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CHAPTER 1

Describing Effective Teams

The only reason for being interested in teams at all is to examine their potential for achieving positive outcomes for users and other key stakeholders in ordinary service environments. But what constitutes effectiveness? This chapter explores this question from the perspective of users, carers, staff, policy-makers, politicians and the wider society. While these perspectives will never be wholly aligned I argue that focusing on effective working relationships between staff and service users provides a way of working with these tensions in the best possible way. Before examining these various stakeholder perspectives on what effectiveness means, let’s look at the social psychological model of team effectiveness that underpins the structure of this book.

A model for team effectiveness

West (1994) considered team effectiveness to have three main components:

- **Task effectiveness**: the extent to which the team is successful in achieving its task-related objectives.
- **Mental health**: the well-being, growth and development of team members.
- **Team viability**: the probability that the team will continue to work together and function effectively.

Teams are only likely to be viable over the long term if they are both effective in meeting their objectives and can attend to the well-being of their members. For example, the Daily Living Programme was an innovative service that nonetheless proved to be
unsustainable because of poor morale and lack of support from key stakeholders (Audini et al., 1994).

West developed his model of team effectiveness with particular emphasis on ‘reflexivity’. He argued that teams are effective to the extent that they reflect upon their objectives, strategies and processes, as well as their environments, and adapt these aspects of their worlds accordingly (West et al., 1998). In contrast to other models of team effectiveness, which focus on more static processes, this formulation captures the dynamic nature of ‘complex decision-making teams’. These are teams fulfilling seven criteria:

- *They operate in uncertain, unpredictable environments.* Chapter 2 will review the ever-changing social policy context in which teams operate.
- *They work with uncertain and unpredictable technology.* For CMHTs, the uncertain nature of risk assessment and management is a key example.
- *It is unclear how tasks should be performed on a day-to-day basis.* CMHTs are perhaps unique in that not only is there a contested evidence-base for much that is provided to users, but also there are often ideological schisms within the team concerning the very nature of mental distress and its care and treatment.
- *Team member interdependence is high.* Where teams are targeted on people with the complex health and social care needs, there is an obvious need for team members with different backgrounds to combine their efforts to achieve successful outcomes.
- *Autonomy and control for the teams are relatively high.* It is only with the advent of the NSF that a high level of prescription has become evident. How this policy is translated into practice remains to be seen. The experience of previous highly prescribed policy imperatives, such as the care programme approach (CPA), would suggest that change will only occur where practitioners are in support of the change (Bindman et al., 1999).
- *The tasks that the team are required to perform are complex.* Work in mental health teams may require high levels of technical knowledge, for example, in terms of the application of complex psychological theory, the effects and side effects of prescribed drugs, and unravelling the vagaries of the benefits system. In addition, practitioners may experience ethical and intellectual
tensions, for example, regarding their roles as caring professionals responding to need alongside their increasingly explicit role as an agent of social control.

- There are multiple components of effectiveness, and the team is responsible to multiple constituents. This chapter describes the many different outcomes that different stakeholder groups seek from CMHTs.

West’s model of group reflexivity is particularly applicable to knowledge-based teams of professionals with diverse backgrounds such as CMHTs (West, 1996). He describes two dimensions of reflexivity as part of the achievement of team effectiveness:

- Task reflexivity: demonstrated in the team’s ability to achieve the team’s objectives. For example, critiques of CMHTs have focused on their tendency to neglect people with the most severe and long-term mental health problems (for example, Patmore and Weaver, 1991a; Sayce et al., 1991). Subsequent guidance has emphasised successful targeting as the key task of CMHTs (Department of Health, 1996, 1999, 2001a). Later in this book we will explore those features of team design that promote the successful achievement of this objective.

- Social reflexivity: demonstrated in the team’s ability to promote the well-being of its members. Factors influencing morale among team members will be explored below and in Chapter 8.

