

This is a post-peer reviewed version of an article accepted for publication. Until the paper is assigned to a volume and issue, please cite as ‘in press’:

Hannigan B. ‘There’s a lot of tasks that can be done by any’: findings from an ethnographic study into work and organisation in UK community crisis resolution and home treatment services. *Health: an Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*. DOI: 10.1177/1363459313501359

‘There’s a lot of tasks that can be done by any’: findings from an ethnographic study into work and organisation in UK community crisis resolution and home treatment services

Ben Hannigan

Cardiff School of Health Care Sciences, College of Biomedical and Life Sciences, Cardiff University, Eastgate House, 35-43 Newport Road, Cardiff, CF24 0AB, UK

Email: hanniganb@cardiff.ac.uk

Author biography:

Ben Hannigan is a Reader in Mental Health Nursing in the Cardiff School of Health Care Sciences, and has a practitioner background in community mental health nursing. He has written widely in the fields of mental health policy, services and practice and blogs at <http://benhannigan.com>

Abstract

Across the United Kingdom (UK) large numbers of crisis resolution and home treatment (CRHT) services have been established with the aim of providing intensive, short-term, care to people who would otherwise be admitted to mental health hospital. Despite their widespread appearance little is known about how CRHT services are organised or how crisis work is done. This paper arises from a larger ethnographic study (in which 34 interviews were conducted with practitioners, managers and service users) designed to generate data in these and related areas. Underpinned by systems thinking and sociological theories of the division of labour the paper examines the workplace contributions of mental health professionals and support staff. In a fast-moving environment the work which was done, how and by whom reflected wider professional jurisdictions and a recognisable patterning by organisational forces. System characteristics including variable shift-by-shift team composition and requirements to undertake assessments of new referrals whilst simultaneously providing home treatment shaped the work of some, but not all, professionals. Implications of these findings for larger systems of work are considered.

Keywords

ethnography; health policy; mental health; organisation of health services; profession and professionalisation

Introduction

The mental health system in the United Kingdom (UK) is complex and in motion, with contributions being made by workers with a variety of occupational backgrounds employed by both health and social care agencies (Hannigan and Allen, 2006). In recent years this system has been subject to sustained policymaking attention, leading to a proliferation of new types of team (Hannigan and Coffey, 2011). It is in this context that crisis resolution and home treatment (CRHT) services have emerged. In all parts of the UK these have become the favoured means of ensuring people in mental health crisis have access to intensive, short-term, support in as least restrictive an environment as possible (Department of Health, 2001; Welsh Assembly Government, 2005; Scottish Executive, 2006; Department of Health, Social Services and Public Safety, 2011). Their central purpose is to provide community-based care to people who would otherwise be admitted to psychiatric hospital (Johnson and Thornicroft, 2008), and their origins can be traced to pioneering developments in the Netherlands in the 1930s (Querido, 1968) and to later evaluated innovations introduced in parts of the USA (Stein and Test, 1980; Davis et al., 1972), Canada (Fenton et al., 1979), Australia (Hoult, 1986) and the UK (Marks et al., 1994).

Despite their rapid and widespread appearance little is known about how crisis services are organised, or how crisis work is done. This is a major omission in a context in which rigorous, theoretically informed, examinations of approaches to providing health and social care are increasingly prized (Fulop et al., 2001). This paper arises from a larger ethnographic study which set out to make a novel contribution in this area. Its aims are to examine the workplace contributions of mental health professionals and support staff, and to explore how roles are shaped. Underpinned by systems thinking and sociological theories of the division of labour the paper takes seriously the idea that organisational features play a

critical part in 'patterning' (Strauss, 1978) work and that this, in turn, has implications for larger professional jurisdictions (Abbott, 1988).

Work and organisation

From Freidson (1976) comes the insight that divisions of labour are realised through social interaction, and from Strauss (1978) the idea that roles are accomplished through negotiation. To these interactionist observations can be added an 'ecological' perspective emphasising the world of work as an interrelating social system (Hughes, 1971). Hughes also writes about the 'mandate' claimed by occupational groups (referencing the appeals they make to contribute to society) and their 'licence' (which refers to what they can actually do). He observes that systems are constantly shifting in response to a variety of forces, so that over time the 'bundles of tasks' attached to occupational groups change and modifications take place in technical divisions of work. For Hughes these movements can have additional implications for social roles, or for what he refers to as the moral division of labour. Abbott (1988) extends this thinking by applying a systems approach to the study of professions, introducing the idea of 'jurisdiction' to refer to the control groups have over particular areas of work. Abbott follows Hughes in observing that work in interrelated systems is fluid, and to this adds a new emphasis on the importance of competition. He argues that professions both defend and advance their jurisdictions, making appeals to their possession of sufficient, relevant, underpinning abstract knowledge. This staking of jurisdictional claims is done in three spheres: the public, the legal and the workplace. For Abbott it is in the last of these that roles are actually realised, and in circumstances where professionals work in organisations what they do is open to shaping by situation-specific features, everyday negotiations and custom.

