

**The impact of organisational change on professionals working  
within a Community Mental Health Team (CMHT): A  
psychodynamic perspective.**

**Bridget Hanley**

**Thesis submitted in partial fulfilment of the requirements of  
Staffordshire and Keele Universities for the jointly awarded degree  
of Doctorate in Clinical Psychology**

**July 2016**

## **Acknowledgements**

I am extremely grateful for the support and guidance provided to me by my supervisors Dr Helen Scott, Dr Helena Priest and Dr Cat O'Callaghan throughout the process of writing this thesis. I would also like to thank the staff members who volunteered their time to take part in the study. Many thanks go to my husband for his patience, love and support.

**Preface:**

American Psychological Association (APA) referencing has been used throughout this thesis in adherence to the author guidelines for the journals the author intends to submit.

**Word Counts:**

Literature Review: 8,894

Empirical Paper: 8, 525

Commentary and reflective review: 2, 448

Total word count: 19, 867

**Contents**

|   |    |
|---|----|
| Thesis abstract .....   | 6  |
| Chapter 1: Literature review .....  | 7  |
| Professional role ambiguity, role conflict and team culture in community mental health: a review of the literature.                     |    |
| Abstract .....  | 8  |
| Introduction.....   | 9  |
| <i>Rationale for review</i> .....   | 13 |
| Method .....  | 14 |
| <i>Search strategy</i> .....  | 14 |
| <i>Study selection</i> .....  | 14 |
| <i>Inclusion criteria</i> .....   | 14 |
| <i>Exclusion criteria</i> .....   | 15 |
| <i>Critical appraisal</i> .....   | 15 |
| Results .....   | 15 |
| <i>Figure 1. Literature Review Process</i> .....  | 17 |
| <i>Table 1. Synthesis Table</i> .....   | 18 |
| <i>Overview of selected studies</i> .....   | 22 |
| Quality Appraisal .....   | 23 |
| <i>Themes across the literature</i> .....   | 30 |
| Discussion & Clinical Implications .....  | 32 |
| <i>Limitations</i> .....  | 34 |
| <i>Implications for future research</i> .....   | 34 |
| Conclusion.....   | 35 |
| References.....   | 36 |
| Appendices.....   | 42 |
| <i>Appendix 1: Critical appraisal questions (qualitative)</i> .....   | 42 |
| <i>Appendix 2: Critical appraisal questions (quantitative)</i> .....  | 42 |
| <i>Appendix 3: Table 2. Responses to critical appraisal (qualitative)</i> .....   | 43 |
| <i>Appendix 4: Table 3. Responses to critical appraisal (quantitative)</i> .....  | 44 |
| <i>Appendix 5: Author guidelines</i> .....  | 45 |
| Chapter 2: Research report .....  | 49 |
| The impact of organisational change on professionals working within a Community Mental Health Team (CMHT): A psychodynamic perspective. |    |
| Abstract .....  | 50 |
| Introduction.....   | 51 |
| <i>Aims and Objectives</i> .....  | 56 |
| Research question.....  | 56 |
| Methodology .....   | 57 |
| <i>Sampling</i> .....   | 57 |
| <i>Ethics</i> .....   | 58 |
| <i>Data Collection</i> .....  | 58 |
| <i>Semi structured interviews</i> .....   | 58 |
| <i>Participants</i> .....   | 59 |
| <i>Table 1. Demographics of participants</i> .....  | 59 |

|  |     |
|--|-----|
| <i>Analysis</i> .....  | 60  |
| Results .....  | 61  |
| <i>Figure 1. Model of categories</i> .....                   | 62  |
| <i>Categories</i> .....                                      | 63  |
| Summary.....   | 72  |
| Discussion .....   | 73  |
| Clinical Implications.....                                   | 75  |
| Original Contribution/ Limitations.....                      | 76  |
| Conclusion.....  | 77  |
| References.....  | 78  |
| Appendices.....  | 82  |
| <i>Appendix 1: Ethical Approval</i> .....                    | 82  |
| <i>Appendix 2: Research &amp; Development Approval</i> ..... | 83  |
| <i>Appendix 3: Participant Information Sheet</i> .....       | 85  |
| <i>Appendix 4: Consent form</i> .....                        | 87  |
| <i>Appendix 5: Interview Schedule</i> .....                  | 88  |
| <i>Appendix 6: Ethical Amendment</i> .....                   | 89  |
| <i>Appendix 7: Confidential clause</i> .....                 | 90  |
| <i>Appendix 8: Example of initial coding</i> .....           | 91  |
| <i>Appendix 9: Example of focused coding</i> .....           | 92  |
| <i>Appendix 10: Example of memos</i> .....                   | 93  |
| <i>Appendix 11: Sorting process</i> .....                    | 94  |
| <i>Appendix 12: Author guidelines</i> .....                  | 95  |
| Chapter 3: Commentary & reflective review .....              | 98  |
| <i>Introduction</i> .....                                    | 98  |
| <i>Process</i> .....   | 98  |
| <i>Ethics</i> .....  | 98  |
| <i>Literature Review</i> .....                               | 99  |
| <i>Methodology</i> .....                                     | 100 |
| <i>Reflexive Journal</i> .....                               | 101 |
| <i>Implications for future research</i> .....                | 103 |
| <i>Conclusion</i> .....                                      | 103 |
| References .....   | 104 |

## **Thesis Abstract**

The recent Francis Report (2013) emphasised how organisational culture within the NHS represents an important determinant of safe and effective health care systems. Therefore, it is crucial to inquire into the contexts and causes of dysfunctional organizational dynamics within the NHS. A review of the literature was undertaken, focusing on the relationships between professional role ambiguity, role conflict and team culture in community mental health. The review identified that role ambiguity and role conflict have detrimental consequences to services, creating tensions between staff members, adversely impacting on the continuity and appropriateness of workload. The need for further research into the impact on client care is also highlighted by this review. Finally, the review suggests that there is a need for role ambiguity and conflict to be managed more effectively, enabling staff to work within a stable and supportive context. The second part of this thesis comprises a research study using grounded theory methodology to explore the impact of organisational change on staff working within a community mental health team. The study revealed that staff experienced a sense of denigration of professional values and low morale in the face of austerity measures, incessant regulation and industrialising therapy. The analysis identified a number of social defences within the team. The findings of this study suggest increased consideration should be given to the way in which rapid change and restructuring of mental health services dismantle the containing aspects of the organisation. The practical implications include a need for better balance between work structures and systems, and the needs of individuals. The final part of this thesis is a reflective account of the author's experience of undertaking the research, including reflections on the literature review, methodology and findings, implications of the study and possible areas for future research.

**Chapter 1: Literature review**

**Professional role ambiguity, role conflict and team culture in community mental health: a review of the literature.**

***Abstract***

Role ambiguity and role conflict represent significant factors that can impede the development of positive organisational culture. In the wake of the recent Francis Report (2013), which emphasised how organisational culture within the NHS represents a key determinant of safe and effective health care systems, it appears timely to review and critically appraise the evidence examining the relationship between role ambiguity, role conflict and team culture in community mental health teams in the UK and abroad. Databases were searched using key terms to identify relevant research articles from 1999 until January 2016. Search results were screened and sorted according to inclusion and exclusion criteria. Thirteen articles were included for evaluation and their content was analysed thematically and critically appraised. All the studies suggest that role conflict and role ambiguity need to be managed more effectively to ensure good team working.

***Key words:*** role ambiguity, role conflict, organisational culture, Community Mental Health Team (CMHT)



## ***Introduction***

“Mental health services have gone through a radical transformation over the past 30 years – perhaps more so than any other part of the health system.” (Kings Fund, 2014, p.2).

Organisational restructuring over three decades has completely transformed the landscape of mental health services in the UK. Mental health professionals have moved from working within a model of acute and long-term institutional care to one where care is provided by multi-disciplinary teams in the community; defined as “where members, operating out of their disciplinary bases, work parallel to each other, their primary objective being that of co-ordination” (Opie, 1997, p.263).

The impetus for multi-disciplinary community-based care originates in a combination of economic and social factors influencing all Western welfare states since the 1950s (Sawyer, 2009). In the second half of the twentieth century, a shift in social attitudes and the development of the human rights movement started to take place across post-war Europe. This was reflected in the UK by the introduction of a number of new laws protecting the rights and freedoms of the individual, including the Mental Health Act (1959) which initiated the policy of de-institutionalisation of asylums and advocated care in the community. Another incentive for this policy of rapid deinstitutionalisation was the rising levels of debt experienced in Western Europe, which resulted in economic restructuring and modernisation of public services (Sawyer, 2009). Therefore the movement towards treating people in the community was not accompanied by significant funding of community mental health services (Barham, 1997).

As disillusionment with the medical model grew, the multidisciplinary community mental health team (CMHT) approach gained in popularity. This service model drew on a psychosocial understanding of mental health, and advocated for more democratic organisational structures and the incorporation of service user involvement (Galvin & McCarthy, 1994). The CMHT approach for delivering mental health services is repeatedly recommended in recent national health policy frameworks (Department of Health, 1999; Onyett, 2007), as a means of providing a

better integrated and more comprehensive service delivery whereby a range of mental health professionals collaborate, share knowledge and skills to meet service users' needs more effectively. According to two systematic reviews of the literature, (Malone, Newron-Howes, Simmonds, Coid, Joseph & Marriot, 2001; Simmonds, Marriot, & Tyrer, 2007), Community Mental Health Teams (CMHT) are associated with a reduction in hospital admission and re-admission rates, fewer cases of suicides and increased satisfaction for service users. Nevertheless, Maddock (2015) maintains there has been limited empirical research carried out which identifies the outcomes of multi-disciplinary working, thereby categorically substantiating or refuting these claims.

The community mental health service model has been in a constant state of transition, involving numerous service changes and the persistent renewal of frameworks and practice guidelines (e.g. Department of Health, 1990-2012). The publication of Modernising Mental Health Services (1998) and the National Service Framework for Mental Health (1999) prompted the development of new service models in mental health, including assertive outreach, crisis resolution and home treatment and early intervention, with the aim of improving provision of evidence-based services for people with severe mental health problems. Policy documents outlining the nature of the work force required for these new services were released soon after, including the New Ways of Working (2007) and Creating Capable Teams Approach (2007). However, in recent years, service redesign has resulted in a number of crisis and home treatment teams being decommissioned or restructured (Kings Fund, 2014, p.6), or being merged into generic community mental health teams. The introduction of Improving Access to Psychological Therapies (IAPT) services and the government's recent Health and Social Care Act (2012) have also brought further restructuring to mental health services. Moreover, these rapid and successive changes to services have recently been accompanied with significant funding cuts, with around 40% of mental health trusts in the UK experiencing reductions between 2013 and 2015, signalling a 'crisis' (Kings Fund, 2015) or even a "system failure" (Siddique, 2015, cited in Kings Fund, 2015) in community mental health services.

These changes have clearly had a significant impact on the mental health services workforce, blurring the lines of responsibility and accountability and diminishing the clarity of roles between healthcare professionals working within community mental health teams (Brown, 2000). Whilst the National Service Framework and introduction of IAPT services instigated an increase in staff numbers, particularly for psychiatrists, psychologists and therapists, the number of mental health nurses in services has been in significant decline (Royal College of Nursing, 2014). Conversely an overall decrease in staffing has taken place alongside the integration and decommissioning of specialist community teams. Furthermore, the increased emphasis on recovery-orientated care has demanded a greater flexibility in working practices, service organisation and the development of a more generic workforce. A reconfiguration of professional roles and the skill sets of mental health teams has recently been taking place; many specialist clinical posts have been cut whilst the numbers of junior nurses, allied health professionals and non-clinical staff such as assistant practitioners, technicians, peer support workers and volunteers are being increased. A number of professional roles are being redesigned, for instance with the expectation that mental health nurses will take on the role of prescribing of medicine, (Kings Fund, 2015).

Sawyer, (2009, p. 457) claims “along with the deinstitutionalisation of service users, professionals themselves have also been ‘deinstitutionalised’ – pushed out of their (traditional) professional frameworks, with clearly differentiated roles according to disciplinary expertise, into multi-disciplinary teams with devolved responsibilities for managing clients.” The continuous changing and restructuring of professional roles in community mental health appears to be contrary to research suggesting that clear roles and responsibilities for team members are essential for good team functioning and staff satisfaction (Borrill et al. 2000). Studies in other fields have also demonstrated that maintenance of clear roles is a significant factor in ensuring good collaboration (Reeves & Mann, 2004) and job satisfaction (Davis, 2013; Papastyliaou, Kaila, & Polychronopoulos, 2009). Writers in the field of psychodynamic literature, in particular, stress how important stable boundaries and structure are for ensuring good working relations in teams. Professional boundaries are considered to act as a container for anxiety for mental health staff (Willshire, 1999), and a lack of clarity surrounding roles is thought to result in anxiety driven

behaviour in professionals such as denial and alienation, which frequently have negative effects on team working, (Heginbotham, 1999). If allowed to develop, conflicts within teams may obstruct the provision of quality care with intergroup conflict cited as a possible factor in the recent failure of care at the Mid Staffordshire NHS trust (Whitby & Gracias, 2013).

Stokes, (1998, p. 128) maintains that “unless the management of organizations is sufficiently stable to be able to provide a clear definition of purpose and a reliable container for the inevitably ambivalent feelings of those they employ towards those in authority, then the organization will express its disorder through individual and interpersonal disorder in its members...” Ballatt and Campling, (2011, p. 137) acknowledge that if a work organisation becomes unstable, then it no longer is experienced “psychologically as a safe place.” Heginbotham (1999, pp. 258-259) concludes that role ambiguity “is often the root of organisational conflict” and asserts that a team requires time and effort in order to be able to understand the values of its members and establish alignment of their theories and models. However, in the current system of the NHS, the opposite appears to be occurring with different occupations “auditioning for status and resources” (Crawford, 2008, p.1061).

Role ambiguity, therefore, appears to remain a recurrent difficulty in community mental health services (Belling et al., 2011; Hannigan & Allen, 2011; Maddock, 2015). Rizzo, House, & Lirtzman, (1970) define role ambiguity as including; lack of a clear definition of the expectations connected to a role, lack of clarity about how to fulfil the role, lack of clarity about criteria for successful fulfilment of the role. Role conflict is defined as incompatible expectations of what a role ought to achieve. Onyett (1997) correlates role clarity with a sense of professional identity and organisational identification. This is important because a sense of shared group identity is considered essential for successful team working (Haslam et al., 2006). According to Onyett, (1997) professionals need to identify with both the team and their profession in order to co-operate effectively, and emphasises the importance of providing clarity as to how professionals are working to meet the team’s objectives. This suggests professionals can work more collaboratively when they are clear about how their goals link with a common agenda.

However, the emphasis on professional autonomy and adherence to the various professional philosophies working within community mental health are considered contributory factors to conflict, resentment between professionals, and poor team functioning (Colombo, Bendelow, Fulford, & Williams, 2003; Onyett & Ford, 1996; West, Tjosvold, & Smith, 2003). For example, the medical model used within psychiatry, may not be readily compatible with frameworks used by psychologists or social workers. Thus there are competing perspectives on the origins and treatment of mental health difficulties, inviting the development of rivalries between ‘camps’. Moreover, at times of organisational change, health professionals have been found to cling to their professional roles (Bainbridge & Purkis, 2011; McNeil, Mitchell, & Parker, 2013), and a number of recent studies have demonstrated specific professionals’ dissatisfaction with generic working in CMHTs, for instance psychologists (Mistral & Velleman, 1997), psychiatrists (Vize, 2008), Community Mental Health Nurses (Crawford, 2008) and occupational therapists (Fox, 2013).

#### *Rationale for review*

In undertaking this literature review, the author is investigating the systemic implications of role ambiguity for the culture of the team as a whole. Organisational or team culture is potentially a rather vague term but has been defined as the “learned, shared and tacit assumptions on which people base their daily behaviour” (Schein, 1985, p.29); it is evident in the organisation’s physical environment as well as the values and beliefs of those that work in it. Ballatt and Campling (2014, p.125) describe it as “a kind of internal working model of the organisation,” and Wellin (2014, p.73) remarks organisational culture is apparent in “the stories people tell, the symbols they use, the rituals and routines people follow, and in the way power is exercised.”

The recent Francis Report (Francis, 2013, p. 13) emphasised that organisational culture within the NHS represents a key determinant of safe and effective health care systems because it is one of the “main drivers of actions and behaviours at work,” (Wellin, 2014, p.74). The report highlighted a large number of errors, omissions and abuses taking place and a negative culture found within the Mid Staffordshire Hospital Trust. As role ambiguity and role conflict evidently represent significant

factors which can impede the development of positive organisational culture, it appears timely in the wake of this report to review and critically appraise the evidence examining the relationship between role ambiguity and team culture in community mental health.

## ***Method***

### *Search strategy*

A systematic search strategy was used to identify and review literature addressing the question, ‘what is the relation between role ambiguity, role conflict and team culture in community mental health?’. The host databases EBSCO (MEDLINE, PsycINFO, AgeLine, CINAHL and Academic Search Complete), Web of Science and Science Direct were all searched for available content published after the date 1999 (when the policy document National Service Framework, which had introduced a number of new service models into community mental health was published), up until the end of January 2015 with the intention of identifying relevant literature. Google scholar was also used to do a final search for any papers that might not have been identified through the databases. In order to yield as full and complete a search as possible, the following terms were included in the search strategy: “Community mental health” and “professional roles” OR identit\* OR boundar\* OR demarc\* with no limiters. The terms ‘role ambiguity’ and ‘role conflict’ were not included as this narrowed down the results too much, excluding potentially relevant articles. References were also manually ‘hand searched’ from key journals and reference lists to ensure that no articles had been overlooked.

### *Study Selection*

A total of 819 papers were initially identified. Exclusion and inclusion criteria were then applied to the abstracts of identified studies in order to ascertain which were most relevant and appropriate for inclusion in the review.

### *Inclusion Criteria*

- Peer reviewed empirical studies
- Considered the relation between role ambiguity and team culture in community mental health teams in the UK and abroad, to establish any points of resemblance between services.

- Published in or translated into English
- Published after the date 1999 (when the policy document National Service Framework was published)

*Exclusion criteria*

- Reviews, reflections, commentaries and general opinion pieces
- Book chapters
- Dissertations
- Not CMHTs (Community Mental Health Teams)
- Solely a uni-professional view of CMHT (Community Mental Health Team) working rather than perspectives of multi-professionals.

*Critical appraisal*

No specific appraisal tool encapsulated the methodology of all the studies reviewed, thus in order to ensure that the appraisal was as comprehensive and meaningful as possible, a combination of tools were used in the formation of a methodological checklists (see appendix one and two) for qualitative and quantitative studies respectively. For the qualitative studies, a set of questions were developed which was informed by the Critical Appraisal Skills Programme Qualitative Checklist (CASP, 2013) and guidelines for assessing validity in qualitative studies by Yardley (2000). For the quantitative studies, questions were compiled and adapted from the CASP Cohort Study checklist and guidelines for critical appraisal of quantitative studies by Young and Solomon (2009). Summary tables (appendix three & four) illustrate the way in which the studies met these criteria. Each paper was allocated a quality index score according to the sum of the twelve responses on the checklist, indicating the level of quality of the study.