**Effectiveness in the eye of the beholder**

It is important that mental health practitioners, users and carers, fully understand the difficult and contradictory nature of work in mental health. Since different interest groups may define effectiveness in different ways, it is also important to maintain an awareness of the power relationships that exist between staff and service users, and among the other key interest groups involved in mental health service provision. These interest groups include users, managers, the variety of provider agencies, the criminal-justice system, the commissioners of services, local and national politicians, carers and the wider public. This analysis should include a clear understanding of the potential for good and harm involved in receiving mental
health services. Without this it is difficult to achieve a critically constructive perspective on the role of CMHTs.

This is not the place for a full exploration of the sociology of mental health services (see instead Pilgrim and Rogers, 1999). This discussion will merely summarise some of the different expectations of various stakeholders in order to explore common interests and unavoidable tensions.

Our starting point is to consider how an expressed need on the part of service users is seen as a legitimate focus for intervention. Most commentators view need as being negotiated between users, professional mental health service staff and other key stakeholders such as the authorities that pay for services. In other words there is (1) a professional/service provider/commissioner view of need, (2) what users seek from services and, (3) an area of negotiated need that is the overlap between (1) and (2) (Slade, 1994; see Figure 1). What constitutes a legitimate need is therefore influenced by basic human values about what services should achieve for people, the respective powers of the agencies involved in negotiation, and the absolute level of resources that are available to meet the demand. This is determined by similar processes of negotiation at higher levels. The NHS and Community Care Act (1990) defined need as ‘the requirement of individuals to enable them to achieve,
maintain or restore an acceptable level of social independence or quality of life’. What is acceptable clearly bears upon our level of expectation.

We shall start with a user perspective, and then explore the role of mental health services as a provider of therapeutic input, practical help, social control and surveillance. We shall also examine the ways in which these expectations serve to produce social policy, and create issues for staff.

**User perspectives on effectiveness**

The following provides only a broad-brush account of key messages that occur consistently when asking users about what is sought from mental health services. It does not substitute for your own local inquiries into what the current and potential users of your services perceive as important. Being responsive to the needs of users requires sensitivity to changing needs, and recognising that people with different problems, backgrounds and cultures require different responses. Users do not represent a single culture or community. Different groups have different needs of services and find that services respond differently to them.

In that we are all users, or potential users of mental health services, the outcomes sought by service users will be familiar to everyone. Figure 2 illustrates how the needs that CMHTs might address form part of what mental health services as a whole should help people achieve, which in turn is informed by what all of us need to live fulfilling, effective lives.

**Strategies for living**

Maslow (1954) described a hierarchy of needs ranging from basic needs for sustenance and safety, through needs for belonging and love, and the promotion of one’s self esteem, through to the ultimate goal of ‘self-actualisation’ wherein one’s potential is realised and self-fulfilment is achieved. Many of these key themes are echoed in the user-led Strategies for Living study (Faulkner, 2000). Mental health service users described living well as involving the achievement of a feeling of being accepted, achieving a sense of belonging,
feeling supported, achieving purpose and meaning in life, experiencing peace and relaxation, being able to think positively, finding personal expression, distraction and control over one’s life.

Good personal relationships were seen as the key to fulfilling these ends. This included relationships developed with friends, families and partners, with professionals and through involvement in voluntary sector projects. The relationships needed to provide emotional support which itself entailed the need for acceptance of the individual in their totality, and for the relationship to offer love, physical affection and understanding. Relationships provided companionship with people who one could talk to and with whom one could share experiences and interests. They gave life meaning by providing a sense of belonging, a sense of purpose and someone to live for. Relationships also provided practical support, a fulfilling home life, and financial support.