This general approach to systems, services and work has informed a steady stream of qualitative studies investigating work and roles across the health care arena (see for example: Allen, 1997; Allen, 2000; Carmel, 2006; Foley and Faircloth, 2003; Mizrachi et al., 2005; Reeves et al., 2009; Salhani and Coulter, 2009; Speed and Luker, 2006; Timmons and Tanner, 2004). Deployed in the mental health field, it has been used to support the theoretically informed analysis of large-scale policy and historical change (Hannigan and Allen, 2006) and to underpin empirical investigation into smaller-scale systems found in local organisational settings (Hannigan and Allen, 2011). As this paper exemplifies, a feature of data-based studies in this tradition is their potential to show what members of different occupational groups actually do in the workplace and the relationships between this and larger jurisdictional claims.

The study

The study from which data are drawn in this paper aimed to examine the setting up, functioning and system impact of an exemplar CRHT service, along with exploring the work and roles of staff and retrospectively investigating the experiences of people passing into, through and out of crisis care. A paper already published focuses on system connections and the consequences of establishing crisis services (Hannigan, 2013), and a second paper introduces and explores the idea of ‘critical junctures’ using data on service user experiences (Hannigan and Evans, in press). Information on the aims, design and methods of the study is given in both articles, but is summarised here for completeness.

National Health Service (NHS) research ethics committee and local research governance approvals were secured, following usual procedures, for a project using an embedded case study design (Scholz and Tietje, 2002; Yin, 2009). The larger case examined was a single interprofessional CRHT team in Wales, UK, set explicitly in its surrounding

system context. The smaller, embedded, units of analysis (the individual case studies within the larger, organisational, case study) were four people with experience of using the CRHT team's services and their surrounding network of involved workers. Ethnographic methods (Hammersley and Atkinson, 2007) were used, with all data being generated over an 18 month period from the middle of 2007 by a principal investigator with a professional background in community mental health care but with no direct past or ongoing involvement in the services studied. Fieldwork began in the second year of the team's operation.

In order to find out about the establishment, functioning and wider impact of the case study team, data were created through semi-structured interviews conducted with managers and practitioners located both in, and out, of the new service. Participants were identified because the positions they occupied in the local system gave them clear stakes in the CRHT service, and via snowball sampling (Coleman, 1958) through which existing participants suggested others who might also be invited to take part. Signed consent was given by each participant, and each interview was conducted using a flexible style working from a broad topic guide. This guide reflected the aims of the study, and focused on the CRHT team's origins and operation, the work of team members and its integration with (and its effects on) other service components. With participants' agreement, routine events were also sampled and observed. These included the CRHT team's weekly business meeting and meetings held with staff working elsewhere in the system convened with the aim of managing work across the interfaces. Contemporaneous, descriptive, notes were made at these events (Emerson et al., 1995). National and local policy documents and service specifications were secured, and treated as data.

Similar methods were used to generate the embedded case study data. The focus in this part of the project was on retrospectively understanding the unfolding 'trajectories' (Strauss et al., 1985; Hannigan and Allen, 2013) of people who had used the CRHT team's

services, including examining their views and experiences and the roles fulfilled by workers directly involved in their care. Potential service user participants were selected in consultation with professionals with ongoing care and treatment responsibilities, who also extended initial invitations to take part on behalf of the principal investigator. Four people with experience of using the CRHT team were identified in this way and consented to join the study. Semi-structured interviews were held with all four, each focusing (again using a flexible style) on experiences during the journey into, through and out of CRHT services. With each service user participant's permission, access was secured to his or her NHS practitioner records covering the period of crisis care, from which anonymised handwritten notes were made. These records were used as data, and as a way of identifying workers to whom invitations to participate could be sent. Flexibly conducted, semi-structured, interviews focusing on roles and the organisation of services were held with participants consenting in their capacity as providers of care during phases of crisis. Participants in this segment of the study included workers located inside the CRHT team, along with staff located in other parts of the system who had referred users into the case study service and those assuming responsibility for ongoing care following discharge.

Audio-recording qualitative research interviews is a way of promoting reliability (Silverman, 2005), and this was done in all but two cases. On both of these occasions detailed, contemporaneous, handwritten notes were taken instead. Interviews spanned a period of up to 90 minutes each, and in all cases summaries were made following completion for inclusion in the final dataset. Full transcripts were made of each audio-recording, during the preparation of which all personal and place identifiers were removed. Handwritten notes taken during the course of the two interviews which were not audio-recorded were wordprocessed. Fieldnotes created during observations were written up in full, and along with the handwritten notes made from NHS records were wordprocessed. Names of people and

places were removed from wordprocessed copies of policy documents and service specifications.

