their professional roles of taking it in turns to read and pick up on anything that was within their professional realms because this is a group expectation and thus more clearly conveyed. On the other hand, one cannot know whether attendees were aware of the consultant psychiatrist's preferences and simply chose to ignore them. The consultant psychiatrist told me that she had considered handing referrals out one at a time, so attendees could not continue with this practice. This would make her expectations clearer and more easily understood. Attendees may possible alter their behaviour and thus their self-concept in response to this.

Identity has been an extensively investigated area within the realms of sociological enquiry and offers relevance when seeking literature to review in relation to Handling Role Boundaries, through the constant comparative method. The theory of Handling Role Boundaries postulates that SPA meeting attendees employ strategies to manage the plethora of roles that are inherent in the multidisciplinary environment they operate within. The complexities of this are reinforced by the fact that such diversity of roles exists not just between individuals, but also within individuals. The resolution of the main concern inevitably involves strategies to handle these roles and their related boundaries. The identity literature offers some insight into how facets of the self affect

our everyday actions and experience of the social world. Identity and interaction are inextricably related because they both guide our shaping of reality and determine our experiences (Giddens, 2009; Jenkins, 2008; Stets and Burke, 2005; McCall and Simmons, 1966). The theory of Handling Role Boundaries describes aspects of identity and interaction in the attendees' progression through the SPA meeting and their endeavour to resolve their main concern in decision making.

According to Giddens (2009) identities are complex and come in multilayered forms. A basic categorisation of identity would be primary identities (i.e. produced early in life) and secondary identities (social roles and achieved statuses). Some elements of identity are less rigid than others and can alter as people's lives progress. Jenkins (2008) investigates the phenomenon and facets of identity and highlights that there is a treatment of demarcation regarding understanding of individual and collective identities. He argues that,

> *…with respect to identification, the individually unique and the collectively shared can be understood as similar in important respects…the individual and the collective are routinely entangled with each other…individual and collective identifications only come into being within interaction…the theorisation of identification must therefore accommodate the individual and the collective in equal measure…* (2008:37-38).

Stets and Burke (2005) describe identity as multiple parts of the self and inevitably is related to social structure,

> *One has an identity, an "internalized positional designation" (Stryker, 1980, p60) for each of the different positions or role relationships the person holds in society* (2005:8).

The authors further elaborate that identities equate to meanings that one may hold as a group member, a role-holder, or a person e.g. the meanings we give to being a father. Interaction takes place between people who have positions or statuses in groups of societal organisations (Stets and Burke, 2005). One claims an identity in an interaction

and in this directs what may and may not be talked about, as deemed appropriate for that identity. Modalities of interaction are moved to and from with ease and the authors acknowledge that one may operate more than one identity at a time. Clearly Handling Role Boundaries supports the notion of multiple identities. However Stets and Burke (2005) also infer that in claiming an identity, there must also be alternative identity for another to claim e.g. a husband identity may play out in relation to a wife identity. However, Handling Role Boundaries does not support this wholeheartedly. In the context of SPA meetings, it is likely that there will be more than one representative of a professional group. Beyond professional identities, there may be scope for alternative identities e.g. stable members and new members; the leader/ Chair and non-chair; readers and listeners etc. What Handling Role Boundaries disputes, however, is that alternative counter identities are needed for one to claim an identity.

These conceptions suggest that theories constructed to encompass ideas about identity such as Handling Role Boundaries should accommodate the phenomenon in its individual and collective form. Jenkins (2008) reflects on the work of Erving Goffman and Anthony Giddens and further comments that there are three prominent "orders" that describe human nature. This is shown in Box 6.3:

1. The individual order: Human world is made up of embodied individuals and their thinking processes

2. The interaction order: Human world is based on relationships between people and their interactions

3. The institutional order: Human world consists of pattern and organisation- based on established ways of doing things

Box 6.3: Three "orders" as adapted from Jenkins (2008).

Jenkins (2008) makes a strong argument to insist that one must reflect on all three "orders" when attempting to understand the social world. With the individual order, selfhood is created through the process of social construction which is achieved through socialisation and interaction. There is constant engagement in defining and re-defining oneself and essentially, self-definition is based on an amalgamation between how we see

ourselves and how others see us. This implies that awareness is present and supports Mead's (1934) insistence that when forming perceptions of ourselves, there must be consideration applied to how others see us. The points present within the theory of the individual order shares some of the pertinent characteristics of Handling Role Boundaries by emphasising not only self-perception but the perception others hold. Recognition was a key phase within the theory and encompassed attendees' perception of themselves and how they perceived their colleagues. However, one can also identify within Handling Role Boundaries how perceptions by others applied to oneself can affect the behaviours of attendees. This is clearly demonstrated in the Positioning phase in which attendees *take their place* to fulfil expectations that they perceive to be relevant to them. For example, one individual may consider how their fellow attendees perceive them in professional terms as for example a social worker. This may compel them to feel the need to listen out and pick up on elements that fall within social care realms. Alternatively or alongside this situation, attendees may also perceive this person to be good at time keeping. Thus as well as picking up on social care issues, this particular attendee may take responsibility for checking time and ensure discussion does not sway into irrelevant realms. Jenkins (2008) suggests that such processes of defining oneself are instigated through our earliest engagements in socialisation as part of cognitive functions. It is understandable that such processes will be emphasised in a meeting setting in which ongoing interaction is present. The re-defining element also shares similarities with Handling Role Boundaries, particularly in its cyclic structure. Chapter 5 explained how information gained from the Balancing phase informs the Recognising phase as new characteristics may be generated and thus subsequently associated with individuals. Humans are not rigid and constant: they develop and modify. Moreover, they are a subject to changing contexts and in the era of recession and great social changes, roles and responsibilities change as job descriptions alter. CMHTs possibly find their target clients are different from those they were authorised to cater for at earlier times.

The interaction order is based on much of Goffman's understanding of the performance-driven processes one employs when negotiating identity. This is influenced by our own perceptions of the self and also awareness of how others see us. This is captured through the procedure of impression management (Goffman, 1959). We are conscious of presenting ourselves in a way that will be received in a certain manner by others. However individuals do not have access to full control over how their selves are interpreted by others. Goffman (1959) implies that impression management is conceived out of human nature,

When an individual enters the presence of others, they commonly seek to acquire information about him or to bring into play information about him already possessed…Information about the individual helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him. Informed in these ways, the others will know how best to act in order to call forth a desired response from him… (Introduction).

Handling Role Boundaries is a strategic process and Goffman (1959) and Jenkins (2008) discuss impression management as a strategy that is done with intention to achieve a purpose. Evidence of impression management being employed by SPA meeting attendees is present and can be identified by reflecting on how they handle role boundaries. The assessment of individuals that Goffman (1959) alludes to, closely relates to the Recognition phase and as the Positioning phase predicts, Goffman also indicates the tendency for expectations to be made. Seeking a desired response can also be detected when reflecting on accounts by SPA meeting attendees. One team leader discussed his desire to present the CMHT to newcomers in a way that did not appear disrespectful in the handling and discussion of clients' problems. As discussed in Chapter 5, he spoke about the sometimes jocular atmosphere that evolved within SPA meetings in Area 7 but conveyed his reluctance to appear too flippant in front of new members. This subject revealed that he sometimes curbs the jocular atmosphere to promote a more serious manner. This demonstrates some principles of impression management by identifying that in some circumstances, attendees strategically act in ways to generate a certain image and thus a particular opinion. Moreover, if *compromise and negotiation* are employed through the Balancing phase, this can be interpreted as wanting to achieve a certain result, for example, for a certain team to take on a case. Adjusting one's approach by offering some reassurance as opposed to demanding they take on the case is appropriate given that the main concern revolves around working together. The interaction order and impression management thus describes some elements of attendees' behaviours. However, not everyone negotiates and some subjects revealed that caution was needed when dealing with certain "characters" of the group. This implies that not all attendees seek to present a favourable impression of themselves.

Jenkins (2008) finally discusses the institutional order which revolves around collective identities, which is either personally or collectively identified and the shared situation

understood and accepted. He captures the significant role of institutions and organisations in stimulating collective identities,

> *Institutions are established patterns of practice, recognised as such by actors, which have force as "the way things are done". Institutionalised identities are distinctive due to their particular combination of the individual and the collective…Organisations are organised and task-oriented collectivities; they are groups. They are also constituted as networks of differentiated membership positions which bestow specific individual identities upon their incumbents…* (2008: 45).

This aspect of the institutional order resonates with SPA meeting attendees because it is clear that being part of a mental health team has dealt both individual and collective activities and may have also influenced certain personality traits. The SPA meeting is one of the areas of team working in which strategies need to be employed to handle the many roles circulating. Shared investment in the meeting priorities of working together to locate the client in the best place instigates the Handling Role Boundaries process. The subjects did not term their self-perceptions "institutional identity" but what they disclosed captures the themes that Jenkins (2008) discusses. The combination of collective and individual identities occasionally presented a conflict for attendees. One subject in Area 7 spoke about holding back personal viewpoints which were influenced by his social care background, in order to allow the CMHT priorities to take precedence. This is termed *sacrificing* within the Balancing phase of Handling Role Boundaries. Such conflict meant that the subject needed to confront both aspects of his identity and an assessment took place which allowed one to become more dominant at that particular point. For another case, it might have reverted back to relatively equal measures or with his social care perspectives becoming more prominent. This emphasises both the complexities of identities and the complexities of mental health clients' problems. Through his theorising of human ordering, Jenkins (2008) offers some relevant contributions to the identity thesis and thus is applicable to SPA meeting attendees. Moreover, as with Handling Role Boundaries, his work shows attempts to capture the complexities inherent in human identities.