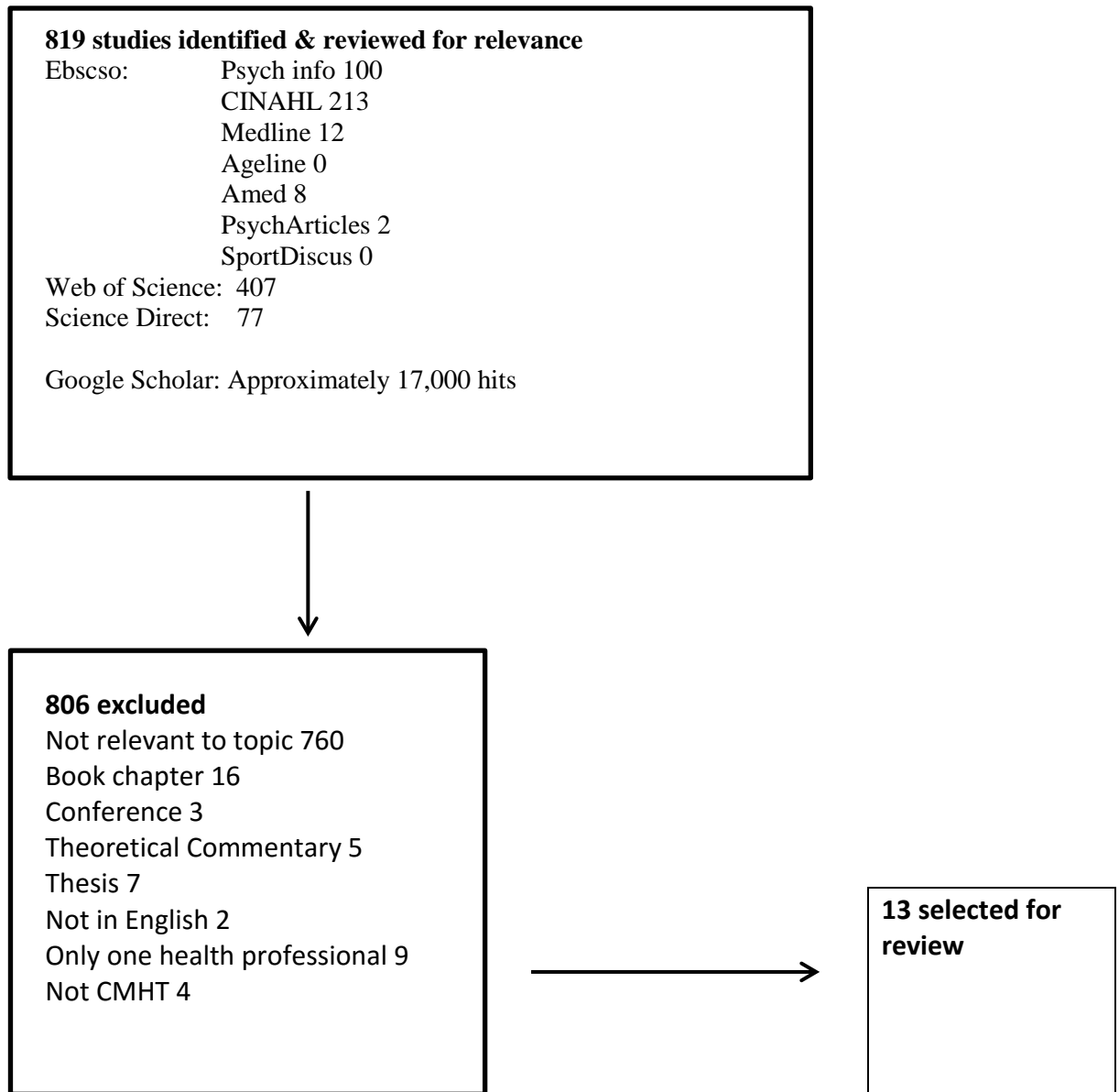
***Results***

A total of 819 papers were identified as potentially relevant to this review. After applying the inclusion and exclusion criteria, 806 papers were excluded, leaving a total of 13 papers for review. This process is illustrated using a flow chart in figure one (see below). These final thirteen articles were then read in detail and reviewed in two stages. The first stage of the review comprised a critical review of

methodology and methods used. As the majority of the studies in the review were qualitative, the content of the studies were compared and contrasted and recurrent themes across the literature were identified and are outlined in the second section of the review. A synthesis table was developed as part of this review process, which enabled the researcher to summarise the contents of each article (table one).



**Figure 1. Literature Review Process**



**Table 1. Synthesis Table**

|   | <b>Author (s) &amp; Year &amp; place</b> | <b>Design/ Methodology</b>                                   | <b>Participants</b>  | <b>Aim(s)</b>  | <b>Main findings</b>   |
|---|--|--|--|--|--|
| 1 | Norman & Peck (1999)<br>UK               | Discussion workshop  | Clinicians, service managers, academics from National Reference Group (number not specified).  | Establish an inter-professional dialogue between mental health care professions in order to identify key problems of inter-professional working in adult community mental health services.                           | <ul style="list-style-type: none"> <li>• Loss of faith by mental health care professionals in the system in which they work</li> <li>• Strong adherence to uni-professional cultures</li> <li>• Absence of a strong and shared philosophy of community mental health services</li> <li>• Mistrust of managerial solutions to problems</li> </ul> |
| 2 | Peck & Norman (1999)<br>UK               | Discussion workshops   | 61 participants (7 psychiatrists, 11 nurses, 12 social workers, 12 occupational therapists, 7 clinical psychologists, 3 community support workers)                 | Enhance role relations and perceptions of CMHT staff through facilitated workshops and explore their own   | <ul style="list-style-type: none"> <li>• Wide variety in ways different professionals perceive themselves and others improving inter-professional working in community mental health requires active participation by staff and cannot be prescribed by governmental or professional organisations.</li> </ul>                                   |
| 3 | Brown et al (2000)<br>UK                 | Semi-structured Interviews / Grounded Theory                 | 29 participants (range of psychiatrists, psychologists, occupational therapists, social workers, community mental health nurses and mental health support workers) | To investigate the implications of the teamwork approach for professional identities and occupational boundaries for those working in community mental health.   | <ul style="list-style-type: none"> <li>• Blurring of roles in CMHTs liberating to some but concerning to others.</li> <li>• Professionals perceived lack of structure and abandonment by management which both eroded and reinforced boundaries.</li> </ul>  |
| 4 | Gulliver et al (2002)<br>UK              | Workshop discussions and observations and document analysis. | 10–15 self-selected participants from each discipline Involved in mental health service provision.   | Identify the extent to which the integration of health and social services within the new Trust impacted on boundary activity, and the extent to which it focused this activity on teams rather than on professions. | Boundary activities identified during a period of integration of health and social services within mental health services<br>Protecting Difference<br>Making Connections<br>Creating commitment  |

|   |                              |  |   |   |   |
|---|------------------------------|--|---|---|---|
|   |                              |  |   |   | Conclude managerial initiatives can have positive impact on inter-professional collaboration but rhetoric advocating destruction of professional boundaries is 'unwise'   |
| 5 | Carpenter et al 2003. UK     | Questionnaire (profession and team identification scale, the team climate inventory the role clarity and role conflict scales the attitudes to community care questionnaire the Job Satisfaction Scale, General Health questionnaire to investigate the relationships between service organisation, professional and team identification, psychological wellbeing and job satisfaction | 31 Social workers<br>82 Health professionals  | Investigate the relationship between the organisation of community mental health services, and professional and team identification, team functioning and psychological well-being and job satisfaction of staff working in Community Mental Health Teams                     | <ul style="list-style-type: none"> <li>• CMHTs with integrated health and socials service and targeted on people with severe mental health problems associated with better team functioning and experience less role conflict.</li> <li>• Social workers found to be less positive about team functioning and experience more role conflict than other health professionals.</li> </ul> |
| 6 | Lankshear (2003) UK          | Case Study (One site comprising 6 CMHTs)   | 55 semi-structured interviews with managers, social workers, community mental health nurses, occupational therapists and psychiatrists.                             | Identify the strategies employed to manage the problems created by the disparity between the stated and agreed purpose of the teams and the actual pattern of referrals.  | <ul style="list-style-type: none"> <li>• A number of strategies were identified to manage conflict including isolation, homogenisation, fraternisation, negotiation and manipulation.</li> <li>• A sixth strategy was designed to ameliorate the loss of professional identity experienced by those who were operating in a 'foreign' milieu – that of demarcation.</li> </ul>          |
| 7 | Larkin & Callaghan (2005) UK | Questionnaire to measure mental health professionals' perceptions of inter-professional working.   | 165 community mental health workers<br>74 nurses<br>6 occupational therapists<br>46 social workers<br>22 psychiatrists<br>10 psychologists<br>5 others<br>2 missing | To examine if the presence of core structures (operational policy, meetings, same office space, clarity around roles and responsibilities, common policies and teambuilding activity) influenced professionals' perceptions of inter-professional working within their teams. | <ul style="list-style-type: none"> <li>• A chi-square test showed that there was a statistically significant difference among different professionals' perceptions of how well their role is recognised and understood.</li> </ul>  |
| 8 | Simpson (2007)               | Multiple Case study design (participant observation/semi-  | 31 participants (15 CMHNs, 15 service users, 4 CMHT   | To enhance the understanding of the structures and interactions within CMHTs that   | Factors that impacted on the ability of care co-  |

Impact of organisational change

|    |                                |  |   |   |  |
|----|--------------------------------|--|---|---|--|
|    | UK                             | structured interview/ document review)                                     | managers, 2 psychiatrists, 2 social workers, 2 occupational therapists, 6 carers)                                   | facilitate or impede effective teamwork and case management.  | ordinators to act effectively included: 'structure and procedures'; disrespect and withdrawal; humour; and undermining 'safety and disclosure'.<br>Care co-ordination was enhanced when team structures and policies were in place and where team interactions were respectful. Where members felt disrespected or undermined, communication, information sharing and collaboration were impaired, with a negative impact on the care provided to service users. |
| 9  | Donnison et al (2009) UK       | Semi-structured interviews/ IPA (Interpretative Phenomenological Analysis) | 7 participants (one social worker, psychiatrist, two community psychiatric nurses and three clinical psychologists) | To explore conceptual models employed by community mental health team (CMHT) staff in the care of their clients and how CMHT clinicians communicated with one another, particularly in relation to complex clinical work.   | Four emergent themes found in data: <ul style="list-style-type: none"> <li>• Complex and competing demands</li> <li>• Managing complex demands</li> <li>• Identity with the team</li> <li>• Approaches to clinical work</li> </ul>   |
| 10 | Elstad & Hellzen (2010) Norway | Focus Group Interview  | 6 participants from Occupational therapy, nursing and social care.  | To explore professionals' experiences of their work and professional role, in order to highlight important aspects of contemporary community mental health work.  | The main themes developed in the analysis were: <ul style="list-style-type: none"> <li>• to be consultants, supporters, and carers in daily life</li> <li>• to really see the person and facilitate social contact</li> <li>• a liberating role</li> <li>• expectations from and attitudes of other health care professionals</li> </ul>   |
| 11 | Belling et al (2011) UK        | Interpretative Framework Approach : semi-structured interviews             | 113 health and social care professionals  | To identify and explore facilitators and barriers perceived to influence continuity of care by health and social care professionals working in adult multidisciplinary CMHTs (and associated acute wards, general practices, and representatives of voluntary organisations). | <ul style="list-style-type: none"> <li>• Positive experiences of working in co-located, integrated multidisciplinary teams which facilitated continuity.</li> <li>• Tensions and conflicts present over professional identities, role blurring</li> <li>• Co-existence of a separate team of psychologists in one organisation illustration of challenges of cross boundary</li> </ul>   |

|    |                        |  |  |   |  |
|----|------------------------|--|--|---|--|
|    |                        |  |  |   | <p>working.</p> <ul style="list-style-type: none"> <li>• Generic working was a source of concern, e.g. lack of training for new aspects of roles e.g. medication management by social</li> </ul>   |
| 12 | Hannigan, (2011) UK    | Case study: semi-structured interviews, observation of routine events and document review. | 66 purposively sampled NHS and local authority planners, managers and senior practitioners and service users.                            | To investigate real-life roles and responsibilities in community care.  | <p>Differences found across two CMHT sites:</p> <ul style="list-style-type: none"> <li>• Local organisational features</li> <li>• Workplace histories of interagency and inter-professional relations</li> <li>• practical contextual features such as the size of NHS and local authority organizations,</li> <li>• availability of new members of staff to fill gaps</li> </ul> <p>When role blurring occurs:</p> <ul style="list-style-type: none"> <li>• practitioners looked to their professions' larger jurisdictions to underpin their appeals to coordinate and provide care against the claims of potential competitors.</li> <li>• may also encourage staff to undertake tasks which stretch their capability.</li> <li>• service user continuity is also likely to be compromised</li> </ul> |
| 13 | Maddock (2015) Ireland | Participant Observation & Interview/ IPA (Interpretative Phenomenological Analysis)        | 5 purposively selected participants (clinical lead, social worker, community psychiatric nurse, psychologist and occupational therapist) | To explore multidisciplinary teamwork in contemporary mental health settings, particularly what aids and hinders the process of multidisciplinary team working, and the social work contribution in such teams. | Professional role blurring and stereotyping were found to impact the division of labour on this team, with role negotiation found to be an integral part of retaining a professional's practice identity   |

### ***Overview of selected studies***

Eleven of the thirteen studies used a qualitative approach. Two of the studies, Donnison, Thompson and Turpin, (2009) and Maddock (2015) used an Interpretative Phenomenological Approach (IPA) and semi-structured interviews to elicit participants' views. Donnison et al. (2009) recruited seven participants (one social worker, psychiatrist, two community psychiatric nurses and three clinical psychologists) from two CMHTs in the UK, and Maddock (2015) had a sample of five participants (clinical lead, social worker, community psychiatric nurse, psychologist and occupational therapist) drawn from one team in Ireland. Brown, Crawford, and Darongkamas (2000) used semi-structured interviews and grounded theory to analyse the interview data from a sample of 29 participants from three separate teams in the West Midlands. Belling et al. (2011) used semi-structured interviews with a sample of 113 professionals working in eight different CMHTS in Greater London, and associated in-patient wards and GP practices. The authors describe applying a framework analysis to the data set.

Norman and Peck (1999) and Peck and Norman (1999) report the findings of a study which comprised an 'inter-professional dialogue' in community mental health services. The first paper describes the discussion carried out with members of the professional organisations in the National Reference Group whilst the second reports the findings from a discussion carried out with clinical staff working in CMH services. Sixty one participants (seven psychiatrists, eleven nurses, twelve social workers, twelve occupational therapists, seven clinical psychologists, three community support workers took part in the clinical working group discussion. There is no clear description of the method used to analyse the data in either paper. Gulliver, Peck, and Towell (2002) employed a similar approach to Peck and Norman (1999) using discussion workshops with a sample of fifteen diverse professionals working in CMHTs in a trust in Somerset.

Lankshear (2003) carried out a case study, using semi-structured interviews with fifty-five participants, (managers, social workers, community mental health nurses, occupational therapists and psychiatrists) drawn from six CMHTS in the North of England. Simpson (2007) carried out a multiple case study and interviewed thirty-one participants (fifteen CMHNs, fifteen service users, four managers, two

psychiatrists, two social workers, two occupational therapists, and six carers) from seven community health teams from one city in the UK. Hannigan and Allen (2011) conducted sixty six interviews with a range of planners, managers, senior practitioners and service users across two sites in Wales. A coding frame was created and used to identify inductive and deductive codes within the data. One study employed a focus group method and participant observation to obtain data from a sample of six participants from a range of disciplines (occupational therapy, nursing, social work) across three CMHTs in one Norwegian city (Elstad & Hellzen, 2010) and then used thematic analysis to derive themes.

Two studies (Carpenter, Schneider, Brandon, & Wooff, 2003; Callaghan & Larkin, 2005) utilized a quantitative methodology and survey designs. Carpenter et al. (2003) carried out questionnaires, comprising a number of different scales, including the profession and team identification scale (Brown et al., 1986); the team climate inventory (Anderson & West, 1994); the role clarity and role conflict scales (Rizzo et al. 1970); the attitudes to community care questionnaire (Haddow & Milne, 1995); the Job Satisfaction Scale, (Dyer & Hoffenberg, 1975); General Health questionnaire (Goldberg & Williams, 1978) to investigate the relationships between service organisation, professional and team identification, psychological wellbeing and job satisfaction with thirty one social workers and eighty two health workers from a range of mental health trusts in the England. Callaghan and Larkin, (2005) conducted a questionnaire, to measure mental health professionals' perceptions of inter-professional working with two hundred and forty four community mental health workers from a range of CMHTs in East London and statistical analysis using Spearman's Rank Order Correlation and Chi-square tests were carried out with the data.

### ***Quality Appraisal***

With reference to the critical appraisal checklist (appendices one & two), none of the studies met all the criteria. Four of the qualitative studies met eight out of the twelve of the criteria (66%) (Brown et al., 2000; Elstad & Hellzen, 2010; Maddock, 2015; Simpson, 2007) and two fulfilled seven of the criteria, scoring 58% (Donnison et al., 2009; Lankshear, 2003) suggesting they represent a good quality of evidence. Three of the studies met five of the twelve of the thirteen criteria (41%) (Belling et al.,

2011; Gulliver et al., 2002; Hannigan & Allen, 2011), indicating an average level of quality. Norman and Peck (1999) and Peck and Norman scored only 33% on the quality index and with three of the criteria on the checklist, which indicates a low level of quality. In regards to the two quantitative papers, both Carpenter, et al. (2003) and Larkin and Callaghan scored seven (58%) of the 12 criteria indicating a good level of quality. The next section will provide an outline of the strengths and limitations of the thirteen papers, guided by the appraisal tools.

### *Aims and Justifications*

All of the authors of the studies in this review clearly set out their aims. However, a number of the studies (Belling et al., 2011; Gulliver et al., 2002; Hannigan & Allen, 2011; Norman & Peck, 1999; Peck & Norman, 1999) did not clearly justify the research methodology in terms of an underlying epistemology. According to Yardley (2000), this connection needs to be clearly made to lend the study 'coherence'. In terms of the two quantitative studies, Carpenter et al. (2003) provide a clear explanation of the aim of their study and do outline clearly their hypothesis. Although Larkin and Callaghan (2005) list a number of research questions, they do not test a stated hypothesis.

### *Recruitment, Sample, Generalisability/Transferability*

All the qualitative studies recruited participants from community health teams either in the UK or abroad. The size of samples in the studies reflected the qualitative nature of the majority of studies, with most studies having a sample of less than ten participants. These sample sizes are in keeping with qualitative forms of methodology which "attempt to understand a relatively small number of participants' own frame of reference" (Smith, 2008, p. 2). However, two studies claiming to use a qualitative method analysing interviews, had large samples of 117 (Belling et al., 2011) and 66 (Hannigan & Allen, 2011) which are extremely large for qualitative studies. All studies included a range of professionals working in a CMHT, which enables a multi-professional rather than just a uni-professional view of team working.

Two of the studies, (Elstad & Hellzen, 2010; Gulliver et al., 2002) used 'self-selected' participants, whereby staff members volunteered to take part in the study



which may have skewed the sample towards participants who wanted to express a certain view. The other qualitative studies included in the review used purposive sampling. Such non-probability sampling methods are commonly used in qualitative studies as the aim is not to produce a statistically representative sample or draw statistical inference. However, they are not as stringent as a random approach which may negate charges of researcher bias in the selection of participants (Shenton, 2004) which would reduce the credibility of the research findings. It is possible, therefore, that researcher bias may have influenced the data in the qualitative studies included in this review. For instance researchers may have imposed their own assumptions and ideas on the research study or assumed a cultural bias in the recruitment of participant and interpretation of the data.

Two of the studies employed IPA (Donnison et al., 2009; Maddock, 2015). A characteristic feature of this method is the 'idiographic' nature of studies, with the intention to provide an in-depth interpretation of the individual's experience and detailed analysis of each case in turn. Therefore, samples in IPA studies should be homogeneous (Smith et al., 2009) enabling the researcher to identify any psychological variance between the participants by drawing out the similarities and differences. However, the sample in the Donnison et al's (2009) study had a large variability in the time participants had worked within the team, whilst in the study conducted by Maddock (2015), the mean number of years since qualification was seven, but they also included one member staff who had worked eighteen years within the team, thereby decreasing the homogeneity of the samples.

In regards to case studies, Merriam (2009) states that case selection precedes case analysis and should comprise an indication of both why the particular case was selected and whether the case is typical or untypical. None of the case studies in this review provide any justification for the choice of case (Gulliver et al., 2002; Lankshear, 2003; Peck & Norman, 1999; Simpson, 2007). For example, although Hannigan and Allen (2011) explain why community mental health care was chosen as a general focus for their study, there is no further detail given as to why the two selected cases were chosen for the study or whether they are typical or untypical of other cases.

Some of the qualitative studies list ‘lack of generalisability’ (the extent to which research findings can be applied to settings other than that in which they were originally tested) as a limitation (Elstad & Hellzen, 2010; Maddock, 2015). However ‘theoretical transferability’ is considered a more appropriate aim with qualitative studies (Johnson, 1997) because they do not generate replicable findings but readers may find that ideas or insights can be transferred across research settings. In order to judge theoretical transferability, the reader needs to know as much contextual information as possible such as the participants’ ethnicity, social and cultural background) in order to “situate the sample” (Elliott, Fischer, & Rennie, 1999). However, all eleven qualitative studies omitted this information and therefore it is difficult to ascertain their transferability.

In regards to the two quantitative studies, Larkin and Callaghan (2005) recruited potential participants from a population of ‘all professionals employed in community mental health teams in East London’ excluding students, administrative staff and teams of uni-professionals (less than three different professionals). The study had a sample size of 165 with a response rate of 67.62%. The study by Carpenter et al. (2003) drew their sample from seven CMHTs within the UK which were classified into four ‘districts’. The authors acknowledge that the sample size reduced from 113 at time one (1998/1999) to 77 at time two (1999/2000) and concluded that the sample sizes were too small to draw conclusions regarding the differences between the two dimensions of service organisation. Carpenter et al. (2003) also acknowledge the numbers of certain professionals were quite small, (psychiatrists, psychologists and occupational therapists) which may have precluded a representation of their views. Carpenter et al. (2003) that the conclusions of the study are tentative due to the size of sample which therefore diminishes the study’s generalisability.