Aside from the achievement of effective relationships, the study highlighted other strategies for living such as religious and spiritual pursuits, physical exercise, and hobbies. Having enough money, and achieving the right medication was also highlighted as important to effective survival. It is important to note that this study found that the required supports were normally drawn from sources other than mainstream services.
What users seek from mental health services

The Audit Commission (1994) commissioned a review of user surveys that looked more narrowly at what users seek from services. Users particularly sought help with finding employment and finance, including access to the welfare benefits to which they were entitled. The remarkable consistency of reports from users about the importance of social factors such as housing, finance and occupation is reflected in the equally consistent failure of services to afford these aspects adequate attention (Carpenter and Sbaraini, 1997).

The review also highlighted the need for more 24-hour crisis facilities offering out-of-hours contact, non-hospital crisis centres, and more voluntary sector and user-run services. There was also a demand for increased sensitivity to ethnic and cultural needs, and users having more rights, and respect from service providers. Rights included improved equality of access to services, and access to advocacy when required. Users sought greater involvement in decision-making, both in their own care and in service management and development. Users sought staff who listened.

The importance of information was evident. This included details of treatment options available, the effects and side effects of medication, and the range of services available. It was also important for people to be aware of the rules and expectations on admission, complaints procedures and their expected length of stay in hospital. Users wanted to be made aware of the roles and responsibilities of staff, rules of confidentiality and their rights to a second opinion.

Other changes that users saw as likely to improve care included better collaboration and cooperation between agencies, better liaison with local interest groups (for example, those concerned with minority ethnic groups), more efficient handling of complaints, the use of crisis cards, more help for carers and more user-only forums.

In order to develop a tool to evaluate CMHT effectiveness, Richards and Rees (1998) mapped what a range of stakeholders expected CMHTs to achieve. The stakeholders involved in developing these effectiveness criteria included users, carers, advocates, practitioners, policy-makers, managers, and researchers. The study highlighted the importance of CMHT workers’ ability to build relationships based on friendliness and trust with users and carers. The first
contact with services was seen as an important point for the subsequent development of a good quality relationship. Staff needed to be able to address users’ emotional responses with sensitivity and consistency.

This study also highlighted the need for users to be involved in decision-making about both their own care, and in evaluation and service development. Having a clearly identified individual within the team was important to promote this accessibility. Accessibility meant achieving a clear point of contact, short waiting times, and a rapid response.

It is also important to stress that users did not want to be involved with the CMHT for the sake of it. They had an expectation that the CMHT would be effective in improving their quality of life, clinical symptoms and social life. This, in turn, required interventions that could be expected to work.

Enabling users to make informed choices was seen as a way of promoting users’ autonomy, and required both the provision of choice and information about what was available. Information needed to be well-researched, unbiased and effectively presented in verbal and written form.

**What do carers seek from mental health services?**

There is often a danger of lumping user and carer interests together as if they represent a single-interest group. While they will share many of the same concerns, particularly concerning their involvement in services and the accessibility and choice of provision, there may also be differences in emphasis.

Outcomes sought by people with caring roles include (Audit Commission, 1994; National Schizophrenia Fellowship, 1995):

- Receiving enough advice and information to support the person experiencing mental distress in the best possible way.
- Someone to talk to, for example, a named team member for carers who will avoid professional jargon (Carpenter and Sbaraini, 1997). This support needs to be available out of normal working hours.
- Having emotional support when necessary.
• Being able to work.
• Being as financially secure as possible.
• Getting a break from caring responsibilities.
• To be able to sustain a social network and avoid isolation.
• Being valued and respected by services.
• Seeing the person they support receiving high quality services that meet their needs.
• Having a voice, both in terms of individual advocacy and also at a strategic level.

In terms of general service priorities, carers highlight the need for daytime occupation with flexible hours and a focus on employment skills, and special support for users who have had frequent hospital re-admissions. They also highlight the need for 24-hour access, alternatives to hospital, including home treatment or crisis resolution, early intervention to prevent crises, a range of residential provision with different levels of staff support, and more self-help schemes. The importance attached to self-help schemes and other resources aimed at furthering independence would appear to undermine the oft-encountered stereotype of carers as over-anxious and over-protective.