By the end of the period of data generation a total of 34 interviews had been conducted, with these representing the larger part of the project dataset. In addition to the four interviews conducted with service users, eleven were conducted with CRHT team members and ten with workers based in the local system's community mental health teams (CMHTs). These were the teams carrying the responsibility for coordinating and providing service users' ongoing care, and from where most referrals to the crisis service came. Three interviews were held with psychiatric hospital staff, and six with people working either elsewhere in (or across) the system. Staff participants' occupational backgrounds included nursing, psychiatry, social work, occupational therapy, clinical psychology and (non-professionally qualified) care support. All interview transcripts, the records of the two unrecorded interviews, NHS case note extracts, field notes and local policies were entered as separate primary documents into a project-specific 'hermeneutic unit' created using version 5.5 of the qualitative data analysis software package Atlas.ti (Scientific Software Development, 2009). Each of these 43 anonymised primary documents was read in close detail, and initial, formative, notes were added using the software's memoing facility. This was followed by systematic and detailed coding, during which meaningful units of data (or 'quotations') were identified and tagged. Some individual codes were created through an inductive (or bottom up) reading of data. Others, reflecting the general focus of the study, were created in advance and were linked to data bits in deductive (or top down) fashion (cf. Coffey and Atkinson, 1996). Codes were used to both distinguish and connect data segments, and to aid the direct retrieval of extracts. As examples, codes were attached to data items relating to particular areas of work (such as assessing suitability for crisis care, and managing medication) and to points in each service user participant's journey through the system. This

approach taken opened the dataset up to a variety of different analyses, including that developed through the medium of this paper with its focus on the organisation of the case study team, professional and support staff members' work and roles and their relationships to service users' experiences.

Findings

Establishing crisis services: negotiating space in the workplace

The crisis services workplace was an entirely new one, presenting itself as a forum for the advancement of professional claims to fulfil space in an evolving division of labour.

Although national policy pointed towards the expected characteristics of the team (Welsh Assembly Government, 2005), the responsibility to negotiate its occupational composition and workers' anticipated roles fell to actors distributed throughout the immediate system.

How nurses, social workers, psychiatrists, psychologists, occupational therapists and support staff might be attached to the team was therefore a matter for local decision-making, but always in a context in which the range of options was framed by prevailing organisational features. One of these was the existence of limited funds (including for staff costs), released only through closure of a hospital ward elsewhere in the local system (Hannigan, 2013). A second was the involvement of two statutory agencies in the setting up and staffing of the team. Although lead agency responsibility for the new service lay with the NHS health care provider, the area's local authority (which had responsibility for social care) was a concerned and involved partner. It was this organisation which employed the system's social workers, who at the time data were generated were the only professionals able to fulfil statutory Mental Health Act responsibilities connected to the compulsory assessment and treatment of people with mental illness.

Managers and senior professionals described some of the ways in which these organisational features had patterned the negotiations which had taken place over the CRHT team's initial commissioning and establishment. An early decision needing to be made had centred on team leadership and management. In a break from the then-current practice employed across the local system the choice had been made to appoint a single person (with a nursing background) to the task of managing, on a day-to-day basis, the new team's anticipated complement of combined health and social care staff. A strong case for this novel cross-agency role was made by a senior, NHS-employed manager, with system-wide responsibilities:

NHS Manager: I don't see how you can run an organisation, a service which you have no control over. Call me old fashioned. [...] I just think, you know the buck has to stop with someone otherwise you run the risk of a service being incredibly vague, dissipated [...] Not good. Not good for anyone. [...] For goodness sake, you know, make us a proper team with a team manager. (Interview, NHS manager: primary document (PD)9)

A second, but more openly contested, initial decision was that of appointing a senior psychiatrist to a full-time position in the new service. Participants identified the responsibilities of this post-holder as providing clinical leadership and managing medical care for the short period during which service users were on the team's collective caseload. They also talked of an alternative model having been proposed, involving junior doctors providing day-to-day input under the direction of senior locality psychiatrists fulfilling ongoing medical responsibilities to service users on their caseloads including during episodes of crisis. This idea had reportedly fallen in the face of powerful clinical leaders arguing for a dedicated CRHT team psychiatrist as a stated means of concentrating crisis care expertise for the benefit of all, but also as a route to securing a leadership position in the workplace for a

doctor. A knock-on effect described was a reduction in the availability of medical time to the new team, reflecting the relative costs of employing a senior practitioner.

In a team where a decision had been made to appoint both a manager and a senior psychiatrist to full-time posts and where nurses (as the largest of the professional groups providing specialist mental health care) would invariably be employed, negotiations had had to take place to secure places for members of other groups. In the first of two examples demonstrating senior staff members' jurisdictional claims for their professions to be represented, an occupational therapist (OT) who had directly participated in negotiations over CRHT team composition said:

Occupational therapist: [...] it became apparent that there is a role for occupational therapy, even when people are in a very acute medical crisis, there is a role. [...] OTs are problem solvers, that's, the basis of our training is around resolution of difficulties, around problems and the strategies that we can support people in developing to manage the situation that they find themselves in and to make informed choices about where they want to go in their situation. (Interview, occupational therapist: PD3)

In this second example, a senior social worker advanced their profession's claim by appealing to the particular contribution made by practitioners who were 'approved' (and therefore able to apply for compulsory assessment and treatment), and to a more general social work distinctiveness:

Social worker: [...] an ASW [approved social worker] has that depth of experience that another social worker in the crisis service that is not an ASW won't have, because you know, the training they have to do and all the training sessions that ASWs do is very high quality, very thorough and to have got through that and I think they and I think just by the nature that they've got a social work training they do bring another dimension too, so I would like to see them there. (Interview, social worker: PD8)

Shared interfaces, managing workflow and organising tasks

By the time data generation commenced near the start of the team's second year of operation, formal CRHT team composition had been negotiated and a local service specification and associated documents agreed. In addition to the manager's and senior psychiatrist's positions places nominally existed for: a junior psychiatrist; eight nurses; two social workers; a clinical psychologist; an occupational therapist; five support workers; and two administrative staff. Staff absence meant that no occupational therapist worked in the team during fieldwork. Considerable turnover was also observed, with vacancies needing to be filled by workers brought in from other parts of the system.

The following analysis demonstrates how the work which was done and by whom reflected enduring professional jurisdictions but also, crucially, a recognisable patterning. The CRHT team shared interfaces with multiple other components within the immediate, interrelating, system and its positioning and the nature of its collective responsibilities were significant. Referrals for crisis care assessment between Monday to Friday, nine to five, working hours came from locality community mental health teams whose staff were responsible for the provision of ongoing secondary mental health care. Multiple requests for new assessments could arrive within single spans of duty. In all cases, following their independent assessments of referrals crisis team professionals were obliged to decide between offering home treatment (for a usual maximum of eight weeks), admitting to hospital or declining as ineligible. The responsibility to respond to urgent requests in this way, whilst also providing intensive home treatment to people accepted onto the team's caseload, made for a fast-moving and unpredictable working environment. In this context the team's process for managing workflows on a shift-by-shift basis revolved around a regularly updated whiteboard, contained on which was basic information about the team's current caseload of up to 22 people. Shifts commenced with the review of all names on the board, the allocation

of one professional to a coordination role and the apportionment of tasks amongst the four or five workers likely to be on duty.

Interview data generated with practitioner and service user participants, and detailed review of written crisis team service user health records, revealed how many of the everyday tasks attached to the service's professionals reflected the larger jurisdictions they have secured. Doctors prescribed medication, and nurses administered and monitored this. Social workers exercised their 'approved' status when required, and attended to matters concerned with service users' families and finances. A clinical psychologist provided face-to-face therapy with people internally referred by colleagues. Contextual features, however, also put pressure on taken-for-granted roles. As the following analysis shows, the composition of the workforce on a shift-by-shift basis, the requirement for the team to balance requests for assessment with home treatment and the expectation that the team function on a round-the-clock basis exerted a cumulative impact. During spans of duty these features interacted with important implications for what some (but not all) people did, as a nurse observed in the extended data extract which follows. Revealed here, in the interview yielding the verbatim quotation used in this paper's title, is the extent to which tasks described as 'shared' were more likely to become attached to some team members (nurses, social workers and OTs) than to others (doctors):

Researcher: What are the factors that have a bearing on who does what in the team, and why would, for example, a newly accepted service user gravitate towards, or be allocated to, a nurse or a social worker or an OT or a psychologist or a psychiatrist? How does that work?

Nurse: It is actually quite problematic because in any, the turnover of service users in the team is very high and a lot of the work is not exactly, it's progressive in a sense, but what you can deliver within any one span of duty or within one day is limited by who you actually have available to work. So therefore you might in principle decide that, oh I don't know, that somebody needs help to register as needing accommodation and they're probably not going to do it on their own because they're not terribly well, that's why they've come under the care of the team, so that it's appropriate for someone from the team to be giving them information, assessing whether they are going to be going down and do that task themselves, if not

offering help and support to do it. Any number of people could actually do it, it could be a support worker, it could be a nurse, it could be a social worker, it could be the OT, it could even be a medic if the medic has seen that person for some other reason, although it would be unlikely to allocate that particular task to one of the medics. But there's an awful lot of role overlap between the unqualified staff and the qualified staff and between the nurses, social workers and OT. There are some things that you would only expect one of those disciplines to do, but there's a lot of tasks that can be done by any, and so therefore who it's done by would just depend on the needs of the total group of service users on any particular day and who is actually in work to do that work. (Interview, nurse: PD17)

Work and roles in an immediate organisational context

Interactions between workplace jurisdictions, taken-for-granted roles and the situation-specific demands made on the service played out differently for different groups. The two psychiatrists in the team concentrated their work during Monday to Friday, nine to five, working hours. Their customary tasks centred on initial face-to-face mental and physical health assessments and the ongoing evaluation and treatment (including through the prescribing of medication) of service users accepted for community crisis care. The team's senior psychiatrist also claimed the leadership role as formally envisaged in the post, saying:

Psychiatrist: I think the role of the consultant psychiatrist in most mental health teams is as a clinical leader and I think that's the role that I fulfil in this team. (Interview, psychiatrist: PD18)

One team member described the existence of an informal intra-professional division of work through which the more senior of the two doctors was involved in the care and treatment of the service's (otherwise unspecified) more 'complex cases'. Between them, to make sure that each person on the team's collective caseload was medically reviewed (as per the service's standard) at least once per week, both doctors prioritised their work for the days ahead but simultaneously maintained sufficient flexibility to accommodate urgent assessments of those newly referred.