### *Research Design & Methodology*

Transparency, defined as providing detailed accounts of the data collection procedure and analysis, is an essential component of qualitative studies because it enables the reader to understand the process of the research and the reasons why decisions were undertaken (Yardley, 2000). Some of the qualitative studies did describe the data collection procedure in detail (Brown et al., 2000; Elstad &

Hellzen, 2010; Maddock, 2015), and provided readers with an example of the interview guide in the appendix to their article, which allowed for greater transparency. Belling et al. (2011); Gulliver et al. (2002); Lankshear, (2003); Peck and Norman, (1999) did not provide a clear description of the procedure used to analyse the data. Belling et al. (2011) referred to the application of ‘‘a theoretical framework’’ for analysing data but the framework was not then explained. Gulliver et al. (2002) referred to the model for data analysis utilized by a previous study conducted by Cross et al. (2000), however neither study provided adequate information as to how these were applied to the data in the respective studies, which impacts on their quality or credibility (Hyett, Kenny, & Dickson-Swift, 2014). Brown et al. (2000) used a grounded theory approach and quotations were included to support the authors’ findings and there was some description of the analytic process used.

Larkin and Callaghan, (2005) used a questionnaire comprising a set of 20 questions in order to measure mental health professionals’ perceptions of inter-professional working. However, there is no indication of whether the questionnaire used in the study is validated. Furthermore, both the quantitative studies (Carpenter et al., 2003; Larkin & Callaghan, 2005) used self-report measures, which could have the potential for bias. For instance participants might wish to present themselves to the researcher in a particular way, but this self-presentation might not be accurate or might be misleading. The validity could therefore be diminished.

Both the quantitative studies were cross-sectional. Cross-sectional studies do not address causal relationships between variables. Therefore the causal effects of variables of interest cannot be identified in these studies. Carpenter et al. (2003), used a range of statistical tests, both parametric and non-parametric (Kruskal-Wallis, ANOVA, Regression) and Larkin and Callaghan (2005) applied a spearman rho correlation and chi-squared test to their data. Although these tests seem applicable, given the data, there is little justification as to why these tests were used above others. The results of these analyses are provided in a coherent and detailed manner with P values, degrees of freedom and confidence intervals included in both papers which are beneficial to determine precision e.g. effect sizes. The clarity of the

findings could have been increased by the inclusion of visual graphs, enabling different results to be identified and compared more easily.

### *Validity & Rigour*

A significant measure of validity in qualitative studies is whether or not the interpretations arrived at by the researcher is evidenced by sufficient excerpts of data, (Elliott et al. 1999; Yardley, 2008). Eight of the qualitative studies did include quotes in support of themes generated (Donnison et al. 2009; Elstad & Hellzen, 2010; Hannigan & Allen, 2011; Maddock, 2015). However, two studies (Belling et al. 2011; Gulliver et al. 2002) did not include any quotations from the interview data and Hannigan and Allen's study provides only two excerpts from a sample of 66 participants to support their findings, which thus diminishes the credibility of their findings. Donnison et al. (2009) did not clarify which participant expressed which quote; it was not clear, therefore, if a broad reflection of views across the samples had been included or whether there was a bias towards the representation of certain participants' views in these studies. Furthermore, Smith (2011) states that IPA studies with samples of four to eight participants should include extracts from at least three participants for each theme in order to ensure sufficient evidence for the analysis. However, neither Donnison et al. (2009) nor Maddock (2015) do this, therefore it is difficult to ascertain whether the themes are representative of all the participants taking part of the study.

Four of the studies (Gulliver et al., 2002; Hannigan & Allen, 2011; Maddock, 2015; Simpson, 2007) employed triangulation of data collection or analysis, incorporating data from various sources (observations, document reviews, interviews) which, it could be argued, allowed for a more "rounded, multi-layered understanding of the research topic" (Yardley, 2000, p.222). The intention is that the different sources corroborate each other and all contribute to a more enriched picture emerging from the data.

Lankshear (2003) incorporated checking of the appropriateness of the coding frame and allocation of themes by a peer reviewer, in order to increase validity. The peer check would be intended to confirm that the frame and themes make sense, are useful, and identify any areas for further analysis (Yardley, 2008). Three of the

studies (Elstad & Hellzen, 2010; Gulliver et al., 2002; Lankshear, 2003) adopted respondent validation, allowing participants to read their transcripts and ensure their views are not misrepresented, as a strategy to ensure a higher degree of accuracy and authenticity to the researchers' interpretations. However, Yardley (2008, p.242) emphasises that there is a need to ensure that participants understand and are able 'to relate to the complexities of the analysis. Simpson (2007) provides an account of the ways in which credibility (the extent to which a true picture was presented) was achieved in the study, including the use of memo writing and progress reports to illustrate how the author arrived at his interpretation.

Showing sensitivity to context contributes to the validity of the study by engaging with the nuances of the theoretical approach and the data (Yardley, 2008). Most of the studies did not have sufficient information to determine sensitivity to context. One study did demonstrate a particularly high level of sensitivity to participants when considering the social contextual influences on their responses in the interviews, by discussing how participants' political concerns and fears may have influenced their responses in the study (Brown et al. 2000). One study provided some context relating to the historical development of the CMHT (Elstad & Hellzen, 2010) which was relevant as it provided some context to the current service.

In regards to the two quantitative studies (Carpenter, 2003; Larkin & Callaghan, 2005), no comments were made in either paper regarding potential confounding variables, such as length of time working in the service.

### *Reflexivity & Ethics*

The inclusion of a reflexive component is considered to be a significant feature of high-quality, qualitative research (Hammersley, 1987; Mays & Pope, 2000). Elliott et al. (1999) maintain that discussing the potential impact of the researcher's values and assumptions enhances the transparency and, therefore, the validity of qualitative research by providing the reader with a greater understanding of the process of interpretation. For example, a researcher might become more aware of how their own assumptions lead them to interpret data in particular ways. Although Simpson (2007, p. 411) does mention the use of 'critical reflection' with supervisors to challenge 'assumptions and values', none of the articles provide a reflexive account

of the researchers' engagement with the data. It is not possible, therefore, to establish the extent to which the authors' priorities may have influenced their reading of the data and therefore led to biased interpretations.

It is always important to follow ethical procedures in both quantitative and qualitative studies, to ensure that participants are not affected adversely by the process of research. The studies included in this review were concerned with staff working in mental health organisations, particularly staff perceptions of their working environment. Potentially the subject matter may have been distressing for participants. Therefore it would seem important for studies to incorporate clear descriptions of ethical procedures. Only three of the studies reviewed reported they obtained ethical approval (Belling et al., 2011; Elstad & Hellzen, 2010; Simpson, 2007).

***Themes across the literature:***

***Lack of definition in CMHT work***

A number of the studies included in this review assert that professionals working in community mental health settings perceive their work as lacking clear definition and structure (Brown et al., 2000, index score of 66%; Elstad & Hellzen, 2010, index score of 66%; Maddock, 2015, index score of 66% ; Norman & Peck, 1999, index score of 33%; Peck & Norman, 1999, index score of 33%), without clear aims and policies (Donnison et al, 2009, index score of 58 %; Gulliver et al. 2002, index score of 41%; Simpson, 2007, index score of 66%). Furthermore, without clearly demarcated roles, professionals are obliged to compete for professional territory, which can often result in confusion and conflict between staff members (Hannigan & Allen, 2011, index score of 41%; Maddock, 2015). Simpson (2007, p. 412) describes how lack of structures in CMHTs creates a vacuum which fosters ‘‘uncertainty and anxiety’’ amongst professionals. Brown et al. (2000) acknowledge that uncertainties regarding service structures, and feeling ‘abandoned’ by management, increase staff concerns about unclear professional boundaries. Examples given by participants included, inconsistent chairing of meetings, membership of an overly wide variety of teams, ambiguous interfaces with other agencies and organisations, all of which create discontinuity and uncertainty within the team.

*Staff perceptions of role ambiguity*

In two of the studies, participants voiced mixed opinions, recognising that a more egalitarian and generic way of working enabled staff to feel less restricted, but also that this way of working brought its own uncertainty (Brown et al., 2000; Elstad & Hellzen, 2010). However, the majority of studies in this review showed that where role ambiguity did exist within teams, it was perceived by professionals as negative and potentially undermining autonomy, with professionals less confident about using their own judgement (Belling et al., 2011; Maddock, 2015). Erosion of professional roles and identities resulting from generic, cross boundary working is perceived as threatening because professionals are less clear whether their particular roles are valued (Belling et al., 2011; Donnison et al., 2009; Hannigan & Allen, 2011). Donnison et al. (2009) and Brown et al. (2000) found that at times of reorganisation, pressure or when feeling under threat, professionals retreat into their disciplinary identity, which provides familiarity and reassurance, implying that cross-boundary working becomes more difficult to accomplish. Hannigan and Allen, (2011) demonstrated that even in CMHTs with a strong culture of ‘blurred boundaries’, disciplinary identity is greatly valued by staff, revealing that professionals like to maintain strong professional roles and identities. Whilst, Carpenter et al. (2003) which obtained an index score of 58%, revealed that greater role clarity is associated with higher job satisfaction, Lankshear (2003) with an index score of 58%, identified homogenisation and demarcation as two strategies that professionals working within community mental health teams will employ to assuage conflict, by making working practices as integrated and clearly defined as possible.

*Limited understanding and respect of other professionals’ roles*

A number of the studies indicated that professionals working in CMHTs are lacking core competencies for patient-centred collaborative practice by demonstrating only limited understanding of each other’s roles (Donnison et al., 2009; Elstad & Hellzen, 2010; Larkin & Callaghan, 2005, with an index score of 58%; Maddock, 2015). Professionals working within CMHTS are found to subscribe to differing models (social, psychological, biological) and explanations of mental illness which accentuates difference and rivalry between professionals (Donnison et al., 2009; Maddock, 2015). This diversity of models can split teams into medical professionals versus psychosocial professionals (Maddock, 2015) and Larkin and Callaghan

(2005) suggest that ‘‘professional tribalism’’ may exist within teams with professionals becoming overprotective of their roles. The lack of shared understanding impacts on inter-professional communication, in turn resulting in role blurring and stereotyping of professionals and inhibiting of participation in case discussions (Maddock, 2015). Furthermore, lack of inter-professional respect between team members results in low morale, increased feelings of resentment and being undervalued, leading to adoption of ‘defensive’ positions and withdrawing from team interaction and cooperation (Hannigan & Allen, 2011; Maddock, 2015; Peck & Norman, 1999; Simpson, 2007). Gulliver et al. (2002) suggest that seeking a shared culture, defined through a unifying language to develop a positive shared identity between professionals in CMHTs, can mitigate the conflict arising from blurred professional roles.

#### *Impact on quality of care provided to clients*

Two studies suggested that the lack of structure of community mental health services could at times negatively impact on the provision of care to clients, for instance staff not attending meetings regarding clients or sharing information (Belling et al., 2011; Maddock, 2015). Concerns regarding the lack of training currently being provided for professionals’ preparation for new generic roles or expansion of their current ones were raised and the risk implications of professionals being encouraged to take on tasks beyond their capability were highlighted in two studies (Belling et al., 2011; Hannigan & Allen, 2011).

#### *Discussion and Clinical Implications*

All thirteen of the studies in this review provided a clear and concise statement of the findings of their study which are presented in a table one. Nevertheless, these findings and their clinical implications should be considered alongside an acknowledgement of the design and methodological limitations of the studies, demonstrated within this critical appraisal. Five of the qualitative studies scored a low level or fairly low level of quality with index scores of less than 50%, (Belling et al., 2011; Gulliver et al., 2002; Hannigan & Allen, 2011; Norman & Peck, 1999; Peck & Norman, 1999). Although the two quantitative studies obtained a good level of quality with index scores of 58%, (Carpenter, 2003; Larkin & Callaghan 2005),



the sample in the former study was not representative and therefore the findings from this study should also be treated with caution.

All the studies suggest that role conflict and role ambiguity need to be managed more effectively to ensure good team working. Two of the studies highlight the way in which continual organisational change and lack of structure in services are increasing role ambiguity and fragmentation of services (Brown et al., 2000; Carpenter et al., 2003). Three studies (Donnison et al., 2009; Maddock, 2015; Simpson, 2007) show that a lack of clarity of role leads to greater defensiveness in professionals, who then cling to their sense of having a particular professional identity. This appears to lead to increased conflict and rivalry between team members who are feeling under threat.

Two of the studies present these changes more positively (Gulliver et al., 2002; Hannigan & Allen, 2011). With these studies the changes are seen as a part of the modernisation agenda that is driving the adaption of increasingly flexible and cross-boundary working in community mental health services. Hannigan and Allen (2011, p.6) suggest that flexible working may be a reflection of the recent cuts in funding , “where professionals able to fulfil enlarged bundles of activities present themselves as one way of securing cost savings”. Gulliver et al. (2002) state that clear goals and consensus can be created between professionals, especially when management is effective at unifying team goals and identities.

Three of the studies highlight an increased need for training; for example, Maddock (2015) suggests training could be targeted to develop inter-professional role negotiation skills. Belling et al. (2011) suggests training should prioritise integrated team working and team leadership, role development and competencies within CMHTs, change management, and management of temporary workers. These priorities are intended to help with the integration of CMHTs in conditions of fragmentation and change. Donnison et al. (2009, p.315), advocate whole team training as a means of resolving tensions between professionals by addressing ‘heterogeneity’ of roles and competencies, which may be achieved through developing a “common language in which to discuss clinical work” that helps professionals to understand the demands of each other’s role.

The studies included in this review highlight a relationship between lack of structure in services, limited clarity of roles and poor team working in community mental health. The themes evident in this review reiterate the proposal made by Rushmer (2005, p.77) that integrated working and blurring the boundaries are frequently confused. She states that whilst the former produces successful inter-professional team working, the latter commonly results in ‘‘ambiguity, confusion with the potential to lead to resentment and distrust’’. This review substantiates her claim that the solution is the existence and maintenance of clear boundaries, which must be negotiated and agreed between professionals.

#### *Limitations of the review*

The current review has limitations that should be taken into account. The quality of the evidence included in the studies was analysed and summarised. However a lesser quality of evidence in the studies did not prevent them being included in this review, therefore the overall robustness of findings may be diminished. Additionally, there is a possible publication and language bias. The review did not ascertain where additional unpublished literature was available, or literature published in a different language and therefore may have omitted some relevant research. However, the review followed a literature searching procedure that generated a significant range of data that was felt to be appropriate to the review.

#### *Implications for future research*

Implications for further research can be gleaned from most of the studies. The implications address how inter-professional working can be made less threatening to individuals and more effective as a whole. For example, Larkin and Callaghan (2005) talk about the importance of having joint policies that shape the working of all the members of the team, while acknowledging that more research is needed into the relationship between the professionals perceptions of their own roles and others and the impact this may have on inter-professional teamwork. Belling et al. (2011); Donnison et al. (2009); Elstad and Helzen, (2010) and Maddock, (2015) all propose that the development of the professional skills base is important. Maddock (2015) also suggests that professional education should be available at university level and also in the workplace. Elstad and Helzen (2010) emphasise the need for the

professional to have the right skills for the role. Simpson (2007) highlights the importance of giving CMHTs the opportunity to develop trust through openness and reflective discussion. This highlights the need for further research into how trust within teams could be developed or diminished and has an obvious link with the present study. Furthermore, the review highlights that there is limited evidence evaluating the impact of role ambiguity and role conflict on the quality of client care and this therefore appears to be an area that warrants further research.

### ***Conclusion***

It is evident from this review that staff role ambiguity and conflict can have detrimental consequences to services, creating tensions between staff members, adversely impacting on continuity, appropriateness of workload. Only three of the studies highlighted an increased risk to service users' safety which suggests that further research is necessary in this area. This review also highlights the need for role ambiguity to be managed effectively in order to ensure that staff members do not feel threatened and assume defensive positions. Incorporating more interdisciplinary competences in the training and education of professionals is perceived as one solution, enabling professionals to have a common basis of skills, knowledge and understanding. But is this sufficient? If it is indeed the case that organisational change and uncertainty create breeding grounds for role conflict, then there needs to be greater recognition of this fact by those who drive policy, so that CMHT working can develop in a more stable and supportive context, for example with increased funding and with less pressure to meet performance targets.

Word Count: 8,894

## **References**

- Anderson, N. & West, M.A. (1994). *Team climate inventory: Manual and user's guide*. Windsor: ASE.
- Bailey, D. (2012). *Inter-disciplinary working in mental health*. Basingstoke: Palgrave Macmillan.
- Bainbridge, L. & Purkis, M.E. (2011) The history and sociology of the health professions. Do they provide the key for new models of inter-professional collaboration? In S. Kitto, J. Chesters, J. Thistlethwaite, & S. Reeves (Eds.) *Sociology of inter-professional healthcare practice*. (pp 23-38). New York: Nova.
- Ballatt, J. & Campling, P. (2011). *Intelligent kindness: reforming the culture of healthcare*. London: RCPsych publications.
- Belling, R., Whittock, M., McLaren, S., Burns, T., Catty, J., Jones, I.R., Rose, D. & Wykes, T. (2011). Achieving continuity of care: Facilitators and barriers in community mental health teams. *Implementation Science*, 6, 1-7.
- Borrill, C. S., Carletta, J., Carter, A., Dawson, J. F., Garrod, S., Rees, A., ... & West, M. A. (2000). *The Effectiveness of Health Care Teams in the National Health Service*. Birmingham: of Aston in Birmingham.
- Brown, R., Condor, S., Mathews, A., Wade, G., & Williams, J. (1986). Exploring inter-group differentiation in industrial organisation. *Journal of Organisational Psychology*, 59, 273-86.
- Brown, B., Crawford, P. & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health & Social Care in the Community*, 8, 425-435.
- Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. (2003). Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health care. *British Journal of Social Work*, 33, 1081-1103.
- Colombo, A., Bendelow, G., Fulford, B. & Williams, S. (2003). Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science & Medicine*, 56, 1557-1570.
- Corrigan, P.W., Diwan, S., Champion, J. & Rashid, F. (2002). Transformational leadership and the mental health team. *Administration and Policy in Mental Health and Mental Health Services Research*, 30, 97-108.
- Crawford, P., Brown, B. & Majomi, P. (2008). Professional identity in community mental health nursing: A thematic analysis. *International Journal of Nursing Studies*, 45, 1055-1063.

Cross, R.L., Yan, A. & Louis, M.R. (2000). Boundary activities in boundaryless' organizations: A case study of a transformation to a team-based structure. *Human Relations*, 53, 841-868.

Davis, J.K. (2015). Supervision of peer specialists in community mental health centers: Practices that predict role clarity. *Social Work in Mental Health*, 13, 145-158.

Department of Health (1998). Modernising Mental Health Services, Safe, Sound and Supportive.

Retrieved from: [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003105](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003105)

Department of Health (1999) *National Service Framework for Mental Health*. London: Department of Health. Retrieved from: [www.gov.uk/government/publications/qualitystandards-for-mental-health-services](http://www.gov.uk/government/publications/qualitystandards-for-mental-health-services).

Department of Health (2007) Mental Health: New Ways of Working. Developing and sustaining a capable and flexible workforce. Retrieved from: [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_074495.pdf](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074495.pdf)

Department of Health (2007). Creating capable teams approach (CCTA): best practice guidance to support the implementation of new ways of working (NWW) and new roles. London: SO. Retrieved from: [http://webarchive.nationalarchives.gov.uk/20071104143416/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh\\_074501](http://webarchive.nationalarchives.gov.uk/20071104143416/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_074501).

Donnison, J., Thompson, A.R. & Turpin, G. (2009). A qualitative exploration of communication within the community mental health team. *International Journal of Mental Health Nursing*, 18, 310-317.

Dyer, J. & Hoffenberg, M. (1975). Evaluating the quality of working life. *The Quality of Working Life*. Vol 1. New York: Macmillan/Free Press.

Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

Elstad, T.A.& Hellzén, O. (2010) Community mental health centres: a qualitative study of professionals' experiences. *International Journal of Mental Health Nursing*. 19,110-118.

Fox, V. (2013). Professional roles in community mental health practice: generalist versus specialist. *Occupational Therapy in Mental Health*, 29, 3-9.

Francis R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary*. London: The Stationery Office.

Galvin, S.W. & McCarthy, S. (1994). Multi-disciplinary community teams: Clinging to the wreckage. *Journal of Mental Health*, 3, 157-166.

Goldberg, D. & Williams, P. (1978). *General Health Questionnaire (GHQ)*. Swindon, Wiltshire, UK: NFER- Nelson.

Gulliver, P., Peck, E. & Towell, D. (2002). Balancing professional and team boundaries in mental health services: pursuing the holy grail in Somerset. *Journal of Inter-professional Care*, 16, 359-370.

Haddow, M. (1995). Attitudes to community care: development of a questionnaire for professionals. *Journal of Mental Health*, 4, 289-296.

Hammersley, M. (1987). Some notes on the terms 'validity' and 'reliability'. *British Educational Research Journal*, 13,73-82.

Hannigan, B. & Allen, D. (2011). Giving a fig about roles: policy, context and work in community mental health care. *Journal of Psychiatric and Mental Health Nursing*, 18, 1-8.