What do staff seek from work in mental health services?

Members of any organisation act in pursuit of individual and collective goals that may deviate from the formally stated aims of the organisation. It cannot be assumed that the function of CMHT membership for CMHT members is to produce outcomes valued by service users or carers, or indeed to achieve any of the effectiveness criteria highlighted above. It is just as plausible to argue that the function of team membership may be to earn a living, to fulfil a need to help people, or to exercise a desire to achieve social control of people experienced as socially and morally alien to oneself.

The research does, however, suggest that team members derive job satisfaction and a sense of reward from clinical work, particularly where they are able to be effective in their work (Heim, 1991; Onyett et al., 1995; Payne and Firth-Cozens, 1999). This remains true even where that clinical work is a source of stress. Barriers to effectiveness,
such as lack of resources, work overload and bureaucracy are key sources of pressure (Edwards et al., 2000; Onyett et al., 1995).

Onyett et al. (1995) found that teamworking itself was the most frequently cited source of reward among 445 CMHT members. Respondents valued being in a team with supportive colleagues and working well together in a committed, cohesive and sometimes humorous way. For example, the consultant psychiatrist who cited: ‘Relationships with colleagues – mutual support, respect and fun’, as a source of reward and the occupational therapist who felt ‘The atmosphere of the team is very supportive and open and we all share a slightly off-key sense of humour.’ The UK ‘Care in the Community’ demonstration programme (Knapp et al., 1992) also found the most frequently cited areas of satisfaction were relationships with colleagues (cited by 93 per cent of their sample) and Borrill et al. (2000) found team membership to be associated with improved mental health among staff in their large-scale study of team effectiveness.

Other sources of reward that were highlighted in the Onyett et al. (1995) study included opportunities for innovation, variety, challenge and training. One community mental health nurse (CMHN) valued the ‘team’s continued commitment to in-service training – stops you going stale’. Other valued tasks included inter-agency work, group work, supervising others, project work and management. Some people made particular mention of the benefits of community work, such as the nurse who valued ‘supporting people in the community – not being divorced from the social realities’, or the CMHN who valued exposure to ‘the broad-range of life situations encountered in the client group’.

Herzberg et al. (1959) regarded the avoidance of dissatisfaction with extrinsic factors of the job such as pay and security as a more basic, lower-order need than the achievement of satisfaction through intrinsic factors of the job such as a sense of achievement or meaning from one’s work. Koelbel et al. (1991) found that social service, variety, and opportunities to use one’s abilities were major sources of satisfaction among nurse practitioners. Dissatisfaction was expressed with pay, promotion, policies and practices, recognition and supervision and relationships. Similarly, Knapp et al. (1992) found the main sources of dissatisfaction were income and promotion prospects.

It is possible to conclude that staff are most concerned to achieve a sense of intrinsic satisfaction through being able to feel effective
in their work. This allows people to derive some meaning and social value from their work, even when it is stressful. While it is also important to avoid extrinsic sources of dissatisfaction (like low pay and status) when considering what staff seek from their work, it is important to ensure that the work environment allows staff to be maximally effective in order to promote the mental health of both staff and service users.

**What does society expect from mental health services? – The tension between care and control**

Staff, users and their carers form part of the societies in which we live and the cultures that characterise them. As Rose (1996a: 353) observes:

> While our political, professional, moral and cultural authorities still speak happily of ‘society’, the very meaning and ethical salience of this term is under question as ‘society’ is perceived as dissociated into a variety of ethical and cultural communities with incompatible allegiances and incommensurable obligations.

Mental health services sit within these cultures, and act to maintain the interests of certain groups. Mental health services are certainly concerned with helping troubled individuals in whatever way possible. However, they also demonstrate a role in controlling behaviours that are deemed socially unacceptable. Furthermore, since the goals of mental health service interventions are often shaped by prevailing cultural norms and definitions of normality, mental health service provision also serves to maintain and shape social values.