Looking more intimately at Goffman's (1959) work on impression management and the presentation of self in everyday life, one can reflect on the theatrical analogy he uses to

identify any significance for the experiences of SPA meeting attendees and also scope for collaboration with the Handling Role Boundaries theory. According to Goffman (1959), social life consists of front regions and back regions; the former allows space for formal roles while the latter provides freedom to shed the constraints of such role and assume informal identities. Preparation for formal roles is completed backstage and allows "actors" a more relaxed domain to suspend formal language and demeanour. It is difficult to apply this analogy in a simple manner to the context of the SPA meeting and attendees. The meetings could be construed as a "backstage" from the clinical encounters the professionals engage in. There was a sense of informalities within the meetings and language was not always formal. Moreover, on some occasions a light-hearted manner was reverberated with joking and laughter. This reflects findings from a study by Tanner and Timmons (2000) where they conducted observations in an operating theatre, particularly investigating "*…the role of space in structuring social action in the operating theatre…*" (p975). This study primarily discusses the dynamics of doctor and nurse relations. As with SPA meetings, Tanner and Timmons could not easily categorise operating theatres in Goffman's front stage and back stage domains. Physically, the operating room was located often in the basement of the hospital and the nature of conversations, language and use of first names indicated backstage elements. Furthermore, behaviour between doctors and nurses differed here than in other hospital arenas. This included times where these professionals would joke with one another, and also surgeons carrying out some tasks that are within the nurses' remit. Moreover, reference to patients, who were anaesthetised, was sometimes deemed by the researchers as disrespectful. However, front stage elements also prevailed in the fact that patients *were* present, regardless of them being anaesthetised. Staff also did conform to professional roles, for example, the theatre nurses would make way for the surgeons to walk past whereas in the vice versa situations, surgeons did not move and nurses were expected to walk around. Moreover even if nurses had made plans, they tended to defer to surgeons.

I found that the SPA meetings too reflected some behaviour that Goffman would designate as front region behaviour. The meetings did have a formal agenda which in the context of the main concern, required subjects to maintain their clinical roles. Furthermore, I noticed that there was some reiteration of formal identities when conversing with students. For example, in Area 1, one consultant psychiatrist tested a student on their definition of a condition. There was a metaphorical sense present where members did not wish to step on each other's toes and were quick to identify who cases were for if the referral seemed clear. Checking with the team leader for confirmation of

actions to be taken was also common among attendees. Positioning the SPA meeting in terms of regions may not be as easily applicable since it is difficult to define with precision attendees' behaviour as formal or informal. There are times when attendees' personality traits emerged and thus needed to be handled. Goffman's (1959) work is more likely to place personality emphasis in the context of informal back regions. The complexities arise from the frequent merging of formal and informal behaviour within SPA meetings and the accommodation of professional, personal and group aspects of identity. The Handling Role Boundaries theory is relevant and caters for these multifaceted aspects of the decision making process since formal and informal behaviours can be accounted for.

According to Stets and Burke (2005), understanding identity and interaction can be done from two different perspectives: agency and social structure. The latter indicates that actors play a role in a stable social structure. The former perceives individuals as agents who take on roles and make behavioural decisions, which might involve negotiation and compromise. They reiterate their belief in the reciprocal relationship between agency and structure. The structural symbolic interactionist approach (Stryker, 1980) espouses various underlying principles (Stets and Burke, 2005):

1. Behaviour is dependent upon a named world and such names have meanings that arise out of shared responses and behavioural expectations as materialising from social interactions.
2. Symbols are used to allocate positions in the social structure
3. Persons recognise one another as occupants of positions and come to have expectations
4. Persons create internalized meanings and expectations with regard to their own behaviour
5. Such expectations form the basis for social behaviour

Whilst advocating the structural symbolic interactionist approach, Burke and Stryker focus on two different elements (Stets and Burke, 2005; Stryker and Burke, 2000; Stryker, 1980). Stryker is interested in how social structure accounts for one's identity and behaviour, whilst Burke focuses on the internal dynamics of the self that produces behaviour. The Handling Role Boundaries takes into account both of these elements and does so because it draws heavily upon the notion of the self encompassing multiple

identities. Some of these identities are informed heavily by structure e.g. professional capacity and conduct, whilst others may be the result of internal processes that then redefine elements of the structure e.g. aspects of personality traits that become patterned regularities and thus need to be incorporated into the structure.

Since at the heart of Handling Role Boundaries theory is the term "role" it is useful to explore its treatment theoretically and how this resonates with my intentions to use it. The nature of role theory has led to much confusion due to its early proponents applying the term in different ways (Biddle, 1986). However, Biddle (1986) maintains that it offers integral theoretical understanding into a key element of social life,

> *It explains roles by presuming that persons are members of <u>social positions</u> and hold <u>expectations</u> for their own behaviours and those of other persons…* (Biddle, 1986: 67).

Furthermore, Stryker and Burke (2000) suggest that social roles relate to expectations that are associated with certain positions that are present in networks of relationships. The theory of Handling Role Boundaries extensively advocates these definitions and shares such assumptions about social beings such as attendees of SPA meetings. These social positions may be formally defined as with professional roles, or have a more informal status, such as the traits of one's personality. Handling Role Boundaries maintains that such role aspects of identities do not always manifest separately and are not always competing for prominence. They are capable of merging and as such, behaviour observed may by an amalgamation of such roles.

According to McCall and Simmons (1978), role identity relates to the character someone creates in relation to his or her particular social position. These authors emphasise the two dimensional nature of role identity: The conventional dimension relating to the expectations inherent in social positions; and the idiosyncratic dimension, which denotes the interpretations individuals bring to roles. The level of conventional behaviour compared to idiosyncratic ones depends upon the individual. This treatment of "role" takes into account the structural restrictions placed upon roles and the individual agency that also plays a part in contributing. Moreover, in line with Handling Role Boundaries, McCall and Simmons' definition also embraces the notions of professional identities and

personality as contributing to a person's behaviour. These authors suggest that because the self consists of multiple identities, role identities need to be dealt with by putting them into hierarchy of prominence (Stets and Burke, 2005; McCall and Simmons, 1978). Organisation of roles is not something Handling Role Boundaries emphasises, since the importance of one role may be promoted or demoted depending on how the situation unfolds. However, in the initial Recognising phase, it is likely that role choices are narrowed down, and attempts to prioritise the roles appropriate for the SPA meeting would take place in this phase. The Balancing phase may signal where role priority changed and where elements of personality may overtake professional aspects.

Stryker (1980) similarly suggests that multiple role identities need to be organised (Stets and Burke, 2005) and describes a salience hierarchy taking place. According to Stets and Burke (2005),

> *Whist the prominence hierarchy of McCall and Simmons addresses what an individual <u>values</u>, the salience hierarchy focuses on how an individual will likely <u>behave</u> in a situation. What one values may or may not be related to how one behaves in a situation although there is a significant relationship between the two (p12).*

With this in mind, Handling Role Boundaries embraces the notion of a salience hierarchy as postulated by Stryker (1980) as opposed to McCall and Simmons' prominence hierarchy. Some SPA meeting attendees admitted in interviews that they knew when it was appropriate to hold back certain views and personal beliefs in order to bring the decision making process to an end. This was of pertinence in the Balancing phase when one may decide to put the collective interests of the group first rather than one's agenda based on personality and/or professional role. One must consider the sanctions and rewards associated with devising a salience hierarchy and proceeding with a particular identity over another. According to Stryker and Burke (2000) the term "commitment" is integral to this part of the debate,

> *Commitment refers to the degree which persons' relationships to others in their networks depend on possessing a particular identity and role; commitment is*

measurable by the costs of losing meaningful relations to others, should the identity be forgone (p286).

This suggests that salience of roles depends on the social surroundings and individuals present and the extent to which one's relations with said individuals will be compromised. This does appear to be relevant to SPA meeting attendees and is encompassed to some extent in Handling Role Boundaries. For example, the phases of Recognising and Balancing allow attendees to determine what aspects of identity (i.e. roles) are appropriate and needed for the situation. These may change depending on how the situation evolves, but this occurs within the context of needing to make decisions together. Thus some role choices will be restricted and/or pushed lower down the salience hierarchy. However, Handling Role Boundaries does make room for role deviance. As discussed in Chapter Two, this refers to situations when expected "norms" are not obeyed (Eaton, 2001). With regards to Handling Role Boundaries, changes in "norms" are potentially accepted and worked with, particularly when one looks at the theory in its cyclic form. Changes to one's persona may emerge during the Balancing phase, for example where aspects of personality may become more obvious. In the context of SPA meetings, this may involve an attendee being willing to negotiate when before they were known for being stubborn. If this becomes a patterned form of behaviour, it may become a recognised trait of that person in the Recognising phase and thus be expected of them in future discussions about clients. Since a change of "norm" of this type contributes to the resolution of the main concern of SPA meeting attendees to make decisions about clients, this makes it more likely for this behaviour to be expected. If the "norm" deviation revolved around something that would not contribute to effective discussion e.g. getting up in the middle of the room and dancing, it is highly unlikely that this will become a patterned form of behaviour, since it would be swiftly halted and discouraged.

Burke's interest in role identities relate to the internal dynamics at play (Stets and Burke, 2005; Burke, 1980). Interaction contributes to individuals' understandings of meanings relating to their role identities.

…other individuals act towards the self <u>as if</u> the person had an identity appropriate to their role behaviour… (Stets and Burke, 2005)

Through negotiating, the person deals with situations where their own understandings, which may not comply with others' understanding of their roles. This paves the way for role identities to have multiple meanings with certain role traits being more dominant than others. This can explain why two people with the same roles may display different behaviours.