Haslam, S. A., Ryan, M. K., Postmes, T., Spears, R., Jetten, J., & Webley, P. (2006). Sticking to our guns: Social identity as a basis for the maintenance of commitment to faltering organizational projects. *Journal of Organizational Behavior*, 27, 607-628.

Hyett, N., Kenny, A. & Virginia Dickson-Swift, D. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being*, 9.

Iqbal, N., Rees, M. & Backer, C. (2014). Decision making, responsibility and accountability in community mental health teams. *Mental Health Practice*, 17, 26-28.

Jaskyte, K. (2005). The impact of organizational socialization tactics on role ambiguity and role conflict of newly hired social workers. *Administration in Social Work*. 29, 69-87.

Johnson, J.M. (1997). Generalisability in qualitative research: excavating the discourse. In J.M. Morse (ed.) *Completing a Qualitative Project: Details and Dialogue*. (pp. 191-208). London: Sage.

KingsFund (2014) *Service Transformation: Lessons from Mental Health*. Retrieved from [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/service-transformation-lessons-mental-health-4-feb-2014.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf).

KingsFund.(2015) *Mental Health Under Pressure*. Retrieved from: [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/mental-health-under-pressure-nov15.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15.pdf).

Lankshear, A.J. (2003). Coping with conflict and confusing agendas in multidisciplinary community mental health teams. *Journal of Psychiatric and Mental Health Nursing*, 10, 457-464.

Lloyd, C., King, R. & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health*, 11, 255-265.

Maddock, A. (2015). Consensus or contention: an exploration of multidisciplinary team functioning in an Irish mental health context. *European Journal of Social Work*, 18, 246-261.

Malone, D., Newron-Howes, G., Simmonds, S., Marriot, S. & Tyrer, P. (2007) Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality. *Cochrane Database System Review*, 1, 1-39.

Mays, N. & Pope, C. (2000) Assessing quality in qualitative research. *British Medical Journal*, 320, 50.

McNeil, K.A., Mitchell, R.J. & Parker, V. (2013). Inter-professional practice and professional identity threat. *Health Sociology Review*, 22, 291-307.

McSherry, R. & Pearce, P. (2011). *Clinical Governance: A Guide to Implementation for Healthcare Professionals*. New Jersey, USA: John Wiley & Sons.

Merriam, S.B. (2009). *Qualitative Research: A Guide to Design and Implementation: Revised and Expanded from Qualitative Research and Case Study Applications in Education*. San Francisco, USA: Jossey-Bass.

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

Noble, H. & Smith, J. (2015). *Issues of validity and reliability in qualitative research*. *Evidence Based Nursing*, 18, 34-35

Onyett, S. & Ford, R. (1996). Multidisciplinary community teams: Where is the wreckage? *Journal of Mental Health*, 5, 47-56.

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

Onyett, S. & Campling, J. (2002). *Team Working in Mental Health*. Basingstoke, UK: Palgrave Macmillan.

Onyett, S. (2007). *Working Psychologically in Teams*. Leicester, UK: British Psychological Society.

Opie, A. (1997). Thinking teams thinking clients: issues of discourse and representation in the work of health care teams. *Sociology of Health & Illness*, 19, 259-280.

- Papastylianou, A., Kaila, M. and Polychronopoulos, M. (2009). Teachers' burnout, depression, role ambiguity and conflict. *Social Psychology of Education*. 12, 295-314.
- Peck, E. and Norman, I. J. (1999). Working together in adult community mental health services: exploring inter-professional role relations. *Journal of Mental Health*. 8, 231.
- Rabin, S., Feldman, D. & Kaplan, Z.E. (1999). Stress and intervention strategies in mental health professionals. *British Journal of Medical Psychology*. 72, 159-169.
- Reeves, S. & Mann, L.S. (2004). Overcoming problems with generic working for occupational therapists based in community mental health settings. *The British Journal of Occupational Therapy*, 67, 265-268.
- Rizzo, J.R., House, R.J. & Lirtzman, S. I. (1970). Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly*, 150-163.
- Royal College of Nursing (2014). Frontline first: turning back the clock? Mental health services in the UK. London: Royal College of Nursing. Retrieved from: [www.rcn.org.uk/newsevents/news/article/uk/rcn\\_warns\\_of\\_turning\\_back\\_the\\_clock\\_in\\_mental\\_health\\_care](http://www.rcn.org.uk/newsevents/news/article/uk/rcn_warns_of_turning_back_the_clock_in_mental_health_care)
- Rushmer, R. (2005). Blurred boundaries damage inter-professional working. *Nurse Researcher*, 12, 74-85.
- Sawyer, A.M. (2009). Mental health workers negotiating risk on the frontline. *Australian Social Work*. 62, 441-459.
- Schein, E. H. (1985). *Organisational culture and leadership*. San Francisco, CA: Jossey- Bass.
- Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.
- Simmonds, S., Coid, J., Joseph, P. & Marriot, S. Community mental health team management in severe mental illness: a systematic review. *The British Journal of Psychiatry*, 178, 497-502.
- Simpson, A. (2007). The impact of team processes on psychiatric case management. *Journal of Advanced Nursing*, 60, 409-418.
- Smith, J. A., Flowers, D. P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Thousand Oaks, CA: Sage Publications.
- Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5, 9-27.



Sorrells-Jones, J. & Weaver, D. (1999). Knowledge workers and knowledge-intense organizations, part 1: a promising framework for nursing and healthcare. *Journal of Nursing Administration*, 29, 12-18.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15, 215-228.

Yardley, L. (2008) Demonstrating validity in qualitative psychology. In Smith, J.A (Ed.) *Qualitative Psychology. A Practical Guide to Research Methods*. (pp.235-251). London: Sage.

Young, J. M., & Solomon, M. J. (2009). How to critically appraise an article. *Nature Clinical Practice Gastroenterology & Hepatology*, 6, 82-91.

Vize, C., Humphries, S., Brandling, J. & Mistral, W. (2008). New Ways of Working: Time to get off the fence. *The Psychiatrist*, 32, 44-45.

Wellin, M. (2014). Managing Culture change in the NHS: An overview. Implementing Culture Change within the NHS: Contributions from Organisational Psychology. Occupational Psychology in Public Policy (OPIPP) Group Report. Retrieved from [https://www.bps.org.uk/system/files/userfiles/Division%20of%20Occupational%20Psychology/public/17689\\_cat-1658.pdf](https://www.bps.org.uk/system/files/userfiles/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf)

West, M.A., Tjosvold, D. & Smith K.G. (Eds.). (2003). *International Handbook of Organizational Teamwork and Cooperative Working*. Chichester: John Wiley & Sons, Ltd.

Willshire, L. (1999). Psychiatric services: organising impossibility. *Human Relations*. 52, 775–804.

**Appendix 1. Critical Appraisal questions for Qualitative research**

CASP, (2013); Yardley (2000)

1. Is it easy to read and make sense of?
2. Is there a clear statement of the aims?
3. Is there adequate coherency?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collection method appropriate?
6. Is there adequate reflexivity?
7. Have ethical issues been taken into consideration?
8. Is there a clear statement of findings?
9. Is there sensitivity to context?
10. Does the study evidence transparency?
11. Does the study have transferability?
12. Does it have adequate rigour?

**Appendix 2: Critical Appraisal for Quantitative research**

CASP, (2013); Young & Solomon, (2009)

1. Is the study question relevant?
2. Does the study test a stated hypothesis?
3. Is the study design appropriate for the research question?
4. Was the recruitment strategy appropriate?
5. Is the sample representative?
6. Have the measurements been validated?
7. Are statistical analyses performed and presented correctly?
8. Are confounding variables taken into account?
9. Are the results precise and believable?
10. Are the results generalizable?
11. Have ethical issues been taken into consideration?
12. Does the research clearly define its clinical implications and contribution to the field?

**Appendix 3. Table 2. Responses to critical appraisal checklist (Qualitative)**

| Studies                 | Q1 Is it easy to read and make sense of? | Q2 Is there a clear statement of the aims? | Q3 Is there adequate coherency? (i.e. fit between theory and method) | Q4 Was the recruitment strategy appropriate? | Q5 Was the data collection method appropriate? | Q6 Is there adequate reflexivity? (i.e. has the relationship between researcher and participant been adequately considered) | Q7 Have ethical issues been adequately considered? | Q8 Is there a clear statement of findings? | Q9 Is there sensitivity to context? (i.e. theoretical and socio-cultural context/ perspectives of participants been taken into account) | Q10 Does the study evidence transparency? (i.e. clarity in presentation of methods and analysis) | Q11 Does it have transferability? (i.e. is sufficient contextual data included to enable reader to transfer to other situations) | Q12 Does the study have adequate rigour? (i.e. triangulation, verification checks, etc.) | Quality Index Score |
|-------------------------|--|--|--|--|--|---|--|--|---|--|--|--|---------------------|
| 1 Norman & Peck (1999)  | Yes                                      | Yes  | unable to determine  | unable to determine                          | yes  | no  | No   | Yes  | unable to determine   | no   | no   | no   | 33%                 |
| 2 Peck & Norman (1999)  | Yes                                      | Yes  | unable to determine  | unable to determine                          | yes  | no  | No   | Yes  | unable to determine   | no   | no   | no   | 33%                 |
| 3 Brown et al (2000)    | Yes                                      | Yes  | Yes  | yes  | yes  | no  | No   | Yes  | Yes   | yes  | no   | no   | 66%                 |
| 4 Gulliver et al (2002) | Yes                                      | Yes  | unable to determine  | no   | yes  | no  | No   | Yes  | unable to determine   | no   | no   | yes  | 41%                 |
| 5 Lankshear (2003)      | Yes                                      | Yes  | unable to determine  | yes  | yes  | no  | No   | Yes  | unable to determine   | yes  | no   | yes  | 58%                 |
| 6 Simpson (2007)        | Yes                                      | Yes  | unable to determine  | yes  | yes  | no  | Yes  | Yes  | unable to determine   | yes  | no   | yes  | 66%                 |
| 7 Donnison et al (2009) | Yes                                      | Yes  | Yes  | yes  | yes  | no  | No   | Yes  | unable to determine   | yes  | no   | No   | 58%                 |
| 8 Elstad & Hellzen      | yes                                      | Yes  | yes  | No   | yes  | no  | yes  | Yes  | Yes   | yes  | no   | yes  | 66%                 |

Impact of organisational change

|    |                      |     |     |                     |     |     |    |     |     |                     |     |    |     |     |
|----|----------------------|-----|-----|---------------------|-----|-----|----|-----|-----|---------------------|-----|----|-----|-----|
|    | (2010)               |     |     |                     |     |     |    |     |     |                     |     |    |     |     |
| 9  | Belling et al (2011) | Yes | Yes | unable to determine | No  | yes | no | Yes | Yes | unable to determine | no  | no | No  | 41% |
| 10 | Hannigan (2011)      | Yes | Yes | unable to determine | Yes | yes | no | no  | Yes | unable to determine | no  | no | no  | 41% |
| 11 | Maddock (2015)       | Yes | Yes | Yes                 | Yes | yes | no | no  | Yes | unable to determine | yes | no | yes | 66% |

**Appendix 4. Table 3. Responses to critical appraisal questions (Quantitative)**

|    | Study                     | Q1 Is the study question relevant? | Q2 Does the study test a stated hypothesis? | Q3 Is the study appropriate for the research question? | Q4 Was the recruitment strategy appropriate? | Q5 Was response rate high enough for sample to be representative? | Q6 Have the measurements been validated? | Q7 Are statistical analyses performed and presented correctly? | Q8 Are confounding variables taken into account? | Q9 Are the results precise and believable? | Q10 Are the results generalizable? | Q13 Have ethical issues been taken into consideration? | Q15 Does the study clearly define its clinical implications and contribution to the field? | Quality Index Score |
|----|---------------------------|------------------------------------|---|--|--|---|--|--|--|--|------------------------------------|--|--|---------------------|
| 12 | Carpenter (2003)          | Yes                                | Yes   | Yes  | Yes  | No  | Unable to determine                      | Yes  | No   | Yes  | No                                 | No   | Yes  | 58%                 |
| 13 | Larkin & Callaghan (2005) | yes                                | No  | Yes  | Yes  | Yes   | Unable to determine                      | Yes  | No   | Yes  | No                                 | No   | Yes  | 58%                 |

**Key:**

**Yes = 1 point**

**No = 0 point**

**Unable to determine = 0 point**

## **Appendix 5. Author Guidelines for submission to Journal of Interprofessional Care.**

Manuscript submission guidelines (for chapter one), retrieved from:

[http://www.tandfonline.com/action/authorSubmission?journalCode=ijic20&page=instructions#.Vx8V\\_fkrK00](http://www.tandfonline.com/action/authorSubmission?journalCode=ijic20&page=instructions#.Vx8V_fkrK00)

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read them and follow the instructions as closely as possible.

Should you have any queries, please visit our Author Services website or contact us at [atauthorqueries@tandf.co.uk](mailto:atauthorqueries@tandf.co.uk).

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

### **Electronic Submission**

Manuscripts for consideration should be submitted online via the Journal's ScholarOne Manuscripts website.

Manuscripts must be written in English and should be double spaced and use 12-point font. The main document, title page, and any tables/figures/boxes should each be submitted as separate files. The main document that will be sent for review should contain no identifying information. The title page, submitted as a file not for review, should include the title of the paper, author names, work titles and affiliations; contact information (email, mailing address, telephone number), keywords and running head. Manuscripts should be prepared in accordance with American Psychological Association's (APA) guidelines – see below for further details. On receipt of the submission, all listed authors will be immediately acknowledged by email.

All submissions are assessed initially to determine their suitability for publication in the *Journal of Interprofessional Care*. An email will be sent to the authors, usually within 3 to 4 weeks, if a manuscript is considered not suitable for publication. Manuscripts that are assessed as having potential for publication are sent, with no identifying author information, to peer reviewers.

The Journal's editors oversee the process of peer review: they correspond with authors and make decisions on the submitted papers. Following the receipt of the reviewer's comments, editors will make one of the following decisions: publication without revision; publication after minor revisions, publication after major revisions or rejection. A manuscript may need to undergo a number of revisions prior to a final acceptance. Accepted papers may also be edited to meet certain standards on presentation and structure. Authors can track the progress of their manuscript on the ScholarOne Manuscripts website.

The following issues must be addressed by authors submitting manuscripts to the *Journal of Interprofessional Care*:

- All submissions to the Journal must include full disclosure of relationships that could be viewed as presenting potential conflicts of interest. If there are no conflicts of interest, authors should state that there are none. (See Declaration of Interest section, below, for further details about disclosing this information.)
- All research submissions should include information about approval by the relevant research ethics board within the text of the paper.
- All authors must comply with the following policies on Authorship, Submissions, Plagiarism and Peer Review; Clinical Trials Registry; and Copyright and Submissions.
- Authors should provide clear and consistent terminology in their paper (see below).

### **Types of Manuscripts Accepted**

The *Journal of Interprofessional Care* publishes the following:

1. Peer-reviewed Original Articles (research studies, systematic/analytical reviews, theoretical papers) that focus on interprofessional education and/or practice, and add to the conceptual, empirical or theoretical knowledge of the interprofessional field.
2. Peer-reviewed Short Reports that describe research plans, studies in progress or recently completed, or an interprofessional innovation.
3. Peer-reviewed Interprofessional Education and Practice Guides that offer practical advice on successfully undertaking various interprofessional activities.
4. Non-peer-reviewed Guest Editorials that discuss a salient issue related to interprofessional education and practice.
5. Non-peer-reviewed Book and Report Reviews that offer summaries of recently published books and reports (published on the Journal's Blog).

### **Original Articles**

These papers should usually have no more than 8,000 words (including abstract, main text and references). The total number of words should be indicated in the ScholarOne

Manuscripts system during the online submission process. Authors wishing to submit manuscripts that exceed 8,000 words should contact the Editor-in-Chief before submission.

#### Abstract

The abstract should be written in paragraph form (not structured with sub-headings) and describe the main elements of the manuscript using no more than around 300 words.

#### Keywords

4-6 keywords, that address both methodological and content areas, should be selected. Keywords should be listed both in ScholarOne Manuscripts system during the submission process and on the title page.

#### Manuscript text

The text should be divided into sections with the headings: Introduction, Background, Methods (with sub-headings on Methodology/Research design, Data collection, Data analysis, and Ethical considerations), Results/Findings, Discussion (including a discussion of limitations) and Concluding comments. However, these headings may be altered depending upon the type of work being presented. Formatting of headings and subheadings should follow APA style. References should be APA style as noted below.

#### Tables, Figures and Boxes

Tables, figures and boxes should be referred to in text as follows: Table 1, Table 2, Figure 1, Figure 2, etc. The location at which a table, figure or box is to be inserted in the text should be indicated clearly on the manuscript. Each table/figure/box must have a descriptive title that explains its purpose. Each table/figure/box must be uploaded separately from the main document. Tables and boxes are considered textual and should be included in a format compatible with MS Word.

#### Illustrations

Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- sized to fit on journal page
- EPS, TIFF, or PSD format only

If embedded in text files, please check figure resolution.

Color art will be reproduced in color in the online publication at no additional cost to the

author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if print reproduction costs are paid. Print Rates: \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

#### Footnotes

If necessary, footnotes can be included in a manuscript. Number all text footnotes consecutively throughout the manuscript and compile them on a separate page at the end of the manuscript.

#### Appendices

While the journal may publish one or two short appendices, longer appendices can be published online if the authors supply a URL (website address) where readers can locate them.



**Chapter 2: Research report**

**The impact of organisational change on professionals working within a  
Community Mental Health Team (CMHT): A psychodynamic perspective.**

***Abstract***

The aim of this study was to use a psychodynamic perspective to explore and analyse the effects of organisational change upon staff working in a Community Mental Health Team (CMHT). A grounded theory (Glaser & Strauss, 1967) methodology was employed to analyse data obtained from eight interviews with a range of staff members. Analysis of the data identified one core category and five key categories. 'Corroding good work: an ethos in decline' represents the core category and refers to the staff members' sense of demoralisation of their professional values and integrity. The first key category, 'System reform,' refers to staff members' perception of cultural change within the CMHT with an increased emphasis on regulation, performance management and proceduralisation. Three further key categories were identified, which described unconscious defences and were labelled 'Caring clinicians and uncaring managers', 'Contesting professional spaces', 'Disconnecting and isolation'. The fifth key category is titled 'Consequences' and describes the impact of the working culture. The findings of this study identify a need for better management practice, support, training and supervision of staff are essential and staff's health and needs are the foundation of safe practice.

**Key words:** CMHT, organisational change, staff, social defences.

### ***Introduction***

The recent Francis Report (Francis, 2013, p. 13) highlighted a large number of errors, omissions and abuses taking place within the Mid Staffordshire Hospital Trust. The report stated that an “unhealthy and dangerous” culture existed within the Trust whose effects included “a lack of openness to criticism, a lack of consideration for clients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions about the judgements and actions of others, and acceptance of poor standards”. In the wake of this report, it is imperative to inquire into the contexts and causes of dysfunctional organizational dynamics within the NHS. Staff stress, intergroup conflict (denigrating an ‘outgroup’) and feelings of disgust experienced by staff towards clients are said to be factors that could have influenced the culture of care at Stafford (Whitby & Gracias, 2013). It is also highly likely that organisational change (the Trust was attempting to obtain foundation status at the time), may have had an impact upon the working culture. Wren (2014, p.19) acknowledges that the NHS is not able to “contain” or manage the anxieties of the staff when she states “currently, the organisational culture in the NHS often produces insecurity and competition without adequate containment, thereby reducing safety, increasing anxiety and fear and disabling learning.” Previous research has identified the detrimental effects of organisational change on health staff teams and working practices including increased absenteeism, poor health, increased stress, poor psychological functioning, and low morale (Durdy & Bradshaw, 2014; Hashmat, Upthegrove & Marzanski, 2015 King & Anderson, 1995; Stokes, 1994). Powell & Morris (2001) acknowledge that such personal experiences of organisational change can indicate problems at a structural level and the Berwick review (2013, p.9) linked staff anxiety with client safety, stating “fear is toxic to both safety and improvement.”