A single, part-time, psychologist was attached to the team. This person fulfilled a closely contoured role exempt from otherwise shared routines (such as shift coordination and the need to immediately respond to new referrals) permitting concentration on other tasks including therapy provision and staff supervision:

Clinical psychologist: [...] I think that the psychology role is seen as distinct or unique or added, I don't want to use those terms but, so there's a permission given in the team, implicit or explicit, I think it's largely explicit, of people operating outside that.

[...]

If people want psychologists to do those other things [such as shift coordinating] then they lose out on things that you know, they lose out on the supervision or, [...] you know, psychological intervention for a range of other problems, that's where they lose out.

(Interview, clinical psychologist: PD20)

In contrast, to be a nurse in the team meant joining a seven day per week, round-the-clock, rota and assuming responsibilities for assessing new referrals, providing home treatment and taking turns to coordinate shifts. Over spans of duty sometimes stretching beyond 12 hours nurses were exposed to constant reordering of their work as the team's priorities changed, as is depicted in detail here:

Nurse: [...] if you're on shift coordinator, you've set out everybody's work on the board, and...

Researcher: The whiteboard, yes.

Nurse: [...] and allocate different people to different things, and the phone rings and everything has to change because people are going off to do assessments, so everybody has to be reallocated, and that can happen four or five times a day [...] by the time your thirteenth hour is ticking around, and an assessment comes in and then you work, you're supposed to finish work at half past eight, and you finish work at ten, you're very tired by that point, quite stressed.

[...]

Well you try and stay in [the team base] as much as possible when you're coordinating, to keep your finger on the pulse, but that's not always possible. So sometimes you're there, and sometimes you're not, and you carry a bleep then, so you're paged if necessary.

[...]

It is complex and you know, I was completely paranoid that I would miss things, you know, somebody wouldn't be getting their medication or something because you've left them off

the allocation. [...] You've got to be really flexible, really, really flexible. You know you might think nobody keeps a diary, there's no point, you know, you might have an allocation for the day somewhere and then change it as it progresses. [...] I used to be so relieved when I used to get to somebody's house because I knew exactly what I was doing for the next hour. (Interview, nurse: PD16)

Like nurses, the tasks attached to social workers also involved assessing new referrals and providing services to people on the team's collective caseload. Being part of the frontline workforce had clear implications for roles. Here a social worker describes their work as 'generic', before making reference to carrying out tasks more typically associated with nurses:

Social worker: The day-to-day client contact that involves assessing their mental state at the day, their needs of the day, their progress, assessing what other services to pull in, assessing whether a psychological assessment is necessary. In fact even just taking and supervising on medication, which is traditionally a nursing role but it wouldn't make sense for a nurse to double up and do two visits to a person who is quite safe to visit, if I could pop the medication in and say prod the patient to take it. I'm not actually allowed to actually give and administer medication but I can prompt [...] (Interview, social worker: PD21)

Beyond this, as approved social workers (ASWs), the two practitioners in post during the larger part of fieldwork also had specific authority and responsibilities to engage in statutory Mental Health Act duties. To ensure their availability throughout as much of the extended day as possible the preference of some key participants was for social workers to work on opposite shifts stretching from early morning to early evening. Local institutional arrangements militating against this included a reluctance on the part of some local authority managers (who already resourced an out-of-hours social services team which included ASW cover) to support what, from their position, was a duplicate service. With the local authority refusing in these circumstances to pay its crisis services staff the enhanced rates of pay it normally would for working beyond standard hours, social workers in the new team were described as reluctant to participate in shifts spanning the evening and certainly never into the

night. The likelihood of the team's social workers, in turn, appearing together on the team's rota to cover the earlier part of the 24 hour working day had implications for the content of their work, driving their allocation to 'generic' tasks in the manner described by the social work participant above. A nurse claimed that social work colleagues' resistance to cover the extended working day meant they could not complain when asked to take on nurses' tasks:

Nurse: [...] it's a nonsense to have two social workers on an early shift [...] there should be one on an early shift, one on a late, an overlap in the afternoon which is the busiest but the potential for a social worker to be able to see a Mental Health Act assessment through, to be able to write up properly before finishing their duties without incurring lots of overtime.

[...]

there had been a complaint from the social worker that they were being asked to do nursing duties to which my answer is, they both insist on working early then inevitably they will be asked to do nursing duties because we can't put a nurse on, we've got to put the nurse on the late, to cover what they're refusing to do, so they can't have the penny and the bun.

(Interview, nurse: PD17)

The final occupational group with care providing responsibilities represented in the CRHT team during fieldwork were non-professionally aligned support workers. Distinctively, support workers did not undertake initial community-based crisis assessments. In contrast to many of their professionally qualified colleagues this meant that they were relatively less likely to experience the unpredictable reordering of their time. With high levels of face-to-face contact with service users accepted for home treatment they were able to commit to named service users' care in advance. A support worker said:

Researcher: [...] you mentioned in the case of this gentleman [a service user] that support staff worked with him for three consecutive weekends [...]