Biddle (1986) suggests that despite the variation in theorising role theory, most versions concur that humans are socially aware actors who ascertain expectations through experience and are thus aware of these expectations upon them. The modality of expectations is where theorists tend to clash. There are three main origins of expectations that are referred to:

1. "Norms", which are prescriptive in nature
2. Beliefs, which denote subjective probability
3. Preferences, which concern attitudes

Biddle (1986) argues that all three are capable of contributing to expectations and thus behaviour. These modalities result in roles manifesting for different reasons. Handling Role Boundaries demonstrates how all three of the modalities contribute to behaviour. "Norms" in SPA meetings have been established over time, by actions evolving into patterned regularities and forming established conventions. For example, there are shared understandings in the group as to what consultant psychiatrists should be picking up in referral letters based on their professional capacities. Moreover, there are established conventions which are prevalent in SPA meetings, such as the way in which (in most centres) everybody takes it in turn to read referral letters. These conventions are explained to newcomers. Beliefs also contribute to behaviour observed at SPA meetings and as an integral element of both professional identities and personality aspects. Subjects in both participant observation periods and interviews spoke about what they believed the CMHTs that they were part of should be catering for. Moreover, they also disclosed their beliefs as motivated by their work role, which did not always comply with their role as a CMHT member. This was related to their preferences of actions to be taken and the Balancing phase evolved out of these disclosed incidences where decisions needed to make if roles clashed. Significantly, such clashes and conflicts

would not only be between person to person, but also within one person, something the field terms as "role conflict".

6.4: <u>Handling Role Boundaries and the wider context</u>

This chapter's constant comparison of the BSP with extant literature has helped to further define its properties and has identified points of relevance beyond the immediate substantive area. It is important to now return to the context set up in Chapter 2 to establish how Handling Role Boundaries can be seen as historically contingent, concerning the management of individuals with mental health problems. The BSP labels a social process that concerns the activities of individuals responsible for identifying mental health deviants, who are measured against socially defined "norms". The need to identify and deal with certain forms of deviance sees the health service as the dominant arena where this takes place and mental health professionals are the designated agents with this responsibility. As Chapter Two highlighted, management strategies are influenced by the shape of society and the attitudes present. As with other organisations in British society, bureaucracy controls much of how the NHS operates. Therefore identification and management of people with mental health problems is conveyed within bureaucratic processes. This is evident in having a meeting that discusses case referrals with an agenda to triage and sort through the lists of clients. This activity is further influenced by society's emphasis on risk management and medicalization, both of which the SPA meeting embraces. Specifically looking at the identification process, it occurs in a culture of specialism and multidisciplinary working, which explains why the BSP captures diversity of roles. These individuals are also gatekeepers to their specified services, which run using specified resources. Therefore in this current context, management of deviancy is also affiliated with management of resources. This shapes the identification process, because identifying mental health deviancy now translates into categorising individuals into particular *forms* off mental health deviancy, based on the services these agents represent. Handling Role Boundaries depicts the activity of identifying mental health deviants and the elements that currently concern this, such as diversity of mental health labels, diversity of roles, complexities of interaction, bureaucracy, limited resources, as well as accountability and responsibility. Looking beyond the context for a moment, the BSP must also be understood as a resolution to a particular main concern, i.e. attendees needing working together to find an appropriate place for clients within the meeting. Therefore, as well as concerning the identification of mental health deviants by representative gatekeepers of mental health services,

Handling Role Boundaries occurs to resolve a specific concern for them within the meeting environment where that identification takes place.

Handling Role Boundaries clearly is innovative and offers much to explain multidisciplinary working. It certainly has resonance with existing understandings in this area, but at the same time introduces fresh insight into the relationships between identity, roles and interactions. The constant comparative method employed here with Handling Role Boundaries and extant literature has shown that the BSP is not lacking in its capacity to offer valid useful insight into a very crucial area of mental health clinical activity. Furthermore, it shows potential to explain the behaviours occurring in other substantive areas. This is intriguing, encouraging and serves to highlight the esteem that the BSP can be held in academically and otherwise. These potentials are expanded upon in Chapter 8 and discussion ensues regarding further development of the theory.

6.5: <u>Conclusion</u>

In conclusion, in respect to Glaser's statement that "all is data" (2007; 1978), Chapter 6 has presented literature that has been incorporated into the constant comparative method to assess the phases and properties integral to the Handling Role Boundaries process. Theories and general literature in clinical decision making were discussed to identify significant relevance for SPA meeting attendees and these were highlighted and compared to attributes of Handling Role Boundaries. Literature reviewed has arisen from substantive areas that are similar and variant to SPA meetings. Insights into the sociological treatment of self, identity, interaction and roles were sought after these were two areas that were found to be linked to decision making for health professionals. In addition, these macro-level themes were essential to understand why personality is a significant part of identity and therefore emerges during interactions. Jenkins (2008), Stets and Burke (2005), Biddle (1986), Stryker (1980), Goffman (1959) and Mead (1934) offered the most potential for constant comparative techniques and the areas of relevance and irrelevance have been conveyed. My personal reflections as a participant observer and reference to interview encounters have been drawn upon to provide concrete examples of phases within Handling Role Boundaries. The literature review conducted in the manner evident here demonstrates that Handling Role Boundaries is theory that fits, possesses workability and relevance and can accommodate new ideas when appropriate. As part of the discussion of the overall study findings, Chapter 8 addresses the extent to which Handling Role Boundaries contributes new ideas to

sociological themes as well as highlighting its use for extending GT literature. In addition, it considers its relation to the quantitative data findings of the PhD study. A significant conclusion that can be drawn from this chapter is that the theory of Handling Role Boundaries embraces established notions of self, identity and interaction and offers more elaborated insight into how strongly personality emerges in behaviour, even in professional settings. Finally, the chapter returned to the context established in Chapter 2, which emphasised the historical contingent nature of identifying deviants. The innovative nature of Handling Role Boundaries is recognised and credited with being insightful and offering much potential which is explored in Chapter 8.

7) Commentary on quantitative data challenges

"There is no safety in numbers, or in anything else."

~ James Thurber, New Yorker

7.0: <u>Introduction</u>

Chapters 1 and 3 discussed the initial project's endeavour to evaluate the Trust's system facilities in providing post-SPA meeting data. This was sought to assess the appropriateness of SPA meeting decisions by accessing details as to what services and interventions clients had engaged in and whether these were what had been recommended through the meetings. Personal communication with administrative staff and CMHT mental health professionals established that in common with other NHS facilities, it has been obliged to place a strong emphasis upon efficiency and firm business management. To support this, the organisation has invested heavily in information services intended to record, track and quantify the activities it provides to clientele. Personal communication suggested that it could be possible to use information captured in this way to follow clients' progress through care, and thereby ascertain in retrospect how accurate or appropriate judgments made in SPA meetings had proved to be. However, as information held by the organisation's IT system was accessed and considered, it became clear that these expectations would not be fulfilled. Since the Trust's information services were unable to help in this evaluative enquiry, focused pursuit of qualitative data and grounded theory analysis was emphasised as chapter 4 and 5 has conveyed. However, it is worth here discussing the issues that created difficulty in accessing desired quantitative information and the utility of this information system as a means of collecting, storing and summarising clinical decisions and their consequences including those made by SPA meetings and clients' subsequent progress through care. Using my experience as a starting point, the efficiency of the information system in fulfilling its intended organisational functions is assessed. As discussion ensues, it is recognised that these system facilities are integral to support and aid the running and operation of SPA meetings. Habermas' (1987) work on the life world and system world thesis is consulted to convey this point. Suggestions are presented briefly as possible points for improvement to enhance efficiency of the Trust's information facilities.

7.1: <u>Expectations versus Reality</u>

Pre-data collection consisted of personal communication with CMHT staff including administrative and health worker personnel to ascertain a sense of the system employed in supporting SPA meeting activities and their potential in data extraction. These resulted in the following expectations:

- Each client registered with the Trust is assigned a unique identifier, known as the RIO number, named after the computer software used for these purposes.
- RIO numbers are assigned to clients who become accepted referrals, and this is expected to happen before they are considered at a SPA meeting.
- The conduct of SPA meetings includes the client's name, RIO number and a written record of decisions made.
- As the RIO number identifies all information held by the organisation's IT system concerning that client, matching RIO numbers between written records of SPA meetings and computer records should give access to computer-held information about clients considered at one or more specified SPA meetings.
- This information is intended to provide a record of clients' progress through mental health services. Therefore computer-held records of clients considered at past SPA meetings should reflect how successful decisions were at predicting what actually happened to the clients in question.

The reality was somewhat different. A period of 9- 12 months was allowed to lapse between the SPA meetings in question and the search for computer-held records of client cases that were discussed. However for four of the seven SPA meeting sites studied, significantly fewer records were retrievable than the other three. I could only access between 8.4 per cent and 45 per cent of the total client data from these four centres. This led me to explore the strategies put in place by Trust information officers to acquire such information. Personal communication with CMHT workers and a key Trust information officer established that a RIO number could access details about clients' post SPA meeting interactions with services and their overall mental health careers. By linking this with initial SPA meeting decisions, this could potentially provide an assessment of the appropriateness of SPA meeting decisions. Table 7.1 indicates initial plans relating to actions taken by myself and the Trust information officer.

My actions	Trust information officer actions
Provide officer with: • RIO numbers of clients discussed at SPA meetings within a three month period from seven sites • Where possible, I was to indicate what the SPA meeting decision had been as elicited from meeting notes.	Use the RIO number to unlock system-held data relating to the following: • Incidents of historical interactions with Trust facilities • External referral date (i.e. when non-Trust referrers referred into Trust) • Referring agent • Reasons for referring to SPA meeting • Discharge date (e.g. when the client was discharged from the organisational unit deemed responsible for the SPA meeting) • Discharge reason • Incidents of internal referrals (i.e. referrals between Trust facilities)

Table 7.1: Actions taken

Figure 7.1 provides a representation of the requirements necessary for the information officer to elicit the data in Table 7.1. As the figure indicates, referrals must, at some point, have had an external referral date i.e. where referring agents external to Trust services refer the client into Trust services. However, the program used by the Trust information officer to elicit data required them to put parameters indicating that the referral date had to be within 14 days before the SPA meeting date.