Whilst the impact of organisational change on health staff has been investigated in previous studies, this study provides a new perspective on the subject matter, in that it seeks to explore and analyse the effects of organisational change upon staff working in community mental health settings, drawing upon a psychodynamic understanding of organisational behaviour. The psychodynamic model originates in Freud’s (1900) work on psychoanalysis and the unconscious (those thoughts and feelings that occur out of conscious awareness). This study incorporates the work of

others who extended this model such as Melanie Klein (1946) with her theory of object relations. The term 'object' refers to the other person to whom someone relates. A core assumption of Kleinian theory is that from an early age, the young infant employs various psychological defences as a means of avoiding painful or threatening intense emotions, terrors and fears. The young infant is considered to be at a stage of development when they can only relate to part-objects; they are incapable of perceiving the mother as a whole person and cannot integrate intense conflicting feelings of love and hate. Therefore, the young child will employ the mechanism of 'splitting' in order to protect themselves and relieve anxiety, by keeping separate feelings of love and hate for different aspects of external objects. As the child matures they learn how it is possible to experience both emotions simultaneously and cope with this ambiguity, thereby making a transition to a level of whole-objects. However, when faced with extreme anxiety which they cannot tolerate, individuals may return to the earlier process of 'splitting' their reality into 'good' and 'bad'. The individual 'projects' (assigns) their own feelings of love and hate into others, creating hated or idealised figures and thus maintaining a state of illusory self-idealisation. Although these defences are necessary for survival, they are unconscious and take place without the individual's awareness. Whilst these ideas were originally applied in relation to individual psychology, they are also relevant for groups and organisations and many of the aspects of team working can be explained by unconscious group processes and 'social defences' (Obholzer, 1994). Ballatt & Campling (2014, p.73) also state that unconscious processes influence many aspects of group working, suggesting that people bring "conflicting needs and desires to groups" and that the way in which these are managed can determine how the group interacts. Psychodynamic thinking offers a unique contribution to understanding these group dynamics as it provides a means of analysing unconscious processes and explaining to what extent a team's behaviours are shaped by unconscious defence mechanisms such as denial, splitting, and projection.

The concept of 'social defence' was originally developed by Elliot Jaques (1953, cited in Whittaker, 2011, p.482) to 'refer to unconscious collusions or agreements within organisations to distort or deny those aspects of experience that give rise to unwanted emotion.' This idea was further developed by Menzies Lyth (1959) who

revealed how anxiety around working with vulnerable and sick clients led to the creation of social defences by nurses which became institutionally embedded. The study identified a number of working practices involved in social defences, such as strict routines, division of labour, the idealization of the professional, ‘detachment’ of nurses from the deaths of clients, and the use of identification numbers for clients. Menzies-Lyth (1959) maintained that such practices provided protection for workers against their anxieties whilst simultaneously reducing their emotional investment in clients and resulted in a depersonalised approach to the work. Furthermore, she observed the way in which senior staff tended to respond in a critical and unsupportive manner, often deriding other staff members as irresponsible and responding with strict and repressive discipline. Increased levels of doubt and job dissatisfaction amongst the nurses resulted in high staff turnover, which further destabilised close and effective working relationships with other staff members.

Following the work of Menzies-Lyth, seems to be largely accepted (Hinshelwood & Skogstad, 2000; Rizq, 2011, 2012a; 2012b; 2013; Ballatt & Campling, 2014) that working in health services frequently arouses anxiety, pain, and confusion and has a profound conscious and unconscious impact on staff. This form of work is extremely emotionally demanding for staff, frequently triggering difficult feelings of guilt, blame, dependency and vulnerability (Obholzer, 1994). Hinshelwood and Skogstad (2000) outline the way that organisations are shaped by anxiety and defences. Firstly, specific kinds of anxiety arise from particular types of work, such as health care, where anxieties arise around vulnerability and mortality. Secondly, people cooperate in order to defend against this anxiety, ‘by developing shared, socially required defensive attitudes’ towards the work environment and performing the tasks in certain ways (Hinshelwood and Skogstad, 2000, p.4). If these maladaptive social defences are left unexamined they can have a detrimental effect on clinical practice (Hinshelwood, 1989; Jaques, 1953; Menzies-Lyth, 1959). Furthermore social institutions have been shown to represent containers for societal anxieties regarding life and death. The NHS ‘‘is used as a receptacle for the nation’s projections of death, and as a collective unconscious system to shield us from the anxieties arising from an awareness of illness and mortality.’’ (Obholzer, 1994, p.171). Whilst Rizq (2011, p. 41) maintains that mental health services ‘defend us from overwhelming

anxieties relating to psychological vulnerability, dependence, fragility and deeper fears of madness and loss of control.’

Since Menzies-Lyth’s (1959) study, only a small number of researchers have employed a psychodynamic perspective to understand the functioning of mental health professionals within the NHS. Hinshelwood and Skogstad (2002) used an observational method to explore dynamics and defensive techniques within a mental health hostel and a medical ward. Their study highlighted a number of defensive techniques utilised by staff in order to distance themselves from their clients, enabling them to ‘disavow’ (or protect themselves from) any tension or anxiety within their work. For instance they described the way members of staff developed a high degree of flirtatiousness and excitement in their interactions with each other, which enabled them to free themselves from the pain and suffering of the clients around them. Morante (2005) described a system of psychological defences which protected ward staff from anxieties elicited by their work with clients with acute anorexia. For instance, engaging in more functional tasks such as serving meals and weighing clients diverted the nurses from becoming involved in the more therapeutic (and emotive) role of individual key working.

Kurtz (2001) explored organisational defences used by staff groups working in forensic mental health settings. She described how the staff experienced anxiety not only in response to the real threat of danger from the client group they worked with but also relating to professional survival in the context of an ‘inquiry culture’ (Kurtz, p.71). Practitioners working in this setting were experiencing significant criticism from a number of government inquiries into forensic services which cited incompetent staff and faulty organisational structures as the reasons for poor standards of service and thus created further working pressure for staff. The author described a number of organisational dynamics evident in the unit, including ‘moralism and the defensive use of the medical model’ which referred to the way in which staff over-relied on the medical model as a way of distancing themselves from clients, and projected their own feelings of ‘madness and badness’ into the clients. ‘Protectionism and Machismo’ referred to the superficially confident and controlling working culture which compensated for underlying feelings of powerlessness and ‘flight from thought’ which described staff’s reluctance to

reflect on practice. Kurtz concludes that these defences were the consequences of staff attempts to carry out their work in the face of significant pressure resulting from powerful and unrealistic projections from health service managers and society as whole.

Rizq (2011; 2012a; 2012b) uses organisational case examples to explore unconscious defence mechanisms within a recently introduced IAPT (Improving access to Psychological Therapies) service. The author proposes that IAPT services systematically refute feelings of loss and vulnerability in both staff and clients through three processes: firstly by the promotion of a consumerist ethos and patient choice agenda, secondly the deployment of discourses which minimise notions of fragility and dependence, and thirdly through the proliferation of bureaucratic and surveillance systems which monitor and evaluate staff and clinical activity. Rizq (2013) suggests that these preoccupations with regulation, surveillance and governance in mental health institutions may be understood as symbolic attempts to obtain mastery over feelings of disgust and fear attendant upon working with unwell people.

All of these studies have offered interesting insights into the unconscious dynamics experienced by a range of staff working within the NHS. This study will build on these findings by using a psychodynamic perspective to explore the organisational dynamics specifically of secondary care within a CMHT during a time of organisational change. Ballatt & Campling, (2014) have argued that in contrast to the NHS of the 1950s, about which Menzies-Lyth (1959) reported a near absence of change, currently within the NHS constant change works as a social defence system. The implementation of incessant changes keeps at bay “existential anxieties associated with the uncertainty of sickness, pain and death” (Ballatt & Campling, 2014, p.131). The coalition government’s Health and Social Care Act (2012) implemented further organisational changes within the NHS. Its wider context is the economic crisis and governmental drive towards cutting public expenditure on the NHS, both of which contribute to a backdrop of uncertainty and anxiety for professionals involved in this study. Rizq (2011) acknowledges that although organizational change can encourage the possibility of creativity, through the development of new ideas and innovative services, higher levels of risk and

uncertainty and the loss of familiar ways of working as a consequence of change frequently lead to increased anxiety.

It is intended that this study will provide some insights into the unconscious defences used by the professionals working within a Community Mental Health Team (CMHT), with a view to enabling them to work positively within the context of effective provision of services. Anxiety resulting from loss and change can obstruct the effective functioning of staff teams and services (Powell & Morris, 2001). By gaining an increased understanding of the impact of the current organisational changes on professionals, the author of this study hopes to identify ways in which management may employ helpful strategies to ensure that this anxiety is contained, thereby promoting a supportive working culture and allowing staff to work more positively, preventing the likelihood of stress or burnout.

***Aims:***

To use a psychodynamic perspective to explore the impact of organisational change in institutions on mental health professionals working in a Community Mental Health Team (CMHT). The study will examine the ways in which individuals cope with the pressure to change and manage the anxieties that may result from the change process. The study will examine how professionals perceive and adjust to accommodate alterations to services.

***Objectives:***

To explore the ways in which organisational change is linked to anxiety.

To identify ways in which anxiety is evident in 'social defences' (see above).

To inform ways of managing change compatible with mitigating the effects of social defences on mental health professionals, enabling teams to work positively within the context of organisational change.

***Research Question:***

How do mental health professionals experience the impact of organisational change?



### ***Methodology***

As this study aimed to undertake an exploration of mental health professionals' experiences of organisational change, using a qualitative methodology, this offered a means of "paying close attention to process and unique variation, ethical and interpersonal issues, meaning, context and culture" (Yardley, 2000, p. 215). A grounded theory (Glaser & Strauss, 1967) methodology was considered most appropriate for this study as it was originally designed to study social processes such as this study is intending to explore (Charmaz, 2014; Strauss and Corbin, 1998). Grounded theory is influenced by symbolic interactionism (Blumer, 1969; Mead, 1934) which considers meanings as originating from interaction and social discourse: the particular culture in which the individual is immersed; "self-interaction is interwoven with social interaction and influences social interaction", (Blumer, 1969, p.153).

Grounded theory is considered a diverse method which can be used to study a variety of processes including individual, interpersonal and social relations (Charmaz, 2008). In addition, grounded theory methodology has been used previously in similar studies which have explored staff experiences within an organisational context (Kurtz & Jeffcote, 2011).

In earlier objectivist versions of grounded theory methodology, through the process of data analysis an external reality is thought to be discovered. In contrast, the constructivist grounded theory approach recognises multiple realities and data are considered a co-construction between researcher and participant. Reflexivity, therefore, is integral to this process. This was more in keeping with the author's epistemological position. Although there is a difference in the epistemological positions of psychodynamic approach and grounded theory, Anderson (2006, p.331) maintains they are a "well-suited partnership" and demonstrates how they can be combined effectively for the analysis of qualitative data.

### ***Sampling***

Theoretical sampling was used to recruit participants to the study. Eight participants were recruited to the study in adherence to the recommendations set out by grounded

theorists (Charmaz, 2008) and the guidance for good standards of qualitative studies used for clinical psychology theses (Turpin et al., 1997).

### *Ethics*

Ethical approval was granted by Staffordshire University's Faculty of Health Sciences Ethics and Peer Review Panel (appendix one). In addition, research and development approval was granted by the relevant NHS Trust (appendix two). Information sheets were used to provide participants with a good level of understanding of the rationale of the study and their role within it (appendix three). Informed consent was obtained prior to taking part in the interview (appendix four). Transcripts were typed and saved onto word files and all names and identifying features were removed. Participants were provided with the opportunity to remove any of their comments following transcription of the data files which they did not wish to be included or feared may identify them or others. Following transcription all digital files were deleted immediately.

### *Data Collection*

The researcher presented information regarding the project at a CMHT meeting in order to elicit expressions of interest. Those attending the meeting were informed of the nature of the study and provided with a copy of the participant information sheet. Due to low attendance, the sheet was also sent to other members of the CMHT to generate wider interest. In any follow up contact, the participants were provided with a fuller explanation of the study, the researcher made arrangements to obtain written informed consent prior to conducting face to face interviews. Data was collected in the natural context, i.e. taking place within the work environment of the participants and all interviews lasted approximately forty five minutes to an hour. The interviews were recorded using a digital audio recorder.

### *Semi-structured Interviews*

Interviews are the means by which clinicians using psychoanalytic approaches uncover and reflect on unconscious processes with their individual clients. In the constructivist version of grounded theory research interviews are recognised as a co-construction of reality and represent “a site of exploration, emergent understandings, legitimisation of identity, and validation of experience,” (Charmaz, 2014, p.91). Thus

by utilising interviews, the researcher of this study intended to identify unconscious processes through interpretation of the underlying meanings of the spoken words of the participants, in order “to see behind what is being said or done to what is unconscious or implicit, to understand it, to open it up and explore it...” (Menzies Lyth, 1990, p.464)

In accordance with the grounded theory methodology, (Wimpenny & Gass, 2000), the direction of the interviews was guided by the emerging theory. In accordance with the theoretical sampling approach, data was gathered strategically, analysing previous data before gathering more. From preliminary analysis of data gathered, categories, themes and commonalities emerged which then influenced subsequent selection of participants and questions asked in interviews during data collection (appendix five: amended interview schedule). It was intended that this approach would reinforce and bring to ‘saturation’ point the most prominent themes. Saturation is a process itself guided by the researcher’s developing theoretical understanding and reached when “new data no longer sparks new insights,” (Charmaz, 2008, p.106).

### *Participants*

Eight participants were recruited to the study; all were mental health professionals currently employed by the NHS and working within a Community Mental Health Team but ranging in gender, occupation and length of time employed in the service.

**Table 1.**showing demographics of participants

| <b>ID</b> | <b>Job Role in CMHT</b>         | <b>Gender</b> | <b>Length of service within CMHT</b> |
|-----------|---------------------------------|---------------|--------------------------------------|
| 1         | CMHN                            | Female        | 9 years                              |
| 2         | CPN                             | Female        | 19 years                             |
| 3         | Cognitive behavioural therapist | Female        | 18 months                            |
| 4         | Cognitive behavioural therapist | Male          | 2 years                              |
| 5         | Psychiatrist                    | Male          | 17 years                             |
| 6         | Social worker                   | Male          | 10 years                             |
| 7         | CMHN                            | Female        | 7 years                              |
| 8         | Clinical Psychologist           | Female        | 8 years                              |

### ***Analysis***

A systematic procedure of grounded theory as outlined by Charmaz (2014) was used to analyse the data. Coding is considered the “pivotal link between collecting data and developing an emergent theory to explain these data” (Charmaz, 2008, p.92). Two stages of coding procedures were employed to enable the analysis of the data with the aim of developing a theory. Initial coding comprised fracturing the data into words, sentences and phrases, comparing the various components for any differences and similarities and naming them in succinct terms. At this formative stage the aim was to remain close to the original words of the participants, staying open to all theoretical possibilities and attempting to identify provisional distinct concepts amongst the data which could be considered representative of basic units of analysis. Gerund (a verb form which functions as a noun e.g. reading) and in vivo coding were employed at the initial stage (see appendix eight for example of initial coding of one transcript). The use of gerunds for line by line coding (Glaser, 1978) is a recommended heuristic device which allows the researcher a more in depth relationship with the data. In vivo coding is the incorporation of the participants’ original phrases and ensures the participant’s meaning is preserved. The constant comparative method was used at this point of analysis to form links and observe differences between categories firstly at different points within the same transcript and then across the data set, between different interviews. The second stage of analysis comprised focused coding, whereby the researcher condenses the analysis into those codes which hold more significance or emerge more frequently in the data (see appendix nine). At this stage, there is a theoretical advancement of the analysis, as the codes are given a conceptual definition which lifts the code from being merely a “descriptive tool” to a means of synthesising the data (Charmaz, 2008, p.98).

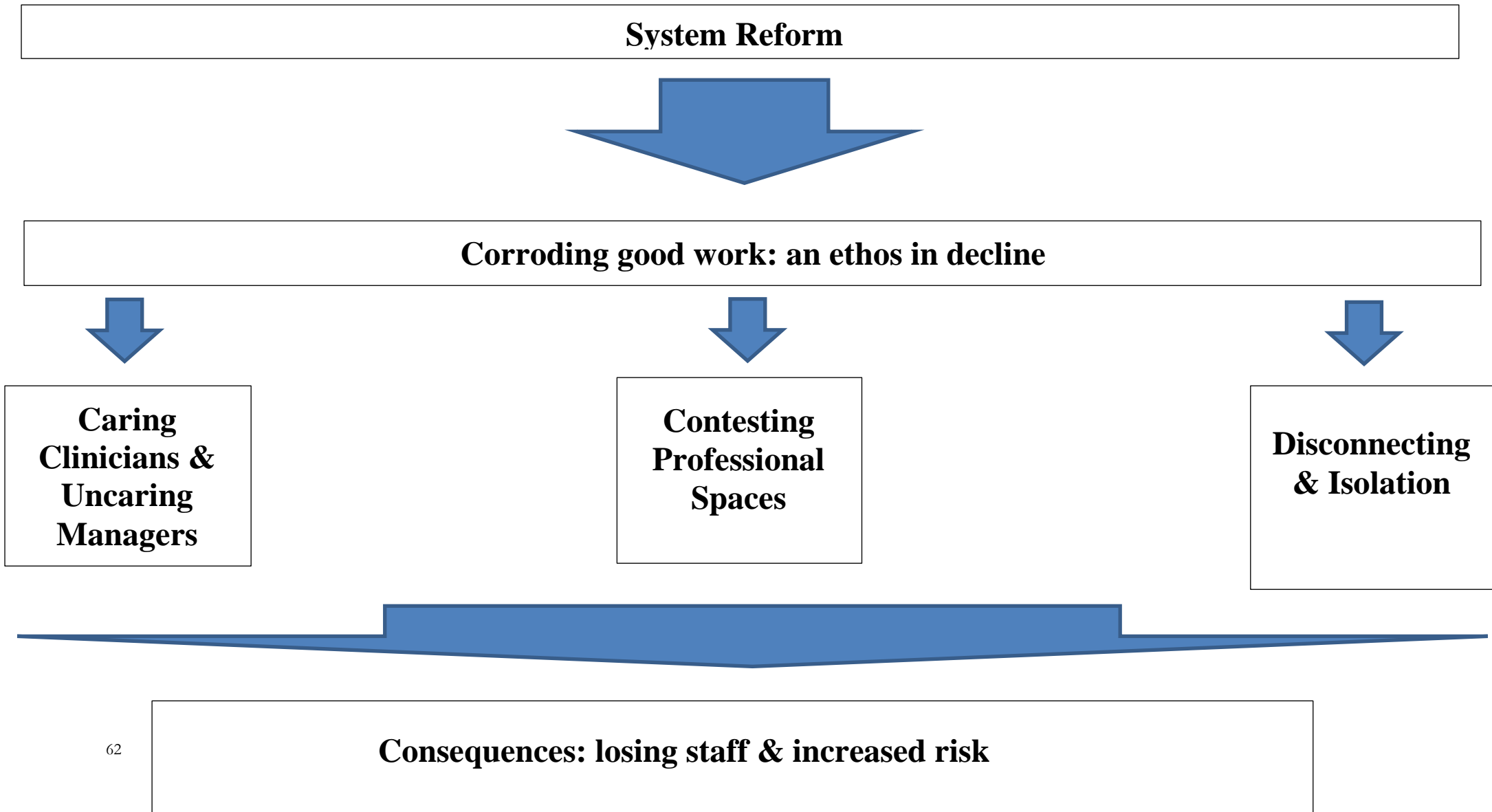
According to Tweed & Charmaz (2012), memo writing in grounded theory provides an audit trail of the decision-making process the researcher undertakes. Memos represent a bridge between the stages of data collection and write up, providing the researcher with the space to explore and analyse ideas regarding codes, “constructing analytic notes to explicate and fill out categories” (Charmaz, 2014, p.163). Memos represent an essential part of the process of theoretical sampling by indicating any gaps in the data and thereby guiding the direction in which to take the study. For instance, through the writing of memos in this study it became apparent

that the voice of the psychologist on the team was missing, who was then recruited (appendix ten). A process of theoretical sorting of memos and codes was undertaken by the researcher (appendix eleven) which enables the integration of categories. A model was produced which illustrated the relationship between the formed categories (see figure one below) and from this the analysis was written up.

### ***Results***

Analysis of the data identified one core category and five key categories in the form of a model (see below for diagrammatic illustration in figure one). The core category, 'Corroding good work: an ethos in decline' refers to the staff members' sense of demoralisation of their professional values and integrity. The first key category, 'System reform' refers to the perception of cultural change within the CMHT with an increased emphasis on regulation, performance management and proceduralisation. In response to the conflict experienced by professionals and the anxieties it generates, three unconscious defences, were identified and labelled as the key categories; 'Caring clinicians and uncaring managers', 'Contesting professional spaces' and 'Disconnecting and isolation'. The fifth key category is titled 'Consequences' and describes the impact of the working culture.