Support worker: [support workers] can do that a lot easier because their time is not taken up by assessments, their time is not taken up by the paperwork that comes from those assessments, OK? So they are able to do that, and I know all of them here will do that, if we start a piece of work with somebody, that the team gives, allows them to be able to do that now, it's a foregone conclusion now that they do this piece of work. They come in on a first shift after being on days off and that gentleman is normally allocated to them, you know. So

it's seen as that, it's just accepted, you know, that if you're doing a piece of work with them [...] They can actually work shifts around him. (Interview, support worker: PD27)

Discussion and conclusion

Published findings from studies into CRHT services have variously focused on: the characteristics of people accepted for home treatment (Brimblecombe et al., 2003); service user outcomes (Johnson et al., 2005); CRHT team numbers and their workforce composition (Onyett et al., 2006); the relationships between demand and supply (Beecham, 2005); and the connections between the widespread commissioning of crisis services and national rates of hospital admission (Glover et al., 2006). Largely missing have been studies into the organisation and delivery aspects of crisis services, a gap which this paper and the larger study from which it arises have helped to fill.

For both Hughes (1971) and Abbott (1988) it is in interactive workplaces where relationships between workers and their tasks are ultimately realised, and where for Strauss (1978) occupational roles are open to patterning by organisational features. Taken together these ideas indicate that we should entirely expect that divisions of labour will, to some degree, be shaped by combinations of forces peculiar to each setting. The analytic challenge is therefore to identify those aspects of 'context' which help explain this contouring, a task also providing a response to calls made to inject into examinations of work and roles a more explicit organisational perspective (Davies, 2003; Currie et al., 2012). In the case of this crisis services workplace, the first of two key findings is that work was recognisably shaped by the team's responsibility to carry out assessments of new referrals in timely fashion whilst simultaneously providing home treatment, using whatever mix of professionals and support staff was available on any given span of duty. A second key finding is that this shaping was felt by some groups of workers more than others.

For psychiatrists and psychologists work in the crisis team customarily mirrored larger jurisdictions. With its underpinning biomedical knowledge base the profession of psychiatry has retained its dominant position in the wider mental health system (Hannigan and Allen, 2006), and within the crisis service this was reflected by the formal establishment of a position for a senior doctor. Informally accomplishing the psychiatrist's role involved, with consent, being exempted from some tasks (such as helping people register for new accommodation, an example given in a previous data extract) in order to be available for others (assessing, diagnosing, prescribing physical treatments and reviewing clinical progress). Clinical psychologists, as was the case in this crisis service, are often in a small minority in mental health teams and occupy positions with high levels of autonomy and control over work (Peck and Norman, 1999). As a valued but scarce resource, the crisis team's psychologist had a mandate to remain a step removed from the unpredictable rhythms of the workplace in order to provide scheduled clinical work and to act as a resource for colleagues.

In the case of nurses and social workers the historic emergence in the UK of a system of community mental health work opened up important, but contested, jurisdictional opportunities for both (Hannigan and Allen, 2006), and as groups of approximately equal status the relationships between the two have been of longstanding research interest (see for example: Sheppard, 1991; Wooff et al., 1988). In this study, nurses with their round-the-clock presence, their numbers and their positioning in the system acted as intermediaries (cf. Allen, 2004). This involved the management of service users' journeys, prioritising and controlling access to resources. Whilst the legal jurisdiction claimed by social workers who were 'approved' meant that only they were able to fulfil statutory Mental Health Act responsibilities (just as only nurses could physically administer medication), on a shift-by-shift basis pressures to share other tasks existed. Overlaps in the content of work, with (for

example) social workers carrying out activities not associated with the wider jurisdictions they have secured, happened when individual team members were prepared to blur boundaries in order to do what needed to be done.

Finally, in the case of support workers their lack of professionally accredited training meant they lacked formal access to a sufficient or relevant abstract knowledge base. Without this, support workers advanced no claims to routinely conduct initial crisis assessments of new referrals. In what was an unpredictable workplace for many of their professional colleagues, support staff were consequently well-placed to promote continuity of care (Freeman et al., 2002) by being available over repeated spans of duty to service users accepted for home treatment.

As modelled in this paper, detailed examinations of exemplar, small-scale, workplaces can generate important new knowledge of the wider systems of which they are constituent parts, and indeed nothing about this crisis team or its immediate surroundings stands out as being particularly unusual in the context of UK mental health services as a whole. The common purpose of CRHT services and their positioning means that all are likely to share multiple interfaces with other local system components, their staff facing competing demands in fast-moving environments, and as such all are dynamic workplaces in which roles are likely to be patterned to some degree. Findings from this study are therefore likely to have relevance and implications beyond the immediate locale in which data were generated. Hughes (1971) observes that, in any system where the ties binding workers to their customary bundles of tasks loosen, changes are immediately detectable in divisions of labour at a ‘technical’ level. Examples are when social workers begin to do medication-related work (as they did in this study) and when nurses fulfil statutory Mental Health Act responsibilities, as they now can in England and Wales following changes to the law post-dating this study’s fieldwork (Coffey and Hannigan, in press). Hughes adds, however, that these technical shifts