External referral date falls beyond specified 14 days=

External referral date – maximum 14 days before SPA meeting

External referral date must fall within 14 days prior to SPA meeting

SPA meeting date e.g. between 1st December 2010 and 28th February 2011

But some referrals may have had an external referral date that was before the specified 14 day period. Thus external date was not retrieved by the information officer. Where this happens, client data could not be traced
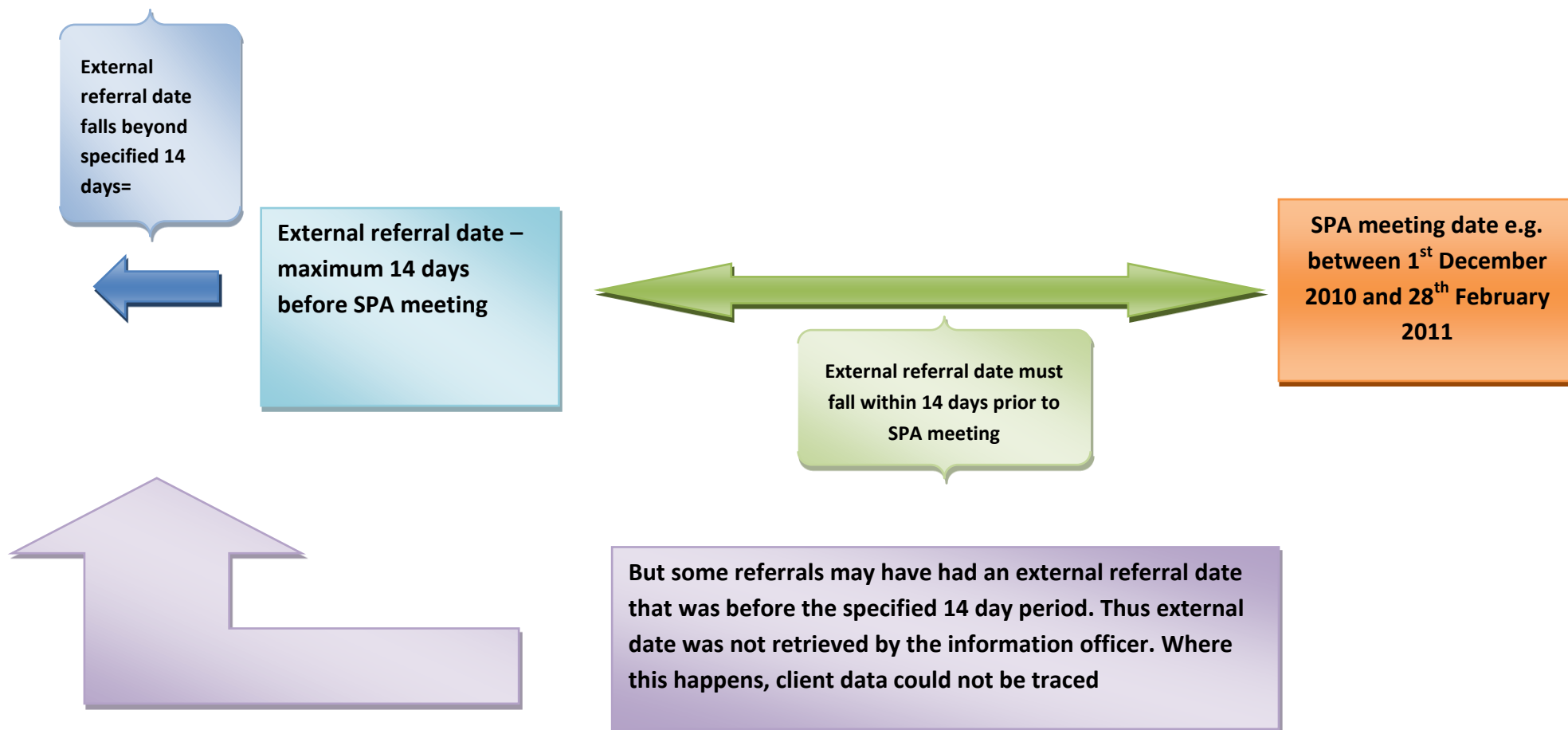
Figure 7.1: Data parameters as required by Trust information officer

The officer found that some referrals lacked RIO data, indicating that clients' details had not been inputted into the system. This warranted its own investigation beyond the realms of this study. Whilst other referrals had an external referral date, this was outside the 14 day window specified by the team (Figure 7.2). Therefore the information officer could not retrieve an external referral date and provide me with subsequent data. As the referrals did not come externally within the time period I was interested in, they were therefore internal referrals at that point. This meant that they were being referred between Trust facilities as opposed to being referred from an external source e.g. GP. This was particularly the case for four of the seven centres: Areas 1, 2, 3 and 5. To retrieve the external referral date and the relevant data for these clients I would have had to increase the time period to before December 2010, and this would have inevitably resulted in collecting more client RIO numbers. To establish the external referral date of these "extra" clients may have proved just as problematic and required increasing the time period once again, thus potentially entering into a somewhat vicious cycle. This exposes a very complex process of acquiring referral data for clients passing through SPA meetings at specific times that is reliant on setting parameters to access desirable information. Data from the other three centres (Areas 4, 6 and 7 were more complete, where between 86.7 per cent to 92.7 per cent of the total client records were retrieved. However, it still proved difficult to ascertain client trajectories with this fuller data and so using such data to complete evaluative plans could not suffice. This is discussed in the following section.

7.2: <u>The challenges inherent in system data</u>

There were certain variables created through development of the SPSS storage system that related to the handwritten records and the IT system supporting SPA meetings. These variables were hoped to aid in the evaluation of post-SPA meeting client data. Table 7.2 shows the developed code book describing the variables of interest.

Variable	Label	Type
RIONo	Client number assigned to clients to be put on the Trust's RIO computer system	Categorical
AREA	Area of SPA meeting	Categorical
GENDER	Gender of client	Categorical
AGE	Age of client at the time of	Continuous

	referral, calculated from DOB and date of ReferralDate (as acquired from Trust Information officer	
ETHNICITY	Ethnicity of client	Categorical
DATERef	Date that current referral was made into SPA meetings	Continuous
SOURCERef	Referring agent of current referral	Categorical
ReferredCOMP	Which team the referring agent referred client to	Categorical
URGENCY	Urgency level given to client	Categorical
REASONRef	Why client was referred to SPA meeting	Categorical
SPAMDate	SPA meeting date	Continuous
MeetingOutcomeWRITTEN	Meeting outcome according to written notes in meeting	Categorical
DISCHARGE	Date that client was discharged from team	Continuous
DISCHARGEReason	Reason for discharge	Categorical
HISTORYNo	Number of past referrals	Continuous
HISTORYDate1	Date of past referral1	Continuous
HISTORYSource1	Source of past referral1	Categorical
HISTORYTeam	Team that past referral was referred to1	Categorical
HISTORYUrgency1	Urgency of past referral1	Categorical
HISTORYReason1	Reason for past referral1	Categorical
HISTORYDischarge1	Discharge date for past referral1	Continuous
INTERNALNo	Number of internal referrals post-SPA meeting	Continuous
INTERNALDate1	Date of 1st internal referral	Continuous
INTERNALTeam1	Where the client was internally referred to1	Categorical
INTERNALDischarge1	Discharge date of internal referral1	Continuous
INTDISCHARGEReason1	Internal referral discharge	Categorical

	reason1	

Table 7.2a: Data definition simple codebook

The closest indication one could get to evaluating post meeting decisions through system data was by comparing meeting outcomes (MeetingOutcomeWRITTEN) and reasons for discharge (DISCHARGEReason). However, as analysis proceeded, with the data from Areas 4, 6 and 7, it became difficult to make clear inferences from the data relating to client trajectories as had initially been hoped. This compromised investigation into the validity of SPA meeting decisions based on available data from the Trust. The system in theory, should be capable of responding to these requests, since categories such as "DISCHARGE" and those relating to internal referrals, clearly input data relating to post-SPA meeting events. However, once the client's journey enters into external organisations, it is difficult to ascertain a full picture of their experiences by just consulting the system. This is exacerbated by the fact that the DISCHARGEReason category relates to discharge from the organisational units responsible for each SPA meeting, e.g. CMHTs and hospital units. Thus, I could not elicit whether or not decisions to send clients onto services such as IAPT (external to the organisational units) were appropriate or not, since nothing is revealed beyond the reason for discharge. This compromises the investigation into SPA meetings, because absence of such information means that one cannot identify the weaker elements of attendees' decision making skills relating to mental health problems and potential training needs. Likewise its overall merits and drawbacks as a procedure for processing and dealing with client referrals on a large scale cannot be assessed sufficiently. Arguably details are available through case notes, but in practical terms, these require time to be accessed and read.

System categories are also potentially problematic because administration is faced with several relevant system recording options for a single situation, which compromises consistency. Moreover there may be scope for removing certain system categories ~~that~~ such as urgency level, since this was rarely mentioned during actual SPA meetings, with attention given to referral letters and case notes. The urgency rating assigned by the duty worker is only apparent when one looks into the Trust's computer system, suggesting that it does not contribute to the decision-making process of SPA meeting attendees.

