From policy to practice: the implementation of developmental community mental handicap teams in Nottinghamshire

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Additional Information:

- A Doctoral Thesis. Submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy of Loughborough University.

Metadata Record: https://dspace.lboro.ac.uk/2134/11944

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ACKNOWLEDGEMENTS

This thesis is the product of contributions, help and support from many people, not least the members of the Notts CMHTs themselves. It never ceased to amaze me how tolerant and generous they were, in giving up time willingly to be interviewed and complete questionnaires, and in letting me attend team meetings. Team members' active support to this research has been a source of encouragement and motivation. Other professionals and managers were also helpful in providing information, material, and not least, time.

I am grateful to my Supervisor, Gerald Wistow, and Director of Research, Professor Adrian Webb, for their support and guidance. I am particularly grateful for their patience in ploughing through the reams of material I have produced over the last 7 years. Special thanks go to Kate Cochrane, for her effective presentation of the final product. Having spent so many hours at the word processor, life will probably never be quite the same again. Finally, the biggest vote of thanks must go to Helen, my wife. Without her patience, help and support throughout, the completion of this research and thesis would have been impossible.
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ABSTRACT

Community mental handicap teams (CMHTs) are currently in vogue, although each of the constituent elements in their title: community; mental handicap; and team, are attracting much debate, hence these different concepts are explored. There is much variation between CMHTs in practice, one example being Notts where the CMHTs have been established uniquely with an explicit development role. This research is an empirical study of the first three CMHTs established in Notts and has two main foci: implementation and teamwork.

Debates in the implementation field between the Bottom-up and Top-down models provide the backcloth for the unfolding of the CMHTs' establishment and development. These models are found to be too polarised and inflexible but a dimensions approach proves useful for overcoming the polarity without losing the insights of either model. Variation between the CMHTs in practice is partly accounted for by their different environments. Negotiation is a key element in the CMHTs' responses to their environments as teams carve out niches for themselves in established structures and processes. This study examines the environments of the Notts CMHTs to understand how they have undertaken such negotiations.

The CMHTs' internal dynamics are also studied, focusing on their experiences of co-operation. Particular aspects are studied in depth, for example, leadership, communication, conflict and roles, and are shown clearly to inter-relate. Further, the models of co-operation employed by the teams are examined. Many theoretical models exist, and these are "tried" against the evidence, rather than trying to make the evidence fit the frameworks. A crucial question becomes: how is the work done, in an individualist or shared manner? A series of classifications is preferred to a composite measure because of differences within teams according to personnel and task. The distinction between teams and networks is seen as valid, with the question of identity emerging as a determining factor.
GLOSSARY OF ABBREVIATIONS AND TERMS USED

AHA(T) Area Health Authority (Teaching)
APMH Association of Professions for the mentally handicapped
ATC Adult Training Centre
BIHM British Institute of Mental Handicap
BIOSSE Brunel Institute of Organisation and Social Studies
CCETSW Central Council for the Education and Training in Social Work
CHC Community Health Council
CMH Campaign for Mental Handicap
CMHN Community Mental Handicap Nurse
CMHNA Community Mental Handicap Nurses' Association
CMHT Community Mental Handicap Team
COHSE Confederation of Health Service Employees
CSS Certificate of Social Service
CVS Council for Voluntary Service
DHA District Health Authority
DHSS Department of Health and Social Security
DHT District Handicap Team
DMO District Medical Officer
DNO District Nursing Officer
DT Development Team for the mentally handicapped
FE Further Education
GNC General Nursing Council
HCPT Health Care Planning Team
IPP Individual Programme Plan
IQ Intelligence Quotient
JCC Joint Consultative Committee
JCPT Joint Care Planning Team
LA Local Authority
Kencap National Association of mentally handicapped children and adults
MIND National Association of Mental Health
MSC Manpower Services Commission
NDG National Development Group
NDT Development Team for the mentally handicapped
NHS National Health Service
NIMROD New Ideas for the care of mentally retarded people in ordinary dwellings - a project in South Glamorgan
Notts Nottinghamshire
PPG Policy Planning Group
RAVP Resources Allocation Working Party
RCN Royal College of Nursing
RHA Regional Health Authority
RNMS Registered Nurse in Mental Subnormality
SRO Social and Recreational Officer
SSD Social Services Department
SSW Senior Social Worker
SV Social Worker
SVA Social Work Assistant
TMAI Team Meeting Analysis Instrument
UMAI Unit Meeting Analysis Instrument
PART I

ISSUES, METHODS and RESEARCH SITE
Chapter 1

Introduction and Overview

Community Mental Handicap Teams (CMHTs) are currently in vogue, embracing the current pre-occupations in the provision of services to mentally handicapped people and their carers: "community care, multidisciplinary teamwork and co-ordination" (Cotmore et al. 1985). A national model of CMHT has been promulgated by the Development Team (DT), but it is clear that much variation exists between teams in practice. One example of this variation is Nottinghamshire, where the CMHTs have been established on a substantially different basis to the national model.

A significant difference between the DT and Notts models of CMHTs concerned their objectives. The emphasis nationally has been on the need to improve service co-ordination. In Notts however, the Social Services Department (SSD) created CMHTs in 1982 in response to a particular problem: the shortfall of hostel accommodation for mentally handicapped adults and a lack of alternatives. The SSD charged the CMHTs with the task of developing alternative forms of accommodation. They considered that the DT's model, which incorporated a "traditional" casework service, was too limited because additional resources were required without which the 'listening ear' approach was of limited value.

To protect the development role, the SSD intended that the CMHTs be established as free-standing teams and that the Area Social Services teams should retain the responsibility for a social casework service. The development of services function was an SSD initiative, but one which found little favour with the Health Authorities. This lack of agreement, compounded by the speed with which the SSD acted, the disruptive effects of the 1982 Health Service re-organisation and a lack of resources, resulted in teams which were initially composed almost entirely of Social Services personnel. Composition was therefore another feature of the Notts CMHTs that distinguished them from the DT model, which emphasised strongly the importance of a multidisciplinary approach. Other differences included: the size of the teams; the size of their areas; and their line management arrangements.

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This research aims to monitor the establishment and early development of the first three CMHTs in Notts. Of particular interest is the way in which the CMHTs negotiated their roles and methods of operation, both externally in relation to their parent agencies and environments, particularly given the SSD's stated commitment to a service development approach, and internally within the teams. This monitoring of the CMHTs was located within key concepts and frameworks provided by the literatures on implementation and teamwork (see Part II).

The key issues drawn from the implementation literature stem from the debate between the proponents of two models: 'Top-down' focussing on policy-making and 'Bottom-up' focussing on action. Hambleton (1983) has outlined five factors which impinge on the implementation process and which may operate as bridging dimensions between the two models (see Chapter 4).

Teamwork, like implementation, is a multidisciplinary field of study. However the literatures on teamwork are more diverse and not well integrated. There is little agreement on the definition of the term 'team' but recently the literature has addressed the question of "when is a team not a team?" by focussing on boundaries and by differentiating between teams and networks. Many different models of teamwork exist (see Chapter 5), varying from a small to a much larger number of variables. Several key factors would appear to be significant in understanding processes of co-operation and these are reviewed in Chapter 6.

While literatures on implementation and teamwork provided the guiding questions and concepts, the literature on evaluation posed the key issues of research method. It is to these broad issues that we must briefly turn, prior to a discussion of the more detailed research methods in Chapter 2. There has been a trend in Social Sciences evaluation research away from the traditional 'objective' approach which was primarily outcome-oriented, to a process-oriented approach. Oakley (1981) for example has criticised proponents of scientific value-free methodologies for misrepresenting social research, by arguing that research in practice is not as presented in textbooks: "It is infinitely more complex, messy, various and much more interesting" (Bell
and Enzel cited by Oakley 1981). Indeed this is a good description of the experience of undertaking the fieldwork for this study.

Some interesting observations on process-oriented research have been made by Room (1980), in a discussion on the evaluation of the European poverty programme: "Here evaluation is akin to the activity of the historian. It deals with the diverse perceptions, goals and actions of the various actors involved; it looks at processes of meaningful interaction rather than merely at outcomes." Room described this approach as "below and within" and distinguished it from the "above and outside" approach, traditionally regarded as the more objective and scientific in nature.

Room (IBID) gave further details of the "below and within" approach: "it recognises the exploratory character of action-research and aims to provide an interpretative history of that explanation; and instead of claiming some privileged and neutral vantage point, the evaluator is involved in a continuing conversation and dialogue with the actors themselves." It is clear from this quote that the "below and within" approach differs from the "above and outside" approach not only in focus, but also according to the role of the researcher. Other researchers have also acknowledged the need for a closer relationship between researcher and subjects and for the researcher to contribute to the research site. Oakley (1981) for example has argued for "No intimacy without reciprocity" on the basis that it is unreasonable for a researcher to expect to soak subjects dry like a sponge without offering anything in return.

Which approach was more suitable for the study of implementation and teamwork issues in the Notts CMHTs? Given the sensitive and subjective nature of the information required, from CMHT members in particular, it was clear that the nature of the relationships established by the researcher with team members would be an important determinant of the quality of information collected. Further, it felt appropriate that the relationships were reciprocal in nature, as it seemed improbable that an aloof stance would be tolerated within such small groups of people over anything other than a short period of time. The "below and within" perspective fitted these requirements more closely. To adopt this, an exploratory approach was undertaken so as to enable a story to unfold.
and the story was focussed around the key issues from the literature reviews.

In an attempt to broach the issues of implementation and teamwork with reference to the Notts CMHTs, the fieldwork for this study covered the first 18 months of the teams' lives from January 1982 to the summer of 1983. Because of constraints on time, the study of teamwork was undertaken with only three of the five teams and they were the first three teams to be established: Bassetlaw, North Nottingham, and Central Notts. For a similar reason the environments of only the first two of these teams were studied, in an attempt to illuminate implementation processes. The balance within the research between the two foci, implementation and teamwork, tilted slightly towards the former as the study of multidisciplinary teamwork became problematic given that the teams initially comprised so few Health Service professionals. Teamwork issues remained pertinent however, even though the teams were barely multidisciplinary.

Unfortunately it proved impossible to test specific hypotheses as originally intended, because of the small number of teams and team members and because of the delay in the teams becoming fully multidisciplinary. Nevertheless the key models and concepts from the literatures were used as templates against which to hold the teams, in an attempt both to understand what was happening in Notts and to assess the explanatory power of the different models.

The structure of this thesis is divided into five parts which contain 14 chapters. Following this introduction, the aims and methods of the research are discussed in Chapter 2. Part I concludes with Chapter 3 which provides a short description of the research site. Part II comprises a literature review of the two main foci of this study: implementation (Chapter 4) and teamwork (Chapters 5 and 6). The literatures are so vast that only the most pertinent issues can be summarised. Part III comprises 2 chapters on service provision for mentally handicapped people and their families. A broad overview of both policy and service delivery is provided in Chapter 7, which teases out recent trends and discusses the concept of community care. The focus in Chapter 8 is on CMHTs specifically, on the national DT model.
and on experiences elsewhere, in an attempt to contextualise the developments in Notts.

The results of the research are presented in part IV, commencing with an outline of the events which led to the establishment of the Notts CMHTs in Chapter 9. Some simple questions regarding the development of the CMHTs are addressed in Chapter 10, for example: what did the teams do? Team members' experiences of teamwork are discussed in Chapters 11 and 12 focussing on the seven facets of co-operation outlined in Chapter 6, plus two others: membership, to determine the teams' boundaries; and a broad category entitled "experiences."

The focus changes from the CMHTs' internal cohesiveness to their external cohesiveness in chapter 13, which focusses on the relationships between the CMHTs and some significant elements in their environments. Some interim conclusions are postulated at the end of some of the fieldwork chapters, prior to the fuller integration of fieldwork material with models and frameworks from the literature reviews. This integration of material is attempted in the concluding chapter in part V.
CHAPTER 2
RESEARCH AIMS AND METHODS

What is the research about?

In monitoring the establishment and early development of the CMHTs in Notts this study has two principal foci: implementation and teamwork. An important factor in determining these foci was the status of this study as a research-linked studentship. A disadvantage of being linked to a bigger evaluation project was that particular limits were set on what I could study. Although this restricted my initial exploration, it was helpful given that many Social Science research students appear to struggle when defining the nature of their research.

The relationship with the evaluation project proved to be a double edged sword. The disadvantage stemmed from unfortunate timing, in that my study was undertaken largely before the evaluation project commenced. The burden of fulfilling a flagship role felt heavy on occasions. This was outweighed by the advantage however, of facilitating access both to the research site and to a broader range of data on local service planning and provision. Further, my studentship was located in a Department, and more latterly in the emergent Centre for Research in Social Policy, which had undertaken a lot of research into implementation and joint planning. In addition the Centre had a growing interest in research into service planning and provision for mentally handicapped people which provided a broader context for my study.

It will be found that the literature reviews throw up a number of issues pertinent to the design of a research programme. To overcome the sterility of the polarised debate between the Top-down and Bottom-up models of implementation (see Chapter 4), the relationship between policies and actions needs to be determined more openly. Consequently to assess the relative contributions of the Top-down and Bottom-up models regarding the CMHTs in Notts, policies and actions need to be outlined without initial assumptions about causality one way or the other. Hence some straightforward and open questions require addressing, for example: how were the CMHTs established? What did they do once operational? Further, the "action and response" approach
requires an exploration of the relationship between the CMHTs and their environments, including their parent agencies, other service providers, and consumers.

It will be seen in Chapters 4 and 6 that a dimensions approach would appear potentially useful for reconciling the two basic models and focusing more sharply the exploration of implementation issues. Hambleton (1983) has suggested five factors which might act as dimensions: policy message; multiplicity of agents; perspectives and ideologies; resources; and the politics of planning. The study of the CMHTs in Notts will provide some evidence as to how useful and exhaustive these dimensions are.

Regarding teamwork, both the models of co-operation and more specifically the different facets of co-operation need to be considered. Different models of teamwork and co-operation are laid bare in Chapter 5, and seven facets of co-operation are discussed in Chapter 6, namely: objectives; roles; leadership; decision making; communication; conflict; and trust. To explore these issues fully requires eliciting team members' experiences and perceptions of co-operation. In this way a picture can be constructed, against which to measure existing frameworks, models and concepts.

To study both implementation and teamwork issues regarding the Notts CMHTs an exploratory approach was adopted. Reflecting the openness of such an approach, and because of several constraints noted in Chapter 1, including the small size of the teams and their restricted composition, guiding hypotheses were favoured over specific hypotheses. Guiding hypotheses were generated by the key issues from the literature such as the seven facets of co-operation and the two models of implementation, which were teased out to form templates against which to hold the teams. These templates helped focus both the acquisition and interpretation of the data, so that the research was not unfocussed even though it was exploratory.

Research methods

Both foci required an understanding of the frames of reference of a number of different actors, from CMHT members to senior managers in Health Authorities and the SSD. In addition, these understandings had
to be gained through a period of time. To handle these complexities it appeared appropriate to use a number of different research tools within the general approach outlined in Chapter 1 as "below and within." The various methods which were employed can be described under four headings: social and informal; observation; interview; and questionnaire.

Social and informal

This aspect of the research was very enjoyable, important and extensive, including: chatting over coffee; lunchtime drinks; squash games; Christmas dinner; leaving parties; a day out; and evening parties. It was a measure of the extent to which I had become "attached" to the CMHTs that I was invited to so many social occasions. A lot of useful information was gleaned in this way. For example, when alone some CMHT members used me as a "pressure valve" to moan about particular irritations. One team member described this process as "cathartic".

It felt appropriate to develop such relationships with CMHT members in order to promote and safeguard the quality of information generated. Was the research in danger of becoming unscientific and biased however? Oakley (1981) has argued that: "the mythology of 'hygienic' research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives." Oakley prefers an "interactive" approach which acknowledges that the quality of information generated depends on the relationship between the "researcher and the researched." The aims of the research, which required an understanding of different frames of reference through a period of time, made an "interactive" approach desirable.

Observation

The bulk of the observation undertaken was in meetings of different kinds, including CMHT team meetings; multidisciplinary meetings between the CMHTs and other professionals; joint meetings between the CMHTs and meetings between the CMHT Senior Social Workers and senior managers from the SSD. The following CMHT meetings were attended:
Bassetlaw: October 1982 - June 1983 22 out of a possible 35
North Nottingham: December 1982 - June 1983 17 out of a possible 22
Central Notts: October 1982 - June 1983 13 out of a possible 14

Observation of CMHT meetings facilitated study of both teamwork and implementation issues. Regarding teamwork, aspects of the teams' structures and processes were considered. The items themselves that arose and how they impinged on the teams' objectives were studied to illuminate implementation processes. The other meetings attended also facilitated study of implementation issues, in outlining the forums used by the teams, their networks, and the extent to which others understood and tried to change the CMHTs' objectives, and vice versa.

The research tool devised for analysing CMHT meetings, the Team Meeting analysis instrument (TRAI) is reproduced in full in Appendix A, together with the notes of guidance. It is based loosely on the unit meeting analysis instrument (UMAI) devised by Sachs and Forman (1980) in their study of Primary Health Care Teams. Most particularly helpful was their distinction between "primary goals" and "organisation structure maintenance" within the analysis of substantive issues. This distinction is pertinent for this study, as it allows for the teams' primary work activities to be separated from issues of teamwork, administration and links with outside agencies.

There are however several differences between this instrument and UMAI, for a number of reasons. First, Sachs and Forman collected their data in a different way which enabled them to undertake a more comprehensive analysis, their unit of analysis being statements rather than items. Second, the nature of the Primary Health Care Teams' work was different to the CMHTs' hence the sub-divisions within the substantive topics have been altered. Third, some of the classifications used by Sachs and Forman appear rather arbitrary or simply difficult to interpret. For example, no definitions of "some" or "much" were offered in describing levels of conflict, hence these have been collapsed together. In addition, the differentiation between "ad hoc" decisions and those with "policy implications" was problematic,
because: it was not always clear if policy frameworks were being
invoked, either explicitly or implicitly; there was vagueness over
whose policy frameworks were being invoked; or even if the different
constituent parts of the team acknowledged the same "team" policy. These,
classifications have therefore been replaced by the dichotomy between
programmed and non-programmed decisions devised by Simon (see
Chapter 6).

The final difference between this analysis instrument and UMAI stems
from the criticism that Sachs and Forman tried to classify issues which
were too subtle and complex for such an instrument. For example, to
measure leadership they used six indicators which were overt and easily
quantifiable, but at the risk of misinterpreting leadership by failing
to account for its more covert forms. Only one of the six indicators is
included in TMAI: initiator of item. A broader and more accurate
picture of leadership was built up through observation and interview,
which incorporated the indicators of leadership used by Sachs and
Forman, but which was not constrained by the computer's requirements.

Interviews

Interviews were conducted with CMHT members, and with other
professionals and managers in their networks. Members of the three
CMHTs were interviewed twice, at the end of 1982 and mid-1983, with the
exception of the Central Notts CMHT, which had only just formed when
this project's fieldwork commenced. With the benefit of hindsight, this
appears to be an obvious oversight, with the chance missed of gauging
the team members' initial expectations and experiences. Members of the
teams' networks were interviewed once only, and only two "networks" were
interviewed because of constraints of time.