**Figure 1. Model of categories**



## ***Categories***

### **1. *'Corroding good work: an ethos in decline'***

This core category refers to the sense professionals had that the values and ethos previously associated with the service were being eroded. Evident from this study was the 'fantasy' of the NHS as the bearer of communal values; whereby society has projected the 'good' into the concept of an organisation based on principles of kinship and fairness in order to support the vulnerable and sick. This core category encapsulates the sense that the NHS as an organisation is an omnipresent benevolent force and repository of society's 'good' feelings:

*'It is about the service, the NHS as a philosophy, here I can go to the GP any time I want to and I don't have to pay a penny and that is such a fantastic system, I really believe in it.'* (ID8)

The clinical work professionals do with clients is perceived as representative of this and is viewed as the primary task of the organisation:

*'...the most important thing is seeing people and making sure that you're doing a good job with them,'* (ID4)

However, the analysis revealed that staff perceives the shift in priorities away from the clinical, therapeutic work as dismantling this ethos and undermining the concept of 'good work'. There was a strong acknowledgement by staff that the mental health difficulties people were bringing into clinics were the social consequences of austerity and that this number was increasing:

*'...people being transferred from DLA, from disability living allowance to personal independence payment or support allowance being rejected so a whole host of issues that are impacting on people's mental health in every area of life.'* (ID6)

Although people approved of the transfer of mental health services out into the community, there was a sense that the resources and facilities were no longer there to provide adequate levels of care for people. The significant gap that was emerging

between what could be provided and the level of expectation was expressed by individuals:

*‘Yeah, we’re going to make the whole of the country into happy healthy people. I don’t know how it’s going to happen. And we set up people with this expectation that that’s what we’re all going to be but the reality is far from it.’ (ID2)*

A number of participants expressed their sense of frustration and also guilt at not being able to provide the care that they were aware many of their clients required. There was a sense that they had become the agents of austerity, enforcing cuts and a harsher regime:

*‘...now we can only offer a certain amount of sessions ... so I find myself saying ‘sorry I can’t, we can’t give you any more than that’... and I am saying that ‘I am sorry, don’t shoot the messenger,’ (ID3)*

There was recognition by one participant that the culture had undermined staff core values and professional selfhood:

*‘It’s a threat to your professional integrity and that’s devastating’ (ID8)*

## **2. System reform**

This category refers to the culture shift described by staff members who noted a significant increased emphasis on regulation, performance management and proceduralisation in their work. There was a lack of human feeling evident in the participants’ descriptions of their daily tasks. Frequently participants referred to their work in terminology associated with mechanical processes:

*‘Sometimes you just feel like you are getting on with it like a robot, I don’t think it’s sustainable for any organisation really, especially when working with a team.’ (ID1)*



Many participants referred to the constant recording and monitoring of activities. In the following description, the sense of competitive drive between professionals in reaching these targets is clearly evident:

*'We're sort of all named on the sheets and you see other colleagues who are maybe 100% but there are always reasons as to why you can't meet those targets.... personally I think we all strive to try and beat 100%.'* (ID6)

Similarly participants voiced frustration at the increasing standardization and regulation that was being imposed on clinicians, as in this quotation the speaker describes the limited power the clinician has in the choice of appropriate therapeutic intervention for clients:

*'I guess everything has become more package orientated...people are being forced to fit into therapies that are perhaps not ideal for them'* (ID5)

Nearly all the participants reported feelings of conflict between trying to meet the increasing pressure of paperwork and computer work versus actually seeing clients and providing therapeutic intervention. There was a sense of frustration at being 'pulled away' (ID3) from actual contact with clients, not having time to do what they perceived as the important clinical work and instead feeling that priority was placed on the completion of menial tasks or attending meetings.

*'We will get asked 'Why haven't you done the CHIPS? Why's your care plan not there? 'Why have the CQUINS not been done? Why's the piece of paper not in that place?' and all the rest of it. Well actually, when somebody's just walked in, in a state of distress, that's what you're dealing with...That's a struggle all of the time.'* (ID2)

One participant expressed a feeling of being overwhelmed by the level of admin tasks they were expected to do and a fear of how this was impacting on their clinical work; they described the sensation as 'spinning plates, just waiting for one to drop off' (ID1). Another participant voiced a reluctance to see clients if they were not acute as they would experience a 'penalty in paperwork' (ID5).

Numerous participants reflected that the emphasis on the completion of paperwork and meeting targets rather than on client care was similar to the failures at Mid-Staffordshire:

*'The focus again is on the payments by results rather than the service we are trying to provide' (ID1)*

### **3. Caring clinicians and uncaring managers**

Many participants emphasised their perception of a divide in priorities between management and clinicians. There was a sense that clinicians had the client's care as their major concern and that there was a shared common purpose to provide treatment to people with mental health problems:

*'I think as a team, there are some people who really genuinely want to help clients, as a team it has got to be one of the most caring teams in terms of clients' (ID3)*

In contrast, senior managers were perceived as too focused on money and profit making:

*'I think they are quite detached about what goes on the ground floor, I think overall it's all about the money, it's a business, and patients aren't necessary getting what they need and getting their needs met' (ID1)*

One participant reflected on what they perceived as a fundamental flaw in the structure of the NHS; rather than administration staff being there to support the clinicians it was inverted. They noted that as individuals progressed up the career ladder, they became increasingly removed from clinical work and therefore lost sight of the central task of client care:

*'I would say one of the biggest problems is in nursing, OT, social work that to get to succeed career wise and to get to the top grades career wise you become a non-clinician, you become a manager. Someone who's maybe a*

*good clinician doesn't mean that they'll be anything like a good manager. So I think that's a system that is really crying out for failure' (ID4)*

A number of participants concluded that supervision was no longer valued or perceived as a good use of time by senior managers. One individual reflected on how lack of support for staff members had a clear impact on their ability to sustain their work load:

*'I apologise now every time I go to one of my managers saying I'm really sorry I know you are busy and one of them was over a quite distressing case, and I still felt this sense of guilt about asking... people haven't got time for you, they just look really busy' (ID3)*

Reflections were repeatedly made regarding the fact that in a mental health trust, staff mental health was not perceived as significant:

*'It's interesting because we're mental health trust aren't we? So we're supposed to be looking after people's mental health so I think you need to be looking after your own staff for your own staff to be able to look after other people (ID7)*

In the following quotation, the participant is explicit in demonstrating the lack of compassion in the way the staff are treated by management and how this results in negative repercussions for staff members. The word '*function*' is repeated four times in this section and brings to mind an image of machinelike management and there is the implication that management are alien or subhuman:

*'No, in a department that's supposed to be there to offer therapy and care and nurture, no I don't think it is sympathetic at all...I think the problem is that when you have managers who **function** at that level...you are quite a special human being if you can **function** like that...but if you have got a manager that **functions** like that well then that is the expectation on the staff and most staff will burn out if they have to **function** in that way, I certainly would.'* (ID3)

Descriptions of a bullying and punitive management were pervasive in the data. Some reflected on the ways in which the emergence of a culture of fear and anxiety was very detrimental to staff well-being. This individual commented on how punishment is undermining the productivity of the work force and impeded the staff's ability to provide client care:

*'I think people don't do their best when they are frightened. Particularly in our job, we need to be secure enough in our job. There is a tipping point when anxiety and stress is helpful but I see it tipping into the side of unhelpful. People are making mistakes. People are forgetting things, and burning out...'* (ID8)

#### **4. Contesting professional space**

The merging of teams and changing of roles had led to a lack of clarity of professionals' roles, with a number of people disclosing their uncertainty about what was expected of themselves and others:

*'all of a sudden you wake up in the morning and there's X-team. What does X-team do? Then sometimes their role shifts depending on what you read about a certain patient and you think 'oh right okay, I hear you support people in ... then sometimes they move the goal or change rules ....'* (ID7)

There was a sense of task drift and a loss of purpose:

*'I think it's quite difficult at times when the purpose keeps changes, no one is quite sure anymore what we are supposed to be doing, what we not supposed to be doing. There is always some change happening somewhere.'* (ID1)

Although there was an expression of need for a mix of professionals, who can bring different ideas and skill set to the team, there were a number of reflections regarding the adoption of generic care co-ordinator role in teams and the way in which that was considered to diminish their sense of professional identity:

*'with this new management of change... trying to sort of wipe away people's different professions, what people have trained into, a social worker, a CPN, an OT, everybody has just become a care coordinator' (ID7)*

A number of participants described a sense of having to compete against other professionals or teams in order to get their voice heard or win their argument. There was a perception that there existed a competitive edged culture where teams, rather than co-operating, were operating in competition against each other:

*'I think there's more inter-team rivalries now, I think all teams are more now organised and what's the word I'm looking for, guard their entry points more closely.'* (ID5)

Experiencing a lack of resources, (for instance, in-patient beds) was often deemed a point of contention between different teams.

*'when you shouldn't be fighting amongst yourselves to get what the patient needs, the patient should have what they need without having to put up half a day's battle trying to find a bed,'* (ID1)

There did seem to be a polarisation of views, whilst other teams were deemed as problematic and difficult, professionals frequently described their own team in a very positive light:

*'We do try and pull together and adapt and try and support and help each other out, so that I say thankfully I think it's a good team, we all appear to get on really well.'* (ID6)

### ***5. Disconnecting & Isolation***

The way in which the team was structured and organised was considered to actually impede communication between the professionals and was thought to create barriers:

*'...so patients' care is split into little silos with communication between those silos quite difficult and obviously differences of opinions sometimes of how people are managed.'* (ID5)

The different IT systems used by health and social care was cited by another participant as another way in which boundaries between services were exacerbated and acted as a barrier to communication.

One person expressed a perception that the team had become too large for the members to assimilate and therefore work well together:

*'...because the team is in loads of different offices sometimes it can feel like you are actually in different teams. It was interesting because one member of staff asked me 'those at the other end of the office, are we in the same team?'*  
(ID7)

This individual reflects on the possibility that retreating into separate spaces and removing themselves from the company of other team members was a consequence of the experience of change:

*'Maybe that happens during change in dynamics, change in teams and integration that people become set in their environment and their certain desk and at their certain office.'* (ID6)

There was a clear sense of isolation and fragmentation expressed by a number of the participants:

*'We are so segmented now..., and it is harder to meet up as a team, if you didn't walk around the building you probably wouldn't see anyone all day, it feels at times you are working in isolation.'* (ID1)

One individual expressed their anxiety that further restructuring to the service would impact on a work relationship which they considered very supportive in a difficult work environment:

*'...I think that's what's creating my anxiety a bit more, thinking well they could just whip me away and I have built up a quite good relationship there, working relationship, you know.'* (ID 3)

Observations were made as to the way in which people's manner had changed towards each other on the team:

*'I sometimes think that people are so busy, people perhaps aren't as helpful as they would have been in the past'* (ID1)

The following quotation portrays the way in which staff developed an increased individualistic mentality in the face of high levels of pressure and competition:

*'Everyone in the NHS talks about the frequency and the pace of change the uncertainty and their fear for their jobs, losing your position or being down-banded...I found that really difficult... it created conflict as colleagues were saying 'how can you go up against us?' because everyone tends to, understandably, recoils into that selfishness, look after number one as long as I get my job'.* (ID6)

## **6. Consequences**

Numerous participants described their sorrow that staff who had worked in the trust for a long time were leaving due to the excessive work load, pressure and conflict they were experiencing, and they often cited burn out or stress as the reason. It was noted that experienced staff members were frequently replaced by newly qualified staff and there was an awareness that resources in terms of experience and skills were being lost to the service:

*'There was loads of uncertainty. It broke other people.... I know certain people that never set their foot back here, they say if they and come back here, they go back into the anxiety provoking situations that they felt, they don't feel they were treated right.'* (ID7)

There were a number of expressions of sadness that colleagues were leaving and an acknowledgement that this was understandable in light of the pressures people were currently under:

*'People definitely feel that they are working to capacity and we are still expecting them to take more...we've had people leaving and really they're leaving because they no longer want to work within the pressures...'* (ID2)

As members of staff left, the increasing use of agency staff was viewed as having a negative impact on the continuity of care and represented an obstacle to the formation of therapeutic relationships. One individual recognised that not having the consistency of staff could have a destabilizing effect on the client and have dire results:

*'...some patients can raise certain alarm bells... but knowing them you know what their care plan is this, you've spoken to them, they know you as well and that sometimes can deescalate them but when they've been speaking to someone they don't know that, can end up with a different end result'* (ID7)

It was also evident in the data, that the excessive pressure on the system was resulting in crises and was putting clients at risk:

*'...and they are really buckling under the pressure, and one of the crises I was talking about with a patient we had was because the team was really not coping, because they have massive caseloads now, and you know, when people go into crisis now it is unsafe for people,'* (ID3)

### **Summary**

Grounded theory analysis of the data identified six categories. The category 'Corroding good work: an ethos in decline' thus refers to the staff members' sense of their professional values and integrity being undermined. 'System reform,' refers to staff's perception of a cultural change within the CMHT with an emphasis on regulation, performance management and proceduralisation. Alongside the anxiety that system reform generated in professionals, conflicting feelings were aroused and



their certainty in the intrinsic 'goodness' of their work was shaken. Three unconscious organisational defences were apparent in the work place and labelled 'Caring clinicians and uncaring managers', 'Contesting professional spaces', 'Disconnecting and isolation'. The sixth category 'Consequences' describes the impact of the working culture

### ***Discussion***

The data analysis reveals staff within this CMHT perceived a significant cultural shift taking place within the service. They described their sense of an increasing bureaucracy and depersonalisation in their work, whereby staff were pulled away from actual physical contact with their clients. This is reminiscent of the practices outlined by previous researchers, (Menzies Lyth, 1959; Morante, 2005; Rizq, 2011) which function as organisational defences against the vulnerabilities and anxiety of working with this client group. The concept of 'virtualism' (Hogget, 2010; Miller, 2005) refers to the process of how an 'audit surface' stands in for the real relationship with clients. It appears that ever increasing bureaucracy acts as an 'anti-task', meaning that the primary task of the organisation (caring for clients) has become too difficult or poorly defined and thus staff members find another task to prevent them carrying it out. In this case therefore, bureaucracy enables staff to avoid actual face to face contact with clients and experiencing pain or vulnerability. According to Hoggett (2010) and Long (2008) this represents one of the 'perverse' social defences which occur as a consequence of the regulatory culture now prevalent within public services. According to Long (2009, p.248) '*perverse social defences*' emerge under certain social and organisational conditions:

- Individual pleasure at the expense of mutuality.
- The paradoxical dynamic of denial of reality where what is known is at the same time not known.
- The use of accomplices in an instrumental social relation.
- The self-perpetuation or closed-ness of the perverse dynamic.

Ballatt & Campling (2014) describe 'corrupting forces' which are responsible for this 'perverse' culture taking hold in the NHS. Firstly, the promotion of a market

economy which has brought into being a ‘commodified view’ of service requirements at odds with prioritising the needs of vulnerable clients. Secondly, the industrialisation of healthcare which has heralded a replacement of clinical skills with mechanical processes and systems such as manualised online therapy. Thirdly, excessive regulation and performance management. They argue that a disproportionate focus on these activities fosters a culture of suspicion in public sectors, where “Staff feel this societal mistrust and suspicion, both at a general level and in their encounter with the complex systems of control within which they work.” (Ballatt & Campling, 2014, p. 163)

However, the findings of this study highlight that staff are aware of and averse to this cultural shift and perceive the core values of ‘good work’ as being eroded by ‘perverse’ incentives of reaching targets and completing paper work. There was a sense of the guilt and betrayal expressed by the CMHT staff in having to marketise the health sector, which appears to go against the principles and values they believe the NHS (and they) stand for. As a consequence of these overwhelming feelings, which were difficult to manage, unconscious defences were apparent. Splitting was evident, which enabled the professionals to maintain their association with the good object and project difficult and guilty feelings into management. Professionals repeatedly voiced their perceptions that management were insensitive to client and staff needs, bullying and uncaring. Conversely, clinicians were deemed as caring and compassionate. This reiterates the findings of Gerada & Wilde (2015, p.55) that the NHS, “...has turned into a neglectful and persecutory parent, which is making unreasonable demands on those who care for the most vulnerable in society.” Inter-professional rivalries and conflict emerged, whilst further splitting was evident in the way that staff members regarded their own teams as ‘good’, whilst seeing other teams as ‘bad’. Dissociation and cutting off were also apparent, as many staff voiced their sense of disconnection from each other within the CMHT whilst having feelings of rivalry and opposition for other teams. This frequently escalated into people no longer investing emotionally in their role and ultimately leaving, which in turn impacted on client care.

### ***Clinical Implications***

This study has met its aim of analysing how individuals in CMHTs respond to organisational change. This utilised a psychodynamic framework, enabling the identification of social defences in professionals working in CMHTs. The study has met its objective of exploring links between organisational change and anxiety. Another objective was to consider how change could be managed to mitigate these negative effects. The findings of this study suggest, therefore, that greater consideration should be given to the way in which rapid change and restructuring of mental health services dismantle the containing aspects of the organisation, which result in defences and polarized perceptions in staff. The practical implications suggest that there is a need for better balance between work structures and systems, and the needs of individuals. As Kennedy (2013) suggests, this could be achieved by focussing on compassionate care rather than service pathways and performance targets. Informed by the findings of the current study, psychologists might be able to undertake support work with CMHTs, for example by helping clinicians and managers understand each other's roles and pressures. Staff might be enabled to feel contained and therefore function better as a group. Support, training and supervision of staff are essential and staff's health and needs are the foundation of safe practice. The author strongly agrees with the recommendations outlined by Wren (2014, p.20) as to the ways psychological challenges for health care staff working in the NHS can be anticipated and managed:

- Providing space for reflection (e.g. adopting a Schwartz Centre round model and promoting other forms of reflective practice).
- Exploring with management and staff whether work design promotes adaptive defences.
- Consciously paying attention to the content of the work, its emotional impact and the structure and designs of jobs, roles and teams.
- Paying attention to the processes supporting the work, (meetings, supervision, and management of risk).
- Ensuring that skills and resources of management at every level are treated as being of crucial importance.

In addition, the five qualities of a therapeutic environment (Haigh, 1999 cited in Ballatt & Campling, 2014, p.80) provides a useful measure of the prerequisites needed for ensuring that staff psychological needs are met, thereby supporting staff to provide adequate and compassionate care to clients. The five qualities consist of attachment as defined as “a culture of belonging, in which attention is given to joining and leaving, and staff are encouraged to feel part of things”; containment which refers to “a culture of safety, in which there is a secure organisational structure and staff feel supported, looked after and cared about within the team”; communication, meaning “a culture of openness, in which difficulties and conflict can be voiced and staff have a reflective, questioning attitude to the work”; involvement which is defined as “a living- learning culture, in which team members appreciate other’s contribution and have a sense that their work and perspective are valued” and agency referring to “a culture of empowerment, in which all members of the team have a say in the running of the place and play a part in decision making”.

### ***Original Contribution / Limitations***

This study represents an original contribution to the research evidence concerned with social defences in mental health services. Although work has been done within primary mental health services (Rizq, 2011; 2012a; 2012b; 2013), there is a gap in the current knowledge base relating to secondary care which this study addresses. Moreover, this study uses an interview methodology, enabling the exploration of participants’ responses at greater depth. In the time allowed for this study, eight interviews were carried out and analysed using grounded theory method. The author did not interview senior managers, which would be useful to verify whether they are aware of staff perceptions and ascertain their own attitudes to staff vulnerability. Although the eight interviews provided a wealth of data, it is possible that saturation point was not reached. The author is in agreement with Dey (1999) that the concept ‘saturation’ is imprecise and ‘theoretical sufficiency’ is a better aim, whereby researchers using the grounded theory method obtain categories suggested, rather than saturated, by the data. As with any qualitative research with a small sample, caution must be exercised in extrapolating general implications from these findings. Nevertheless, the study does appear to contain a significant degree of ‘theoretical transferability’ as findings of this study were shown to be consistent with previous

research carried out in this area. Therefore despite its small scale, there is significant applicability for the findings beyond this particular study.

### ***Conclusion***

Menzies Lyth (1959) argued that healthcare staff defended against feelings of vulnerability by becoming emotionally detached from clients. Similarly, the findings of this study suggest that secondary mental health services appear to be defending against the vulnerability of their own staff and the clients through the implementation of increased bureaucracy which depersonalises their work. However this study has also highlighted that staff perceive kindness as central to their work with clients, encapsulated in the term ‘good work’, with clients seen as vulnerable and deserving of the staff’s efforts. The impact of cuts to funding, increasing regulation and accountability and industrialising therapy is creating a significant challenge to the ethos of caring and trust. As a consequence, staff experience a sense of diminished professional values and low morale. Defences that emerged included splitting; management are perceived as cut off, lacking understanding or even neglecting of these needs whilst clinicians are deemed as compassionate. Inter-professional rivalry and conflict, and dissociation and isolation are also in evidence. The consequences highlighted in this study include increased risk to client safety and staff wellbeing, and high staff turnover. In the subsequent paper, the author will reflect on the experiences of working in a multidisciplinary team undergoing rapid change, whilst considering how interdisciplinary team work might benefit from psychological consultation.

### **Disclosure statement**

No potential conflict of interest was reported by the authors.