As highlighted in Chapter 5, the discussions and decision making process in SPA meetings can be complex, and as ascertained from the MeetingOutcomeWRITTEN variable, the noted decision often contains specific details such as mental health professional taking responsibility. Moreover, with "bring back" cases, the actual actions a person might take, such as making a telephone call, can be recorded. Additionally the actual team that SPA meeting attendees decide to refer to is noted. With pre-defined computerised categories on the Trust computer system, such details cannot easily be inputted and need to be inserted into the options that best represent them. This is difficult, because there may be occasions when more than one option is relevant. The Trust system does feature a comment box, named "Discharge comment" which offers a space to put specific details, and this is often where one would find the same information as is written in meeting notes. For example, when "discharge reason" is "transferred to Primary Care", the "discharge comment" may say "IAPT". Therefore, the system is capable of accommodating the level of detail that is captured through written notes and information such as the actual team that is being referred to post-SPA. This may be useful to mental health professionals, because if the same client is re-referred into SPA meetings, access to detailed information via the computer system is efficient, swift and helpful in the absence of case notes. However, inspection of the "Discharge comment" option on the data file provided by the information officer and his team, exposed the problem of pre-defined categories. This compromised consistency, as shown in Table 7.2b.

Area	Discharge reason	Discharge comment	Problems
Area 2	Other reason (Comment Box)	Declined an appointment	There is an option within "Discharge reason" called "Client did not engage", which also sums up this situation
Area 3	Inappropriate referral	SPA (Date)- Referred on to IAPT	In other areas, to refer onto IAPT is not "inappropriate", but recorded as "Transferring to Primary Care".
Area 3	Other reason (Comment Box)	SPA (Date)- Faxed to Psychology SPA	Within "Discharge reason", this may also be described as "Transferred to another service or team".
Area 5	Inappropriate Referral	Referral to be forwarded to IAPT-	In other areas, to refer to IAPT is recorded as "Transferred to Primary

		Close referral	Care" within "Discharge reason"
Area 5	Other Reason (Comment Box)	Back to GP/ IAPT	Above, transferring to IAPT was recorded as "Inappropriate Referral" for Area 5; here "Other Reason" has been selected
Area 1	Other Reason (Comment Box)	Patient phoned to say he does not want to see a doctor	This could also have been referred to as "Client did not engage" within "Discharge reason"
Area 1	Transferred to another service/ Team	From SPAM refer onto IAPT	In other areas, to refer to IAPT is recorded as "Transferred to Primary Care"
Area 1	Other Reason (Comment Box)	CLOSED- referred to IAPT	The above IAPT referral was inputted as "Transferred to another service/ Team" for "Discharge reason"; Here it is "Other Reason".
Area 6	Inappropriate referral	Inappropriate referral	The comment is not providing extra information and could have therefore been left blank. Or details of actions to be taken would have been useful

Table 7.2b: The use of the "Discharge comment" box

7.3: <u>Lifeworld and system world</u>

Thus far, the chapter has discussed the potentially problematic nature of certain system categories and the ways in which the realities of SPA meeting discussions may be difficult to transfer to the Trust system. The latter cannot always be relied upon to provide accurate trajectories of clients. This relates to the wider discourse of lifeworld and system worlds particularly as interpreted by Habermas (1987) in his theory of communicative reason and action. Habermas discusses modern society as comprising of two perspectives: The lifeworld and the system. The lifeworld denotes social worlds with meanings for individuals and groups and is directed by intersubjectivity and

communicative rationality. There are three main structural components of the lifeworld where individuals relate to others:

1. The ability of the individual to share appreciation of the situation and contribute accordingly
2. Collective identity where support is extracted from being a group member
3. Culture- change is achieved when knowledge is gathered

In contrast the system world is characterised by instrumental rationality and consists of organisations and institutions. Actors within the system world are motivated by the endeavour to maximise economic profit and communication. This demeans the importance of mutual understandings and relationships between individuals.

Following Habermas' (1987) theory, the SPA referral process, as an activity that is part of the wider Trust can be seen as an environment where the lifeworld and the system are both present, arguably competing for prominence. Froggatt *et al.* (2010) suggest that most organisations as part of the UK health system, feature the lifeworld and system world as being in dynamic interaction with each other. Habermas (1987) argues that a consequence of this dynamic and complex nature of systems can result in the uncoupling of the lifeworld and the system and the colonization of the former by the latter. I argue that the lifeworld and mutual understandings of mental health professionals within SPA meetings are becoming uncoupled from the systematic processes and bureaucracy of the wider NHS organisation (a meso level construct). However, the quantitative data do not support the notion that the lifeworld has been colonized by the system as yet. Iles (2011) on the other hand alludes to the idea that NHS caregivers have been colonized by the system and this results in unsuccessful reforms with well-meaning workers *"trapped in a system that is fostering poor care"* (p4). Iles (2011) argues that the managerial paradigm now dominating the NHS was introduced with good intentions but it has superseded all ways of thinking and this is detrimental. She warns that any future reforms may relate more to rationing because this is the culture that is prominent now. She claims that any reforms must keep the system in consideration because the NHS (which also reflects wider societal processes) is influenced by bureaucracy. The motivations have altered the shape of care and agendas now revolve around figures, targets and contracts.

According to Habermas, the lifeworld is strengthened and can be on equal par with the system world where collective engagement occurs. The SPA meeting environment sees the dynamic of the professional lifeworld strongly emerging. The mutual respect for the importance of decision making is recognised and the attendees share an endeavour to resolve a common main concern which involves connecting, interacting, compromising, listening and respecting. Clients are discussed in terms of being "people" referred to by names even though by this stage they have been allocated a client number (RIO number). Client trajectories are awarded air time by making use of case notes and attendees' personal reflections and experiences are drawn upon. The meeting environment provides an ideal sphere where communication succeeds and can keep the lifeworld prominent.

However evidence shows that the meetings are also what Habermas terms "contested spaces" and are likely to be exacerbated by the strength of system requirements. Formally or informally, there is an awareness of an agenda and a function that the meeting has to achieve- each client has to be discussed and some form of decision needs to be made for them. Administrative recording of such decisions takes place within the meetings and here the identities of clients are translated into numbers and the professionals and/or teams charged with dealing with them are usually recorded by letter initials. Moreover, the recording of these decisions does not reflect the detail usually present in discussions. The contested space of the meetings explains why both personality and formal forms of identities are present: the meetings provide a chance for colleagues or even friends to meet and catch up and there is a sense of informality in the language used. Light-hearted humour and first name terms were used and occasionally expletives were also noted in some centres. However, there was also an awareness of the responsibility and aims that the meeting needed to achieve and a checklist approach was often used and reiterated when time was moving on. SPA meetings are an arena where attendees are relied upon to wear their professional "hats"; sometimes, letters were addressed to specific individuals. However, the informal dynamics of colleagues and conversation also saw personalities and less formal identities emerge and sometimes play a part in decision making as well. The reminders of strict time frames and number of referrals sometimes stifled thorough discussions and restricted the temptation to stray from client discussion. Thus the instrumental rationality inherent in the system world (i.e. the agenda and functional role of SPA meetings as part of an activity provided by an NHS organisation), was felt and manifested within the attendees' lifeworld where mutual

understanding, informalities and light-heartedness emerged. It seems that overall the system world dominates such arenas because going back to the main concern of attendees, this relates to an organisational requirement- to allocate clients to services/interventions within a timeframe.

The difficulty with the computer records and retrieval of adequate client trajectories, reflects the impersonal and restricted space given to clients' computerised records. Numeric identities are allocated for ease of access as opposed to anonymity since names are still included in the system. However the implementation of comment boxes suggests that perhaps the system too is a contested space that sees elements of the lifeworld impinging on its territory by including a space to record the detail that would have occurred in meetings.

Within the context of this project, the lifeworld reflects the everyday experiences of individuals working in mental health services and the conditions that they face e.g. multidisciplinary encounters, limited resources, and responsibility for decision making. The system world refers to the broader context and the patterned social arrangements of the NHS organisation and society. It takes into account the funding and targets services face, the bureaucratic arrangements, accountability culture and various guidelines and regulations. Thus the manifestations of the system world can shape the lifeworld experiences and this could denote colonisation. The lifeworld and system world competing manifestations can contribute to an environment of contestation. However, when there is present a communicative space that allows the bridging of the lifeworld and system world, colonization is less likely (Froggatt *et al.* 2010). The dynamics of the system world, lifeworld and communicative space are illustrated in Figure 7.3. The SPA meeting can be seen to provide this communicative space because it offers a forum where formal and informal identities can emerge. For example, attendees can talk in non-professional discourses, they can vocalise worries and convey any objections they have to bureaucracy. Moreover, Froggatt *et al.* (2010) highlights that communicative spaces enable any distortions that emerge from colonization to be sorted out. Such milieu means that system-dominated institutions can engage with the vital lifeworlds of individuals who inhabit them and vice versa.
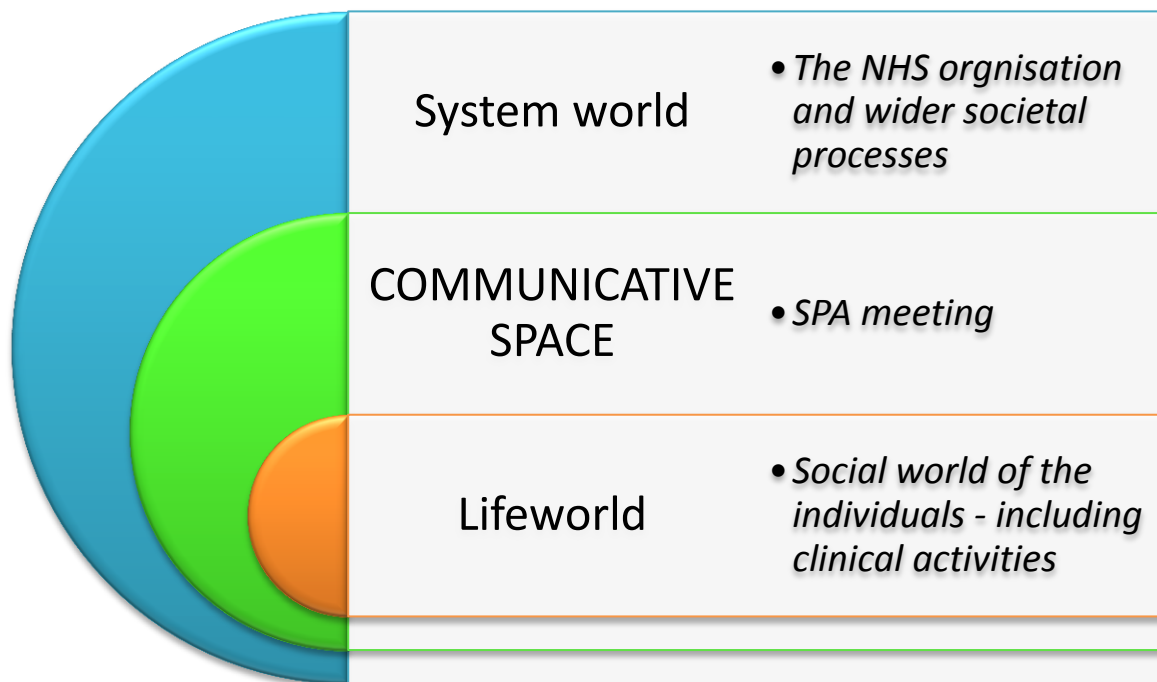
Figure 7.3: Dynamics of system world, communicative space and lifeworld