The interview schedules are presented in Appendices B1 - B4.
Interviews with CMHT members focussed primarily on teamwork issues and
the internal life of the teams, while interviews with network
professionals acknowledged an external viewpoint and considered their
perceptions of the CMHTs' objectives and functions, and their contacts
with the CMHTs. In some cases it was not clear if a professional was a
CMHT member. Rather than impose a definition of "team," I asked
respondents whether or not they saw themselves as team members, and
asked them to list the other CMHT members. In this way it was possible to use the professionals' own definitions of "CMHT." Their replies determined whether they received the CMHT or the network interview schedule.

I failed to capitalise on the strength of my relationships with team members, because the interview schedule was too rigid. With hindsight, a more flexible interview schedule would have been appropriate, to allow the interview to be led to a greater degree by the interviewee, thereby becoming more spontaneous, and allowing for a deeper exploration of some of the issues. My approach did modify during the project, as witnessed by the removal of the coding boxes for computerisation. These were inappropriate both because of the nature of the questions, and because of the small scale of the project (see Appendices B1 and B2).

As noted above, this study was located within a Department which was undertaking other research projects in Notts, notably into joint planning and an evaluation of the CMHTs. Consequently I had access to interviews with senior SSD and Health Authority officers which had been conducted by other researchers, and I used a small number of these. This was a benefit of my studentship being linked to a bigger project, although such material obviously had to be used carefully as it may have been collected in a different way to that collected by me.

**Questionnaires**

A questionnaire was distributed to each CMHT member a short while before the interviews were conducted. Questions related primarily to "teamwork" issues, including objectives, roles, decision making, influence, morale, respect and trust. The question on roles was derived from a number of sources, including the outline of Social Worker and CMHN roles in the Development Team's first and second reports (1978 and 1980), the study of CMHNS undertaken at Bristol university (Hall and Russel 1979) and from Nottinghamshire SSD's development objectives for the CMHTs. The section on trust incorporated questions on all four indicators of trustworthiness: intentions; reliability; knowledge; and competence. The statements used, in addition to those for the commitment indicators, were adapted from questions asked by Cook and Wall (1980) in their study of blue collar workers. The section on trust was repeated at the second round of interviews for the Bassetlaw and
North Nottingham CMTs, so as to measure the amount of change over a six month period.

Despite much planning, the questionnaires proved to be rather a blunt instrument for collecting the sort of information required. For example, team members found the question on objectives rather ambiguous, the question on roles too open, and the question on decision making difficult to interpret. Because of these difficulties, analysis of the information generated from these questions is problematic. The questionnaires themselves changed through the project. They became shorter with the removal of some questions misplaced in a questionnaire and of others better suited for thousands to respond to rather than twenty. In addition, in a similar way to the interview schedules, a more realistic appraisal of the scale of the study dictated the withdrawal of the computer coding boxes. These changes are apparent in a comparison of the questionnaires in Appendices C1 and C2.

These self-critical comments of methodology highlight an important feature of the research: that it was very much a learning process. The road travelled was from a quite "traditional" starting point whereby hypothesis testing and quantative data seemed central, to a far more qualitative and exploratory approach in which guiding questions and flexible research instruments were to the fore. Such a process of change and development may seem desirable in a PhD student but undesirable in a research project. However, Oakley's (1981) point is precisely that social research lacks complete objectivity however well designed, while the "below and within" approach to evaluation positively advocates the more reflexive style of research which was gradually adopted with increasing confidence as the project unfolded.

What were the issues and problems resulting from use of the research methods outlined above? They will be discussed under five headings: access; pilot; contamination; alignment and bias; and recording.

**Access**

Access to information and people within the statutory agencies was virtually guaranteed as a result of this project being linked to a larger evaluation project to be undertaken by the Social Sciences Department of Loughborough University. Further, Nottinghamshire AHT(T) had agreed to make a financial contribution to the evaluation project
from joint finance. Clearly therefore, it was in the agencies' interests to allow access to appropriate information.

Access to CMHT members themselves was greatly facilitated by getting to know them from the beginning of the teams' existence, at their induction course. Perhaps as a result of their being part of something new and exciting, team members felt keen about the research. Having got to know the first two teams well, the Central Notts CMET was keen not to be overlooked. Gaining access to team members' thoughts and perceptions was more difficult than to documentary information, being dependent upon the nature and quality of relationships formed with them. Because relationships are on-going, the negotiation of such access is on-going and should never be taken for granted. In other words, relationships with team members, including all of the nuances, subtleties and complexities involved, formed the medium through which access was negotiated to the subjective information required.

**Pilot**

The Notts CMHTs were, and are, unique and as the study was of the first three established it was not possible to pilot some of the research tools elsewhere. Fortunately, a Bassetlaw CMET member was leaving the team soon after this project's fieldwork commenced and he was interviewed and completed a questionnaire as a "mini-pilot." This resulted in a number of changes to both the interview schedule and questionnaire. Further modifications were made later reflecting the change in emphasis within the methodology from quantitative to qualitative, noted above.

TMAI was developed largely from Sachs and Forman's (1980) instrument, UMAI. Unfortunately, it had not been possible to obtain a copy of Sachs and Forman's unpublished paper, which provided details of UMAI, until after the completion of the fieldwork. Consequently TMAI was not piloted during the fieldwork although this would have been desirable. Nevertheless it appeared to be such a useful instrument that it has been applied post-hoc.

**Contamination**

Contamination is greatly disapproved of by many research textbook writers, who explain at length how to avoid such an occurrence. In this study it was impossible to avoid making an impact on the research site
however. Team members regarded me as "attached" to their teams, hence it felt appropriate for them to ask me to "contribute" and for me to oblige. Dependent upon one's view of social research, this could be seen either as enabling or contaminating.

Contributions to the research site took various forms, one means being feedback from the results of the interviews and questionnaires. That there would be such feedback was welcomed by the teams. The feedback was presented in a series of papers to each team member and each team discussed the results in a team meeting, at which I was present to record their reactions, "explain" the results and facilitate discussion.

Ideas and quotes were not attributed to individuals within the papers for the purposes of anonymity, although because the teams were so small it may have been possible to match some of the responses with respondents. Potentially this was a serious problem, as it may have impaired team members' honesty if they had foreseen this, although in practice team members appeared to be very open and honest, surprisingly so given the sensitive nature of the information imparted. Further, far from being dishonest, one team member admitted (albeit two years later) that he had been willing to be honest and critical of other team members with the aim of influencing them through the research feedback, and suggested that other team members had done likewise. Clearly there are dangers that the researcher will be engulfed in others' "games," nevertheless such feedback was one mechanism in the implementation of an enabling role.

Discussion of feedback was one aspect of participant observation in team meetings. Another example was responses to requests for information on the progress of the project. On occasions team members also asked for my opinion or for information they thought I might have. Clearly there had to be guidelines for deciding which information could be imparted: if information had been given in confidence and was easily attributable, it was not divulged; but if the issue was a more general one, for example regarding national policy or innovations in service provision, it was appropriate to pass on the required information thereby fulfilling the enabling role. In practice however, it could be difficult to adhere to the guidelines, particularly if the decisions
were made on the spot under pressure from team members anxious for a particular piece of information.

Although I felt my contributions to the research site generally deserved the "enabling" label, there were occasions when the "contamination" label was more appropriate. For example, one team meeting was hurried so that the Senior Social Worker and I could play squash afterwards. Another meeting was delayed, awaiting my arrival. On other occasions it was clear that my presence reminded team members of issues they might not otherwise have thought of. For example, one team was particularly sensitive about their "network," and these sensitivities were heightened by my presence at team meetings: "I don't want to say something about someone, and then find it written in a book." This problem lessened through time as team members got to know me.

Summarising, I have presented my experiences as a researcher of an "enabling" role. Contributing to my particular research site was not automatically negative and contaminating, but more often positive and constructive. In any case it was impossible to avoid participating in teams which were so small, with between five and seven members, and with which I had so much contact. This approach allowed me to reciprocate, thereby changing the balance in an otherwise one-way relationship. If I had not done so, working relationships with team members would have been less strong, with a deleterious impact on the quality of information collected. Nevertheless, I faced a number of problems and had to consider very carefully the boundaries I wished to impose on this approach.

**Alignment and bias**

Bias was a problem to which this research was prone by its very nature. In trying to understand team members' frames of reference, there was a danger that this was done differentially. It would clearly have been injurious to the research if I had become associated with one or more sub-groupings within teams, since it would have detracted from the quality of the information offered by those subgroupings who felt I was no longer trustworthy because I was overly influenced by others.

I tried very hard not to align myself closely with or against any particular people or subgroupings within teams. This was much more
difficult than it sounds. For example, during team meetings, one team member could be the scapegoat and the butt of others' jokes. I faced the dilemma as an observer of wanting to laugh at a joke which I found funny, but not wanting to further alienate the team member who might not have been overjoyed at being singled out for scapegoating. My response to this dilemma was often a sympathetic smile.

The danger of alignment was not only present within teams, but also between teams and others, in two particular ways:

(i) As part of the Implementation study, I was keen to learn how well other professionals understood the CMHTs' objectives and role, and to learn about the extent and nature of the contacts between the CMHTs and those professionals. Some of those professionals however had come to associate me with a CMHT, and it may have been difficult for them to be completely honest with me, especially when wishing to criticise a CMHT. To combat this I asserted my "objectivity" as a researcher, but unlike with CMHT members, time was not on my side.

(ii) Between CMHTs. For part of the study I spent less time with one CMHT than with the other two, and the members of that CMHT became aware of this, and felt they were playing a subsidiary role in the research. This had happened for several reasons, and was most regrettable. Nevertheless, there was still scope for the "social and informal" aspects of the research with this team, and team members appeared to be very honest in interviews, hence it does not appear to have been as detrimental to the research as it could have been.

Recording

Written notes were taken during both meetings and interviews, without recourse to a tape recorder. Initially, note taking appeared to provide sufficiently comprehensive information. Within team meetings however, it would have been more useful to have had a complete account of what was said for the analysis of team dynamics. Tape recording
would have provided this, as well as leaving more scope for the recording of non-verbal behaviour and for the formulation of ideas, rather than simply trying to write down as much as possible in a mechanical way. As a result, more reliance can be placed on some team meeting observation data than others. For example, I am confident that every item discussed was recorded, slightly less confident that the number of each team members' contributions was recorded, but do not pretend to have recorded everything that was said. The analysis of leadership is one item which suffers from the limitations of the data.

There were similar limitations to the note-taking in interviews. Mechanical note-taking impaired the quality of the information generated, not just because one is unlikely to be able to write down all that is said, but also because it distorts the interaction between interviewer and interviewee. Is it reasonable to expect an interviewee to divulge highly sensitive information when the researcher has his nose stuck in his notebook? Reciprocity is difficult to achieve when the researcher does not respond as one would expect in ordinary conversation, through eye contact for example. Further, the concentration on note-taking made it more difficult to think ahead properly during an interview, hence departing from the interview schedule, no matter how appropriate, was more problematic.

Tape recording would help to overcome some of the problems above, although it is not without problems of its own, for example "topic slippage" (Atkinson, M. 1983). Another problem is the sheer volume of data that taping inevitably produces. There are further problems for postgraduates. During this project the Social Sciences Department had insufficient taping equipment. Even if it did, it is doubtful that a postgraduate student could have commandeered such a resource for a period of time as great as nine months (the duration of the bulk of the fieldwork), and had the necessary typing done afterwards.

Finally, I faced an ethical problem concerning information gained primarily from the "social and informal" parts of my work. Sjoberg and Nett state succinctly: "frequently researchers, in the course of their interviewing, establish rapport not as scientists but as human beings; yet they proceed to use this humanistically gained knowledge for scientific ends, usually without the informants' knowledge " (cited by
There were many occasions when team members provided information in an informal manner. It was inappropriate to ask them to stop while I found a notebook, hence I tried to remember what they said and wrote it down afterwards.

Some of the information provided informally was of a confidential nature. Was it ethical to record such information? Because team members were clear about the nature of the research and were keen to help, I do not think they would have qualms about the information being recorded, but would be more concerned over its future use. My guidelines were that if information had been given confidentially, it would not be presented to others. I am therefore happy that I have not broken any confidences of team members, but questions remain as to whether it was ethical to record such information after the event, without their knowing.

**Learning opportunities**

Learning opportunities are significant as arguably they should be an important criterion of the success of post-graduate studentships. My studentship has provided many learning opportunities, for example about the nature of social science research and research methods. I have become more aware of the debates surrounding qualitative research and have learnt from the experience of operationalising research methods, for example about the problems of bias and the importance of relationship-building. In addition I have learnt from my mistakes over questionnaire design and had to learn to use a computer for the team meeting analysis instrument.

The studentship provided a lot of scope to explore issues of interest to me which was both challenging and daunting. This generated a lot of information which I had to learn to manage, by referencing and cross-referencing for example. Similarly with material generated by the fieldwork research, which presented a further challenge because of originating from a number of different sources. I had to learn to be efficient and organised. Perhaps most importantly, I learnt about myself as a person, for example my capacity for work as this study has involved hard work both on a full-time basis when undertaking the fieldwork and on a part-time basis undertaking the analysis and writing up.
Summary

This study has two principal foci: implementation and teamwork. An exploratory approach was adopted for both, whereby templates were generated from the key issues in the literature reviews, and against which the teams could be considered. It was intended also that the explanatory power of the frameworks and models themselves would be judged according to the results in an attempt to avoid squeezing the evidence to fit the models, as per square pegs and round holes. A variety of research methods was considered appropriate, given the complexity of the task. These were based in a "below and within" approach, and on the basis that relationships with team members should be reciprocal in nature.

How adequate was this approach? As expected, it proved crucial to employ a variety of research methods. A good example occurred over the issue of trust, as weaknesses in the questionnaire, from its failure to account for differences across team members, were highlighted by observation. As the project progressed, the more strongly I felt that the information I was receiving from CMHT members was dependent upon the relationships I had established with them. Consequently my investment in generating the "social and informal" aspects of the research appeared a secure one. In addition I also felt increasingly strongly that relationships should be based on reciprocity and therefore that the enabling role I was adopting was appropriate.

Regarding the research methods more specifically, ideally the team meeting analysis instrument should have been ready for piloting before the fieldwork began. I adhered to the interview schedules too rigidly, thereby precluding spontaneity and a deeper exploration of issues, and should have had more realistic expectations for the questionnaires. Finally, if I were to repeat this project, I would almost certainly tape interviews and team meetings where possible: to reduce the distortion in interaction within interviews, while providing extra thinking space; and to facilitate a deeper analysis of team meetings, such that a unit of analysis could become a statement rather than an issue.
CHAPTER 3

THE RESEARCH SITE: COUNTY PROFILE OF NOTTINGHAMSHIRE

Geography and Demography

Nottinghamshire comprises 216,000 hectares, with its main City, Nottingham, near the southern tip of the County. A population of just under one million was recorded in the County in the 1981 census, and was shown to be part of an upward trend:

Table 3.1 County population

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>977,900</td>
</tr>
<tr>
<td>1981</td>
<td>994,300</td>
</tr>
<tr>
<td>1990</td>
<td>1,009,400 (projected)</td>
</tr>
</tbody>
</table>

SOURCE: Nottinghamshire SSD Research and Information Unit (1984a).

The population is unevenly distributed within the County, over half of it concentrated in the City of Nottingham and adjoining districts to the South West of the County. Most of the rest of the population are situated in an urbanised belt of coalfield towns and villages extending down the western side of the County, in contrast to the East of the County which is predominantly rural with two market towns comprising the only significant centres of population.

In a national survey of disadvantage, the City of Nottingham was ranked 16th in the Country, with only Liverpool, Manchester, Leicester and twelve London boroughs deemed to have higher levels of disadvantage (Notts County Council Planning 1984). A County-wide study of disadvantage conducted by the County Council in the early 1980s (Notts County Council Planning 1983), found that most of the disadvantage was concentrated in the City of Nottingham.

Structures

Couched within the County Council, the Social Services Department (SSD) had three operational divisions organised on a geographical basis: City, County-north and County-south, which were further sub-divided into six, three and four operational areas respectively. The SSD's senior management structure in 1981 is represented in Table 3.2.
Table 3.2

SENIOR MANAGEMENT STRUCTURE - NOTTINGHAMSHIRE SOCIAL SERVICES DEPARTMENT

DIRECTOR OF SOCIAL SERVICES

DEPUTY DIRECTOR
POLICY and PLANNING

ASSISTANT DIRECTOR
(Advice Development & Training)

Training
Inspection and registration of Private Old People's Homes,

Childminders,

Day Nurseries

Advisers on client groups

Voluntary groups

ASSISTANT DIRECTOR
(South)

4 Area Offices

Establishments

Transport & Services

Meals on Wheels

Information and Library

Caterers

ASSISTANT DIRECTOR
(North)

3 Area Offices

Establishments

Assessments/ Collections

Information and Library

Caterers

ASSISTANT DIRECTOR
(City)

6 Area Offices

Establishments

Transport & Services

Meals on Wheels

Information and Library

Caterers

ASSISTANT DIRECTOR
(Planning and Research)

Planning Research

Health/Social Services Liaison

ASSISTANT DIRECTOR
(Common Services)

Establishments

Transport & Services

Meals on Wheels

Information and Library

Caterers
Nottinghamshire Area Health Authority (Teaching) (AHA(T)) administered Health Services in the County until reorganisation in April 1982. It consisted of four Health Districts: Nottingham North; Nottingham South; Central Nottinghamshire; and Bassetlaw. The AHA(T) boundaries were coterminous with the County Council's, but the Health Districts' boundaries overlapped those of the Social Services Divisions, most notably the North Nottingham Health District which cut across all three Divisions. The Bassetlaw Health District boundaries coincided more happily with other agencies, being coterminous with a County Council Area and a District Council. In the 1982 reorganisation the two Nottingham Health Districts were combined to form Nottingham District Health Authority, which with a population of approximately 600,000 is one of the largest in the country. The remaining Health Districts, Bassetlaw and Central Nottinghamshire also became District Health Authorities and Bassetlaw with a population of only 100,000 is one of the smallest in the country.

Two Joint Consultative Committees were established in Nottinghamshire in 1974, one between the AHA(T) and the County Council and the other between the AHA(T) and District Councils. The Joint Care Planning Team (JCPT) was established in 1976 and four JCPT sub-groups were established, including one for mental handicap services.

Expenditure

The fortunes of the SSD regarding expenditure reflected changes in political control of the County Council. For example, between 1977 and 1981, under Conservative control, real growth in the SSD was limited to 5%, a long way behind the 2% per annum increase considered necessary by the DHSS to maintain the same ratio of services to need. In contrast the Labour administration levied a supplementary rate in 1981, and by 1984/5 the SSD's spending was 11.5% higher than in 1981/2, compared to an average increase for the shire counties of 8.7%.