There has been an explosion of popular interest in counseling and psychotherapy. The remit of mental health services has now expanded to include a much wider range of mental distress. For many people it may provide a secular alternative source of meaning and relief from unhappiness that was formerly achieved by religious observance. One might predict that this would make the barrier between ‘mental illness’ and ‘normality’ more blurred and permeable thereby reducing stigma. A less benign interpretation is that this expansion in a therapy industry serves to ‘pathologise’ that which might formally have been considered
normal human misery or distress by creating new medical categories of questionable validity.

A culture that is overconcerned with the management of risk also extends the remit of mental health expertise from diagnosis of dangerousness or vulnerability among people confined in institutions, to evaluation of failures of self-management in community encounters. These may arise from failures to budget, cook, maintain tenancies or cope with family relationships (Rose, 1996b). Rather than aspire to achieve recovery of roles among mental health users, the emphasis shifts to ‘management’ of risk within these various domains of the user’s life. Users are already highlighting concerns about the role of intensive community team treatment in exercising this level of control and surveillance (Smith et al., 1999a).

This cultural concern with management of risk also has implications for staff. We are all to a greater or lesser degree potentially a risk to others or ourselves in these ordinary life domains. Yet this culture inculcates a fear of accountability and blame among mental health practitioners for events that they feel to be out of their control.

Stigma is an enduring feature of mental health problems. People with a psychiatric history fare worse than other disabled people when returning to work. Only 13 per cent are in employment compared with over a third of disabled people generally (Office of National Statistics, 1998). Sayce and Measey (1999) highlight that this cannot be accounted for by the nature of the mental health problems themselves as mental distress is not a reliable predictor of work capacity (Anthony et al., 1995) and unemployment rates can be significantly reduced when people are offered real jobs but with intensive and flexible support (Bond et al., 1997; Crowther et al., 2001). Read and Baker (1996) in a large-scale survey of users reported that 34 per cent had been sacked or forced to resign from employment. Unsurprisingly, Link et al. (1997) found that 75 per cent of seriously mentally distressed people would not tell a prospective employer about their psychiatric history.

Sayce and Measey (1999) also highlight the problems that people with mental health problems have in accessing housing in the community of their choice. There was an increase in NIMBY (‘Not in my backyard’) campaigns in the 1990s that often resulted
in delays in implementation or the relocation of mental health projects, and occasionally attacks on residents and staff. Read and Baker (1996) reported that 26 per cent of their sample had moved home because of harassment, 47 per cent had been abused or harassed in public and 14 per cent subject to physical assault. They also found that access to key opportunities such as life insurance, mortgages or holidays could also be threatened by revelation of a psychiatric diagnosis. Indeed, even access to basic medical care is threatened with users reporting difficulty and delays getting tests for physical problems because the complaints are initially interpreted as manifestations of their mental health problems. This is of great concern, particularly in view of the high rates of heart disease and other major illnesses among people with mental health problems (Department of Health, 1994a).

There has been a marked social policy shift with the New Labour Government of the late 1990s towards recognising the importance of social inclusion. Landmark features include the New Deal for disabled people concerning employment opportunities, an emphasis on achieving effective partnerships between key agencies to reduce exclusion through local ‘Action Zones’ for health and education, and the establishment of a Disability Rights Commission. However, this has gone hand in hand with policies that continue to emphasise containment and concealment of people with the most publicly unacceptable manifestations of mental distress, as well as providing psychiatrists with a new mandate for social control.