There are some suggestions that this chapter makes to possibly instigate service improvements:

1. Better storage of referral history, namely reasons for discharge.
2. Better storage of internal referrals, namely reasons for referrals
3. Better universally defined categories for reasons for discharge, for current referrals, internal referrals and referral history. In particular, it needs to be more clearly defined as to what "inappropriate referral" means.
4. Strategies for inputting data that relates to clients' experiences with services external to SPA meeting organisational unit e.g. IAPT
5. Direct computer recording of meeting decisions within the meeting itself via a laptop computer.

The quantitative findings allow a debate to emerge relating to Habermas' lifeworld and system world concepts and pave the way for recommendations. What is clear is that the system world is powerful in healthcare settings. It is an essential component of the NHS as an organisation and thus will always be implemented in supporting Trust activities such as the referral process. However, just as importantly and drawing on Froggatt *et al.*

(2010), the nature of SPA meetings means that mental health professionals have a forum where they can couple the lifeworld with the system world and prevent it from being overtaken. The possible suggestions to improve the Trust system may contribute to a better dynamic between the two worlds and ensure that the computer system more accurately represents the realities of discussions. Particularly, accommodating system facilities in meetings (e.g. making computer notes during the meeting) may preserve the accuracy and recording of discussions in the meeting: thus even where a shortened version of the longer discussion is entered into computer, the nature of what is recorded is not distorted or causing any confusion. This further demonstrates how the lifeworld and system world do not have to be uncoupled and incompatible.

However, the commentary in this chapter is only intended to be a reflection on the situation regarding the system facilities supporting the Trust activity of SPA meetings. As emphasised in earlier chapters, the main contribution this project can significantly offer to the Trust is comprehensive insight into the process behind decision making in conceptual terms. Chapter 8 considers this contribution more deeply and its innovative quality as a theoretical product.

7.4: <u>Conclusion</u>

In conclusion, this chapter is necessary to expand on why initial evaluative intentions of the project could not be fulfilled. It allows appropriate consideration to be given to the dynamics of the system that is in place to support and contribute the NHS activities such as the SPA meeting. The chapter found relevance in identifying aspects of Habermas' (1987) work in discussing the difficulties of system and lifeworld compatibility. It concludes that the SPA meeting offers a useful forum for maintaining system and lifeworld elements without colonization of the latter. Suggestions are made to encourage and better dynamics between the two worlds and enhance the management of this key clinical activity for this Trust's mental health services. However, the discussion here can only emerge as a commentary and does not seek to make firm recommendations. The contribution to knowledge is provided by the theoretical product of Handling Role Boundaries and this is explored further in Chapter 8

8) Conclusions

"Every ending is a new beginning"

~ Marianne Williamson, Spiritual Teacher

8.0: Introduction

This chapter continues the discussion on Handling Role Boundaries by reflecting on its innovative contribution to several fields and exploring how it can be developed further. Chapter 6 concluded that although the BSP relates to previous findings, such as identity, interaction and role theory, it offers new contributions as an innovative contextualisation of the notion of multiple roles. This chapter will expand on the relevance that Handling Role Boundaries has at the macro and micro levels of understanding and will look specifically at the implications it has for SPA meetings as an integral clinical activity. Furthermore propose how it can be integrated in the Intervention mode to see measure its use in practice. Handling Role Boundaries has allowed access to the gatekeepers of this Trust's mental health referral process and should therefore be considered in terms of why this is useful and what it can lead to.

8.1: Handling Role Boundaries

Chapter 6 showed that the integrated theory of Handling Role Boundaries has resonance at the micro and macro level of understanding and captures the findings of previous studies and theories, whilst contributing new ideas to the debate. At a micro-level, Handling Role Boundaries had much to offer regarding decision-making practices of mental health professionals. In multidisciplinary environments, other studies had also found that role conflicts, negotiation, respect and awareness occurred (West *et al.* 2012; Kane and Luz, 2011; Griffiths, 2001). Often, aspects of the decision making process that Handling Role Boundaries uncovered resonated with other decision making theories, but used different terms. However, Handling Role Boundaries provided rare insight into the circular pattern of decision making by highlighting the significance and aftermath of the Balancing stage. In doing so, it awards personality traits as much attention as

professional forms of identity. When attendees engage in compromising and volunteering (which might stem from personality), over time such behaviour may become part of the Recognising stage, where attendees associate these incidents with that particular person's identity and form expectations around this. For example, they may expect the person to be open to compromising in the future. Moreover Handling Role Boundaries is a specific process needed to resolve a particular main concern: coming to a decision in a time frame under certain conditions i.e. working together to find a place for clients within the meeting realms. This provides extended understanding into why sub-stages including *negotiating and compromise, volunteering* and *sacrificing* are pertinent to the decision-making process. In short, it accounts clearly for the Balancing phase. Another important aspect of Handling Role Boundaries, is its acknowledgement that some facets of decision making do not rely on verbal incidents– in most situations, the phases occur as thought processes, for example, Recognising, forming expectations as part of Positioning and *sacrificing* where one holds back a certain view for the sake of resolution.

On a macro level, Handling Role Boundaries confirms what previous theories have established: Identities are complex and exist in multiple forms with reliance on shared meanings and interpretations (Stets and Burke, 2005; Stryker, 1980; McCall and Simmons, 1978; Mead, 1934). The GT shifts from the traditional symbolic interactionist stance as postulated by Mead (1934) and resonates with a more structural approach (Stryker and Burke, 2000). Handling Role Boundaries agrees with Stryker (1980) and McCall and Simmons (1978) that where multiple identities exist, a strategy to organise them is needed. The BSP concurs with Stryker's notions of a salience hierarchy and predicts that positions of salience can change based on how the situation and aspects of decision making proceed. For example, in Balancing role boundaries, SPA meeting attendees may find it necessary to employ personality traits rather than stances associated with professional roles. It is difficult to always discuss professional and personality roles as separate entities, because the GT uncovered the notion of them merging.

The Recognising and Positioning phases of Handling Role Boundaries, though not explicitly stated, reflect the significance of "norms" and related expectations. The theory signifies that "norms" evolve, are not rigid and to some extent allow role deviations. However, as structural symbolic interactionists emphasise, individual actions (such as deviating from "norms") occur within the context of the wider social structure, which has been established from behaviours that have become patterned and accepted. Thus,

there is a level of deviance that can be accepted and contribute to "norm" changes but not all deviances will be accepted. This notion is reflected in the Handling Role Boundary phases, with Recognising containing a significant sub-stage *Awareness of manner of SPA meetings*, giving resonance to this established environment that exists with regular ways of doing things and conventions. The major third phase of Weighing Up allows situations to be reflected upon, possibly (but not restricted to) when role deviance occurs. Responses can then be planned and executed in the Balancing phase.

Stryker (1980) and Burke (1980) in a joint paper, offer insights into identity following the structural symbolic interactionist approach, but differ in their focal points: The former investigates the impact of structure on individual action whilst the latter explores the internal processes at play regarding individual action. Significantly, in a joint paper, Stryker and Burke (2000) offered their thoughts on the two directions merging. Handling Role Boundaries encompasses these integral aspects and demonstrates their contribution to identity and their significance for the decision making process. The consideration given to structural influences on individual agency is captured in the Recognising phase, which gives attention to the established conventions that should be acknowledged and gives attendees a sense of direction on how to proceed. Moreover, "norms" and boundaries relating to professional role identities are likely to be informed by societal influences and presentations of these roles, for example, knowing the capabilities of consultant psychiatrists. Furthermore the next phase of Positioning relies on formation and fulfilment of expectations occurring as a result of recognised conventions and beliefs. Whether fulfilment of expectations manifest is another matter and that is where Weighing Up and Balancing are pertinent. As discussed all four major phases of Handling Role Boundaries encompass significant internal processes that contribute to role fulfilment and deviation.

However, what must be highlighted are the innovative aspects of Handling Role Boundaries, particularly in its reference to personality traits individuals who also act in their professional capacities. The BSP demonstrated successfully how these elements enter into the decision making process through interactions and understandings of one another. Ebbs and Timmons (2008) confirm that sociological literature rarely gives attention to this issue particularly when looking at doctor-nurse dynamics. Handling Role Boundaries accepts personality traits as one of the many forms of identity that contributes to multiple roles. As mentioned before, Stryker's (1980) hierarchy of salience appears to be relevant within SPA meetings, but not to the extent that one role becomes

more significant than the other. SPA meeting attendees may find that more than one role needs to be played out at the same time. For example, a person who is a consultant psychiatrist and who likes the meetings to run on time, will, perhaps towards the last few referral letters, take care of time keeping *and* focus on picking out medical issues within letters.