Word Count: 8,525

## References:

- Anderson, J. (2006). Well suited partners: psychodynamic research and grounded theory. *Journal of Child Psychotherapy*, 32, 329-348.
- Ballatt, J., & Campling, P. (2014). *Intelligent kindness: reforming the culture of healthcare*. London: RCPsych publications.
- Berwick, D. (2013). A promise to learn, a commitment to act: the Berwick Review into Patient Safety. National Advisory Group on the Safety of Patients in England. London: Department of Health. Retrieved from [http://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226703/Berwick\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_report.pdf)
- Blumer, H. (1969). *Symbolic interactionism*. Englewood Cliffs, New Jersey: Prentice Hall.
- Care Quality Commission. (2012). The Speaking Up Charter. Retrieved from [http://www.cqc.org.uk/sites/default/files/media/documents/final\\_speaking\\_up\\_charter\\_cqc\\_version.pdf](http://www.cqc.org.uk/sites/default/files/media/documents/final_speaking_up_charter_cqc_version.pdf)
- Charmaz, K. (2003). Grounded theory. *Strategies of Qualitative Inquiry*, 2, 249.
- Charmaz, K. (2008). Grounded Theory. In J. Smith (Ed.). *Qualitative Psychology: A Practical Guide to Research Methods* (pp.81-110). London: Sage.
- Charmaz, K. (2014). *Constructing grounded theory*. London: Sage
- Cooper, A. (2001). The state of mind we're in: social anxiety, governance and the audit society. *Psychoanalytic Studies*, 3, 349-362.
- Department of Health. (2012). Health and Social Care Act. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>
- Dey, I. (1999). *Grounding grounded theory*. San Diego, CA: Academic Press.
- Durdy, H., & Bradshaw, T. (2014). The impact of organisational change in the NHS on staff and patients: a literature review with a focus on mental health. *Mental Health Nursing*, 34, 16-20.
- Francis R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary*. London: The Stationery Office.
- Freud, S. (1900). *The interpretation of dreams*. Standard Edition of the Complete Psychological Works of Sigmund Freud. London: Hogarth Press.
- Gerada, C & Wilde, J. (2015). Care, Compassion and Concern in the NHS. *The Journal of Psychological Therapies in Primary Care*, 4, 47-68.

Glaser, B. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine de Gruyter.

Haigh, R. (1999). The quintessence of a therapeutic environment: Five universal qualities. *Therapeutic communities: past, present and future*. London: Jessica Kingsley.

Hashmat, H., Upthegrove, R., & Marzanski, M. (2015). Impact of functionalisation on staff morale in CMHTs. *Progress in Neurology and Psychiatry*, 19, 24-27.

Hinshelwood, R. D. (1989). *A dictionary of kleinian thought*. London: Free Association Books.

Hinshelwood, R.D & Skogstad, W (2000). *Observing organisations: anxiety, defence, and culture in health care*. London: Bruner Routledge.

Hinshelwood, R.D & Skogstad, W. (2002). Irradiated by distress: Observing psychic pain in health care organizations. *Psychodynamic Psychotherapy*, 16, 110-124.

Hoggett, P. (2010). Government and the perverse social defence. *British Journal of Psychotherapy*, 26, 202-212.

Jaques, E. (1953). On the Dynamics of Social Structure A Contribution to the Psycho-Analytical Study of Social Phenomena. *Human Relations*, 6(1), 3-24.

Kennedy, A. (2013). A compassionate formulation of task drift in mental health staff. *Mental Health Review Journal*, 18, 73 – 82.

King, N & Anderson, N. (1995). *Innovation and change in organisations*. London: Routledge.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis*, 27, 99-110.

Kurtz, A. (2001). A psychodynamic view of two forensic mental health services. *Criminal Behaviour and Mental Health*, 12, S68-80.

Kurtz, A & Jeffcote, N. (2011). 'Everything contradicts in your mind': A qualitative study of experiences of forensic mental health staff in two contrasting services. *Criminal Behaviour and Mental Health*, 21, 245–258.

Long, S. (2008). *The perverse organisation and its deadly sins*. London: Karnac.

Mead, G. (1934). *Mind, self and society*. Chicago: University of Chicago Press.

Menzies Lyth, I. (1959). The functioning of social systems as a defence against anxiety. *Human Relations*, 13, 95-121.

Menzies Lyth, I. (1990). In E. Trist, (Ed), *The Social Engagement of Social Science, Volume 1: A Tavistock Anthology: The Socio-Psychological Perspective* (Vol. 1), (pp. 463-475). Pennsylvania, USA: University of Pennsylvania Press.

Miller, D. (2005). What is best 'value'? Bureaucracy, virtualism and local governance. In P. Du Gay (Ed.). *The Values of bureaucracy*. Oxford: Oxford University Press.

Morante, F. (2005). Applying psychodynamic thinking in a staff support group to reflect on service change and clinical practice in a specialist psychiatric service. *Psychodynamic Psychotherapy*, 19, 103-120.

Obholzer, A. (1994). Managing social anxieties in the public sector. In A. Obholzer & V.Z. Roberts, (Eds), *The Unconscious at work: Individual and organisational stress in the human services*. (pp.169-178). London: Routledge.

Obholzer, A & Roberts, V.Z. (1994). *The Unconscious at work: Individual and organisational stress in the human services*. London: Routledge.

Powell, S & Morris, A. (2001). Loss and change in primary care: working with organisational anxiety. *Psychodynamic Psychotherapy*, 15, 207-223.

Rizq, R. (2011). IAPT, anxiety, and envy: A psychodynamic view of NHS primary care mental health services today. *Public Sector Practice*, 27, 37-54.

Rizq, R. (2012a). The Ghost in the machine: IAPT and Organizational melancholia. *British Journal of Psychotherapy*, 28, 319-335.

Rizq, R. (2012b). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice*, 18, 7-24.

Rizq, R. (2013). States of abjection. *Organization Studies*, 34, 1277-1297.

Smith, J. A., Flowers, P., Larkin, M. (2009). *Interpretative Phenomenological Analysis. theory, method and research*. Thousand Oaks, CA: Sage Publications.

Strauss, A & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory*. Newbury Park: Sage.

Stokes, J. (1994). The Institutional Chaos and Personal Stress. In A. Obholzer & V.Z. Roberts (Eds). *The Unconscious at work: individual and organisational stress in the human services*, (pp. 121-128). London: Routledge.

Turpin, G., Barley, V., Beail, N., Seaire, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods:



suggested guidelines for trainees and courses. *Clinical Psychology Forum*, 108, 3-7.

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. In A. R. Harper & D. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, (pp. 131-146). West Sussex: John Wiley & Sons, Ltd.

Whitby P, & Gracias S. (2013). Reflecting on the Francis Report: This has happened before. *Clinical Psychology Forum*, 249, 13-17.

Whittaker, A. (2011). Challenges for the Munro Review? *Journal of Social Work Practice*, 25 (4), 481-495.

Willig, C. (2001). *Introducing qualitative research in psychology*. Buckingham: Open University Press.

Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: is there a difference? *Journal of Advanced Nursing*, 31(6), 1485-1492.

Wren, B. (2014). Managing Staff Experience to improve organisational culture. Implementing Culture Change within the NHS: Contributions from Organisational Psychology. Occupational Psychology in Public Policy (OPIPP) Group Report. Retrieved from [https://www.bps.org.uk/system/files/userfiles/Division%20of%20Occupational%20Psychology/public/17689\\_cat-1658.pdf](https://www.bps.org.uk/system/files/userfiles/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf)

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*. 15,215-228.

## Appendices

### Appendix 1. Ethical Approval



Faculty of Health Sciences

#### ETHICAL APPROVAL FEEDBACK

|                            |  |
|----------------------------|--|
| <b>Researcher name:</b>    | <b>Bridget Hanley</b>  |
| <b>Title of Study:</b>     | <b>A qualitative study of the impact of organisational change on professionals working in a Community Mental Health Team: a psychoanalytic perspective</b> |
| <b>Award Pathway:</b>      | <b>DClinPsy</b>  |
| <b>Status of approval:</b> | <b>Approved</b>  |

#### Action now needed:

Your project proposal has now been approved by the Faculty's Ethics Panel and you may now commence the implementation phase of your study. You do not need to approach the Local Research Ethics Committee. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

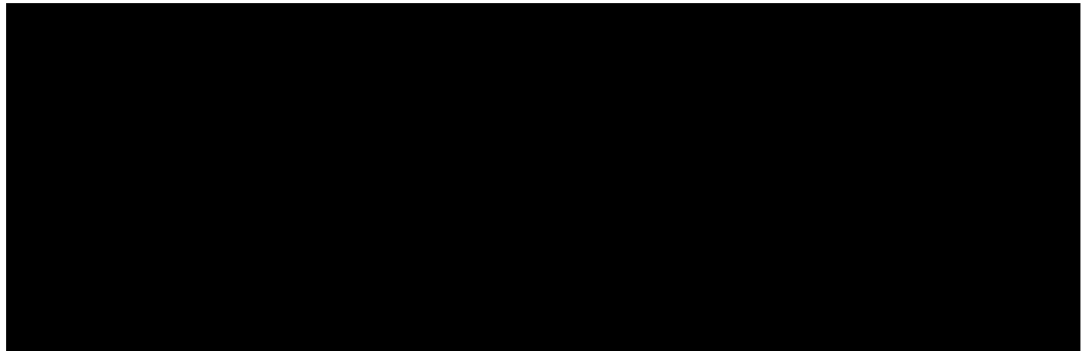
#### Comments for your consideration:

Thank you for forwarding the amendments requested by the Panel

A handwritten signature in black ink, appearing to read 'Karen Rodham'.

Signed: Prof Karen Rodham (Chair of the Faculty of Health Sciences Ethics Panel)  
Date: 8<sup>th</sup> October 2014

## Appendix 2. Research and Development Approval



15 January 2015

R&D Ref: CHC0107/RD

Mrs Bridget Hanley  
Trainee Clinical Psychologist

Dear Mrs Hanley

**Study Title: The Impact of organisational change on a CMHT: A psychodynamic study**  
**Chief Investigator: Mrs Bridget Hanley**  
**Sponsor: Staffordshire University**

I can confirm that the above project (R&D application) has been reviewed and given NHS Permission for Research by the Research & Development Department for [redacted] Trust, and the details have been entered onto the R&D database.

I note that this research project has been approved by Staffordshire University Ethics Panel (8/10/2014).

NHS permission for the above research has been granted on the basis described in the application and supporting documentation. The documents reviewed were:

| Document                  | Version Number | Date       |
|---------------------------|----------------|------------|
| Protocol                  | 1              | 29/10/2014 |
| Patient Information Sheet | 1              | 29/10/2014 |
| Consent Form              | 1              | 29/10/2014 |

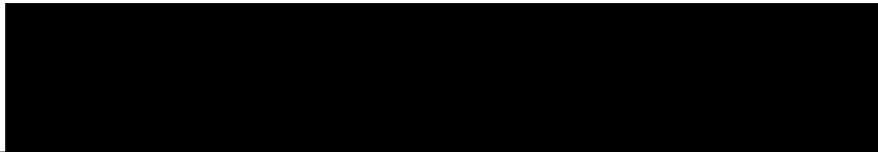
The research Sponsor, Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D Office should be notified of any such measures, the reasons for the action and any further action required. The R&D Office should also be notified within the same time-frame as that of the research ethics committee and other regulatory bodies.



R&D-TMP-001

Version 4.1 (01/12/2013)

Page 1 of 2



Approval by the R&D Department therefore assumes that you have read, understand and agree to comply with the following:-

- ❖ Research Governance Framework ([www.doh.gov.uk/research](http://www.doh.gov.uk/research))
- ❖ ICH Guidelines on Good Clinical Practice
- ❖ Data Protection Act 1998
- ❖ Mental Capacity Act 2007
- ❖ Medicines for Human Use (Clinical Trials) Regulations 2004
- ❖ Human Tissue Act 2004
- ❖ All applicable Trust policies & procedures

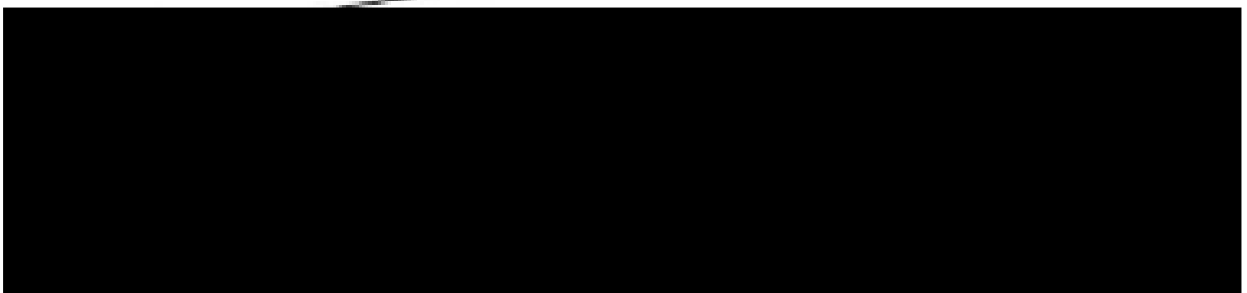
In line with these requirements, may I draw your attention to the need for you to provide the following documentation/notifications to the R&D Office throughout the course of the study, and that all amendments (including changes to the local research team) need to be submitted to, and approved by R&D, in accordance with IRAS guidance:-

- ❖ Annual Progress Report (form sent by this R&D Office)
- ❖ End of Study Declaration Form (available via IRAS)
- ❖ End of Study Report (produced by the Chief Investigator)
- ❖ Changes to study start and end dates
- ❖ Changes in study personnel

Please note that this NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework, and other legal and regulatory requirements. This will be achieved by random audit conducted by this department.

I would like to take this opportunity to wish you well with your research. If you need any further advice or guidance please do not hesitate to contact us.

Yours sincerely



R&D-TMP-001

Version 4.1 (09/12/2009)

Page 2 of 2

## Appendix 3. Information Sheet

### Participant Information Sheet.

A qualitative study of the impact of organisational change on professionals working in a Community Mental Health Team: a psychodynamic perspective

I would like to invite you to take part in a research study. This study aims to explore the impact of organisational change on professionals working within a community mental health team. The study will examine the effects of organisational change upon individuals including the ways in which individuals cope with the pressure to change and manage the anxieties that may result from the change process. The study will examine how professionals perceive alterations to services resulting from organisational change and how individuals adjust to accommodate the alterations to services.

Before you decide it is important for you to understand why the study is being done and what it will involve. Please take the time to read this information carefully and talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

#### Do I have to take part?

No, it is up to you to decide if you wish to take part. If you decide to take part, we will ask you to sign a consent form. However, you are free to withdraw from the study at any time, without having to give a reason. If you decide to withdraw from the study at a later date any information about you or provided by you will not be included in the study if you do not wish it to be.

#### Why have I been invited to take part?

You have been invited to take part in this study because you work in a Community Mental Health Team and this is the focus of the study.

#### What will happen to me if I agree to take part?

The researcher will invite you to carry out an interview in a location that you feel comfortable with. The interview will last for approximately one hour and will be digitally recorded.

#### What will happen after the study is finished?

A summary report of the findings will be available should you wish. It is intended that the findings of this study will be disseminated in relevant journal publications and conferences.

#### Will my taking part in this study be kept confidential?

Only the researcher and her supervisors will have access to the anonymised version of your information (i.e. with name and any other identifying features removed). It is possible that the university and NHS Research and Development department may need access to the anonymised data for audit purposes. Once the interviews have been transcribed the tapes will be destroyed. All data will be kept in a locked cabinet within a locked room. We will endeavour to maintain confidentiality regarding any information which you give us, by anonymising the transcripts. In reports and publications emerging from the study, no identifying features will be used. We do acknowledge that as the study will involve a relatively small number of participants, that there is a remote possibility despite these measures that some individuals might be recognised from their or others' comments. You will be given the opportunity to remove any of your comments which you do not wish to be included. If during the course of the interview, there is any disclosure of bad practice within the trust, the researcher is required to disclose this information via the appropriate channels in accordance with the Speaking Up Charter (Care Quality Commission, 2012).

**Possible Risks in taking part in this study**

It is possible that you may find the subject matter of the interviews stressful to discuss. If for any reason you become distressed during or post interview you will be offered a debrief session with a qualified clinical psychologist and should you require further support you will be provided with details of the staff counselling service.

**Possible Benefits of taking part in this study**

We cannot promise that the study will benefit you personally, but the information you provide may help to identify helpful strategies for professionals working in mental health services. It is hoped that the findings of this study may help the wider community by identifying ways to promote a more supportive working culture within the NHS, allowing staff to work more positively and reducing the likelihood of stress or burnout. The researcher is conducting this study as part of her doctoral training in clinical psychology and it is hoped that it will result in an academic qualification.

**In case of an adverse event**

In case of an adverse event, such as fire or medical emergency, normal NHS or university procedures will be carried out and there will be staff on hand should they be needed to assist.

**Who has reviewed the study?**

This study has been reviewed by the Faculty of Health and Sciences Research Ethics Committee at Staffordshire University.

If you have any questions or would like further information please contact:  
Bridget Hanley (Trainee Clinical Psychologist)  
Email: [w038837a@student.staffs.ac.uk](mailto:w038837a@student.staffs.ac.uk)

**A qualitative study of the impact of organisational change on professionals working in a CMHT: a psychodynamic perspective. Information Sheet. Version 1. 29.10.2014**

## Appendix 4.

### Consent Form

**A qualitative study of the impact of organisational change on professionals working in a Community Mental Health Team: a psychodynamic perspective.**

Please tick box

I confirm that I have read and understand the information sheet Version 1 dated 29.10.14 for the above study. I have had the opportunity to consider the information, ask questions and am satisfied that I have had all the information that I require.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

I understand that my name and any identifying features will be removed from the transcript.

I agree to the interview being digitally recorded and I understand that once the interviews have been transcribed the digital files will be deleted.

All data will be stored on computer files and access will be restricted to ensure confidentiality.

I agree to my comments being quoted in the final report and any subsequent publications and I am aware that I will have the opportunity to review how my information will be used in the final report any publications resulting from this study.

I agree to take part in the above study.

---

Participant name \_\_\_\_\_ Date \_\_\_\_\_  
Signature

---

Person taking consent \_\_\_\_\_ Date \_\_\_\_\_  
Signature

**A qualitative study of the impact of organisational change on professionals working in a CMHT: a psychodynamic perspective.  
Consent form. Version 1. 29.10.2014**

## **Appendix 5. Interview Schedule**

### **A qualitative study of the impact of organisational change on professionals working in a CMHT: a psychodynamic perspective. Interview Schedule. Version 1. 29.10.2014**

Can you give me some background of your role within the team?  
E.g. How long have you worked in this team? What roles have you had in that time?

How have those roles changed in recent times? In what ways?

Have there been any changes to services which you have noticed and if so, in what ways?

Have any these changes influenced your practice day to day, in what ways?

Do you think working in a CMHT requires change and if so what changes would you make?

How do you feel that change is brought about?

What role do you think government has in the organisation and re-organisation of services?

How do you think your role is perceived by others on the team? By management? Has this changed at all?

Do managers and staff ever have different priorities? How do they affect you? How do others respond?

Do you think the team or its cohesion has been affected in anyway? In what ways?

How do you feel you have been supported in your role in a period of change? If not, why?

Do you think your team shares a common purpose during periods of change and do you think this is important?

How do you think the team deals with conflict, particularly at times of change?

#### **Additional Questions**

What do you think has been the impact of payment of results?

How do you think the recent changes have been managed?

How have you coped with expectations, from clients? Management? Societal?

Differences between positive and negative change?

What can be done to help the situation?



## Appendix 6. Ethical Amendment



Faculty of Health Sciences

### ETHICAL APPROVAL FEEDBACK

|                            |   |
|----------------------------|---|
| <b>Researcher name:</b>    | Bridget Hanley  |
| <b>Title of Study:</b>     | A qualitative study of the impact of organisational change on professionals working in a Community Mental Health Team: a psychoanalytic perspective |
| <b>Award Pathway:</b>      | DClinPsy  |
| <b>Status of approval:</b> | Approved  |

#### Action now needed:

Your amended project proposal has been approved by the Faculty's Ethics Panel and you may commence the implementation phase of your study.

Thank you for informing the committee that you wish to employ the services of a professional transcriber, and your explanation as to how participants' confidentiality will be maintained, and data protected.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

A handwritten signature in black ink, appearing to read 'Karen Rodham'.

**Signed:** Professor Karen Rodham  
Chair of the Faculty of Health Sciences Ethics Panel

**Date:** 13<sup>th</sup> July 2015

**Appendix 7 : Confidentiality clause**

During your transcription of these audio files you may become aware of, or have access to information relating to students, patients, members of staff, other people or other Health Service business of a confidential nature. You must maintain confidentiality at all times. All copies of the audio files and transcripts must be deleted and any hard copies destroyed once the transcription is complete and the researcher has acknowledged safe receipt. In accordance with Staffordshire & Keele University rules and procedures, any breach of confidence will be viewed most seriously.

From:

*Bridget Hanley*

BRIDGET HANLEY Date: 16/07/15

I am returning this signed copy of the Confidentiality clause as confirmation of my agreement to the terms contained therein.