Nottinghamshire AHA(T) was considered by the RAFP formula to be an underfunded Area in an underfunded Region. The solution was seen to be a capital led one, and a major capital building programme was started across the Area, but with particular concentration in Nottingham. The new mental handicap unit was commissioned and built during this period,
but most of the growth was in the acute sector. Indeed, the AHA(T) found it increasingly difficult to improve services for the "Priority groups" such as the mentally handicapped because of its capital commitments, particularly after 1976 when Regions no longer granted automatic revenue funding for new capital schemes. Therefore, despite the increase in resources, 700 beds remained unopened in Nottingham hospitals by 1982.
PART II

CONCEPTS AND THEORIES
CHAPTER 4

ORGANISATIONAL THEORIES AND IMPLEMENTATION

Introduction

The literature on implementation will be reviewed to provide templates for the guiding hypotheses. This review is preceded by a discussion of trends in the study of organisations, thereby contextualising the recent growth in interest in implementation. The two basic models of implementation will be considered (Top-down and Bottom-up) followed by a discussion of the scope for a combination of approaches and of the factors which help to shape implementation processes. Alternative organisational contexts for teams are briefly considered, as these too impinge on implementation processes. The foregoing material is summarised at the end of the Chapter, with an attempt to assess which concepts and questions are most useful for guiding the empirical research.

The Study of organisations: a crisis

By the 1970s the study of organisations had become dominated by functionalist and positivist theories, for example the "contingency theory." All these conventional approaches were facing a "crisis" (Benson 1977a) however, concerned with four analytical problems:

i. Action: Traditional studies, claimed Benson (IBID), viewed hierarchies as if they were "independent" of people, thereby ignoring the "processes of group life." Instead, research needed to focus "attention upon the production and reproduction of organizational reality in the ongoing interactions of people."

ii. Power: had been studied within functional frameworks, as distributed according to goals and outputs. This standpoint assumed that such goals and outputs formed a stable reference point, without acknowledging that they too were based on an underlying power distribution.

iii. Levels: organisations had been construed as distinct entities, both from their sub-groups and from their environments. This notion was attacked both from "micro-process perspectives," with
claims that organisational goals were reified and attributed with a false objectivity, and from "macro-structural studies," which sought explanations for organisational behaviour in the organisations' networks.

iv. Process: the analysis of organisations had proceeded assuming "stability in major organisational features" (IBID) and failed to consider adequately changes in organisations themselves and their environments, and the causes of such changes.

Despite this "crisis", "the underlying framework [had] none the less remained essentially a pluralist one, which [assumed] that conflicts of interest within organisations and indeed within societies [could] ultimately be accommodated" (Dawson and Wedderburn 1980). More recently however, two developments have challenged the conventional approach: an increased interest in the nature of power within organisations; and, linked to this, the emergence of a "radical" approach to the study of organisations.

Organisations and power

The growth in interest regarding power in organisations owed a lot to the studies of community power, the catalyst being Bachrach and Baratz's (1970) study of poverty in Baltimore in the 1960s. They studied "non-decision making," which they defined as: "a decision that results in suppression or thwarting of a latent or manifest challenge to the values or interests of the decision maker." The typology of non-decision making they devised included force, intimidation and coercion, and more indirect forms such as the mobilisation of bias, which is the invocation of existing political norms: "The moral of this story for students of organisation was clear. They ... had over emphasised the more overt manifestations of power to the neglect of an intensive analysis of less obvious but more far reaching differences of interest" (Dawson and Wedderburn 1980).

A refinement of this "two dimensional view" of power has resulted in a "three dimensional view" of power, which: "allows for consideration of the many ways in which potential issues are kept out of politics, whether through the operation of social forces and institutional
practices or through individuals' decisions" (Lukes 1974). Crenson's (1971) study of air pollution is a good example, showing the impact of both inaction and the reputation for power. Lukes (1974) concluded, regarding the strength of this approach: "it does not interpret non-decision making behaviourally; it considers the ways in which demands are prevented from being heard, through the exercise of this inaction; and is not solely concerned with the power of the individual, but considers institutional power."

These advances in the analysis of community power have undoubtedly informed studies of power in organisations. For example, in a discussion of power within the NHS, Webb and Wistow (1986) claim that the professionals' power, particularly that of doctors in the "acute medical specialisms," was not merely an "active power" defined as "the power to decide or to influence decisions" but: "was also a more pervasive power: 'a mobilisation of bias.'" These doctors had achieved such power by creating a climate in which "health" had become synonymous with the curing of acute illness.

New approaches and theories in the study of organisations have paid more attention to the issue of power than hitherto, notably: Strategic contingencies; political economy; and the resource dependency model. Underpinning the Strategic contingencies approach is the view that organisations consist of sub-units which form a: "complex, shifting coalitional aggregation of interest groups" (Hemmings 1979). Each of these units is vying for position within and resources from the larger organisation, although they may have different goals to those of the larger organisation. The theory stipulates that each unit earns power to the extent that its functions are essential to the other units within the organisation. Central to this is the notion of domain: "the degree of exclusivity, autonomy and dominance indicating the extent to which a unit has secured control over its domain activities" (Hemmings 1979).

The political economy approach stresses two key aspects of organisations: their political and economic structures and processes. Further, there are both internal and external aspects of a political economy, thereby making it a useful tool in considering both intra- and inter-organisational behaviour. The internal polity refers to the formation and maintenance of both formal and informal groupings, their
values and cohesion, the external support they receive and their relative power. The internal economy focuses on the means rather than the ends, and in particular on the factors which combine to produce an output. Externally, political aspects of organisations are concerned with "control over legitimation, resource base, goal definitions, and the channels for exertion of influence" (Wamsley and Zald 1973) while economic aspects focus on the behaviour required to obtain the "factors of production and the exchange of output at organisation boundaries" (IBID).

An observation of this model is that over time, organisations develop characteristic ways of dealing with service delivery demands from their environments. However: "Other bodies which structure their activities in a manner different from that which the focal organisation displays, constitute a potential threat to the claimed efficiency and effectiveness of the latter and because of the serious ramifications this entails for future legitimate resource acquisition, is likely to induce its displeasure" (Hemmings 1979). When the other organisation is in a separate domain, it will be denigrated, but the implications are more serious if it is in the same domain, as the focal organisation will attempt to force the other organisation to withdraw. To achieve either, the organisation will have to rely on "the invocation of extra normative support ... in the form of forced coalitions amongst the less secure bodies" (IBID). Alternatively it can use power derived from resource dependency.

The resource dependency model suggests that power structures reflect the operation of exchange transactions, where there are differences in the nature of the resources the different actors possess (IBID). In its simplest form, the model postulates that A has power over B if A possesses resources B would like to possess. In addition, A may desire the resources held by B. Hemmings has outlined a number of options as they present themselves to B: he could re-evaluate the value attached to the resources held by A; find alternative sources; form a coalition among A's recipients; or threaten to increase the price of his own resources. A has similar options, and the result is a complex pattern of interactions based around bargaining.
An extension of this model views A's and B's power differentials as indexed by the following:

a) The relative difference between them in the elasticity of their motivated investment in the resources provided by the other;

b) The difference in the range, volume and importance of the two sets of resources;

c) The differences in each actor's ability to buy the other's resource elsewhere;

d) The difference in their ability to form coalitions;

e) The difference in the ability of each actor to withstand the hostile environment in which the bargaining takes place (IBID).

Central to these new approaches to power in organizations are the issues of Resources and Domain. Benson argues that: "the basic prime mover behind organisational activity is the acquisition of a secure and adequate supply of money and authority" (cited by Hemmings 1979). Webb and Wistow (1986) prefer the terms Resources and Domain, instead of money and authority, where resources include the stocks and flows of staff, capital and other commodities, and where domain involves the legitimation of activities. To these Webb and Wistow (1986) add "organisational cultures," which encompass: "sets of values, beliefs, ways of viewing problems, bodies of knowledge, technologies, routines and processes ...."

The ways in which organisations derive and use their power have been examined, and the currency of the interactions both within and between organisations has been noted: Resources, Domain and Culture. But the question of motivation remains: Why should an organisation or unit wish to use its power? In other words the question becomes Why instead of How. Most of the approaches above assume or imply that organisations act in self-interested ways. Webb and Wistow concur, referring to the Partisan mutual adjustment model from the Planning field. This model is an alternative to the Rational Planning model, and: "operates from the assumption that behaviour is primarily self interested and rational in a narrow or sectional sense, rather than in a system wide, and altruistic sense. In essence, it carries the model of 'economic man' into the arena of public policy" (IBID). The "jockeying for position" and bargaining discussed in the models above occur therefore when the
opportunity for mutual benefit presents itself to two or more organisations, or when an organisation feels threatened and tries to preserve its domain, resources or culture.

**Benson: A Marxian Dialectical View**

The second development to challenge the conventional pluralist approach, based partly on the growth in interest in power in organisations, has been the emergence of a "radical" approach, enunciated by Benson. It is a "dialectical" theory, and is couched within a Marxist perspective. This approach has four principles: Social Construction/Production; Totality; Contradiction; and Praxis.

1. Social Construction/Production

Benson applauds the recent trend within studies of organisations to make more central the study of "organisational realities." The use of an Action perspective focuses on the history and sequences of events and contexts (Benson 1977a). As part of the social world, an organisation is "always in a state of becoming" (Benson 1977b). The social world is continually in a state of construction, arising from interactions, which as repeated, build into a set of institutional arrangements. In this way, an organisation's major features: "are the outcroppings of the process of social construction" (IBID) and an organisation can be regarded as a product of past acts of social construction.

Social construction itself is constrained by its context, notably the existing social structure, hence: "The production of social structure......occurs within a social structure" (IBID). Of particular interest to the "dialectician" in the development of relations and structures is the social process through which they have been produced. Benson (1977a) acknowledges the contribution of "Negotiated order theory" which: "is a process-oriented perspective stressing the continuous emergence of organisational arrangements out of the ongoing interactions of participants" (IBID). An observation of this theory is that because arrangements are continuously negotiated, they are much less stable than they may appear. The Negotiated order theory does however fail to consider structural boundaries: "While it may be true .... that negotiation is present in all social situations, the structural problem is to grasp the relations between situations - the ways in which some negotiations set limits upon others" (IBID).
2. Totality

Arising from the social construction of arrangements and organisations, Benson argues the appropriate approach is "relational" in nature, in considering: the organisation as a whole; how its components inter-relate; and the links between the organisation and the larger society. The traditional separation between an organisation and its environment is questioned: "The essential continuity, the relational character of social life must itself be analysed and not overlooked in a search for analytical boundaries and units of analysis" (Benson 1977b).

The organisation's components are viewed as a network, which is only "partly rationalised" despite attempts by the organisational elites. In this way the substructure forms the basis for a "latent social system" within the established order. In studying power within organisations, Benson welcomes the approaches outlined above: strategic contingencies; resource dependency; and political economy, because they: "grapple with the underlying, non-rationalised bases of control within the organisation" (IBID) although he regrets that none were cast within a broader dialectical framework. In Benson's approach, power is elevated from being one factor among many, to the "essential core" from which other features proceed.

3. Contradiction

"The social order produced in the process of social construction contains contradictions, ruptures, inconsistencies, and incompatibilities in the fabric of social life" (IBID). Such contradictions occur because some factors, internal and external to the organisation, remain beyond rationalization. As a result, the degree of change possible in arrangements "seemingly determinate in structure" is easily underestimated. Indeed, contradictions make change more likely, as they provide a continuing source of tensions.

Some contradictions are generated from within the organisation, for example from the reward and control structures. Occupants of particular organisational locations will develop models of arrangements based on their unique problems and priorities. Many different models evolve therefore, some of which will be incompatible or in conflict with others. Because social construction is ongoing, alternatives will
continually be generated, and hence existing arrangements will continue to be confronted. Contradictions may also be generated from outside the organisation, and then imposed on it: an organisation may have to undertake contradictory functions, the prison system being one example, or it may be dependent on contradictory sources for support.

4. Praxis

Benson's focus on praxis considers both existing arrangements, and through social construction, changes to those arrangements: "creative reconstruction of social arrangements on the basis of a reasoned analysis of both the limits and potentials of present social forms" (IBID). Dialectical analysis should progress beyond reflexivity to reconstruction by removing constraints and limitations on praxis. Benson's approach contributes to this by showing how arbitrary and uninevitable are existing social arrangements. Nevertheless, questions remain, and Benson concludes by asking: "Under what conditions can people reconstruct organisations?" (IBID).

To summarise, Benson's approach is a Marxian dialectic. It is process-oriented, with particular attention paid to: power and action. Patterns of organisation are regarded as uninevitable, particularly as they have evolved from and are continuously confronted by social construction. This in turn is based on contradiction, which reflects contradiction in the wider society.

The scope and flexibility of Benson's approach have been shown by Hambleton (1983) in studying "Central - Local relations." He outlined three theories which illuminated particular aspects of Central - Local relations: procedural planning theory; inter- and intra-organisational theory; and the State's response to fiscal crisis. While planning and inter-organisational theories were context-less, fiscal crisis considered structural issues, but failed to explain particular changes in relationships. Hambleton showed how Benson's model could reconcile the different approaches: "[Benson's] approach when analysing the operation of a policy sector is to distinguish between a 'deep structure' of rules and interests which strongly influences a 'surface level' of substantive policy and administrative arrangements. The rules and interests are in turn a reflection of the wider power structure within society."
Benson's approach has clearly added a new dimension to the study of organisations. However, while: "the questions and problems ..... are well formulated the answers and indeed the methodology for generating the answers are still relatively undeveloped" (Dawson and Wedderburn 1980). Much remains to be done before the answer to Benson's concluding question quoted above can be supplied by empirical work.

**Professionals in organisations**

Many welfare occupations like to consider themselves "professions." A lot of work has been undertaken, for example by Etzioni (1969) and Rowbottom (1978), in explaining the nature of professional authority, the relationships between different occupations, and between professional and managerial forms of authority. In the debate over the appropriateness of professional vis a vis bureaucratic norms, bureaucracies are usually viewed negatively as being too rigid, while professional norms are more positive and counteract these, for example Etzioni (1969): "Only if immune from ordinary social pressures and free to innovate, to experiment, to take risks without the usual social repercussions of failure, can a professional carry out his work effectively. It is this highly individualised principle which is diametrically opposed to the very essence of the organisational principle of control and co-ordination by superiors i.e. the principle of administrative authority."

Such a sharp dictotomy is not valid however, for a number of reasons, including: bureaucracies such as Social Services Departments have themselves become increasingly "professionalised"; and while it may limit the number of options, procedural guidance does not remove the need for the exercise of professional judgement (Hallett and Stevenson 1980). More broadly, criticisms have been levelled at professionalism as a form of organisation, as people cannot be led to serve an occupation by becoming committed to its ideals alone, since they must become committed to a concrete career and to concrete, historical institutions (Freidson 1970). Further, professionals develop a sense of pride regarding their work, based on its special nature, hence they see both their work and themselves as extraordinary (IBID). As a result: "There is a kind of professional imperialism which contrary to
territorial imperialism, gets narrower rather than broader .... The thrust of professional activity is generally to build barriers that would keep the profession and its clientele safe from those beyond the pale, while at the same time seeking jurisdiction over all that cannot be excluded" (Sheps 1974).

There has been a shift of focus within the sociology of occupations recently, in an attempt to break free from the "strait-jacket" (Johnson 1972) of professionalism. For example, there has been a shift from all-embracing generalities; as embodied in the trait and functionalist approaches, to an emphasis on the historical context, with studies of specific occupational structures at particular points in time. There has been an increased emphasis on power, particularly in focusing on the institutions which have arisen to reduce the uncertainty and social distance in relationships between service providers and receivers. Johnson (1972) for example, has argued: "A profession is not an occupation, but a means of controlling an occupation .... Professionalism .... becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of particular occupations."

But how does occupational control relate to broader structures such as the mode of production? Johnson (1977) has pointed to a duality in the organisation of knowledge, based on the Indetermination - Technicality ratio, deriving: "from the more fundamental dualism characterising the capitalist mode of production." The duality of Capitalism incorporates both: the labour process, involving the social division of labour, creation of real use value and technicality at the level of the occupational organisation of knowledge; and the surplus value producing process, specific to capitalism, which involves the functions of capital and the conditions for indetermination (Carchedi, cited by Johnson 1977).

Technicality refers to the extent to which a systematic body of knowledge is utilised in the justification of competence or expertise, that justification resting in turn upon the creation of a rationalised and transferable body of knowledge. Because of the transferability of the knowledge however, it is vulnerable to codification and ultimately to routinisation and fragmentation. Indetermination is the other aspect
of the duality, which is concerned with the structure of uncertainty. Because technical knowledge is not the only or necessarily the most important form of knowledge learned during socialisation into the workplace, there is a limit to what can be codified and transferred, and hence there is still a basis for uncertainty and mystique. The Indetermination - Technicality ratio is reflected in two apparently contradictory trends: specialisation and holism. With the proliferation of knowledge has come the realisation that no single individual can encompass it all, hence there has been a need to limit "knowledge areas": "New specializations grow in a sloughing off process, from the original ones, thus speciality boundaries are in continuous redefinition" (Brill 1976). At the same time there has been a fundamental change in the basic manner of thinking about humanity, moving toward a perception of the world as: "an integrated whole of organised complexity" (IBID).

Dingwall (1980) has applied these two trends to General Practitioners, and argued that they can claim a "technical competence" in specific aspects of medicine, while also adopting a holistic vision "as a generalised expert in the problems of living." In this way doctors are powerful because they adhere to both sides of the Indetermination - Technicality ratio by having a specific knowledge base around which it is possible to maintain mystique. Social Workers on the other hand, have a knowledge base, but in an area where many laymen feel they also have some expertise. The knowledge base itself has received much criticism from sociologists and psychologists, and yet these are the disciplines upon which it is supposed to be based. As a result therefore, Social Workers are less powerful than doctors because their profession has been less successful in establishing a widely accepted knowledge base, and has failed to maintain a mystique, despite their attempts to generate a pseudo-scientific language.

The growth of the bureaucratic form of organisation is also explained by Johnson (1977) by reference to the stages in the development of Capitalism. It is seen to stem from both the labour process and the surplus value producing process. Within the context of bureaucratic organisations, professional occupations are agents of both collective labour and global capital functions. The more or less of the one or the
other they adhere to, the more or less they will be influenced by technicality or indetermination, and hence the more or less they will be able to resist external pressures. In this way the power bases of occupations have been considered by focusing on the sources of their power and on wider social structures. This is a good example of not considering organisations as "separate" from their environments, but of considering the "relational character of social life," as advocated by Benson (1977b).

Implementation: Early Studies

The study of organisations has spawned a new area of interest: implementation. This has in fact been studied for many years, although recently a different terminology has developed (Hill 1979). Indeed, it has become much more fashionable to talk of implementation and implementation problems. While this field of study has moved towards its own synthesis, it remains very dependent on well-established disciplines, such as organisational psychology and sociology.

Study of implementation commenced in America, with a recognition that while policy making had been studied, little was known of what happened after policies had been passed. Interest grew, given the apparent frequency of problems in implementation processes as policies failed to achieve their goals. For example, in their study of job creation, Pressman and Wildavsky concluded: "...that, even with the odds stacked in favour of agreement being reached at every key decision point, the normal expectation should be that new programmes will fail to get off the ground and that, at best, they will take considerable time to get started" (cited in Hambleton 1983).

This growing concern about the ineffectiveness of much planning activity is one of two reasons given by Hambleton for the increasing interest in implementation, the other being a proliferation of policy planning systems. Such systems mushroomed in both America and Britain in the 1960's and 1970s, examples including PPBS and PESC. In essence these were corporate planning attempts to link Central Government and local agencies and improve the formulation and execution of policy, by stressing the link between comprehensive strategies and precise expenditure programmes (Barrett and Fudge 1981, Hambleton 1983).
Approaches to the Study of Implementation

"Top-down" and "Bottom-up" describe the two broad approaches to the study of implementation, each of which will be outlined.