8.2: <u>Handing Role Boundaries: The Intervention Mode</u>

As has been documented thus far, the theory of Handling Role Boundaries emerged from being developed in the Gerund mode to develop and deliver a BSP that accounted for the ways that SPA meeting attendees resolved their main concern. This main concern of working together within the meeting to find an appropriate place for the client influenced activities and behaviours observed in the meetings. The four-phase theory seeks to provide theoretical expertise for the people who engage in the activities of SPA meetings. This conceptual clarity can be grasped by attendees and help them in understanding why they do the things they do. Highlighting the key elements in their decision making process can help them to see practically how their time is spent and how they go about fulfilling the meeting agenda. Awareness can potentially give them the means of modifying decision-making by enhancing the positive aspects and working to improve those that do not contribute to the effectiveness of the meeting. According to Artinian (2009) progressing to what is known as the Intervention mode can transfer one's substantive theory to practical settings and help assess the theory in terms of its clinical impact. Findings from such investigations can then be analysed and potentially improve clinical practice and aid in refining the theory. One must not forget Glaser's (1967; 1978) directives for grounded theories to be modifiable. Developing one's theory in the Intervention mode must only be done once relationships between the variables are adequately established, and at this stage, I am confident that this is the case with Handling Role Boundaries. The parsimonious theory has demonstrated its fit, work and relevance as both a linear and cyclic form of conceptualisation and conveys its logic by making links with incidences in the data (Chapter 5). Sub-stages have also been fully developed and accounted for through the constant comparative method of analysis.

As well as disseminating the GT to the social group being studied, Artinian *et al.* (2009) provide examples where the theory has been presented to other individuals affected by the identified process. For example, Satinovic (2009) generated a GT known as

"Remodelling the Course of Life" concerning individuals with multiple sclerosis and their coping mechanisms. This was then developed as an intervention study with the aim of helping nurses to improve their practice in treating patients with multiple sclerosis, by presenting the theory to them and then assessing their practice. Learning about the nature of such patients' experiences will help nurses *"to promote and empower the patient to integrate the illness into his or her life, and to help the patient explore possibilities or a good life in spite of the illness…"* (p332). Similarly Giske (2009) developed an intervention study to help nurses provide better care for patients on a Gastroenterology ward who went through the BSP of "Preparative Waiting" to cope with being in the diagnostic phase.

Dissemination would entail the following:

1. Brief paper handouts consisting of Handling Role Boundaries in its diagram form and definitions of each phase and sub-categories.
2. A formal presentation of the theory through Power Point, with a question and answer session.
3. Online access to a fuller account of the theory on request.

Bearing in mind other GT studies that have progressed to implement the theory in the Intervention mode, it is suggested that the theory of Handling Role Boundaries is disseminated to the following individuals for particular reasons (Table 9.1).

Individuals offered copies of theory and invitation to presentation	Reason
All SPA meeting attendees in the seven centres	- Since these attendees have accommodated my presence at meetings and further obliged to allow me to interview them, it is empowering for them to get a sense of what has come out of the findings - It will offer them a theoretical account of why they behave the way they do and could help them in improving meeting discussion and overall efficiency.
GPs who refer into SPA meetings	- The discussions in SPA meetings revolve around referral letters, which are mainly received from GPs. It was often mentioned that GPs' presentation of the clients was not always adequate. - Conceptual understanding into the decision-making process and the challenges faced by attendees as they

	approach the task, may help GPs and referrers to feel better inclined to write better quality referral letters.
	- GPs would be able to learn about the varied boundaries that secondary mental health professionals and IAPT team members are faced with and could encourage them to learn more about professional remits and form more appropriate expectations.
	- GPs overall management of clients with mental health problems could improve by becoming more aware of what mental health services exist to help and where GPs should be taking responsibility i.e. enhancing awareness into where responsibility lies for clients in which situations.
Mental health team members who do not attend SPA meetings	- The attendees present at the SPA meetings are representatives of wider mental health teams who have particular remits, organisational traditions and procedures. It would be helpful for members of such teams to understand how the SPA meeting agenda is executed in real-life decision-making and the challenges inherent in this. The important and valid sub-stages of *compromise and negotiating* and *sacrificing* as part of the Balancing phase may even lead to some teams modifying their remits.
Senior members of the Trust	The centres that run these meetings are hospital and CMHTs. The conditions identified as impacting on the Handing Role Boundaries BSP would be useful for managers to understand the limitations of the meetings as well as what works well. For example, time is one major condition that cannot be divided equally for each client- some will warrant more than others. Perhaps SPA meetings might be more effective held a couple of days a week (as is the case in one centre).

Table 8.2: Disseminating Handling Role Boundaries

Handling Role Boundaries is likely to be of more use for those who do not attend SPA meetings and who therefore have little descriptive understanding of the process that takes place during meetings. The conceptualisation of this activity can be presented in diagram form and accompanied with fuller accounts to help individuals grasp the process occurring in these multidisciplinary environments. This could lead to wider service improvements and better liaisons between CMHTs, specialist mental health services and primary care referrers.

The Intervention mode will require a full study being designed and planned with aims and intentions fully defined. At this stage dissemination of the theory would be the primary aim but to measure its impact on clinical decision making within SPA meetings would require decisions as to whether a comparison study would be useful. This would involve withholding the theory from certain centres and then disseminating it to selected ones and associated professionals. SPA meeting discussions could then be observed and compared between centres who had been given the theory and those that had not. This is certainly something to think about for future investigation and gives some ideas about how an intervention could take place.

In addition to this micro-level impact, Handling Role Boundaries can further its conceptual power by broadening from the substantive area to develop into a Formal GT (Glaser, 2007; 1978). Being able to see some general implications within one's substantive theory opens up this possibility and this is something that I have explored in Chapter 6 discussions on decision-making and identity. Assessing the application of Handling Role Boundaries to other substantive areas where decision making takes place is a good start. Use of the constant comparative method, would involve comparing several substantive areas together and developing and modifying the theory,

> *…seeing the core category working beyond the immediate substantive area studied engenders a need to study it generally…* (Glaser 2007:99).

In relation to Handling Role Boundaries, this will be more of a challenge, because the nature of the BSP means that it relies on certain conditions within the substantive area e.g. a social group consisting of varied identities and a task that revolves around decision making. However Handling Role Boundaries is not immune to general implications: there are other substantive areas that it may possibly apply to as suggested in Figure 8.2.

Figure 8.2: Possible substantive areas that may be relevant

8.3: <u>The wider picture</u>

The study of SPA meetings has been integral for several reasons. Understanding SPA meeting attendees as gatekeepers is the first step to understanding why emergence of the BSP is important. It allows access to an element of their lifeworld and clinical activity and uncovers something that would have likely remained unknown. Providing this gateway to the gatekeepers is significant because the activities of attendees have effects for further individuals and groups: clients, referrers, specialist teams and Trust personnel. Therefore understanding the facets of their decision making behaviour (through the conceptual BSP) can potentially benefit these affected groups by allowing attendees to see which aspects of their decision making can be improved or maintained. However, as discussed in Section 8.2 and Table 8.2, Handling Role Boundaries' potential for service improvement is more likely if revealed to non-attendees of SPA meetings.

In chapter one, the thesis sought to emphasise that certain behaviours have been constructed as deviant and historically have been managed in relation to societal processes appropriate for that time. These have been documented and reflected upon and SPA meetings represent one strategy of dealing with people defined as having mental health problems. Health services, and by consequence, procedures such as SPA meetings depend upon bureaucratic interventions. In order to continue tracking societal treatment of people with mental health problems, it is vital to establish understanding into SPA meetings as a significant clinical activity and critical juncture in the mental health career of clients. This PhD study has developed this understanding to revolve around the internal mechanisms and components of decision making. Investigating this angle provides the Trust responsible for such activities with a picture of complex decision making process that exists. Given the policy driven field, there is certainly room for this PhD study to have relevance in social policy as well and as it stands currently, offers the possibility of liaising with others in the field to have a better impact.

Besides the need to document this important clinical activity, the emergence of a credible GT from the study has significant relevance for the field of Sociology namely relating to the themes of identity and roles and the related topic of interaction. As well as concurring with current understandings of these themes, Handling Role Boundaries has been able to offer new insights and awareness of pertinent elements of decision making within multidisciplinary teams, such as the significance of personality. Moreover, the increasing sociological interest in mental health and illness focuses on the professionals at the heart of mental health practice (Busfield, 2001). Handling Role Boundaries captures the activities of mental health professionals and can provide further sociological understanding into this growing area of interest. The theory could potentially elevate from this substantive field to a more formal status, if it could be applied to other substantive areas and subsequently compared as part of GT methodology (Artinian *et al.* 2009; Glaser, 2007; Glaser, 1978). Further research would be required to establish this. However, in its current form, Handling Role Boundaries offers a useful account of the practicalities associated with Glaserian GT methodology and the theoretical product that can be achieved. This therefore demonstrates this PhD study's relevance for methodological literature. This is useful since GT is recognised as an evolving methodology and it is helpful for new researchers to gain insight into how it is used (Edmonds and Gelling, 2010). Considering the first notable description of GT was over forty years ago, newer papers will be welcomed to demonstrate the prevalence and

validity of such a methodology for sociological research and also the ways in which principles can be interpreted and realistically employed. The findings offer scope for improvement that can be presented to the Trust authorities and employees and can impact the internal dynamics of decision making and the immediate environment within which this exists.