can have additional consequences for enduring social roles and for interprofessional relations. Whilst some staff were prepared to blur boundaries others perceived pressure to share tasks as an unwanted challenge to their identities, exemplified by the reference to a social worker's complaint at doing 'nursing duties'. Where boundaries were blurred this may have promoted efficiency, and ensured that service users' needs were met on a day-to-day basis. However, as has been pointed out in related studies of work and organisation (see for example: Hannigan and Allen, 2011) processes of this type raise questions not only about social roles and interprofessional relations, but also about the competence and preparedness of staff to take on new tasks.

In sum, the crisis services workplace emerges as fast-moving and dynamic, in which what people do reflects professional jurisdictions and (critically, for some more than others) a recognisable patterning by organisational forces. In a wider context in which taken-for-granted relationships between workers and their tasks are coming under heightened pressure (Nancarrow and Borthwick, 2005) findings from this study add to the existing evidence of a mental health system in a state of flux (see for example: Hannigan and Allen, 2011). More generally, all health and social care systems must continue to be examined in this way, both to better understand their changing shape and to appreciate the wider and longer-term implications for occupational groups, the content of their work and for role relations.

Acknowledgements

Grateful thanks are extended to all participants in this study, to Professor Davina Allen for mentorship, and to Dr Michael Coffey for helpful comments on an earlier draft of this paper. Thanks are also extended to the Research Capacity Building Collaboration (RCBC) Wales which funded the study.

References

- Abbott A (1988) *The system of professions: an essay on the division of expert labor*. Chicago: University of Chicago Press.
- Allen D (1997) The nursing-medical boundary: a negotiated order? *Sociology of Health and Illness* 19(4): 498-520.
- Allen D (2000) Doing occupational demarcation: the 'boundary-work' of nurse managers in a district general hospital. *Journal of Contemporary Ethnography* 29(3): 326-356.
- Allen D (2004) Re-reading nursing and re-writing practice: towards an empirically based reformulation of the nursing mandate. *Nursing Inquiry* 11(4): 271-283.
- Beecham J (2005) Access to mental health supports in England: crisis resolution teams and day services. *International Journal of Law and Psychiatry* 28(5): 574-587.
- Brimblecombe N, O'Sullivan G and Parker B (2003) Home treatment as an alternative to inpatient admission: characteristics of those treated and factors predicting hospitalization. *Journal of Psychiatric and Mental Health Nursing* 10(6): 683-687.
- Carmel S (2006) Boundaries obscured and boundaries reinforced: incorporation as a strategy of occupational enhancement for intensive care. *Sociology of Health and Illness* 28(2): 154-177.
- Coffey A and Atkinson P (1996) *Making sense of qualitative data: complementary research strategies*. London: Sage.
- Coffey M and Hannigan B (in press) New roles for nurses as approved mental health professionals in England and Wales: a discussion paper. *International Journal of Nursing Studies*. <http://dx.doi.org/10.1016/j.ijnurstu.2013.02.014>
- Coleman JS (1958) Relational analysis: the study of social organizations with survey methods. *Human Organization* 17(4): 28-36.

- Currie G, Dingwall R, Kitchener M and Waring J (2012) Let's dance: organization studies, medical sociology and health policy. *Social Science & Medicine* 74(3): 273-280.
- Davies C (2003) Some of our concepts are missing: reflections on the absence of a sociology of organisations in Sociology of Health and Illness. *Sociology of Health and Illness* 25(Silver Anniversary Issue): 172-190.
- Davis AE, Dinitz S and Pasamanick B (1972) The prevention of hospitalization in schizophrenia: five years after an experimental program. *American Journal of Orthopsychiatry* 42(3): 375-388.
- Department of Health (2001) *The mental health policy implementation guide*. London: Department of Health.
- Department of Health, Social Services and Public Safety (2011) *Service framework for mental health and wellbeing*. Belfast: Department of Health, Social Services and Public Safety.
- Emerson RM, Fretz RI and Shaw LL (1995) *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- Fenton F, Tessier L and Struening EL (1979) A comparative trial of home and hospital psychiatric care. *Archives of General Psychiatry* 36(10): 1073-1079.
- Foley L and Faircloth CA (2003) Medicine as discursive resource: legitimation in the work narratives of midwives. *Sociology of Health and Illness* 25(2): 165-184.
- Freeman G, Weaver T, Low J, de Jonge E and Crawford M (2002) *Promoting continuity of care for people with severe mental illness whose needs span primary, secondary and social care: a multi-method investigation of relevant mechanisms and contexts*. London: National Coordinating Centre for NHS Service Delivery and Organisation R&D.