1. Top-down

In a Top-down model, policy is given and policy success and failure are governed by the strength and weakness of the implementation process. This model incorporates two assumptions:

(i) That policy making and administration can be separated.
(ii) That there are clear and explicit goals.

These assumptions are revealed through definitions employed in the early literature on implementation:

"Implementation concerns the processes intervening between the expression of broad policy intentions and policy impact: the achievement, or otherwise, of these intentions" (Webb and Wistow 1980).

"... policy implementation encompasses those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions ..... We should emphasise that the implementation phase does not commence until goals and objectives have been established (or identified) by prior policy decisions; it takes place only after legislation has been passed and funds committed (or after a judicial ruling and accompanying decree)" (Van Meter and Van Horn 1975).

Such a standpoint is ideally suited to a "recipe book" approach, in identifying ways that implementation failure can be prevented. A good example is Sabakier and Mazmanian's (1979): "The Conditions of Effective Implementation: A Guide to Accomplishing Policy Objectives" in which five conditions are outlined for the successful accomplishment of policy objectives.

Within the Top-down research perspective, the Top-down model of policy making is described as: "Policy as intent", whereby "organisations are created to pursue goals which are authoritatively detailed at the top of the organisation" (Webb and Wistow 1986). Such a view sees policy as a means of exercising control or influence over the working of organisations to the extent that the concept of policy becomes: "a means of buttressing political (and hierarchical) control
as the precondition of legitimate action ...." (Webb 1983). While using this type, Webb and Wistow acknowledge the existence of alternatives:
- Policy as Programming, whereby means become ends;
- Policy as Output, whereby policy reflects a Bottom-up rather than a Top-down perspective;
- De Facto Policy, whereby decisions accumulate into an enduring pattern.

Webb and Wistow (1986) make a further distinction between two streams of policy: "Service Policy," concerned with the desired outputs, and "Resource Policy", which impinges upon service policies. Policy implementation is seen as dependent upon the successful handling of "four areas of action" (Webb and Wistow 1982a):
1) KNOWLEDGE/THEORETICAL base, two essential components being the theory of the problem and the theory of causality;
2) POWER/SUPPORT base, including support from professionals and politicians;
3) ADMINISTRATIVE base: "the style of organisation may determine the kinds of policies which can be effectively implemented." One option may be to create a new organisation.
4) RESOURCE environment.

With these "four areas of action" as the backcloth the Implementation process unfolds as a series of logical steps:
- Policy Explication and Communication: often policy explication stops at the level of banner goals thereby allowing much scope for interpretation;
- securing appropriate resource inputs; ) Many specific controls processes; ) tend to be imposed on
- Exercising control over production ) these.
- Exercising control over production outputs;
- Compliance and Support.

Etzioni's three types of Compliance strategy are often cited: sanctions; incentives; and moulding the normative structure, by modifying others' definitions and perceptions of problems and solutions. Webb and Wistow (1982a) claim that normative controls have been dominant
in policy implementation in the Personal Social Services, especially Service policies. They have been popular as they appear compatible with notions of autonomy regarding professional practice. The two factors which predispose agencies to comply are: the "salience" of the policy to their own objectives; and the "congruence" of the ideological base of the policy with the agency's perspective.

A number of gaps in the policy implementation field are pointed to by Webb and Wistow (1982a), notably the gap between banner goals and quantified input and output targets and the gap between service and resource policies. "Intermediate theories" are required they claim, linked to strategic policy issues, but providing sufficient detail for practitioners.

2. Bottom-up

Proponents of the Bottom-up approach to the study of Implementation criticize the Top-down approach because it appears to be detached from the "real world". Barrett and Fudge (1981) for example criticize the "recipe book approach" for recommending conditions which empirical evidence suggests are not found in practice; a static politics-free environment being one example. Particularly pertinent is the questioning of the second assumption underlying the Top-down model regarding clear and explicit goals: are they always feasible or desirable?

More fundamentally however, critics of the Top-down approach claim that the first assumption underpinning it is also invalid, because Policy and Implementation are not so readily separable: "...the interactions which influence the policy-making do not stop once policy is promulgated but carry on to affect the implementation process" (Hill 1979). In a further publication Hill et al (1983) elaborate: "The policy-making process is like the design of a building for a specific occupant by an architect, the implementation process affects policy design quite early on and will continue to influence some details of it even after implementation has begun just as modifications are made to buildings after occupancy."

In exploring the relationship between policy and implementation Hambleton (1983) refers to the Maud Report on Local Government in 1967. This rejected the contention that members were solely policy makers and
that officers were solely implementers, because officers exercised discretion and shaped policy, while members were often concerned with detailed implications of administration. In a similar vein within Central-Local relations, Hill (1979) points to a number of examples where Local Authorities have contributed to policy-making. This is a good example showing that distinctions between policy and implementation are relative: "In the perspective of each successive level, everything decided at that level and above is 'policy' and everything that may be left to a lower level is 'administration'" (Appleby cited by Hambleton 1983). Hambleton (1983) concluded: "There is, then no simple linear progression from policy to implementation." This was acknowledged by Webb and Wistow (1982a) in the three alternative "types" of policy above, and Barrett and Fudge (1981) concur by pointing out that action may precede policy, for example, if the latter is developed from innovations. To illustrate, Hill (1979) notes that in the environmental field, policy has evolved from practice, rather than vice versa.

The result for the relationship between policy and the implementation process is that while: "Policies are formulated with the implementation process in mind,... often it is more realistic to see policies as products of implementation rather than as 'top-down' inputs into the process" (Hill et al 1983). Advocates of the Bottom-up approach argue that this justifies a shift in focus away from the policy, to what happens in practice, and to the organisations involved: an "Action Perspective." This approach seeks to examine how action relates to policy, but without assuming that it follows from policy.

Within this broad approach, Barrett and Fudge (1981) present two alternative ways of conceptualizing implementation: as a negotiating process, and as action and response.

1. Implementation as a Negotiating process

Drawing on Negotiated order theory, Barrett and Fudge (1981) cite Strauss's contention that social orders can be called "Negotiated orders". Negotiation, involving both bargaining and compromise is at the heart of Compliance, through both control and consensus. At this point it is easy to see the different criteria of success employed by the Top-down and Bottom-up approaches. If implementation is seen as putting policy into effect, then compromise represents a policy failure;
but if implementation is seen as "getting something done," then performance becomes the central objective, with compromise as the means to achieve that performance, albeit at the expense of some of the original intentions.

Similar to other advocates of the Bottom-up approach, Barrett and Fudge (1981) do not feel clear lines can be drawn between policy and implementation. Pointing to negotiation, they see policy as a series of intentions around which bargaining takes place, rather than as a fixed entity. Therefore, a sequential implementation process from policy to action is replaced by a Policy/Action continuum, incorporating negotiation between those seeking to put policy into practice and those upon whom action depends. The continuum is represented diagrammatically thus:

**Figure 4.1 Policy/Action continuum**

![Diagram of Policy/Action Continuum](image)

Within this approach, implementation describes the day-to-day working, while policy making is an attempt to limit "the discretionary freedom of other actors" (Barrett and Fudge 1981).

11 Implementation as Action and Response

This perspective shifts the focus from policy to the organisations themselves, in examining the factors which shape their decisions and actions. The organisation is not always taken as the unit of analysis however, because different elements may be involved in different situations. Barrett and Fudge (1981) outline two themes which are pertinent to understanding Action and Response:
1. Differential scope for autonomous action amongst agencies;
2. Use made of it. Three determinants are proposed to account for action or inaction:
   a. Perceptions of the scope for action;
   b. Perceptions of the need for action;
   c. Motivation to act.
Underlying the above are the rules and norms absorbed, through processes such as occupational socialisation, which result in the promotion of certain interests over others. Such processes help to explain not only the decisions and actions taken by organisations but also their response to the decisions and actions of others.

3. Combination of Approaches

Having explored the criticisms of the Top-down approach to the study of implementation, Hambleton (1983) acknowledges that Top-down implementation does occur. This is a notable acknowledgement, because without it there is no recognition that "policy makers" and some "implementers" consider it legitimate for the former to make policies and for the latter to act on them. Nevertheless the Bottom-up approach clearly has a number of strengths, derived in particular from its focus on action and negotiation, in line with recent trends in broader organisational theories outlined above.

The implementation debate has become over-simplified, by polarising the two existing approaches. In an attempt to overcome this over simplification Hambleton (1983) considers that the analysis of planning systems can be both Top-down and Bottom-up: "This combined approach does not see implementation as the mechanical result of policy nor does it view implementation as interaction divorced from policy." Rather, he accepts Barrett and Fudge's policy/action continuum, and the negotiative process contained therein. This combination has the strength of being more open and less blinkered than its constituent models, while drawing on the insights of both.
FACTORS SHAPING THE IMPLEMENTATION PROCESS

Hambleton (1983) has outlined five factors which shape the implementation process and will be discussed in turn:

- The Policy Message
- The Multiplicity of Agents
- Perspectives and Ideologies
- Resources
- The Politics of Planning

These factors may prove to be significant as bridging concepts, in helping to overcome the over-simplification and polarisation of existing approaches.

1. The Policy Message

In justifying his assertion that the nature of a policy may be crucial for the character of the implementation process, Hill (1979) gives a number of examples: that a policy may contain conflicting objectives, or other constraints within it; that it may be constrained by other policies which impinge upon it; and that it may be constrained by scarcity or by control of finance.

The communication of a policy can be important too for the implementation process. Some contend that unambiguous communication will lead to better implementation, but both Hambleton (1983) and Hill (1979) feel ambiguity can arise for a number of reasons: because it is difficult to specify standards; or because of uncertainty arising from imperfect knowledge or because policy makers may not know what it is they want to achieve; or alternatively ambiguity may be deliberately fostered, perhaps in an attempt to conceal conflicts between objectives. Ambivalence about a policy, suggests Hill, may be reflected not so much in the policy itself but in the constraints that are set on the implementation process.

If the policy message is left vague, there is a lot of room for interpretation. Hambleton suggests that many Central Government statements are vague and cites "Care in Action" as an example. It will be seen that the 1971 White Paper (DHSS CMND 4683) is another example leaving a lot of scope for interpretation. Further, the meaning of the same message may change through time. For example, for a generation the Government has espoused a policy of Community care for groups such as
the mentally handicapped, mentally ill, and the elderly. But Community Care has meant variously: Local Authority as opposed to Hospital accommodation; domiciliary services; and voluntary and informal care (Hambleton 1981).

Ambiguity need not necessarily be viewed negatively, as it can lead to learning during the implementation phase. Hambleton (1963) goes so far as to say that unless a policy is very narrow, the implementation process will inevitably reformulate as well as carry out the policy.

2. The Multiplicity of Agents

Often more than one organisation is required: to decide on and agree to a policy; to implement a policy; to co-ordinate their actions; or simply to communicate with each other. "Mechanical difficulties" can exist as barriers to achieving any form of agreement or co-ordination. This is well illustrated by Pressman and Wildavsky's study of job creation in Oakland, and the conclusion they reached, quoted above. This reflects Dunsire's contention, cited by both Hambleton (1983) and Barrett and Fudge (1981) that the implementation process involves creating links, as well as activating existing ones. In this way, resources have to be created and legitimacy and motivation re-created during the implementation phase.

Pressures of time are one form of "mechanical difficulty" cited by Hambleton (1983), his example being the ten year plans that the DHSS required SSDs to submit, which suited Central requirements but which placed an "intolerable strain" on local agencies, as they fought to keep pace with annual budgetary cycles. Another example are the differences in structure and process between Health Authorities and Local Authorities which are required to engage in Joint Planning (Wistow 1980b).

3. Perspectives and Ideologies

The impact of attitudes and motivation on organisational behaviour requires further explanation. Where actors operate within different contexts "appreciative gaps" occur, embracing: "a range of subjective factors, including the implementers' cognition of the policy, the direction of their response toward it and the intensity of that response" (Hambleton 1983). Hill (1979) claims that "appreciative gaps"
have occurred in relationships between Central and Local Government: "Our view is that many problems of implementation arise from the centre's failure to comprehend the values, perceptions, motivations, and 'definitions of the situation' held by peripheral actors."

Where appreciative gaps occur, implementers may "screen out" a message if it contradicts deeply-held beliefs, or they may try to sabotage a policy, or more bluntly reject it. Implementers' capacity for such action may depend on the extent of their discretion. Such discretion might itself be a "deliberate recognition of local autonomy" (Hill 1979). There are differential degrees of such autonomy and discretion, depending on the nature of the occupation, the nature of the policy and the organisational setting. Where more than one organisation is involved, mediating bodies may have a role in bridging appreciative gaps. An example from the field of mental handicap is the Development Team, which has tried to build a consensus between Central Government, Local and Health Authorities, and consumers on the direction of future policies for mentally handicapped people.

An intriguing tension has developed in Wales under the All Wales Strategy which is promoting the Bottom-up approach to planning through a pluralist system, but within unambiguous guidelines issued centrally from the Welsh Office. Many carers prefer traditional non-risk taking services which do not correspond with the principles of the Strategy, and the CMHTs have adopted a gradual, incremental approach to reflect their needs (Humphreys and McGrath 1986). A Top-down model would interpret this to some degree as failure, but Humphreys and McGrath caution against this, claiming that it is appropriate for CMHTs to work sensitively towards meeting the needs of carers. This situation would appear to be a good example of the Policy/Action continuum, as the different groupings in both the Centre and the localities engage in bargaining and negotiation to determine the future shape of mental handicap services in Wales.

In a constantly changing and evolving world policies have to fire at "moving targets" (Hill 1979). These constant changes can contribute to appreciative gaps, as with the Sheffield Development Project. In the early 1970s, this was based very closely on the White Paper "Better Services" (DHSS 1971), and hence at that time there was a concurrence
between Central and Local perspectives. While "Better Services" has remained Government policy, there has been a significant shift in ideology and "fashion" within Sheffield (Davidson 1978d). A victim of these changes has been 96-bed hospitals, which were considered small in the early 1970s and which are still sanctioned by the DHSS, but which are now derided within Sheffield as symptomatic of a "buildings-oriented approach" (Axelby and Morrow 1984).

4. Resources

Three hypotheses are outlined by Hambleton (1983) regarding the impact of resources on policy implementation:

1. resources promote implementation activity which fits in with central aims;

2. resources distort implementation activity away from the achievement of central aims, because implementers do not agree with the policy and use the resources for their own ends;

3. implementation becomes: "the management of incremental growth" wherein policy analysis is displaced by the more immediate need to programme spending.

Hambleton feels all three hypotheses are relevant, and may all occur within the same policy.

Resource constraint will have an impact on policy implementation also. Webb and Wistow (1982a) have argued for example that in the 1970s service policies were given a higher priority than resource policies, but that this has been reversed during the period of public expenditure restraint under the Conservative Government from 1979. The effects of economic retrenchment on the Sheffield Development Project on services for the mentally handicapped have also been chronicled. Some parts of the Project were not implemented at all, while others were only partially implemented, including delays in providing new Local Authority and hospital accommodation, and a failure to train all of the residential staff. Davidson (1978a) concluded that "ambitious blueprints" had been replaced by an emphasis on "making-do."
5. The Politics of Planning

The literature on implementation frequently refers to conflict, negotiation and compromise. To help understand these processes, Hambleton (1983) cites Bordach's "Game" metaphor, which focuses on: "The players, what they regard as the stakes, their strategies and tactics, their resources for playing, the rules of play, the rules of 'fair' play, the nature of communications among the players, and the degree of uncertainty surrounding the possible outcomes." Underlying the Game Strategies is the exercise of power, from direct and blunt forms of control to the more subtle mobilisation of bias. It is important to determine the principal interest groups, the goals they pursue, and the ways in which they pursue them.

It will be seen that the 1971 White Paper (DHSS CMND 4683) which is still the cornerstone of DHSS policy towards mental handicap services is a good example of compromise, conflict and bargaining undertaken by interest groups. Similarly the Government's response to the Jay Report arose from bargaining and conflict. Many nurses perceived the Jay report as a threat to their occupation, and were able to articulate their case forcefully. For example they attempted to align their own interests with those of mentally handicapped people, such that the two would be seen to coincide. Consequently the nurses' interests prevailed, as they succeeded in preventing a radical reorganisation of service provision.

Organisational contexts for teams

A team's organisational location and context is an important determinant of its functioning. In acting as a "host" to the team, the wider organisation sanctions the team's work, provides for its "maintenance" needs, usually affords it a "protective umbrella" (Brill 1976), and constitutes a source of stability (Horwitz 1970). The organisation has a big impact on the nature of leadership within a team, by selecting "designated" leaders, and holding the power to confirm the legitimacy of a formal leader's authority. Further, both the productivity and morale of a team may be affected by developments within the larger organisation (Horwitz 1970). Horwitz has summarised thus: "All in all, the complex organisation may be said to provide the main ambience of the team's work life."
A variety of structures to the relationship between a team and its wider organisation are possible. The traditional structure is the Hierarchical pyramid, its lines of communication and responsibility being vertical in nature. Such a structure relies heavily on "link-pins," a term coined by Likert to represent a person occupying positions on two adjoining strata within an organisation. As Brill (1976) acknowledges, few modern organisations adhere to the "classic pyramid," as they allow a greater degree of "give and take" between interrelating components. Nevertheless, modified versions of the pyramid are more common, as Payne (K. 1982) found among Social Services Departments.

An advantage of the hierarchical structure is clarity in the delineation of roles and responsibilities. Several problems may occur, particularly for the link-pins: they belong to two groups which may be in conflict; their leadership position will have been defined by the organisation, whether or not they are appropriate leaders; and they are responsible for the work of the group, in the usual hierarchical manner, although if their team functions "collaboratively," they will tend to share that responsibility (Payne, M. 1982). This last problem can be expressed more generally: that conflicts may be generated when a team's structure and process do not correspond to those of the organisation within which it is working.

Applied to multi-occupational settings, Beckhard (1972) has described the hierarchical structure as "Functional," because team members report separately up vertical lines, and has viewed it negatively: "This structure does not support the team work to be done. Rather it maintains the separation of the various members by having them report up functional lines." An alternative is the "Product" or "Service" model, based not on skills and the services provided, but on needs and demands. In this model, all team members report to a team manager, whose responsibility it is to facilitate the team's work, while the "chiefs of service" act as "technical and emotional supports" to the team members from their occupations. This is very similar to the "Inverted pyramid" advocated by McDougall and Taylor, and presented diagrammatically thus, with particular reference to psychiatric teams:
The advantages claimed for this model are that by permitting horizontal communication, information is transmitted more freely, decision-making is delegated to a greater degree, relationships between team members improve, leading to an increase in team effectiveness and job satisfaction.

The matrix structure is the third model, which is a combination of hierarchy and task-oriented approaches: "representatives are drawn from different parts of the structure or different groups to make up teams which work on particular tasks" (Payne, M. 1982). These representatives have two allegiances: to their structure and to their "special team." To help to explain this model, Beckhard used the distinction between "operating units" and "capabilities" as follows:
This type of structure is used in some complex organisations, and represents many multi-occupational settings. It may be very demanding for those working within it however, as authority is less clearly defined. This lack of clarity might induce some to try and return to a more hierarchical model: "The problem with this kind of arrangement is that staff bear the whole burden of trying to reconcile the differences between the different organisations, and boundaries between different activities are more difficult to draw. But these are the very advantages of the scheme: different specialisms are able to work together in an integrated activity; and there may be advantages in blurring the distinction between different forms of activity" (Payne, N. 1982).