The urge towards containment and minimisation of risk was manifest in government proposals to introduce compulsory treatment in the community and detain people deemed dangerous and diagnosed as having a severe personality disorder, regardless of whether they are regarded as treatable, and whether they have committed a crime (Department of Health/Home Office, 2000). So while there is a new emphasis on social inclusion, new social policies reveal a parallel and more enduring concern with social control and segregation. The commitment to community-based provision and the integration of service users into communities with the full rights of any other citizens seems at best questionable in this context. Thomas et al. (1996) argue that this is because, while the location of care has changed for many, the language of psychiatry and the theory that underpins it has remained the same. They argue that psychiatry has always been founded on
a social policy of exclusion rather than advances in medical science. They point out that:

Isolating the insane from society [through the asylum system] grew out of the Romantic belief in a Utopian society which regarded urbanisation and industrialisation responsible for the growth of insanity (sic). This isolation was linked to a search for medical causes of mental illness, as asylum care isolated the insane from the effects of poverty, overcrowding, alcohol misuse, violence, prostitution and other forms of abuse that characterised industrial urban life. Yet paradoxically this sequestration, and the emerging concept of mental illness, devalued the importance of social factors in relation to insanity. Psychiatrists studied mental illness devoid of any social context, producing a schism between the social reality of mental illness and the interpretation of sufferers experiences. (Thomas et al., 1996: 401)

Despite the emergence of social psychiatry and the development of ‘community care’, the broader picture is of a deepening of this schism. The ‘social reality’ for many users is increased economic polarisation and poverty, particularly among minority ethnic groups (Joseph Rowntree Foundation, 1995). The UK has closely followed America’s passage into a post-industrial economy characterised by upward distribution of income, cuts in benefit entitlements and a loss of low-cost housing stock. At the same time the trend in the two main American psychiatric journals from 1969 to 1990 was away from psychological and sociological formulations and towards biological perspectives, (Pincus et al., 1993).

Concerns about medicalisation of distress and neglect of social factors do not reflect a belief that politicians, and the practitioners and managers who have to implement social policy, are personally malign or politically ignorant. Indeed, we have seen above how most practitioners appear to value their relationships with users as individuals. Nonetheless, there is a tension between care and social control that has long characterised work in mental health services. Mental health workers operate as members of a culture and understanding this culture offers insights into some of the social forces that shape our work.

Mossman cites a ‘mythologised individualism’ (Merelman, 1989) as the contemporary manifestation of these themes. This holds the individual to be virtuous, and naturally free while the collective (or ‘society’) has the connotation of being constraining, centralising,
corrupting, repressive or even evil. This theme has become central to political rhetoric and policy and an important part of popular culture. Examples of the impact on political discourse on both sides of the Atlantic can be found in the hardening attitudes towards welfare, campaigns to address corruption in the working of central government, and claims to reduce the influence of central government to an optimal minimum. The UK has adopted the political imperative, embraced by both major parties, to keep personal taxation to a minimum in order that individuals can exercise maximum choice on how to spend their income. Individualism is also manifest in the emphasis on marrying individual rights with personal responsibilities. In an international context, the cultural triumph of individualism over collectivism has also been powerfully embodied in the expansion of liberal market economies and the collapse of Eastern bloc, so-called ‘socialist’, totalitarian regimes.

Indeed the UK has seen the most dramatic rhetorical emblem of individualism with Margaret Thatcher’s statement that: ‘There is no such thing as Society. There are individual men and women, and there are families’ (Woman’s Own, 31 October, 1987). This reinforces a pre-existing tendency among mental health services. As Handy (1990) pointed out, ‘the mental health system has a tendency to locate the sources of people’s problems within either organic dysfunctions or psychological dysfunctions within the individual or their immediate family…and by so doing it implicitly denies the relationship between social conditions and human experience’.

Mossman (1997) argued that by acting on the premise that socio-economic problems require an individualised professional response, mental health services are affirming their social function of defining and controlling non-criminal deviance. Expansion of social control is premised on the idea that the behaviour of mentally distressed people is an exception to normality, mainly by dint of being biologically induced, and so they become categorically different. This in turn validates a policy of exclusion and confinement.