- Freidson E (1976) The division of labor as social interaction. *Social Problems* 23(3): 304-313.
- Fulop N, Allen P, Clarke A and Black N (2001) Issues in studying the organisation and delivery of health services. In: Fulop N, Allen P, Clarke A and Black N (Eds.) *Studying the organisation and delivery of health services: research methods*. London: Routledge.
- Glover G, Arts G and Babu KS (2006) Crisis resolution/home treatment teams and psychiatric admission rates in England. *British Journal of Psychiatry* 189(5): 441-445.
- Hammersley M and Atkinson P (2007) *Ethnography: principles in practice*. (3rd edition). London: Routledge.
- Hannigan B. (2013) Connections and consequences in complex systems: insights from a case study of the emergence and local impact of crisis resolution and home treatment services. *Social Science & Medicine* 93: 212-219.
- Hannigan B and Allen D (2006) Complexity and change in the United Kingdom's system of mental health care. *Social Theory & Health* 4(3): 244-263.
- Hannigan B and 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): 1-8.
- Hannigan B and Allen D (2013) Complex caring trajectories in community mental health: contingencies, divisions of labor and care coordination. *Community Mental Health Journal* 49(4): 380-388.
- Hannigan B and Coffey M (2011) Where the wicked problems are: the case of mental health. *Health Policy* 101(3): 220-227.

- Hannigan B and Evans N (in press) Critical junctures in health and social care: service user experiences, work and system connections. *Social Theory & Health*.
doi:10.1057/sth.2013.16
- Hoult J (1986) Community care of the acutely mentally ill. *British Journal of Psychiatry* 149(2): 137-144.
- Hughes E (1971) *The sociological eye: selected papers on work, self and the study of society*. Chicago: Aldine.
- Johnson S and Thornicroft G (2008) The development of crisis resolution and home treatment teams. In: Johnson S, Needle J, Bindman J and Thornicroft G (Eds.) *Crisis resolution and home treatment in mental health*. Cambridge: Cambridge University Press.
- Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, White IR, Thompson M and Bebbington P (2005) Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. *BMJ* 331(7517): 599.
- Marks I, Connolly J, Muijen M, Audini B, McNamee G and Lawrence R (1994) Home-based versus hospital-based care for people with serious mental illness. *British Journal of Psychiatry* 165(2): 179-194.
- Mizrachi N, Shuval JT and Gross S (2005) Boundary at work: alternative medicine in biomedical settings. *Sociology of Health and Illness* 27(1): 20-43.
- Nancarrow SA and Borthwick AM (2005) Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness* 27(7): 897-919.
- Onyett S, Linde K, Glover G, Floyd S, Bradley S and Middleton H (2006) *A national survey of crisis resolution teams in England*. London: National Institute for Mental Health in England.

- Peck E and Norman IJ (1999) Working together in adult community mental health services: exploring interprofessional role relations. *Journal of Mental Health* 8(3): 231-242.
- Querido A (1968) The shaping of community mental health care. *British Journal of Psychiatry* 114(508): 293-302.
- Reeves S, Rice K, Gotlib Conn L, Miller K-L, Kenaszchuki C and Zwarenstein M (2009) Interprofessional interaction, negotiation and non-negotiation on general internal medicine wards. *Journal of Interprofessional Care* 23(6): 633-645.
- Salhani D and Coulter I (2009) The politics of interprofessional working and the struggle for professional autonomy in nursing. *Social Science & Medicine* 68(7): 1221-1228.
- Scholz RW and Tietje O (2002) *Embedded case study methods: integrating quantitative and qualitative knowledge*. London: Sage.
- Scientific Software Development (2009) *Atlas.ti: the knowledge workbench*. Berlin: Scientific Software Development.
- Scottish Executive (2006) *Delivering for health: delivering for mental health national standards for crisis services*. Edinburgh: Scottish Executive.
- Sheppard M (1991) *Mental health work in the community: theory and practice in social work and community psychiatric nursing*. London: Falmer.
- Silverman D (2005) *Doing qualitative research*. (2nd edition). London: Sage.
- Speed S and Luker KA (2006) Getting a visit: how district nurses and general practitioners 'organise' each other in primary care. *Sociology of Health and Illness* 28(7): 883-902.
- Stein LI and Test MA (1980) Alternative to mental hospital treatment. I: conceptual model, treatment programme and clinical evaluation. *Archives of General Psychiatry* 37(4): 392-397.
- Strauss A (1978) *Negotiations: varieties, contexts, processes and social order*. London: Jossey-Bass.

- Strauss A, Fagerhaugh S, Suczek B and Wiener C (1985) *Social organization of medical work*. Chicago: University of Chicago Press.
- Timmons S and Tanner J (2004) A disputed occupational boundary: operating theatre nurses and operating department practitioners. *Sociology of Health and Illness* 26(5): 645-666.
- Welsh Assembly Government (2005) *Policy implementation guidance on the development of crisis resolution/home treatment (CR/HT) services in Wales*. Cardiff: Welsh Assembly Government.
- Wooff K, Goldberg DP and Fryers T (1988) The practice of community psychiatric nursing and mental health social work in Salford: some implications for community care. *British Journal of Psychiatry* 152(6): 783-792.
- Yin RK (2009) *Case study research: design and methods*. (4th edition). London: Sage.