8.4: <u>Dissemination</u>

The innovative nature and insight offered by Handling Role Boundaries makes it an ideal subject to disseminate in a number of academic journals, forming a range of article foci. The following table highlights a selection of avenues that I would like to explore in terms of publication:

Journal article title	Article focus
Sociology of Health and Illness	Presenting Handling Role Boundaries in its BSP form as an important aspect of clinical decision making within mental health services. The article would explore the notion of multidisciplinary working and emphasise how Handling Role Boundaries offers a way of understanding the complexities behind this. Also highlighted would be why emergence of this BSP is important to instigate possible service improvement.
British Journal of Sociology	As a conceptual product with strong links to sociological themes, Handling Role Boundaries can be discussed at length. The article would review its relation to macro and micro level concepts such as self, identity, role and interaction. Emphasis would also be placed on how it offers new sociological insight, making developments in the structural symbolic interactionist approach to self and identity.
British Journal of Psychiatry	The history of psychiatry and management of mental health problems is a well-documented area. As a continuation of this, Handling Role Boundaries represents an account into one current form of managing people understood to have mental health

	problems, as part of the SPA process. Thus this article would document the BSP as part of our increasing understanding of chronological Western management of such issues. It would aim to explain why current focus is placed upon mental health professional relationships i.e. the managing agents of this arguably social issue.
The Grounded Theory Review	The PhD study and emergence of a credible theoretical product has been the result in investing time and commitment to the principles of classical grounded theory methodology. Well documented memos capturing the development of this product and reflections on the overall grounded theory journey would form an excellent article for this journal. As all grounded theory products should aim to be modifiable, the article would explore what the next stages may be for Handling Role Boundaries and how this could be made researchable.

Table 8.4: Dissemination of Handling Role Boundaries into articles

The use of Handling Role Boundaries to guide further research is desirable since the concepts are well developed and defined. These emerged by initiating the research in the discovery mode, but now there is scope for pursuing their relevance to other substantive areas by adopting the "emergent fit" mode (Artinian *et al.* 2009). This would involve the researcher beginning with the four concepts of Handling Role Boundaries and using the constant comparative technique to assess their fit, relevance and workability in the substantive area under study.

8.5: Conclusion

In conclusion, this chapter has critically considered the findings of the qualitative data and reflected on its wider implications. The GT of Handling Role Boundaries is both innovative and supportive of previous conceptualisations. Moreover it has strengths in its current form for sociological and methodological literature and offers credible conceptualisation for decision making practices within mental health teams, and beyond.

Taking into account the immediate environment within which decision making occurs, dissemination of this conceptual understanding could lead to better liaison between GPs, specialist mental health services and CMHTs. Clearly a complex process, there may be increased appreciation of this particular element of mental health workers' lifeworlds and the challenges they face in dealing with client case referrals. Furthermore the role of bureaucracy, medical dominance and multi-professionalism are themes that are integral to present-day society and inevitably encroach upon how we deal with this aspect of deviance. Understanding the process that depicts this bureaucratic, medical, multidisciplinary environment is useful to add to the historical analysis of mental health and illness from a sociological point of view. There is the possibility for SPA as a clinical activity operated within the Trust to improve, which will benefit the mental health trajectories of clients. There is scope for the study to extend further in terms of evaluation, sociological theory and methodology. If an intervention study is designed, the effects of the theory on Trust activities can be assessed. This could strengthen or modify Handling Role Boundaries. The theory can possibly be developed to assess its relevance in other substantive areas and potentially elevate it to a more abstract level as a formal theory relating to decision making. This can be done through initiating research in the emergent-fit mode where one begins with the integrated concepts defined by Handling Role Boundaries. The scope for dissemination of Handling Role Boundaries is highly appealing and will be embraced as discussed in Table 8.4.

8.6: <u>Gateway to the gatekeepers</u>

Thus by establishing a gateway to the gatekeepers, theoretical conceptualisation has been achieved in a very crucial substantive area that forms a critical juncture for mental health clients. Through justified focus on these gatekeeping mental health professionals, the study contributes to the documented historical management of individuals exhibiting bizarre behaviours. It takes into account the current complex aspects of decision making in an arena informed by bureaucracy, risk assessment, and multiple roles. This decision making process can potentially be extended to other substantive areas, but even in its current form, it provides innovative insight into the lifeworld of mental health professionals. It is clear that in providing a gateway to the gatekeepers, further gateways have been uncovered and this reaps exciting prospects for future investigation.

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APPENDICES

Appendix 1:

Email received from the National Research Ethics Service (NRES)

RE: Research or evaluation

Melanie Narayanasamy [lqxmjn3@nottingham.ac.uk]

Sent: 16 April 2013 13:12

To: Melanie Narayanasamy [lqxmjn3@nottingham.ac.uk]

From: NRES Queries Line [mailto:queries@nres.npsa.nhs.uk]
Sent: 21 January 2011 16:25
To:
Subject: RE: Research or evaluation

Thank you for your enquiry.

Your query was reviewed by our Queries Line Advisers.
Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee. I deem this to be service evaluation.
If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation (s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.
Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.
This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.
However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.
Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.
If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management

Appendix 2:

Response from Information Governance concerning next steps

From: ████████████████████████████████████

Sent: 10 February 2011 09:41

To: 'Melanie Narayanasamy'

Subject: RE: Research or evaluation

Hi Melanie

There seems to have been a bit of confusion here, but not to worry! You do not need to contact IT but the clinical/ Information Governance groups at each site so they can be assured that the correct procedures are followed in regards to patient confidentiality etc

For evaluation studies there is not a set approval procedure but I have been told that you need to do the following;

1) Obtain local permissions for the managers, so in this case, it will be the chair of each TRAP meeting

2) Gain authorisation from the Clinical Governance Groups within the service, the contact for Adult Mental Health is ██ (explain to her that you have/ intend to get approval from the chair of the TRAP meetings and give

I hope this helps, give me a call if you would like to discuss.

Thanks

████████████

Research Governance Administrator

████████████████████

██████████████

████████

██████████

████████

Appendix 3:

Letter sent to NRES seeking clarification

Faculty of Law and Social Sciences

School of Sociology and *Social Policy*

University Park

Nottingham

NG7 2RD

Tel +44 (0) 115 9515234

Fax +44 (0) 115 951 5232

www.nottingham.ac.uk/sociology

January 19th 2011

Dear NRES,

I wonder if you can help us with a preliminary research ethics enquiry.

I am writing to find out whether or not the following project would require full REC review, or qualifies as an evaluation.

The title of the project is 'Definitions of mental illness and gate keeping by NHS mental health service providers' Triage Referral Arrangement Process (TRAP) meetings in ███████████████

The aim of the project is to evaluate the nature and conduct of TRAP meetings in the ████████████ ████████████

This project will be conducted by a based at the University of Nottingham, School of Sociology and Social Policy department. It is funded jointly by the ESRC, as part of the ESRC CASE studentship scheme, and the ████████████████████████ NHS Trust. It will involve evaluation of the TRAP meetings that take place in ████████████████████ NHS Trust facilities providing for ██████████████████████████████ ██ ██ Field work will entail the investigator collecting qualitative data by attending a sample of TRAP meetings to carry out participant observations and a period to conduct semi-structured interviews with key personnel involved with TRAP meetings. Furthermore, initial administrative data pertaining to patients' mental health service pathway, including the TRAP process, will be collected for quantitative analysis.

The project aims to produce rich data pertaining to the nature and conduct of business of Nottinghamshire NHS TRAP meetings, with specific focus on the following questions:

1. **What are the underlying principles that determine whether or not an individual is considered a "case" of mental illness?**
2. **To what extent do primary and secondary care practitioners agree on this?**
3. **To what extent do different professional groupings agree on this?**

This will be of organisational interest and may have impact upon policy. ██████████████████ Trust's interest rests upon the relative suitability of judgements about the allocation of services to patients, and the overall effectiveness of TRAP in the environment of multidisciplinary team working. The study will inform the decision-making process that determines how ██████████ patients with mental health problems are allocated to secondary services; the relative speed at which this decision is made and from administrative data, review of the outcomes of such decisions.

Please also find a more detailed copy of the planned enquiry which provides further details.

Yours sincerely,

Hugh Middleton, Associate Professor and Honorary Consultant Psychiatrist.

PhD Supervisor

Appendix 4:

Advice from Caldecott Guardian regarding RIO access

From: ████████████

Sent: 01 June 2011 08:14

To: ████████████

Cc: ████████████ Middleton Hugh; ████████

Subject: RE: Caldecott advice on access to RiO

Morning ████████

Thank you for this very clear briefing.

Access to clinical information systems should be for staff that have a clinical relationship with the patient/s. Of course we would want to support and work with the institute on this but in my opinion, as Caldecott guardian, we can only supply a separate report (following the usual requirements) and staff working for the Institute on this particular issue should not have direct access to RIO.

I hope that helps. Please get back to me if you need anything else.

Regards

████

From: ████████████████

Sent: 31 May 2011 18:23

To: ████████

Cc: ████████████ Middleton Hugh

Subject: Caldicott advice on access to RiO

Hi ████████

I wonder if you would be able to provide me with some advice relating to access to RiO?

We're fairly confident in providing and managing access to RiO for clinicians and administrators when they have a requirement to access patient information to support their clinical activities etc. We're also familiar with the process of providing information for approved research, which normally takes the form of reports, following approval from the patient etc. However we are beginning to see more requests lately that don't fit within either of those two categories and is therefore more difficult for us to know how to proceed.

The Trust clearly supports the work carried out by the ████████████████████ for instance, but is it appropriate for us to provide access to RiO for that purpose, even if some of the people carrying out work for the ████████ are in fact RiO users for their clinical role?

A problem I have currently is relating to work Dr Middleton is carrying out on behalf of ███████, which has been approved by the Trust, but is classed as 'Evaluation' work, rather than 'Research'. This particular evaluation needs to work with information about the way in which we respond to new referrals, the allocation process and how long the patient stayed in service. Some staff do not work for the Trust or hold honorary contracts.

Do you feel we should be providing access to RiO, or separate reports? (Considering the new DH requirement for pseudonymisation of course!)

Any help or guidance would be most welcome,

Kind regards,

██

███████████

Systems Administration Manager

Health Informatics Service

███████████████████████

Appendix 5:

QRMH4 PowerPoint hand-out slides