Within these different structures, the Top-down model of implementation would be most efficient within the hierarchical structure. With a greater degree of delegation in decision making, authority and roles less clearly defined, and a more complex set of allegiances, the "Product" and "Matrix" structures would appear to offer greater scope for the Bottom-up approach to implementation.
SUMMARY: A WAY FORWARD

The study of implementation has been located within trends in broader organisational theories, reflecting a greater emphasis on action, negotiation and power. Many different perspectives have been brought to bear in the study of implementation, reflecting its dependence on longer-established disciplines. Two basic models of implementation have emerged: Top-down and Bottom-up. These have been helpful as metaphors, indicating in broad outline the general direction of processes. Necessarily they have been simplistic. The oversimplification has become problematic however as the two models have become polarised. Debate has become increasingly sterile as the proponents have considered the different models and research perspectives to be mutually exclusive, almost in a right or wrong fashion. This is particularly inappropriate given the multi-levelled structure of most organisations, such that distinctions between policy and implementation may be relative.

How can the approaches be reconciled? One possibility is to combine the approaches, such that the relationship between policy and implementation is explored in an open manner, with a recognition that processes can operate in either direction. This requires taking the blinkers off the proponents of the two basic models, by dispensing with some of their assumptions prior to study.

A dimensions approach may also help to reconcile the models, by promoting bridging concepts. Five factors have been discussed which could act as dimensions in this way: policy message; multiplicity of agents; perspectives and ideologies; resources; and the politics of planning. Potentially, this approach appears helpful by combining a greater level of sophistication with the insights from the two basic models, such that detail can complement generalities. Many questions remain to be answered however, for example: how useful are these dimensions as bridging concepts and are they exhaustive? These questions will be taken forward into the empirical research, such that material will be assessed against the two basic models and the five dimensions. Not only should this facilitate analysis of the material, but also allow for judgement of the explanatory power and exhaustiveness of these models and dimensions.
CHAPTER 5

CO-OPERATION AND TEAMWORK
DEFINITIONS AND CLASSIFICATIONS

Introduction

This chapter attempts to provide an overview of the concepts of co-operation and teamwork. Definitions and classifications of both concepts are explored. A narrower focus is adopted in the next chapter, with a more detailed consideration of particular facets of co-operation.

Classification of co-operation at the 'practitioner' level

Tibbitt (1975) has devised a categorisation of co-operation according to the level at which it occurs: 1. Strategic planning; 2. Service integration; 3. Service delivery. The usefulness of such a categorisation claims Tibbitt is that: "It distinguishes a series of levels at which interaction between agencies will occur, it provides a series of goals for interaction, and it distinguishes between what is mainly 'management' interaction and 'practitioner' interaction."

Brill (1976) has asserted that: "Historically, three processes have been described and used to facilitate the necessary relationships between the specialisations in human services: consultation, referral and collaboration." The five major characteristics of consultation are listed as:

1. It deals with a current problem;
2. It is temporary;
3. It is advisory i.e. the consultant does not implement the recommendation;
4. The consultant is usually from outside the service system, and
5. does not possess administrative authority in the service system.

The criterion which differentiates collaboration from consultation is: "That the workers involved have a joint responsibility for carrying out an agreed-upon action." (IBID). Brill argues that a continuum of
collaboration exists, from autonomous to integrative. These classifications owed a great deal to the differentiation by Horwitz (1970) between co-ordinate and integrative collaborative processes. The former: "might be conceptualised as a structure in which each brick is an independent decision made by one of the associated, but primarily autonomous, professionals." In integrative collaboration however, the work is conjoint, boundaries are blurred, there is collegial initiative in offering uninvited suggestions, and continual and informal consultations: "In this type of collaborative process, the team's work might be regarded as organismic, different aspects being so intimately related to the whole as to be devoid of meaning if the integrating pattern were to be abstracted" (ibid). Autonomy, role boundaries and communication are determining criteria.

These same variables were used in the DHSS (1978b) study to classify Social Services teams as "Open" or "Private." The majority of teams were found to approximate to the private system, because Social Workers undertook their casework as individuals, without conjoint action and shared responsibility, and formally related to their Senior Social Worker only. Hence they were akin to Horwitz's "independent bricks" at the co-ordinate end of the continuum. However, team members' interaction was more "integrative" with much discussion, support and advice. The team therefore provided an environment and structure in which team members could be mutually supportive, but in which they worked individually and separately.

A typology of inter-organisational relationships devised by Davidson (1976) also helps to shed light on relationships at the service delivery level:

1. Communication - Talking and sharing information;
2. Co-operation - working together on a small project, through informal arrangements;
3. Confederation - wherein tasks are more clearly limited and well defined;
4. Federation - a formal structure in which tasks are defined precisely and a degree of autonomy is ceded;
5. Merger - wherein organisations give up their separate identities.
The factors of prime importance to Davidson are task and role definitions, and the structures within which these are located. Hallett and Stevenson (1980) used this typology with reference to Area Review Committees in Child Abuse, and concluded that they exhibited some characteristics of a Federation and some of Confederation.

The most complex classification of multi-occupational co-operation has been devised by Bruce (1980) who has promulgated a continuum of co-operation, ranging from zero to total. This in itself highlights a pertinent issue, that of terminology, as Bruce uses the term "co-operation" to embrace all forms of multi-occupational consultation, referral and collaboration, and hence uses it in a much broader sense than Davidson above. Along the continuum Bruce describes three modes of co-operation:

1. Nominal - more lip-service than practice;
2. Convenient - practised but only when convenient to both parties;
3. Committed - practised, and which brings rewards of its own, and a sense of commitment.

Whilst this continuum is straightforward, a relationship's position on it is determined by the measurement of 11 variables (see Table 5.1), some of which are organisational, and others of personal interaction and perception. The basis of this approach is that "each mode of co-operation forms a syndrome of easily recognisable symptoms." Bruce (1980) illustrated how these variables could combine as co-operation developed: "the frequency of contacts increased, as the relevance of such contacts became clearer, as a better understanding of roles emerged, accompanied by the disappearance of stereotypes, as social proximity increased, as mutual trust began to grow, and problems of confidentiality to shrink. All these factors appeared to be associated one with another in the same way as the concurrent symptoms of a disease combine to form a medical syndrome."

This continuum is underpinned by a much larger number of factors than hitherto. Bruce's assertions remain hypotheses however, and have yet to show their accuracy and usefulness, particularly as he has not operationalised the variables.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Nominal</th>
<th>Convenient</th>
<th>Committed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relevance</td>
<td>Scarcely affects agency's role</td>
<td>External to agency's role</td>
<td>Seen as part of agency's role</td>
</tr>
<tr>
<td>2. Skill</td>
<td>Involves no preparation or training</td>
<td>Little preparation or training</td>
<td>Need for preparation and training acknowledged</td>
</tr>
<tr>
<td>3. Regularity</td>
<td>Lacks regularity</td>
<td>Is seldom regular</td>
<td>Regular personal contact</td>
</tr>
<tr>
<td>4. Status differences</td>
<td>Wide status differences persist</td>
<td>Status differences inhibit communication</td>
<td>Status differences ignored</td>
</tr>
<tr>
<td>5. Trust</td>
<td>Lacks personal trust</td>
<td>Seldom leads to personal trust</td>
<td>Mutual trust exists</td>
</tr>
<tr>
<td>6. Confidentiality</td>
<td>Confidentiality a problem</td>
<td>Problem of confidentiality partially overcome</td>
<td>No problem of confidentiality</td>
</tr>
<tr>
<td>7. Role perceptions</td>
<td>Stereotype images</td>
<td>Limited stereotyping persists</td>
<td>No stereotyping of roles</td>
</tr>
<tr>
<td>8. Interaction</td>
<td>Minimal interaction</td>
<td>Mechanistic interaction</td>
<td>Organic interaction</td>
</tr>
<tr>
<td>9. Communication</td>
<td>Frequent failure to communicate</td>
<td>Some failures of communication</td>
<td>Failures of communication exceptional</td>
</tr>
<tr>
<td>10. Service</td>
<td>Agencies give conflicting advice</td>
<td>Advice not coordinated</td>
<td>Clients receive consistent advice</td>
</tr>
<tr>
<td>11. Preventive care</td>
<td>Coordinated preventive care impossible</td>
<td>Preventive care possible</td>
<td>Optimum conditions for preventive care</td>
</tr>
</tbody>
</table>

**Source:** M. Bruce (1980)
Teams and Teamwork: Definitions

Before considering different classifications of teamwork in particular, as opposed to co-operation more generally, various definitions of the term "team" will be explored. As with the term "community," problems in defining "team" are exacerbated because it is a word: "soaked in positive values" (Parsloe 1981). There are many different definitions of the term "team."

At the most basic level, teams have been viewed as interdependent groups. Dyer (1977) for example states: "Teams are collections of people who must rely on group collaboration if each member is to experience the optimum of success and goal achievement." Beckhard (1977) too has emphasised interdependence.

A more explicit emphasis was placed on "common goals" in conjunction with complementary roles by Hunt (1979): "Ideally, teamwork involves the definition of common goals and the development of a plan to which each member makes a different but complementary contribution towards the achievement of the team's aims." Gilmore et al (1974) similarly emphasised common goals. To "common objectives" and "different professional contributions" Kane (1975) added "a system of communication" to comprise the elements of a team. Brill (1976) also included "communication" within his definition of teams, which is itself much more elaborate: "A team is a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate, and consolidate knowledge, from which plans are made, actions determined and future decisions influenced."

Referred to by Brill and Gilmore et al, and made more explicit by both Pritchard and Parsloe is "a sense of purpose" pervasive through a team. For example, the first of the four characteristics outlined by Pritchard (1978, citing Gilmore) as essential to teamwork is that: "The members of a team share a common purpose which binds them together and guides their actions."

With varying degrees of explicitness, different authors have discussed the need for groups to have "a sense of purpose" as a bond transcending lower-level objectives and goals, if they are to function
as teams. A different approach has been adopted by Payne and Scott (1982), whose criteria for a team involve the intensity of relationships between members of a group, rather than their objectives and roles. They state that a team must have four characteristics:

"1. Presence of continuous interaction between a small group of people;
2. The group will tend to have a long life;
3. The group will indulge in frequent face to face work;
4. Often the whole group will work together."

When is a team not a team?

Classification of teams and teamwork

It is commonly assumed that: "Full teamwork is required in all situations" (Hey 1979). The result has been that the term teamwork has been applied in too facile a way to many forms of co-operation. Hey has argued that it may be networks which are required. Payne and Scott (1982) concur, and having outlined the four essential characteristics of a team as above, claim that in comparison a network is characterised by interactions with a wider range of people, accommodating a much wider range of values and individual professional approaches, and that agreement is required only on the most generalised goals.

A similar argument has been advanced by Macdonald (1984a): "If there is going to be a 'team' that members feel committed to as part of their professional identity then there is more of a need to share values and philosophies. If it is a 'network' or an aggregate of individuals, working independently but co-ordinating their work then there is less of a need to share basic assumptions. Most teams seem to be a mixture with a core group and a network of contacts and perhaps part-time members or associates where the shared assumptions will be most important for the core group."
Macdonald has presented the variations of team membership diagrammatically:

**Figure 5.1 Membership/Roles**

- Associate/Liaison role (e.g., with other agencies)
- Part-time member (not core member)
- Core member part-time
- Core members full-time
- Chair person (rotating responsibility?)
- Secretary (rotating responsibility?)

**SOURCE:** Macdonald (1984a)

This diagram is not totally self-explanatory however; for example it is puzzling that the part-time (non-core) member should be presented similarly to the core member part-time, as they might have different affiliations.

To explore further the distinction between teams and networks, Webb and Hobdell (1980) devised a sporting analogy, incorporating football and tennis teams: the tennis team is viewed as a team of individualists, designed to ensure a flow of collegial support and to guarantee good co-ordination in certain circumstances, while the football team is a team of mutually interdependent specialists: "designed to orchestrate different types and levels of skill." Payne and Scott (1982) have used a sporting analogy also, incorporating
football, tennis and athletics teams. A continuum is formed with Team
and football teams at one end, Network and athletics teams at the other
end, and tennis teams in the middle. A rather different picture of
football teams is presented by Payne and Scott's typology than by Webb
and Hobdell however, particularly regarding the "basic tasks and skills
required." Football team members were viewed as "interchangeable,"
because of only "marginal specialisation," whereas Webb and Hobdell's
football team members display "different types and levels of skill."
Clearly, if sporting analogies are to help clarify the issues of teams
and networks, there must be some consensus on the characteristics of
sports teams!
A classification of teams devised by Webb and Hobdell (1980) is the
taxonomy, wherein teams differ on two dimensions: Homogeneity or
Heterogeneity of skills and tasks:

**Table 5.2 Taxonomy of Teams**

<table>
<thead>
<tr>
<th>SKILLS</th>
<th>HOMOGENEOUS</th>
<th>HETEROGENEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOMOGENEOUS</td>
<td>Collegial</td>
<td>Apprenticeship</td>
</tr>
<tr>
<td>HETEROGENEOUS</td>
<td>Specialised Collegial</td>
<td>Complex</td>
</tr>
</tbody>
</table>


The DHSS (1978b) used this taxonomy in the survey of Social Services
teams. Researchers had expected them to be collegial teams primarily,
but found that these were rare in practice, because of so many
unqualified staff. Webb and Hobdell considered that the Apprenticeship
team would be rare, but the DHSS research uncovered a number, whereby
the trainees were the "apprentices."

An alternative approach is Payne's (M. 1982) "spectrum" of teams,
with Work Groups at one end, and Collaborative teams at the other. A
Work Group exists when people work together but do not share work tasks
or responsibility, and do not use their working together to enhance the
work they are doing. Payne states that there is agreement that such
work groups cannot be called teams, and that there is "clear agreement"
over collaborative teams, with most commentators "fairly friendly" towards them, describing them as "integrative" and "mature." While there may be agreement at both ends of the spectrum, Payne notes that there is much confusion surrounding "the middle ground", but distinguishes between leader-centred and individualistic teams. How do they differ? Payne suggests:

- Leader-centred teams are similar to collaborative teams, but with leadership retained by one person, who is also dominant in decision making, and with a repression of conflicts.

- In Individualistic teams, goals, priorities and roles derive from individuals' decisions; the leader acts as an adviser and channel of communication; no attempt is made for shared action and ideals; and the team is a medium for information sharing, not decision making.

To underpin this spectrum of teams, Payne has used a number of different variables: leadership; decision making; communication; conflict; objectives; roles; and personal development. The number and nature of these variables is similar to those used by Bruce to delineate different modes of co-operation. An alternative approach to the "middle ground" between work groups and collaborative teams is to consider not the type of team, but the stage the team has reached as a group in its developmental process. There have been many attempts to describe such a process, the most regularly cited being Tuckman's: "Forming; Storming; Norming; Performing". Table 5.3 lists some similar classifications.

Although the classifications are similar, the categories do differ which make them appear somewhat arbitrary. Lowe and Herranen's is perhaps the weakest because it's a model generated from the experience of just one team. Underlying all of these classifications is the assumption that teams have the same characteristics of groups so that team development stages are predetermined with teams passing through them of their own accord, although Woodcock and Francis (1981) do acknowledge that a group may get stuck in the "Infighting" stage and may therefore need a "push." Parsloe (1981) however considers that the processes of team development are not predetermined, and that the
different stages are best regarded as: "on-going processes which have
greater or lesser importance at different times rather than as clear-cut
phases." Certainly no explanation has been provided for why resolution
should follow crisis for example, instead of a reversion to collective
indecision, or why a crisis should occur at all. A further criticism of
such models is that they do not take account of shifting membership, and
that not only will new team members have to pass through the process
that the team as a whole has experienced, but that other team members
will undergo it again.

Table 5.3 Some Classifications of teams' developmental processes

<table>
<thead>
<tr>
<th>TUCKMAN:</th>
<th>FORMING --&gt; STORMING --&gt; NORMING --&gt; PERFORMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOODY and:</td>
<td>RITUAL --&gt; INFIGHTING --&gt; EXPERIMENTATION --&gt; EFFECTIVENESS --&gt; MATURITY</td>
</tr>
<tr>
<td>FRANCIS (1981)</td>
<td>SNiffing</td>
</tr>
<tr>
<td>BRILL:</td>
<td>ORIENTATION --&gt; ACCOMMODATION --&gt; NEGOTIATION --&gt; OPERATION --&gt; DIssOLUTION</td>
</tr>
<tr>
<td>(1976)</td>
<td></td>
</tr>
<tr>
<td>LOWE and:</td>
<td>DEVELOPMENTAL --&gt; TRIAL --&gt; COLLECTIVE --&gt; CRISIS --&gt; RESOLUTION</td>
</tr>
<tr>
<td>HERRANEN (1978)</td>
<td>STAGE and ERROR INDECISION</td>
</tr>
</tbody>
</table>

An alternative to the team development model is a contingency view,
wherein: "The type of team you have depends on the preferences of those
involved, the nature of the work that they have to do, and the kind of
organisation they are involved in" (K. Payne 1982 citing Lewis). Hence
many different types of team can co-exist and they do not have to move
along a continuum. Payne has adopted a compromise view, whereby teams
may or may not progress through stages, and if they do, it will depend
on the contingencies which affect them.

A final distinction to make is between: multidisciplinary and
interdisciplinary teams. On the basis of Horwitz’s (1970) and McDougall
and Taylor’s (1978) definitions, interdisciplinary teams work
integratively compared to the co-ordinate working of multidisciplinary
teams.
The literatures on teamwork are similar to those on implementation in that they represent many different perspectives. Consequently the study of teamwork can be considered a multidisciplinary field. This has had a number of drawbacks however, manifested most clearly by the lack of consensus in the use of language and terminology which has confused rather than clarified many issues. There is for example little agreement on terms such as "co-operation" and "team."

The term "co-operation" has been used very differently in various contexts. The broader usage of the term favoured by Bruce among others, as opposed to usage confined to a specific type of interaction, is preferred as it can encompass more discrete types of interaction and relationships, such as consultation, co-ordination and collaboration. The term "team" has tended to be used very loosely, often referring to co-operation more generally. The distinction between teams and networks would appear to be helpful, as it helps to specify more clearly the nature of teamwork. Even when authors agree on such a distinction however their attempts to illustrate their viewpoints are undermined by the use of incompatible analogies.

Many different classifications of teams and co-operation have been promulgated, varying from a small to a much larger number of variables. Classifications determined by a large number of variables are based on Bruce's "syndrome" approach. The next chapter provides some evidence for this proposition, as different aspects of co-operation are shown to impact on one another, although the exact nature of the relationships between them has yet to be determined. There is a danger also that where "syndromes" of variables become too complex, that all of the variables might not respond in the same direction, as acknowledged by Payne (M. 1982).