Signed:  
17/07/2015



Date:

**Appendix 8: Initial coding**

| Examples of initial codes  | Data  |
|--|---|
| <p>Fighting ‘gatekeepers’<br/>It keeps changing<br/>Lacking beds nationally.<br/>Increasing pressure on the mental health service</p>  | <p><b>Who are you fighting with?</b><br/>the gatekeepers, which are, it used to be the home treatment team, now I think it is the access team and again that keeps changing, the guidance keeps changing, and also nationally there are no beds, so the pressure is on mental health services all over its not just (name of organisation)</p>  |
| <p>Finding there are difficult personalities in team.<br/>Good vs bad personalities</p>  | <p><b>So do you feel there is quite a lot of conflict within and between teams?</b><br/>Between teams, I think, according upon the personality within the team that you come across, really, some are good, some are bad, but that’s everywhere</p>   |
| <p>Deciding when need to seek management support or dealing with it themselves and ‘ranting and raving’</p>  | <p><b>How do you think you cope with that?</b><br/>Professionally (coughs/ laughs). If it’s something that I think the manager needs to know about then I will tell the manager, if it is something that I feel I can just deal with myself then I will do, and then I rant and rave a bit</p> <p><b>Does that help?</b><br/>Yes (laughs)</p> <p><b>And then you sort of feel you can make a difference?</b><br/>I guess so, I don’t know what else to say about that really</p>  |
| <p>Perceiving the trust as detached/focusing on money &amp; business<br/>Patients’ needs are not being met<br/>Feeling frustrated<br/>Battling against the set boundaries<br/>Some deserving more help</p> | <p><b>Thinking about the trust, can you tell me a bit about their role in the reorganisation of services and how much they understand what’s needed?</b><br/>I think they are quite detached about what goes on the ground floor, I think overall experience I suppose on a personal level as well, it’s all about the money, it’s a business, and patients aren’t necessary getting what they need and getting their needs met, so that can be frustrating from a professional point of view, you are sort of battling against the boundaries that are set, perhaps some should have more help than they are getting</p> |

**Appendix 9: Focused Coding**

|  |  |
|--|--|
| <p>Contesting professional spaces<br/>Role blurring</p>                                | <p><b>Who are you fighting with?</b><br/>the gatekeepers, which are, it used to be the home treatment team, now I think it is the access team and again that keeps changing, the guidance keeps changing, and also nationally there are no beds, so the pressure is on mental health services all over its not just (name of organisation)</p>   |
| <p>Contesting professional spaces</p>  | <p><b>So do you feel there is quite a lot of conflict within and between teams?</b><br/>Between teams, I think, according upon the personality within the team that you come across, really, some are good, some are bad, but that's everywhere</p> <p><b>How do you think you cope with that?</b><br/>Professionally (coughs/ laughs). If it's something that I think the manager needs to know about then I will tell the manager, if it is something that I feel I can just deal with myself then I will do, and then I rant and rave a bit</p> <p><b>Does that help?</b><br/>Yes (laughs)</p>  |
| <p>Caring clinicians and Uncaring managers<br/><br/>Contesting professional spaces</p> | <p><b>And then you sort of feel you can make a difference?</b><br/>I guess so, I don't know what else to say about that really</p> <p><b>Thinking about the trust, can you tell me a bit about their role in the reorganisation of services and how much they understand what's needed?</b><br/>I think they are quite detached about what goes on the ground floor, I think overall experience I suppose on a personal level as well, it's all about the money, it's a business, and patients aren't necessary getting what they need and getting their needs met, so that can be frustrating from a professional point of view, you are sort of battling against the boundaries that are set, perhaps some should have more help than they are getting</p> |

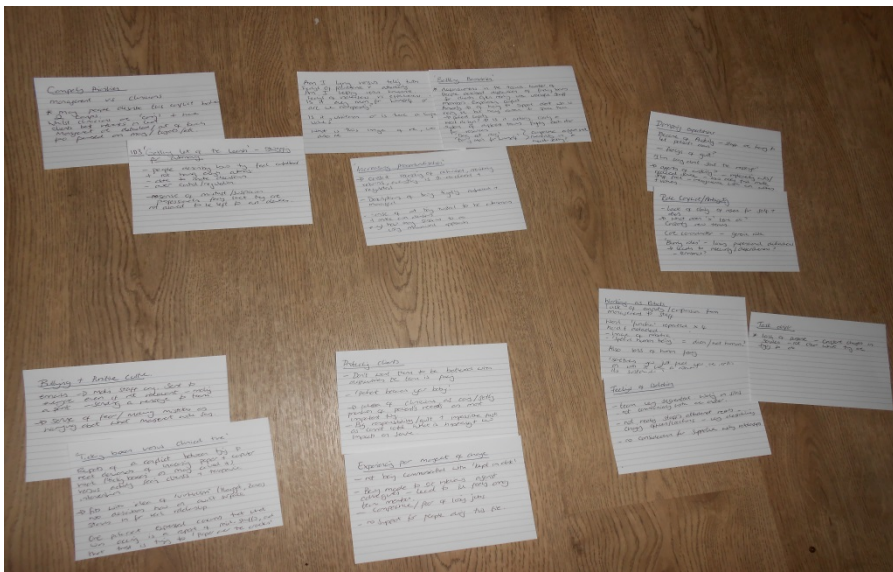
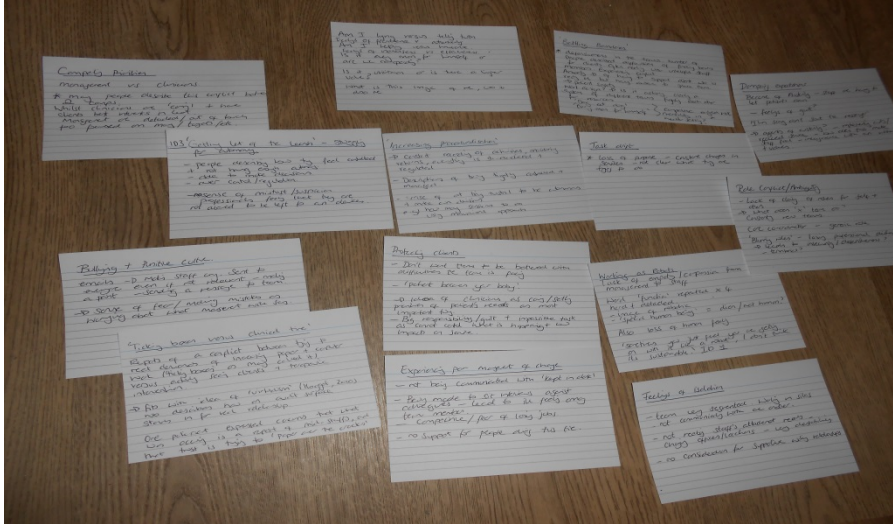
### **Appendix 10: Examples of Memos**

ID3: During this interview, the participant begins extremely stressed, rushed and hurried, no pauses and feels like an onslaught of speech but as the interview progresses, it slows and quietens down. However, this segment of the interview stands out for me – perhaps it clarifies a link between culture and behaviour within the team. The participant is explicit in demonstrating the lack of compassion in the way the staff are treated by management and how this results in negative repercussions for staff members. The participant emphasises the word '*function*', it is repeated four times in this section and the way in which she articulates the word in the recording is hard and detached, almost mechanical. It conjures an image of robotic management and the term '*special human being*' suggests that perhaps there is something alien or subhuman about the way management are.

ID4: There was a sense of sadness in this interview- understandably as the participant had experienced a personal bereavement, but 'loss' seemed to resonate in the interview in other ways too. For instance there is an emphasis on 'losing' staff in this extract and that colleagues are looking elsewhere for jobs and leaving. The participant is explicit in stating that staff are 'losing' confidence in the organisation. There are also descriptions of feeling frustrated at not being able to develop their skills or progress in their career so perhaps there is also a sense of 'losing' skills as well as respect. A lack of solidity and security permeates this interview.

ID7. The interview today was extremely interesting – although at times difficult to follow. There was a lot of background noise, the participant tapped a paper on the chair quite regularly throughout – perhaps they were nervous or anxious about talking about this subject. I also was aware of a lot of noise emanating from surrounding rooms today which sometimes I found distracting. The content was very interesting though. A lot about the way services have merged and teams have been brought together and the consequences of this. Participant suggests that decisions were made that were not really thought through and that there was a big impact for patients in terms of loss of support and also the impact on staff, in that there is less resources for them and that can cause stress for them.

### Appendix 11. Sorting process



## **Appendix 12. Author guidelines for submission to psychoanalytic psychotherapy**

Manuscript submission guidelines (for chapter one), retrieved from: <http://www.tandfonline.com/action/authorSubmission?journalCode=rpps20&page=instructions#.Vx8aDPkrK00>

### ***1. General guidelines***

- Manuscripts should be consistent with the Aims and Scope of the journal.
- A typical manuscript will not exceed 7,000 words including tables, references and captions. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
- Brief reports will be limited to 1,500 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph, as follows:

*For single agency grants:* This work was supported by the <Funding Agency> under Grant <number xxxx>.

*For multiple agency grants:* This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.

- Abstracts of 200 words are required for all manuscripts submitted.
- Each manuscript should have 5 keywords.
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Any acknowledgements authors wish to make should be included in a separate headed section at the end of the manuscript. Please do not incorporate them into notes.
- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

## ***2. Style guidelines***

- Description of the Journal's article style.
- Description of the Journal's reference style. (APA)
- Guide to using mathematical scripts and equations.
- Manuscripts are accepted only in English. Any consistent spelling and punctuation styles may be used. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks.
- We prefer US to 'American', USA to 'United States' and UK to 'United Kingdom'.
- Punctuation of common abbreviations should not be followed by a comma or a (double) point/period (e.g./i.e.).
- The em-dash should be clearly indicated in manuscripts by way of a clear dash (-) or a triple hyphen (---).
- Only the first word in paper titles and all subheads is in upper case; titles of papers from journals in the references and other places are not in upper case.
- Apostrophes should be used sparingly. Thus, decades should be referred to as follows: 'the 1980s saw...' (not the 1980's). Possessives associated with acronyms should be written as follows: UNICEF's findings that...'
- Spell out all acronyms for national and international agencies, examinations, etc. the first time they are introduced in the text or references. Thereafter the acronym can be used if



appropriate, e.g. 'The work of the World Health Organization (WHO) in the 1980s...'. Subsequently, 'The WHO studies of health...', in a reference (World Health Organization (WHO) 1989a).

- The preferred local (national) usage for ethnic and other minorities should be used in all papers.
- Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact [authortemplate@tandf.co.uk](mailto:authortemplate@tandf.co.uk).

### ***3. Figures***

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

### **Chapter 3: Commentary and Reflective Review**

#### ***Introduction***

In this final paper, the author will provide reflections on her experience of undertaking this research, including how the process was triggered and developed, reflections on the literature review, methodology and findings, thoughts about implications of the study and possible areas for future research. The review is written in a way that combines thoughts about all these areas with reflections on the author's responses to different incidents or experiences that in various ways motivated her to do the research. These reflections are informed by excerpts from her research journal that highlight her reactions to the experience of working within a multidisciplinary team.

#### ***Process***

I decided that I wanted my thesis to focus on my chosen area, at an early stage of the course. During my first placement within a community mental health team, I was becoming very aware of the tensions that arose between different members of the team. I began to wonder why at team meetings there was frequently a very low attendance and why the mood was so depressed or lethargic. Coincidentally, I had been reading about unconscious defences and it seemed that the teams' behaviour could be interpreted as a kind of defence mechanism. I started to wonder what they were defending against. It was 2012, and the discourse of 'austerity' was increasingly present within the NHS. Rapid changes were coming into force and people were reacting with a strong sense of grievance to pay cuts and changes in roles and conditions. This wider context of 'austerity' was affecting how people felt about themselves, their roles and their prospects in the profession. I latched onto the idea that the wider context was influencing the individuals' responses to each other and I brought this thinking forward with the rest of the project.

#### ***Ethics***

As the study was exploring the experiences of staff in the NHS it was only necessary to gain ethical approval from the university and also research and development approval from the relevant trust. I attended an MDT meeting at the service I was going to study, in order to discuss the research proposal distribute information sheets

and hopefully recruit participants. Recruitment was initially slow; some people showed an interest but then never responded to further contact. Others stated that they felt they had too much on and were too busy to take part. I began to suspect that people felt reluctant to take part perhaps because they felt vulnerable or exposed even talking to me about this subject. The Francis Report had been released, highlighting the importance of reporting bad practice or ‘whistle blowing’. I was aware that people might feel that they were ‘speaking up’ about bad practice as they saw it and might have felt at risk. Moreover, I would be asking them questions that would highlight difficulties and negative perceptions of their own working lives, that might put them at odds with other professionals. The subject matter was sensitive at a number of levels and these reflections made me even more mindful of the ethical responsibilities associated with the project.

### ***Literature review***

Undertaking the literature review, posed a number of challenges for me. I had initially hoped to review studies investigating social defences within health organisations, as this would be closely linked to the subject of my empirical paper. However, despite a number of commentaries written on the topic, there was a lack of empirical data to review in this area. I therefore decided that a topic on the subject of teams would be appropriate; however, choosing a topic that had not been undertaken before and ensuring an original contribution was problematic. Reading through recent policy documents from the BPS, indicated that role ambiguity was a major factor in team functioning and therefore appeared to represent an important topic to review.

The second dilemma I faced was when to carry out the review. According to Charmaz (2014) this is long disputed topic in grounded theory methodology as early theorists Glaser & Strauss (1967) recommend delaying it until after analysis is complete to ensure that data is not viewed “through the lens of earlier ideas” becoming merely “received theory”. Although my original intention was to do this, it became apparent that this would not be possible in the time available. However, I took consolation in the fact that this position has been rejected by a number of researchers in the field and Charmaz suggests that when analysing the data, ‘a lack of familiarity with relevant literature is unlikely and untenable’.

Thornberg (2012, cited in Charmaz, 2014) advocates an ‘informed grounded theory’ approach which requires assuming a critical and reflective approach to the literature, which is what I believe I have done in my first chapter, where the literature is evaluated in terms of both strengths and weaknesses. In particular, methodological flaws are identified and discussed. However, the review provides the justification I was seeking for carrying out the empirical research. The findings of the review indicated that role ambiguity can result in staff experiencing feelings of being under threat and assuming defensive positions. Moreover, the review suggested that role ambiguity results from a lack of structure and stability in services.

### ***Methodology***

The methodology of grounded theory was chosen to explore the impact of organisational change within staff working at community mental health centre. I was not familiar with this methodology but I was drawn to it because of its roots in social constructionism and from what I had read grounded theory is frequently used to investigate social processes. Charmaz (2014, p.326) outlines how grounded theory is often used to study social justice issues and is commonly focussed on ‘fairness, equity, equality, democratic process, status, hierarchy and individual collective right and obligations’, whilst it involves taking a ‘critical stance towards organisational and social institutions’. This methodology was appropriate as my study was coming from my own feelings of injustice at the financial cuts being made to the public sector and my belief that this was having damaging effects on those working within in it as well as those depending upon it.

Undertaking the interviews was extremely interesting but at the same time, I found it hard to listen to so many staff members who were clearly feeling demoralised and ill-treated in the sector in which I was about to embark on a career. Whilst carrying out the interviews, I simultaneously logged my own experiences of working within a mental health team. I was increasingly aware that there were parallels to the emotions and feelings I was hearing people describe within interviews and my own.

### **Reflexive journal**

May 2015

*'It was a very difficult team meeting today! It was a full house with (name of manager) and (name of manager). I felt quite intimidated, especially when we had to go round and introduce ourselves. As the meeting went on there was a discussion around clinical notes and clinicians not being adequately prepared when they go on visits. Immediately felt guilty as I recalled I had phoned the office for a phone number the other day! Apparently admin staff have complained that they are getting far too many calls for addresses, phone numbers or contents of letters from clinicians on visits...The whole tone of the meeting was quite critical and I came away from it feeling that I was not doing a good enough job. I also had a sense that the needs of admin staff are felt to be more regarded than clinicians and that there was a lack of understanding of the impact of stress and emotional labour that our job entails... There was a lot of ill feeling amongst staff following it and interestingly there was a real split in the team with clinicians going in one room and all the admin staff going in another. I just tried to keep my head down but you could cut the atmosphere with a knife!'*

This excerpt illustrates that my feelings were mirroring the feeling of team members and reflect very similar issues to those apparent in the interviews. I also recognise that my participation in meetings such as this and my own sensitivities will affect how I respond to the data. The feeling of prioritising of admin tasks over clinical work is evident in this extract, similar to some of the statements made by the staff in my study. The sense that clinicians were demoralised, feeling 'cornered' by managers who did not fully appreciate the full range of their professional responsibilities is also evidenced in the excerpt. Following the meeting, in the split between the admin staff and clinical staff is reminiscent of the feelings of disconnect from colleagues that staff described in the study.

June 2015

*'I'm thinking back about earlier today and why it felt so difficult. The team meeting lasted two and a half hours! We fortunately had a break half way through – during which I escaped outside just to get some fresh air and to get out of the stifling atmosphere of the room. During the meeting I felt so overwhelmed by the number of*

*files piled high on the table that we talked through; there were so many desperate and shocking cases that seem to be coming through and now we are such an understaffed team, that it seems we are being asked to perform an impossible task.*

*Something I've notice about the meeting is that there is such a long time spent trying to decipher the process of the referral, where the referral has come from, has the form been completed in the correct manner, is it appropriate for the service and should it have gone on a different pathway. I wonder why, is this a way of detracting from the often upsetting and distressing content of what we hear and discuss?*

*I sat at the end of the table, as usual feeling quite on the periphery. I often find being in the meetings hard as I'm not sure of my role or what I can contribute. This adds to my feelings of helplessness I think. There was also another episode of bickering between two members of the team. One junior member accused the psychologist of not carrying out the assessments fast enough. This was done in a very unprofessional manner, I felt awkward and embarrassed and had to look away. I'm of the opinion that everyone in the team is working at full capacity and everyone is feeling the pressure but I wonder why there is so little solidarity between the team.*

There is a lot in this excerpt which resonates with the study's findings. I describe the increasing expectations clinicians have to meet, but clinicians are still answerable for not meeting the targets they are set. I suggest that discussing procedural issues seems to act as a defence against thinking about the upsetting content of the referrals. Clinicians therefore seem to need to detach themselves from the emotional pressures associated with the work and as already suggested, the huge caseload pressure. I also describe my own role ambiguity as I express my uncertainty as to what I am meant to be doing or what people expect from me. Again, this reflects the study's findings that changes to services make job identities less secure even with experienced practitioners. Finally, in this excerpt the rivalry and conflict between team members is again illustrated, reflecting a key theme in the study.

It is apparent from reading these excerpts that there was a dual process being carried out during the research. On one side, my own experiences influenced how I responded to the data collected in the study. On the other, the process of collecting

data alerted me to team dynamics in my own circumstances, therefore enabling me to analyse the data with greater awareness. A comment from my tutor that the ‘management do not seem like people’ made me recognise the extent to which my own vision of a punitive system oppressing workers was perhaps filtering through into my writing. As part of this reflexive process I can acknowledge how my assumptions and positions have shaped the course and representation of the findings of the research.

### ***Implications for future research***

The findings of this study indicate that greater consideration should be given to impact on staff of rapid change and restructuring of mental health services. The study suggests that these changes compromise the containing aspects of organisations, which result in staff forming social defences and having polarized perceptions of their working environments. An interesting study by Kennedy (2013) suggests that the principles of compassionate care could provide a basis for a different approach to mental health service provision. The findings of the current study indicate that an approach like Kennedy’s, focussing on encounters between individuals rather than structures and systems, could have a positive effect. Psychologists could play a crucial part in helping this kind of change of working culture to take root, by supporting teams and enabling staff to feel safe and function better as a group. I would suggest that it is necessary and timely that further research investigates how such ‘compassionate care’ can be introduced and sustained in community mental health services. The current project has examined this issue almost exclusively from the point of view of clinicians. Further research would also need to examine the issue from the point of view of other individuals involved in the changing services, including clients, senior managers and commissioners of services.

### ***Conclusion***

According to Charmaz (2014, pp.339-340), one of the purposes of grounded theory is to “transform knowledge”. The purpose of research using grounded theory is to “transform practice and social process” and “influence what we study and how we study it”. I feel that my study makes an original and significant contribution in these areas with the potential to influence knowledge and practice for the better in future. The research findings of this study develop the research base concerned with the

effects of rapid organisational change on staff working in mental health teams. This is done within a psychodynamic theoretical approach using a grounded theory methodology. These areas are relatively underexplored by researchers and the combination of professional, theoretical and methodological approaches in this study is, to my knowledge, completely new. Doing this research has transformed my understanding of the research area and will enhance my subsequent practice. I hope that these research findings will also inform the work of other professionals responsible for the planning and delivery of mental health services. In particular I hope that these findings will encourage service providers to recognise the effects of dramatic change on CMHTs and to identify ways in which teams can be made to feel better contained, supported and integrated.

**Word count:** 2, 448

### **References**

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage

Glaser, B.G & Strauss, A. L. (1967). *The discovery of Grounded Theory*. Chicago: Aldine.

Kennedy, A. (2013). A compassionate formulation of task drift in mental health staff. *Mental Health Review Journal*, 18, 73 – 82.