One way in which psychiatry serves to maintain the ‘mythologised individualism’ of post-industrial societies is to provide, as it always has done, the means by which the people that violate categories and threaten personal safety or property can be redefined out of ‘legal personhood’. This has found dramatic expression in the proposals referred to above where people without a formal ‘mental illness’ but instead a ‘severe personality disorder’ may be subject
to detention on the basis of assessed risk, even if they have not committed criminal acts.

Mossman’s (1997) focus on individualism links to the notion of ‘healthism’ whereby health and sickness are both polarised and moralised such that attainment of health, (and increasingly the associated physical beauty), becomes a socially valued and individual goal to which all should aspire. Sickness is thus forgivable only when it is temporary and resolvable within a biomedical model of health (Carpenter, 1994). Where cure is not available the state of ‘illness’ becomes stigmatising and leads to a ‘spoiled identity’ (Goffman, 1961).

Members of CMHTs are both members of societies in which these themes are evident, and individuals charged with managing deviance on society’s behalf. The expectations of them are enormous. The National Service Framework for Mental Health (NSF; Department of Health, 1999) places considerable emphasis on ensuring that staff are competent to assess the risk of suicide by providing training for staff in specialist mental health services in risk assessment and management as a priority. The last of the seven standards within the framework states that, ‘assertive outreach is in place for all individuals who may fail to take their prescribed medication and would then be at risk of depression, severe mental illness or suicide; for those who have a tendency to drop out of contact with services; and for those who are not well engaged with services’ (79). The expectation is that by April 2002 assertive outreach will be in place for all service users on enhanced care programmes who are at risk of losing contact. Compulsory treatment in the community was proposed as a way of ensuring that contact would be maintained and that prescribed treatment administered. As the agents of community supervision, CMHT members are charged with responsibility for the maintenance of public confidence in the policy of community care, a function acknowledged by the Department of Health to be part of the rationale for increased coercion (Atkinson, 1996).

At the same time the NSF exhorted service providers to ‘ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems’. CMHTs and their members are thus charged both with responsibility for social control of deviance and community integration.
Managing the tensions

The enduring strength of the cultural determinants of mental health policy and practice goes some way towards explaining why, despite endless policy shifts, the experience of services by users remains very much the same. How might the tensions between the interests of the groups described be addressed in a way that might improve outcomes for people that use services? How might CMHTs work with individuals and agencies to make things different?

Achieving profound change through local initiatives

The policy context for socially inclusive practice has never been more favourable. The NSF, with its emphasis on mental health promotion, provided an impetus towards greater partnership working locally between health, social services, education, employment agencies and other key stakeholders concerned with the quality of life of people with mental health problems. Subsequent guidance on mental health promotion also provided an invaluable resource for strategy formation and case examples (NHS Executive, 2001). Clinical governance, the framework for continuous quality improvement in the NHS, (Department of Health, 1998b) introduced a national performance framework that places the experience of users and carers at the centre of service development. The guidance on auditing care planning under the care programme approach stressed audit from the user perspective and the need to include assessment and care planning with respect to employment, education, accommodation, income and leisure (Department of Health, 2001b).

However, translating policy into practice requires consideration of the issue of power and conflict. It is easy to exaggerate the level of consensus within systems. Critical theorists stress that the social order is often negotiated from structurally determined positions of unequal strength that frequently work against the interests of users and employees. Handy (1990) stated that:

The nature of power relationships is often poorly perceived by members of an organisation or society and may be subject to systematic distortions by dominant power holders whose structural position in society gives
them an enhanced ability to make their own sectional interests appear to others as universal ones (359).

The changes required to make services truly user-led, based on users’ needs and accountable to users are *profound*, which as Senge *et al.* (1999) point out means ‘moving towards the fundamental’. It is the level of change that has been sought by the UK user movement since the first patients’ councils and advocacy projects were developed in the mid-1980s. Inasmuch as the fundamental nature of mental health services is not easy to observe from within, there is an inevitable element of ‘consciousness raising’ required among users, staff, carers and other key players about power relationships and the cultural forces described above.