Classifications based on a small number of variables have received some criticism, for example Bruce (1978) made the following assertion regarding Webb and Hobdell's taxonomy of teams: "The simplicity of this pattern excludes some important dimensions of teams: hierarchy, for instance, and contemporaneity." Whilst this is true, the complexity of classification should be determined by the questions asked of it. For example, if one wishes to consider tasks and skills, information on
hierarchy may be unnecessary. Further, the different classifications of teams presented above do not have to be used on an either/or basis. The DHSS research into Social Services teams is a good example, using three different classifications of teamwork, each to portray a different aspect of the teams: open v. private; Webb and Hobdell's taxonomy; football v. tennis. There is "no satisfactory" way yet of classifying teams, concluded Parsloe (1981). Perhaps this should read: no one satisfactory way. Indeed, perhaps we should not be aiming for one global classification system which includes all aspects of teams, but rather refine the existing classification systems, and use them as Parsloe herself did in the DHSS research, to illuminate different aspects of teams' working.

An important task for the empirical work should be to delineate the teams' boundaries. The distinction between team and network will be helpful here, using the criteria outlined above, namely interaction and identity. Once the boundaries have been defined other classifications of teamwork may prove useful, for example Webb and Hobdell's (1980) taxonomy. Given that teamwork and co-operation should be the means to the end of service delivery, the question of how the work is undertaken ought to be addressed. The open v. private classification would appear appropriate for this, as would the sporting analogies if there were agreement about the qualities of sports teams.
CHAPTER 6

FACETS OF CO-OPERATION

Introduction

Having reviewed different types of co-operation and teamwork, the focus moves to a more detailed consideration of seven factors which impinge on the process of co-operation:

1. Objectives
2. Roles
3. Leadership
4. Decision making
5. Communication
6. Conflict
7. Trust

A brief resume will be provided on each topic, incorporating relevant research regarding teamwork and inter-occupational co-operation. When considering the dynamics of co-operation: "...it is often forgotten that much of the behaviour of professionals on teams may be explained with the help of group process rather than solely by the interaction of professional roles and statuses" (Kane 1975). An exclusive perspective is eschewed, to avoid overlooking contributions from different approaches. Although each issue is considered separately, it is acknowledged that they are inextricably linked, in a similar manner to Bruce's (1978) "syndrome" of factors.

1. Objectives

In the "building blocks" approach to "effective teamwork" employed by Woodcock and Francts (1981), the first of the nine blocks is: "Clear objectives and agreed goals." Such clarity is not always achieved however. For example, Kane (1975) found that a majority of interprofessional teams had not phrased their objectives so that goal attainment could readily be measured, and were not guided by an overriding belief or ideology. A survey of Social Services teams in the late 1970s found that the teams rarely discussed policies or decided on priorities (DHSS 1978b). A similar conclusion was reached from a survey of Primary Health Care teams, which showed that: "no major policy questions were .... discussed" (McIntosh and Dingwall 1978).
Brieland et al (1973) distinguished between the goals of a team and those of the individual members, and argued that they must be compatible for effective working. This was accepted by members of a Primary Health Care Team where such compatibility had not been achieved. They acknowledged that the team's objectives were only "half the story": "We want what is best for ourselves individually as well as the best for the community" (Ross and Cole 1978).

While broad goals may be the same, more specific goals or priorities may differ. This was well illustrated in a study of the Shiregreen Family Centre, for example (Barnes, M. 1981). The Education and Social Services Departments agreed on the importance of the prevention of early deprivation, but could not resolve differences in their approaches below the level of banner goals. This manifested itself in a number of ways, for example in an inconsistent allocation of places, and fed through to the staff, who exhibited a lack of agreement regarding specific priorities. One reason for these problems was the lack of resources, and this was one of two explanations given by Reid (1965) for the lack of congruence between agencies' operational goals despite the agencies' broad goals coinciding, in the field of delinquency control and prevention.

The second of Reid's explanations was that organisational goals may be tied to various procedural and administrative concerns which become ends in themselves. This scenario was experienced in a psychogeriatric hospital where "patient flow" had become the primary measurement of success, although Social Workers had to consider the needs of families and support structures more broadly (Smith, G. et al 1983). This lack of consensus on objectives reflected a divergence in orientations which proved difficult to reconcile. Another example of such divergence is the attachment of Health Visitors to Primary Health Care Teams, often resulting in: "real difficulties in integrating curative and preventive orientations" (Hunt 1979).

Goal-setting is not a static exercise, as noted by Berelson and Steiner (1964). Thompson and McEwen (1965) have argued that changes in objectives are necessary because: "goal setting .... is essentially determining a relationship of the organisation to the larger society" and hence a change in either the organisation or the environment.
requires a review of the organisation's goals. The environment's impact on the objectives of the Public Assistance Department was explored by Thomas (1965), who concluded that the impact of its setting was greater than that of its size. In a study of three Social Services teams, Black et al (1983) found that they had adapted very little to the communities they served, adapting instead to their political and organisational contexts.

2. Roles

A role consists of expectations, usually constructed by "knitting together a collection of tasks" (Payne, M. 1982). The expectations are both those of the person occupying a position, and others. As it is unlikely that all expectations will be congruent: "an intricate series of inquiries and overtures is the common prelude to agreement on task performance obligations" (Horwitz 1970). Organisations usually try to circumvent this form of role-taking, by "role prescriptions" (Turner 1962). The result is a compromise between "pure" role-taking and the conformity demanded by the organisation. Occupational membership can influence role taking also, as occupations develop their own "moral orders," built around a number of structural and cultural components (Huntington 1983). There is further complexity as occupational membership is overlaid with other dimensions of membership: organisational, work group and status group for example (Whittington 1983).

Resulting from negotiation over roles, individuals can make a large impact on role taking and on team process:

"Social group work has long emphasised the uniqueness of each group, since all groups are collections of unique individuals in dynamic interaction. To some extent, then, each team is an individualistic product of the backgrounds and characteristics of its members, even when the professional make-up of the team remains constant" (Kane 1975).

Brill (1976) outlined seven factors which help to account for an individual's impact on team process: value systems; behaviour patterns and norms; latent characteristics; reference groups; generalist and specialist knowledge; and self image. An example of individuals' characteristics affecting the division of labour within a team is the
"dynamic role division" in the mental health team discussed by Schachor (1976), based: "not only on the different disciplines and their respective professional skills, but also on the personalities of the team members, their special interests and capacities." Horwitz (1970) claims that such characteristics may be as important as team members' occupational affiliation in influencing team process, such that: "the worker will change the position rather than vice versa." Team members from several CMHTs in London concurred with this argument (Cotmore 1985a).

Role expectations can be violated for a number of reasons:
- role ambiguity, if role expectations are not clearly defined or communicated;
- role conflict, if role expectations are incompatible or in conflict;
- role overload, if an individual is incapable of meeting multiple role expectations (Rubin and Beckhard 1972).

Role ambiguity occurs frequently in multidisciplinary practice, whereby roles are "often ill-defined" (Horwitz 1970). Studies of Health Visitors for example, have found them to suffer from: "an elusive and confused sense of occupational identity" (Bruce 1980). Role conflict has followed misunderstanding of the Health Visitor's preventive orientation by other Primary Health Care professionals, resulting in incompatible expectations. As a consequence Health Visitors can be expected to undertake tasks: "which are inappropriate to her role" (Ross and Cole 1978), for example carrying out immunisations and running errands for the General Practitioner. Relationships between other Primary Health Care professionals also appear to be based on a misunderstanding of roles, between General Practitioners and Social Workers for example (Jefferys and Sachs 1983, Ratoff et al 1974). This situation has been mirrored in the relationships between hospital-based doctors and Social Workers (Butrym 1968).

These examples of role conflict tend to confirm Kane's (1975) assertion that: "there is little congruence between the way a profession defines its own role and the way others define it." One cause for the mismatch in role expectations is that professionals may be: "working at different levels without realising it" (Macdonald
Confusion will be avoided if service providers know which of the five levels of work identified by BIOSS, they and others are working on. The problems of role overload are neatly portrayed in a study of School Superintendents, who developed a range of responses from "moral" to "expedient" to "accommodate irreconcilable pressures" (Smith 1973).

Occupational stereotypes can be seen as a form of role conflict, their function being to: "provide a framework .... within which relationships between professionals can be conducted" (Hallett and Stevenson 1980). They have a negative connotation because they reinforce boundaries that divide occupations. Hallett and Stevenson (IBID) have argued that stereotypes are relied on more heavily the more sporadic the contacts between professionals. For example, unlike much interprofessional work which is conducted through "teams," in child abuse work the professionals may meet each other for the first time at a case conference, and consequently stereotypes are used to a greater extent. In relationships between General Practitioners and Social Workers, Sheppard (1985) cautions against accepting the "traditional stereotypes of antagonism and lack of co-operation." He points instead to a greater complexity as both sides incorporate information from the other into their own frames of reference, thereby avoiding open conflict.

3. Leadership

A useful distinction is that between task-oriented and social-emotional leaders (Bales and Slater 1969), or more simply between instrumental and expressive leadership. The Contingency view of leadership does not regard one style of leadership as appropriate for all situations, as a number of determining factors have to be considered, for example the type of team (Payne, M. 1982), the "maturity level" of the work group (Woodcock and Francis 1981), and the extent to which a group determines its own priorities (Berelson and Steiner 1964).

Brill (1976) outlined three types of leader: designated; emergent; and situational. In formal organisations leaders are designated but teams still retain some of the characteristics of informal groups, consequently: "A designated leader should handle the group process in a way which encourages leadership contributions of others" (Kane 1975). Because all team members at some point exhibit situational leadership,
Horwitz (1970) considers leadership as a function rather than as a status or position. Jefferys and Sachs (1983) provide a good example of an emergent leader among a supposedly "leaderless democracy" of General Practitioners. The key to this emergence was a "charismatic authority."

Much research has been undertaken into the determinants of effective leadership showing that: influence should be a two-way phenomenon; the leader should be trustworthy and approachable; and team members should feel their contributions are valued and effective (Payne M. 1982). In teams incorporating a doctor it is usually the doctor who is considered the leader, as in the study by Sachs and Forman (1980). However: "Automatic leadership of a physician, a psychiatrist, or a person with seniority has not enhanced the processes of interprofessional teams" (Kane 1975). Kane supported this assertion by arguing that doctors are too instrumental as leaders, and do not encourage appropriately the situational leadership of other team members.

**Authority**

Leadership is often closely related to authority. In most Social Services teams for example, the team's designated leader is also its manager, and can therefore rely on positional authority. This type of authority can be distinguished from "sapiential" authority and "authority of relevance" (Payne and Scott 1982). In a survey of Social Services teams Parsloe (1981) found that team leaders were happier using sapiential than positional authority although they used neither as much as team members would have wished. Where a designated leader uses positional authority, the authority relationship with team members can be described as "managerial." Much research has been undertaken into management and supervision in Social Services teams. The DHSS (1978b) research concluded that supervision should have two purposes: to establish the accountability of the worker to the organisation; and to promote the worker's development as a professional person. These two purposes did not always coincide however as formal supervision was very "limited," hence Payne and Scott (1982) recommend contracts to clarify the different functions of supervision. In addition, much research has been undertaken into Social Workers' perceptions of the supervision they have received (Smith 1984).
Managerial relationships should be distinguished from two other types of authority relationships: dual influence; and primary responsibility and primacy (Hey 1979). In dual influence relationships, pressures are exerted on team members both from their team and from their professional structure. Primary responsibility is fulfilled if four tasks are undertaken: assessment of needs; undertaking action or ensuring action is taken; refer to others where appropriate; and keep up to date with progress and make further initiatives where necessary (Hey 1979). These duties are termed "Co-ordinative authority" by Hey, and are a good example of situational leadership. More problematic is the question of primacy, that is: "the automatic" assumption of primary responsibility by a particular team member (BPS 1986). The British Psychological Society argue that primacy is incompatible with the allocation of primary responsibility according to an individual client's needs. These issues appear "sharpest" in "permanent team structures" and in fields where there is a "general pressure from other professions to assert their independence of hitherto dominant doctors" (Hey 1979), for example in mental handicap services.

The concept of "key worker" has been closely associated with that of primary responsibility, although they are not entirely synonymous (BPS 1986). The key worker concept has become increasingly popular, and was endorsed by a reanalysis of Plank's (1982) national survey of CMHTs and DHTs which showed that the assignment of key workers was one of two "structural" variables that made the biggest impact on the teams' work (Ferlie 1984). However, there is a danger that the term keyworker is used too loosely, disguising its development in separate settings for different reasons: for example, in residential work to personalise the institution and in fieldwork to help manage cases of non-accidental injury to children (Meteyard 1984). Consequently, the key worker concept encompasses a wide variety of activities and responsibilities. In practice key workers as "frontline case managers" may fail to acquire the resources they require for a number of reasons, including power disparities, occupational socialisation, and inter-occupational conflicts (Ferlie 1984).
4. Decision making

To combine the "root" and "branch" models of Rational Planning and Incrementalism (Lindblom 1968), Etzioni's (1968) mixed-scanning model comprises two sets of mechanisms:

1. Higher order, fundamental policy-making processes which set basic directions;
2. Incremental processes which prepare for fundamental decisions and work them out after they have been reached.

Similar to this distinction is that between programmed and non-programmed decisions:

"Decisions are programmed to the extent that they are repetitive and routine, to the extent that a definite procedure has been worked out for handling them so that they don't have to be treated de novo each time they occur."

"Decisions are non-programmed to the extent that they are novel, instructional and consequential. There is no cut and dried method for handling the problem because it hasn't arisen before, or because its precise nature and structure are elusive or complex or because it is so important that it deserves a custom-tailored treatment" (Simon, cited by Sinclair 1984).

This differentiation between programmed and non-programmed goes beyond Etzioni's of fundamental and incremental, by establishing "criteria for distinguishing between important and less important decisions" (Sinclair 1984). This is achieved by considering not only the nature of the decision, that it is repetitive or consequential for example, but also the nature of the organisation's response, in terms of procedures. Consequently the criteria incorporate both the decision and the decision making process. There is scope for inconsistency between these two factors however, as the manner in which decisions are handled in practice may differ from how they could be handled given their content. Whilst a rider, this does not detract totally from the value gained from highlighting both factors within the classification.

How, in practice, are decisions taken at the service delivery level? Despite bureaucratic controls and regulations, many welfare occupations experience considerable freedom in deciding on their methods and objectives. Regarding Social Workers for example, the DHSS (1978b)
survey found that the majority decided on their own priorities. Sinclair (1984) attributed such discretion to the nature of their role, as most of their work was undertaken out of the office and was not directly observable by team leaders. This freedom contrasts with the controls Social Workers are supposed to face, however. As the Barclay report noted: "Much of the present tension seems to arise from the fact that Social Workers have a great deal of de facto discretion and they need to have it in order to help people properly, yet they work in a structure in which, in theory, they have little or none" (Barclay report, cited by Sinclair 1984).

Changing the focus from individuals to groups, teams need to differentiate a variety of decision making situations. Trying to gain unanimity on all issues would be wasteful, because of a failure to distinguish: who has the necessary information; who needs to be consulted before certain decisions are made; and who needs to be informed after a decision is made (Rubin and Beckhard 1972). Briggs and Van Voorst propose the following distinction: "Highly technical decisions should be made by those with the expertise needed to do so; decisions which effect the whole working environment should be made with complete team participation" (cited by Kane 1975).

Where the whole team is involved, decision making can be undertaken in a number of ways, for example by: default; positional authority; a minority; a majority; consensus; unanimous consent (Schein cited by Brill 1976). It is an interesting paradox that while consensus can be difficult to achieve, it may be used as an excuse for "muddling through" (Payne, M. 1982), and hence can be one of the least difficult forms of decision making to operate. In effect there are different types of consensus, from the lowest common denominator by veto, to muddling through, and to unanimous radical action. Many teams adhere to the fashionable aim of operating as a "democracy," but this may mask an unwillingness to accept responsibilities. Indeed Kane (1975) argues that: "The ambiguity and sometimes inaccuracy of the term democracy as applied to the interprofessional team complicates clear communication from the outset; probably the term should be abandoned."

Moving from the question of how? to the question of what?, in a study of two primary Health Care teams Sachs and Forman (1980) found
that only a minority (26% and 30%) of topics resulted in decisions. The models of teamwork helped determine the nature of the decisions taken, as the team that worked collectively were keener to formulate a general policy for the practice than the team which stressed individual autonomy. Rittenhouse (cited by Kane 1975) found that decisions were reached on only two of the nine policy issues raised by a mental health team; The unresolved issues tended to be those introduced by lower-status team members.

5. Communication

The nature and structure of communication processes impinge on other aspects of teamwork, for example on morale (Warren 1978), creativity (Berelson and Steiner 1964) and trust (Prentice 1975). Regarding trust, Kane (1975) notes that "a basic mistrust sometimes underlies an unwillingness to part with special jargon".

The structure of a group or organisation has a powerful impact on communication and interaction: "Who speaks, when, how, to what purpose, and to what effect are determined by the way in which the group is structured: sometimes by rigid rules and protocol, sometimes by an unspoken but equally rigid framework of accepted customs and group norms" (Brill 1976). One result is that status talks to status, for example hospital doctors talk most to other doctors (Wiessen, cited by Hunt 1979). Similarly Cumming (J. and E. 1965) talked of "caste-like hierarchies" in large mental hospitals, with "little interaction across caste lines."

Formal and informal rank may determine the nature of interaction between occupations. For example, formal rank was related to participation in staff conferences at a psychiatric hospital (Caudhill cited by Hunt 1979). Perhaps the best illustration of occupational status determining the nature of communication between different occupations is "the doctor-nurse game" (Stein 1978). The object of the game is for the nurse to use her initiative by making recommendations, whilst appearing passive and making it look as if the doctor has made the recommendations. Stein criticises this "transactional neurosis" as "stifling" and "anti-intellectual." More broadly Rubin and Beckhard (1972) have criticised communication determined by status and roles:
"Team practice cannot work if roles talk to roles; a much more personal mutual dependency is required."

The national survey of Social Services teams found that almost all teams held regular meetings, most of which were dominated by the allocation of new work (DHSS 1978b). In contrast a survey of 36 Primary Health Care teams found only 19% that held "regular organised team meetings" (Gilmore et al 1974). Of the topics raised in the team meetings of the two primary health care teams studied by Sachs and Forman (1980) a slight majority were "primary goals" as opposed to "organisation structure maintenance" items. The structure and climate of the meetings differed between the two teams, as in the way team members addressed each other for example. Nevertheless in both teams, as well as those studied by Gilmore et al (1974), doctors dominated the team meetings in terms of participation and leadership.

Brill (1976) has argued that the healthier a team's climate, the greater it will use modes of communication supplementary to team meetings. Gilmore et al (1974) found for example that over 60% of communication between team members fell within a "laissez-faire approach," in which team members relied on unplanned encounters. There are a number of determinants of the extent of such modes including the size of the team and the physical proximity between its members. Gilmore et al (1974) found that Health Visitors and District Nurses had a greater awareness of each others' roles and problems when they shared offices. Similarly the doctors in the study by Jefferys and Sachs (1983) attributed changes in the climate and approach of the teams to changes in the layout of their offices.

The question of confidentiality bedevils many multidisciplinary teams. Doctors in particular have been uneasy about divulging information on their patients to other professionals. Other professions have begun to confront this issue also, for example the British Psychological Society (1986) recommend that psychologists share confidential information in a team setting only if consent has been gained for this. Record-keeping within multidisciplinary teams raises similar tensions: should all team members contribute to the same team...
record? Kane (1975) argues that they should, but claims that new record keeping systems meet with resistance: "unless the various professionals are willing to remove the mystique from their work."

6. Conflict

Conflicts can occur in every aspect of a team's work. The sources of conflict are many and include professional education. Dingwall (1977) has described such education as occupational "acculturation" and found that it imbues students with a view of their occupation. Such a view may not be held by other occupations however, resulting in conflict over role expectations, as between trainee Health Visitors and General Practitioners for example (IBID).

Structural factors can result in conflicts also stemming from the division between occupations and from their relative status. Dingwall (1980) concluded that General Practitioners, Health Visitors and Social Workers were attempting to respond to these problems of "exclusion." As each occupation devised different strategies for combating these problems, each contributed to difficulties in co-ordination, and consequently further conflicts were generated.

In practice, team members usually blame personal incompatibility for conflicts (Dyer 1977). This was shown in the Primary Health Care Teams studied by Gilmore et al (1974) for example. Hemmings (1979) warns against elevating "individualistic" factors to such a "central position" in accounting for conflicts however. There are different types of conflict, Payne (M. 1982) distinguishing between "substantive" and "emotional" conflicts. The issue over which conflict has occurred may be obscured however, by "umbrella" or "facsimile" issues, which may be used because they are seen to be more legitimate (IBID).

Conflict is often viewed negatively, to be avoided at all costs. There is a danger of conflict avoidance becoming a goal in itself however (Gilmore et al 1974, Hunt 1979). Despite a temporary reprieve from discomfort: "suppression of real conflict allows negative feelings to foster and causes a breakdown in real communication" (Woodcock and Francis 1981). The "Abilene paradox" is a striking example, and not an uncommon one, of "unhealthy agreement" (Dyer 1977), wherein a group member does the opposite to what he really wants so as to keep the rest
of the group happy. However, because the rest of the group are acting similarly, no-one is happy with the outcome.

As conflict within groups is inevitable it is more useful to view it positively rather than negatively. For example, dissatisfaction with goals and methods of working can lead to constructive change (Brieland et al 1973). In this way conflict is a common occurrence, if not a logical step, in the problem-solving process (Kane 1975).

Paradoxically: "Stable relationships may be characterised by conflicting behaviour" (Hunt 1979), as: "Teams which work well together are capable of coping with confrontation and encourage a high level of openness between team members" (Woodcock and Francis 1981). A good example of such a "confrontational" approach is that described by Ritter (1984) on a general psychiatry ward.

Despite the inevitability of conflict, there is often little evidence of overt conflict in teams, as in the Primary Health Care Teams studied by Sachs and Forman (1980) for example. Several factors may account for this: the small size of the teams; selection procedures for new staff (Jefferys and Sachs 1983); a reluctance to admit to conflicts, from a fear that they will be interpreted as personal inadequacies (Gilmore et al 1974); and power disparities. Such power disparities have been experienced by Social Workers in medical settings, Dana et al (1974) finding that hospital Social Workers "accommodated" themselves by taking on "behavioural and organisational characteristics associated with hospital-based medical care," while Goldie found that they adopted "manipulative tactics or accepted self-imposed restrictions on their activities" in psychiatric settings (cited by Whittington 1983).

Resulting from the inevitability of conflict: "The goal in dealing with conflict is not elimination but resolution" (Brill 1976). As Hunt (1979) found however, avoidance was: "the most commonly adopted method of dealing with problems and communication difficulties ...." Bruce (1978) labels such an approach "dissociative," whereby "good fences make good neighbours." This he distinguishes from "associative" resolution, involving confrontation and "social contracts." Confrontation and openness involve risk-taking and the management of the following skills:
assertion; active listening; and giving feedback (Woodcock and Francis 1981).

An associative conflict resolution is more likely to be achieved if superordinate goals are accepted. These are goals which: "have a compelling appeal for members of each group but which neither group can achieve without the participation of the other" (Sheriff, cited by Bruce 1978). Two determinants of such goals are: common predicaments and a growing awareness of interdependence. Both are neatly illustrated in a relationship between a Nurse and a Social Worker on a renal unit cited by Lowe and Herranen (1978).

7. Trust

Despite much study, trust is still a "slippery concept" (Pearce 1974). One commentator has described the research literature on trust as: "a mass of relatively disconnected and atheoretical findings" (Lindskold 1978). In the social welfare field, trust is usually discussed very loosely. For example Bruce (1978) concluded that trust is one of the determining characteristics of the modes of co-operation between occupations in preventive services for pre-school children, but he failed to define trust or consider its different components.

Based on game theory, credibility research and sensitivity training, Pearce (1974) constructed a model in which trust may be considered as a function of:

i "contingency," or risk taking. The size of the risk will depend on the size of the investment in terms of time and resources. The greater the risk, the greater the vulnerability, and hence the greater is the trust.

ii "predictability," involving A's expectations of B's behaviour. Without predictability, there is no basis for determining whether expectations and trust will be abused. Role-taking provides a framework for such expectations.

iii "alternative options." If there are none, actions are desperate or hopeful rather than trusting.

Within this model Pearce distinguished between a cognitive state of trust and trusting behaviour. The former is comprised of: "the individual's perception of the other's knowledge, competence and motives" (IBID). To these can be added reliability as Giffin (1967)
found it to be significantly related to the attribution of credibility and Cook and Wall (1980) included it as a measurement of trust in a study of blue-collar workers.

The relationship between the cognitive state of trust and trusting behaviours is an independent one, whereby: "Trusting behaviour may or may not be accompanied by a cognitive state of trust" (Pearce 1974) and vice versa. Trusting behaviour involves making oneself vulnerable and Zand (1971) has found that control, influence and information are the key variables in understanding vulnerability: ".... it is useful to conceptualise trust as behaviour that conveys appropriate information, permits mutuality of influence, encourages self-control, and avoids abuse of the vulnerability of others."

Zand also felt his study offered: "qualitative support for the spiral reinforcement model." This model views trust as "reciprocal" in nature, and the spiral can operate either negatively or positively, whereby trust evokes trust and distrust evokes distrust, hence a decline in trust does not leave a neutrality but leads to distrust (Fox 1974).

Stimulation to studying trust has been provided by the link between trust and problem-solving effectiveness, as found by Zand (1971) for example. As with conflict, convenient explanations for ineffectiveness are relied upon, hence the crucial role of trust and distrust tends to be glossed over. In another study of trust within organisations, commitment among blue-collar workers to their organisation was found to be correlated to their trust in their managers, and both correlated negatively with the workers' personal need non-fulfilment (Cook and Wall 1980).

The relationships between trust and other teamwork factors were explored in a study of American schools by Schmuck (1972). The schools were re-organised so that teachers were given greater responsibility for developing their own systems of supervision and accountability. Consequently "formal leaders" made themselves vulnerable by risking criticism from parents. Schmuck concluded: "consensus decision-making requires that the formal leader is trusting of others' abilities and motivations, strong in confidence and skilful in facilitating two-way communication." This is a good example also of the interrelatedness of
several facets of co-operation: decision making; leadership; trust; and communication.

**SUMMARY: A WAY FORWARD**

The empirical research attempted to determine CMHT members' own experiences of co-operation and these experiences can be best understood by hanging them on pegs provided by the literature. Seven pegs or facets of co-operation have been explored in this chapter because they are considered important for understanding more fully the nature of co-operation and teamwork. These pegs can help to focus the collection and interpretation of data, and they generate a number of specific questions.

**Objectives**
How openly were they discussed? At what level were they set? How much agreement was there within the teams?

**Roles**
What impact did individuals make on roles? How specific, discrete and compatible were roles? In what way were role expectations violated?

**Leadership**
What role did the designated leaders undertake? How much scope was there for situational leadership?

**Decision making**
How were decisions taken? How much scope did team members enjoy for decision making on their own work? Were the teams preoccupied with programmed or non-programmed decisions?

**Communication**
How regularly were team meetings held? What was the scope of alternative forums/modes of communication?

**Conflict**
How much overt conflict was evident in the teams? Did conflict avoidance occur? How were conflicts resolved? Were the causes of conflict structural or interpersonal?

**Trust**
To what extent were trusting attitudes and behaviours exhibited within the teams? How helpful were the components discussed above in assessing these?
This literature review represents only the tip of the iceberg of an unwieldy and disparate mass. It is clear that there has been much applied research in this field, for example relating to Health and Social Services. It is equally clear however that there has been little learning across disciplines and fields, such that new concepts and findings are simply tacked onto the existing disparate literatures without any meaningful integration of material. In other words, too often researchers appear to have reinvented the wheel. The problem of loose usage of terminology has also re-appeared, for example regarding the term trust.

It has been seen that both teamwork and implementation are multidisciplinary fields of study, but that they have suffered from different problems. The study of teamwork has been bedevilled by problems of language and a lack of integration of findings. The study of implementation has become polarised between different models, resulting in a sterile debate. The last three chapters have represented an attempt to review and move beyond these problems. To overcome the polarities in the implementation field, a more open approach which combines different models has been advocated, along with consideration of a dimensions approach. For the case of teamwork, the different models have been laid bare, many of which are very similar despite the different terminologies, so as to help determine the significant issues, for example interaction and identification.

The teasing out of dimensions and significant issues will help to focus more sharply the exploration of implementation and teamwork issues regarding the Notts CMHTs. The results of the empirical fieldwork are presented in Part IV. Prior to this, developments in mental handicap services in Notts are contextualised by a discussion in Part III of policy provision at a national level.
PART III

POLICIES, PROVISION AND TEAMWORK IN MENTAL HANDICAP SERVICES: THE NATIONAL PICTURE
CHAPTER 7

THE PLANNING AND PROVISION OF SERVICES FOR MENTALLY HANDICAPPED PEOPLE

Introduction

It has been seen that the use of terminology is problematic in the study of teamwork, but this is also true when discussing mental handicap. This chapter moves from a discussion of the nature and classification of mental handicap to a brief exploration of the history of service planning and provision, including: the extent to which the 1971 White Paper's strategies have been achieved; developments in the 1970s, "the decade of reports"; and Government policy in the 1980s. This historical perspective forms the backdrop to an exploration of the concept of community care and to a discussion of philosophies. Bottom-up as well as Top-down processes are examined, most notably in the discussion of local initiatives in the development of services for both children and adults. Evolving trends and themes are identified within each of the categories of services. The history of mental handicap service development and provision is very complex and there have been many recent developments. To compress this material into just one chapter has been exceedingly difficult, but unavoidable in the confines of a thesis.

The nature and classification of mental handicap

It is readily apparent that there is no agreed definition of mental handicap (MacDonald 1984b, Wistow 1984). Traditionally, mental handicap has been considered as a restricted level of intelligence. An Intelligence Quotient score of between 50 and 70 is usually interpreted as a "mild" mental handicap and a score below 50 as a "severe" mental handicap. IQ testing has been criticised however, firstly as an unreliable measure of intelligence and secondly as an irrelevance to the requirements of teaching (Mittler 1980).

In addition to intelligence, mental handicap usually refers to a person's social competence and ability to adapt: "Underlying all attempts to define mental handicap is the problem of defining adaptation to the demands of the society in which the handicapped person is living" (Mittler
The DHSS (1980a) has adopted a view of mental handicap which encompasses both intelligence and social competence components in the following way: "a general intellectual functioning level which is significantly below average, and problems in adapting to normal behaviour patterns and achieving social skills...."

Terminology has changed significantly in the mental handicap field, and this can be seen from legislation: the Idiots Act (1886); the Lunatics Act (1890); the Mental Deficiency Act (1913); and the Mental Health Act (1959) which distinguished between subnormality and severe subnormality. More recently Heron and Myer (1983, 1984) have argued that both the terms "mental" and "handicap" are inappropriate: mental because of the confusion with mental health; and handicap because it is determined not only by the level of disability, but also by external factors. They have argued instead for the term "intellectual impairment," as more "technically accurate" (1).

Following the Education Act (1981), the Education service has replaced the term "mental handicap" with "severe learning difficulties." Differences in terminology may pose obstacles to interprofessional collaboration however (Cotmore 1986), as in Newcastle, where the Education Department's pre-school service felt that a referral to a group with "mental handicap" in its title such as the CMHT, would cause parents greater anxiety at a difficult time (Sanderson Centre 1983b). A similar change in terminology has occurred in Islington, where the SSD has replaced "mental handicap" with "people with learning disabilities" (O'Brien 1984). The SSD Committee believe it reflects a real change, and not a cosmetic one. This is a pertinent point, as changes in terminology should reflect or lead to changes in the standing of mentally handicapped people.

Prevalence rates of between 2.9 and 3.4 severely mentally handicapped people per 1,000 population were derived by the DHSS (1971) on the basis of three surveys. This would mean: "a total of between 136,000 and 159,000 such persons in England in 1981" (Wistow 1984). Exact numbers are not known, despite the duties laid on Local Authorities by the Chronically Sick

FOOTNOTE(1): This argument is accepted, although the term mental handicap is used in this study to avoid confusion, because it was part of the title of the CMHTs in Notts, and because CMHT members themselves used that terminology.
and Disabled Persons Act (1970) to inform themselves of the numbers of handicapped people within their communities. Indeed, in several areas it has taken specially commissioned surveys to reveal the true prevalence of handicap, as in North Tyneside (1982) for example.

The extent of mild mental handicap is closely associated with social and economic status, and not usually with observable brain damage (Burkitt 1977). This is not true however for severe mental handicap: "severely mentally handicapped children are fairly evenly distributed across social classes" (Mittler 1980). Aetiological factors remain obscure, although the following are known: specific genetic origin, for example chromosome abnormalities, including Down's Syndrome which accounts for one-third of severely mentally handicapped children and one-quarter of severely mentally handicapped adults; and environmental origin, encompassing disturbance or accident at the prenatal, natal or postnatal stages (Burkitt 1977).

As a client group therefore, it is clear that the mentally handicapped are extremely heterogeneous, with "widely varying intellectual, physical and behavioural characteristics" (DHSS 1980a).

History of service provision and policies

Despite the current popularity of community care: "institutional care is our historical inheritance of services for mentally handicapped people" (Tyne 1982). How and why did institutional care become so prominent? Prior to the industrial revolution, mentally handicapped people had not required special provision, but the industrial revolution made more prominent those who were unable to provide for themselves.

The first special provision for "idiots" were small asylums, in the mid-nineteenth century. These were provided in a spirit of reform with the intention of educating the inmates prior to their return to the community. However, as the expected educational attainments did not materialise, the mentally handicapped were assumed to be at fault. In addition, there were changes in societal attitudes, stemming from Britain's colonisation of large parts of the world. Idiots were likened to the natives, who were considered to be "animal-like": "Added to the racist typologies, this idea led easily to the notion that idiots were a degeneration of the purity of the human (i.e. European) race" (Ryan and Thomas 1980). Further, notions of degeneracy became associated with poverty, crime and prostitution (Burkitt
1977). Consequently demands for the control of "degenerates" grew, particularly concerning their reproduction.

Resulting from changes in societal attitudes, the function of institutions changed from the protection of the mentally handicapped person to the protection of society. This was illustrated by the Mental Deficiency Act, 1913 (Burkitt 1977). Institutions proliferated, with a rise of institutional places registered under the Mental Deficiency Act from 6,509 in 1916 to over 50,000 in 30 years, with a peak just after the second world war at a little under 60,000 (Tyne 1982). However, even by the late 1920s, the Board of Control realised the impossibility of providing institutional care for all defectives, hence very tentatively community care became seen as a "useful expedient" (Wilkin 1977), although services outside institutions were still slow to develop (Ryan and Thomas 1980).

The National Health Service Act (1946) transferred responsibility for the institutional care of mentally handicapped people in colonies and asylums from the Local Authorities to the NHS. In so designating deficiency as a "medical problem" (Burkitt 1977), it reflected a further shift in the "official" view of mental handicap: "Since World War II, the identification of mentally deficient people as a widespread social threat has given way to an ideology that characterises them as sick and useless" (Ryan and Thomas 1980).

Packwood and MacDonald (1978) have argued that "convenience rather than clarity" has characterised most legislation for the mentally handicapped, and cite the Mental Health Act (1959) as an example, since it treated mental handicap and mental health similarly. This was despite the attempt to simplify and consolidate legally the provision of services for both the mentally handicapped and mentally ill, as well as advancing such provision. Indeed in 146 clauses, the Act replaced 15 whole Acts and 37 Acts in part (Jones 1972). Most importantly, the Act gave an impetus to community care as Local Authorities became responsible for a range of provision including training facilities, and residential accommodation for those unable to live at home and not requiring specialist medical treatment and training. In addition, mental welfare officers were to be appointed, who could undertake home visiting.

The 1959 Act provided the foundation for policy developments in the 1960s and its implementation was pursued through the ten year health and
welfare plans called for in 1963 by the Ministry of Health in its document "The Development of Community Care" (CMND 1973). Between 1960 and 1971, most of the Local Authority expenditure on mental handicap services was on new training centres, with almost a doubling in the number of places in junior training centres for example.

No such increase was registered for residential care however. Indeed by 1969, 24 out of the 157 Local Authorities in England had 'no arrangements at all for either mentally handicapped children or adults (Wilkin 1977). Further, the provision of non-hospital accommodation for younger mentally handicapped adults was not well established, as most such provision was allocated to the elderly mentally handicapped (Jay 1979). That the NHS was still providing hospital accommodation may account for the under development of Local Authority services (Burkitt 1977).

The number of residents in mental handicap hospitals remained fairly static during the 1960s. The much vaunted "open door" policy of the 1950s had in reality become a "revolving door," whereby increased discharges were matched by increased admissions. Conditions in the hospitals were very poor however, as was revealed in a number of enquiries from the late 1960s onwards, of which that at Ely hospital (1969, CMND 3785) was the first and perhaps best known example. Public awareness was further heightened by Morris's (1969) study of 35 mental handicap hospitals entitled "Put away" which presented the shortcomings of hospital provision very clearly.

In addition to the "official" reports there was a growing voice among academics and researchers, for example Kushlick and Tizard, promoting a "sociotherapeutic" model of care. Not only did this adopt an anti-hospital approach in advocating community-based services, but it also questioned the assumptions on which the "medical model" was established. These developments influenced the nature of the DHSS's response to the hospital scandals (Watkin 1975, Bayley 1983): a White Paper published in 1971 entitled "Better services for the mentally handicapped" (CMND 4683).
Better services for the mentally handicapped: the 1971 White Paper

The White Paper was both a plan for remedying the grossest inadequacies of the hospital services in the short-term, and for establishing a new pattern of services in the long-term (Wistow 1984). It was the first national client group plan produced by the DHSS, and was the first occasion on which epidemiological information was used for planning a comprehensive service on such a scale (Burkitt 1977). 15 general principles underlay the White Paper, for example:

- A family with a handicapped member has the same needs for general social services as all other families. The family and their handicapped dependent require special additional help;
- There should be no unnecessary segregation of mentally handicapped people from their peers or local community;
- There should be a comprehensive initial assessment and periodic reassessment of the needs of each mentally handicapped person and their family;
- Social training, education and purposeful occupation or employment should be provided for a mentally handicapped person to develop to their full capacity;
- Each mentally handicapped person should live with their family for as long as possible. Each family should receive full advice and support;
- On leaving home, the alternatives for a mentally handicapped person should be as homelike as possible, including hospitals (DHSS 1971).