It is therefore important (a) that an ongoing and informed dialogue takes place through every media available on the nature of mental health services, their social role, and how mental health and social inclusion may be promoted, and (b) that access to the means to influencing that dialogue is open, easy and fair. This has implications at a local level with respect to shaping involvement in the processes concerned with one’s own care and in the planning and development of local services, and in terms of broader public education about mental health and illness. Sayce and Measey (1999) argued that such local approaches to promoting social inclusion are likely to be more effective than large national education campaigns. CMHTs have a large role in achieving this local action.

Profound change requires not just doing different things, but rather building capacity to do things in a new way, which in turn requires new ways of thinking. One aim of this book is that members of teams will think differently about their work, and in a way that is more psychologically and sociologically informed. The hopeful and informed ideology embodied within the recovery approach (see Carling and Allott, 2000) is important in this regard and is described in Chapter 6. This profound change in thinking can be brought about through practical means such as team-based training or review, particularly where this provides fresh insights into the perspective of users by involving them in the training and team development process. It is also important to achieve a shared sense of the possible among local stakeholders. Sayce and Measey (1999) and NHS Executive (2001) provide many example of clinicians,
voluntary organisations and user groups that are working together to break down obstacles to inclusion. For example, Perkins et al. (1997) have introduced policies within their NHS Trust that debar discrimination in employment and provide support to promote the employment of staff who use mental health services as members of mental health teams. The Bradford Home Treatment team provides a valuable early example of this approach (Bracken and Cohen, 1999). Voluntary organisations are also active in supporting people to get involved in work, education, religious activities and leisure pursuits. Mind has produced guidelines for local service providers on how to prevent and resolve NIMBY campaigns through working constructively with local communities (Sayce and Willmot, 1997).

Equipped with such examples of best practice, team members are better placed to advocate for the interests of users locally and work alongside them in supporting the kinds of relationships where they come to be seen as contributors to their communities rather than burdens or victims.

At the dawn of this millennium the alignment of user concerns and policy imperatives concerning social inclusion was unprecedented. The challenge is now for these imperatives to be underpinned by adequate resources, for urges towards inclusion to prevail over imperatives concerned with risk management and coercion, and for users, carers and local providers to work in effective local partnerships to produce meaningful change.

**Effective relationships between users and staff as the foundation**

We have seen how users are concerned to feel understood and listened to so that the support they receive is of practical and personal value. They want to improve the quality of their lives and feel able to be included within ordinary community life. Similarly, staff value feeling effective in their work and benefit from the personal contact they have with users through their clinical work. At the same time, employing and funding organisations, politicians and the public at large are concerned with avoiding adverse events and ensuring risk is effectively managed. The evidence reviewed in Chapter 6 will suggest that an emphasis on the establishment of effective relationships between staff and service users will be important
in managing these tensions. If relationships are valued by service users, they promote effective involvement with services, improve clinical and social outcomes, improve the management of clinical risk and may attenuate some of the more oppressive aspects of mental health service provision.

**Conclusion**

This opening chapter has explored the issue of effectiveness from a stakeholder perspective and foreshadowed some issues to be explored in more detail later, such as team design to achieve valued outcomes for users and the mental health of staff, the centrality of effective relationships, and the need for staff to be aware of their context in order to function as reflective and effective practitioners.

Effective working relationships between staff and service users do not in themselves create good mental health services. They provide a necessary, if not a sufficient condition for an environment in which users, their social networks and staff can work together to achieve the best outcomes given the prevailing conditions. The effective assessment, planning, service delivery and the continuity of contact required for on-going provision, monitoring of outcomes and review all require that staff and service users have good reason to want to stay working together. It is a paradox then that perhaps the most important aspect of teams for the provision of services for people with severe and long-term mental health problems is the extent to which they are able to promote successful individual relationships between users and staff.
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