The White Paper was "unusual" (Tyne and Wertheimer 1980) in laying down not only guidelines, but also very clear targets for implementing the developments in services. These target levels were for a 20 year period, thus reflecting "the burgeoning enthusiasm for comprehensive long range planning which was then taking hold in Whitehall" (Wistow 1984). The targets were couched within five strategies of change, as follows:

1. To reduce hospital populations, initially by preventing inappropriate admissions and subsequently by discharging patients who had no continuing need of medical or nursing care;
2. To relocate hospital services to provide a District based service operating from smaller and, where necessary, new hospital units. Such hospitals should provide treatment and not residential care;

3. To improve standards in existing hospitals as an interim measure;

4. To expand Local Authority services greatly;

5. To achieve these objectives within the framework of effective joint planning between Health and Local Authorities (Wistow 1984).

To what extent have the strategies been implemented, and the targets achieved?

1. **To reduce hospital populations**

The 1971 White Paper's target was a 40% reduction in hospital beds by 1991. The number of children resident in hospitals has fallen far more dramatically than envisaged by the White Paper, such that provision is already much lower than the 1991 target. The reduction in adult residents has been much more sluggish: "only 16% against a target of 46%" (Wistow 1984). To what extent have the White Paper's twin intentions of preventing inappropriate admissions and promoting discharges accounted for these reductions?

The Development Team (1980) has reported that hospital admission criteria vary widely, and often appear to be unrelated to the needs of mentally handicapped people themselves. This has been supported by research findings, for example by Wertheimer (1982), who found that the lack of alternatives in the community was the most common reason for admitting children to hospital. The large drop in the number of children in hospital is partly accounted for by a change in "climate," resulting from pressure through groups like Exodus, and culminating in the DHSS's (1980a) acceptance that: "large hospitals do not provide a favourable environment for a child to grow up in." Other changes included: improvements in education services; increased provision of short term care; and improved support to parents (Wistow 1984). More simply however: "Many children in hospital have simply passed through the age barrier and become part of the adult statistics" (Wertheimer 1982).
Despite the increase in hospital short term care provision, the average length of stay of residents is still high. A recent follow-up to a study of residential care in the late 1960s found that 80% of the sample who lived in hospital then, continue to live in hospital 15 years later (Raynes 1984). Both Tyne and Wertheimer (1980) and Wistow (1984) have concluded that the gradual reduction in hospital patient numbers has been more the result of the death rate of patients than of discharge programmes.

It has been seen that the White Paper's twin intentions of reducing inappropriate admissions and promoting discharges have not been the primary explanatory factors for the reduction of hospital patient populations, either for children or adults. Nevertheless several projects have become well established in the discharge of mentally handicapped people from hospital. Shearer (1981a) has outlined the options for children: adoption, fostering, ordinary children's homes, and specialist homes. For adults, Shennan (1983) has reviewed hospital-based projects, and amongst the options are lodgings (Bevan and Deakin 1973) and "cluster flats" (Kerr 1982). More recently there have been larger projects to discharge greater numbers of people from hospitals, including the Derby Development Scheme (Beswick 1984) and North Lincolnshire's "local service" (Porter 1985).

2. Locally based hospitals offering treatment, not care

The 1971 White Paper proposed that new accommodation should be provided in units no larger than 200 beds, and that existing hospitals of over 500 beds should not be expanded. By the end of the decade however, the large traditional institution still accounted for the majority of staffed beds in hospitals: 57% in hospitals with over 500 beds (Wistow 1984). The continued existence of large hospitals has resulted in catchment areas remaining large, with hospitals remote to the populations they serve: over 90% of all beds are located in one third of health districts (IBID).

During the 1970s: "the main thrust of new NHS building has not been into new small units, but rather into new buildings on old sites, often to relieve over-crowding to provide decanting space, or in order that out-worn buildings could be converted for other purposes" (Tyne and Wertheimer 1980). There have been changes in the definition of "small," such that at the beginning of the decade hospitals with 200 beds were generally viewed as small. This was not the case by the end of the decade however. this change affected numerous projects, including the Sheffield Development Project.
(Davidson 1978c) and plans to close Darenth Park (Korman 1983). Within such schemes, initial plans have been criticised for failing to adjust to the changing definition of "small."

The White Paper was also concerned with regimes, arguing for the replacement of custodial regimes by therapeutic programmes, with the aim of facilitating discharges. Oswin (1984a) has described hospital services as "inadequate" however, and pointed out that in one area two out of every seven residents stay on the wards all day, because there are insufficient activities and therapy services. Other criticisms have included those of a parent of a mentally handicapped person in hospital who found the hospital regime "custodial and dehumanising" (Dyer 1981). Case-studies have criticised hospital staff for underestimating residents' potential abilities (Tyne 1981a) and using control techniques which were both ineffective and unjustified (Alaszewski 1982). The film "Silent Minority" showed that newer institutions have not been exempt from such problems. Institutions, both old and new, may have "tended towards 'corruption'" (Chesshyre 1981), whereby the functioning of the institution has become an end in itself rather than a means to the end of caring for residents.

Undoubtedly, a primary reason for hospitals not achieving more progressive regimes has been a lack of staff, as acknowledged by the NDG (1978). The proportion of qualified nursing staff has dropped while changes in employment conditions have meant that: "more staff were required to provide the same level of service to residents who are probably relatively more dependent" (DHSS 1980a). Short (1984) is frank in his assertion that the low level of nurse staffing on wards results in therapeutic programmes having to take "second place" to ward routines. In addition, hospitals have suffered shortages in other specialist staff, for example therapists and psychologists, which has reduced their capacity to implement positive changes.

"On the positive side, the DT has reported an increasing awareness on the part of hospital staff for the need to promote independence and self-sufficiency..." (Wistow 1984). There have been many examples of successful Behaviour modification programmes undertaken by nurses, for example by Bushby (1980); Pope and Buck (1982); Fearis and Wright (1985); Clarke and Freeland (1985); Hardwell and Hawke (1985); and Ellis and McIlroy (1985). These were not without their problems however, and more broadly it is
worrying that the behavioural approach in the mental handicap field appears to be trailing in the wake of developments in psychological theory and practice (Lockyer 1986).

3. Improving standards in existing hospitals

The White Paper endorsed the "minimum standards" exercise, introduced by the DHSS following the Ely hospital enquiry. Guidelines had been issued incorporating: "improvements in patients' food; personalised clothing; minimum staff numbers; and the upgrading of buildings and furnishings" (Wistow 1984) and extra resources were allocated for completing the improvements within five years. Indeed: "The major thrust of NHS mental handicap spending since 1971 has been in up-grading existing hospital buildings" (Tyne and Wertheimer 1980).

By the end of the 1970s however many hospitals still failed to meet all the guidelines, with shortages in ward orderlies and domestics the most common shortfall (Wistow 1984). For example, the conditions at Normansfield hospital were highlighted by an enquiry which found that: "For long periods of time the hospital buildings were neglected and dangerous. They were a patchwork quilt of makeshift repair and poor workmanship" (Normansfield 1977). The failure to achieve even the most basic standards in some hospitals, as at Normansfield, has been degrading for residents, denying them privacy and dignity. Despite the resources pumped into the refurbishment of existing hospitals therefore, and despite improvements in some hospitals, "minimum standards" have not been achieved universally.

There is a second problem with such spending however, in that even when the buildings are upgraded, they are often unsuitable for a community-based service. Indeed, such spending creates a vicious circle as it absorbs resources which could otherwise have been ploughed into new services and which, in turn, could help to reduce the demand on hospital services. St. Lawrence's (Shearer 1981b) and Darenth Park (Hencke 1982) clearly show this dilemma, and the huge amounts of resources which are required to maintain and refurbish large hospitals. This is not an easy dilemma to resolve, although significantly the DT has: "urged authorities to give more consideration to the allocation of resources to locally based facilities before embarking on an upgrading scheme" (Wistow 1984).
4. Expansion of Local Authority services

Local Authorities have increased their day care and residential care resources significantly, but in both cases: with over half the period elapsed, well under half of the extra places required to meet the 1991 target have been provided; and the rate of increase has slowed down (Wistow 1984). Shortages in Local Authority residential provision have been witnessed in many areas, for example under the Sheffield Development Project there was a shortfall of 200 places (Heron 1981) and in Cornwall the Local Authority provides just 8% of residential accommodation (Oswin 1984a). One consequence has been that hospital discharges have not been facilitated, resulting in some Health Authorities taking up the gauntlet of providing alternative accommodation.

The DHSS (1980a) found that 40% of Local Authority accommodation was larger than the White Paper guidelines of 25 places for adults and 20 places for children. More broadly, Local Authorities have been criticised for being too "limited and rigid" (Development Team 1982) in their approach in focusing too exclusively on hostels. As a result, there has been little development of alternatives, such as lodgings and group homes, and hence less possibility of progression from the hostels. Such a progression was advocated by the White Paper, but has also been impeded by the regimes within hostels, where: "the incentive to rehabilitate residents for independent life becomes submerged in day-to-day maintenance" (Tyne 1977).

The shortfalls in Local Authority provision are not surprising given their resource environment. Since the mid-1970s the personal social services have been unable to maintain a "constant level of service output" (Webb and Wistow 1982b) in the face of demographic growth. Although real growth in spending has been maintained nationally, it has been insufficient to provide the 2% per annum increase necessary to maintain service levels. Despite a small growth in mental handicap expenditure as a proportion of Social Services expenditure, it is still dwarfed by NHS mental handicap expenditure: in 1979 per capita expenditure on mental handicap was calculated to be: NHS £6; Social Services departments £2.60; and Education departments £1.40 (Wistow 1984).
5. Joint Planning between Health and Local Authorities

The White Paper urged greater co-ordination between Health and Local Authorities, notably for the discharge of people from mental handicap hospitals to Local Authority accommodation. It made no specific proposals on the mechanisms for such co-ordination. Joint Planning machinery was established from 1974 because of the perceived interdependence of Health and Local Authority Services (Wistow 1980a). Mental handicap has consistently been a priority in the joint planning arena, as more specialist working groups have been established for mental handicap than for any other client group: since the 1982 NHS re-organisation, 56% of JCPTs have specialist sub-groups in mental handicap (Wistow 1986b).

Joint Planning has faced obstacles in both its "Joint" and "Planning" aspects. Regarding jointness, there has been a lack of balance both in numbers and status of Health and Local Authority representatives in the Joint Planning arena, which led Plank (1979) to conclude: "Mental handicap planning seems to be dominated by doctors." Regarding planning, Health and Local Authorities have: "completely different concepts of forward planning" (DHSS 1980a), with Health Authorities required by the DHSS to plan much further ahead than Social Services Departments. Other barriers of process and structure have combined to limit the effectiveness of Joint Planning (Wistow 1980b).

In describing the outputs of joint planning as "modest", Wistow (1986b) observed that less than half the JCPTs had produced a joint strategy for mental handicap services. Hudson (1984) has argued that few JCPTs considered themselves as planning comprehensive local services, noting that joint planning of mental handicap services in over one-third of DHAs was concerned with Health Service provision only. The gulf between the differing priorities of many Health and Local Authorities was dramatically illustrated by the walk-out of Local Authority representatives on the Darenth Park Steering Group (Smith 1982). Consequently, joint planning has not facilitated an integrated approach to shift the balance of care from hospitals to Local Authorities (DHSS 1980a).

Despite this gloomy picture, there have been some promising exceptions. In Kent a "single service partnership" was mooted in 1981 and helped form the basis for the subsequent development of integrated local services. A joint management committee was established for the NIMROD project in South
Wales, comprised of members from the participating Authorities (Blunden and Mathieson 1982). In Sheffield there is a Joint Team of Officers, including representatives from Unit rather than District level, so as to promote integration at the level of operational management (Morrow 1984). What is most remarkable about the "Joint Management Partnership" in Newcastle is that its membership comprises representatives of families of mentally handicapped people and voluntary organisations, in addition to members and officers of the statutory agencies (Newcastle 1981).

The promotion of joint planning was the principal objective of a special financial programme introduced in 1976. Known as joint finance, some commentators consider that it has preserved "a vital area for manoeuvre" (Smith 1980b) in an era of public spending cuts, and has not become silted up as many have feared (Wistow 1986b). Nevertheless, Social Services participation has fallen, with a corresponding increase in the share taken by Health Authorities (Townsend 1984). Despite being a "symbolic breakthrough" (Tyne and Wertheimer 1980), joint finance has been too small to enable a large transfer of responsibilities from Health to Local Authorities. Indeed it was not geared up to this, as it was "only a form of pump-priming" (Tidball 1981). It has however diverted the focus away from broader issues of resource transfers, by absorbing large amounts of time and energy in the joint planning arena, over tapering arrangements for example. Therefore, despite promoting joint planning initially, joint finance effectively constrained its capacity to undertake radical changes, and has promoted an incremental approach.

The 1970s: The Decade of Reports

The 1970s has been described as "the decade of reports" (Mittler 1984) many of which emanated from the National Development Group (NDG). Established in 1975 (LA SSL (75)5), the NDG's role was advisory to the DHSS: "in the development of departmental policy and the strategy for its implementation." Although a victim of the Conservative Government's quango cull, it produced several well received reports in its short life (for example NDG 1977a, 1977b, 1978, 1980b).

The Development Team (DT) is similarly a multidisciplinary body, which advises Health and Local Authorities: "on the planning and operation of their mental handicap services" (Simon 1982). The DT works within the framework provided by the 1971 White Paper, and from this basis has
developed a two-pronged approach to the development of local services for mentally handicapped people: the CMHT (see next chapter) and the Community Unit.

The Community Unit has been described as: "an extension of the hospital service into the community" (DT 1978) fulfilling a number of functions, including short and long term residential care and a base for professionals. The DT regards its flexibility as "crucial," so that it can be: "the centre for the mental handicap specialist services in their district" (IBID). There is still a role for hospital provision within the DT model, although not now for children. Those considered to require the specialist services of a hospital include people with multiple handicaps, behaviour problems or a mental illness.

The DT's model has attracted criticism however, Davidson (1978b) considering it to be too hospital-oriented, and too inflexible to allow for experimentation. Certainly the DT's view of the role of the hospital is not in accord with the "ordinary life" model (Kings Fund 1980) or with the Independent Development Council's philosophy (Mittler 1984). Community Units have attracted most criticism however, for example from East (1983), who considers a "homely atmosphere" impossible to achieve due to the inclusion of so many beds; the mix of short-term and long-term care; and the combination of these with a base for professionals and consultation rooms. It would appear that the much vaunted flexibility of the Community Unit as a strength, has been its undoing. Kirk (1984b) agrees, concluding: "It appears that the missing ingredient is the quantum leap from seeing our clients as items to fit into service pigeon holes to seeing them as individuals who require help to lead an ordinary life."

Other criticisms of the DT have focussed on its role at local level. The DT has not considered itself as an inspectorate, but many consider this to be needed, with the "power to enforce compliance with their recommendations" (Stanley 1985). This would answer the criticisms of the DT as "ineffective," lacking "teeth" and sufficient resources (Tyne and Wertheimer 1980). Since 1985 the DT's reports have been published openly, although doubts linger as to the true extent of openness due to the involvement of the DHSS in deciding on the form and content of reports (Oswin 1984d).
Despite these limitations, the DT's Director considered that: "The team has undoubtedly been influential in bringing about changes in services" (Simon 1982). This has been echoed in Government circles, for example by Lord Glenarthur in 1984, who considered the DT to "act as a catalyst for change." He attributed this in no small part to the DT's Director: "He has made a much valued input and maintained a sense of realism and compassion. Much progress in the mental handicap field has been because of his leadership."

The Court Report on Child Health Services (1976 Cmnd 6684) was critical of the quality and co-ordination of services received by handicapped children, particularly when compared with the treatment of acute illness. Court's proposals were couched within the following oft-quoted philosophy: "Severely mentally handicapped children have more in common with other children because of their childhood than they have with severely mentally handicapped adults because of their common disability."

To achieve an integrated child health service, Court's recommendations included: specialisms within Primary Health Care Teams and District Handicap Teams (DHTs - see next chapter). The report attracted a lot of criticism, not so much for its philosophy and perceptions of need, but for the organisational structures proposed. The only recommendation which was to "survive the onslaught of adverse comment" (Slack 1978) and be accepted by the Government was the DHT.

Published in 1978, the Warnock report (Cmnd. 7212) adopted a broad definition of special educational needs, and argued that education should be provided to meet needs, rather than according to labels. Its recommendations included: improved education and nursery facilities for pre-school disabled children; improvements and greater co-ordination in help to disabled school leavers; changes in teacher training; and the introduction of systematic assessment procedures. Integration was a central theme of the report, and was considered crucial as a "recognition of the right of the handicapped to uninhibited participation in the activities of everyday life, in all their varied forms." Parental participation was also central to the report, a partnership between schools and parents being advocated.

The Government's response to the Warnock report was embodied in the 1981 Education Act, which: "may be a pale shadow of Warnock and it may be
limp and it may have no extra resources. It only applies to children but one key point is that there will be an individual review on each pupil with special needs . . . ." (Mittler 1984). This has been welcomed for increasing: "the schools' accountability in planning, monitoring and maintaining pupil progress" (Coupe and Porter 1986). Priority has been given to the older school-children through the "13 plus formal assessment," although Mittler (1984) considers it a "nonsense to spend all this time on it when it has no legal standing when a child leaves school."

The assessment procedures have been welcomed generally, although one parent has complained that they threaten to undermine the integration of disabled children, because they are too complex (Hulley 1985). Consequently he is thankful that his multiply handicapped daughter was integrated into an ordinary school prior to the Education Act.

The "Report of the Committee of Enquiry into Mental Handicap Nursing and Care" (Cmnd 7468 1979), more commonly known as the Jay report, developed a model of care based on three principles:

1. Mentally handicapped people have a right to enjoy normal patterns of life within the community;
2. Mentally handicapped people have a right to be treated as individuals;
3. Mentally handicapped people will require additional help from the communities in which they live and from professional services if they are to develop to their maximum potential as individuals.

Three concepts central to the model were: individual plans; interdisciplinary teamwork; and a partnership with parents. To implement the model, Jay recommended a doubling in the numbers of residential care staff, thereby facilitating a transition from "basic" care to "active" care. RNMS training was viewed as inappropriate, the report recommending that it be replaced by a course similar to the Certificate in Social Service (CSS), under the aegis of CCETSW, the Social Work training body. The report concluded "that a policy of gradualism will never achieve a decent and dignified life for mentally handicapped people; what is needed is positive action and a political commitment to a major shift in priorities for expenditure."
The Jay report generated an intense debate. Despite almost universal agreement on the report's philosophy and model of care, there was much disagreement with the proposed changes in training, including: the nurse's role was defined too narrowly (Nursing Times 20.12.79); the CSS is not a "professional qualification" (Williams 1979) and is less appropriate than the RNMS in work with the most severely handicapped (Nursing Mirror 8.3.79); and the NHS's contribution to community services was overlooked (Dugdale 1979), especially CMHNs (Joinson 1979).

The debate was conducted in a hostile atmosphere, from "entrenched positions" (Bosanquet 1979). The Nursing Mirror embarked on its "No way, Mrs Jay" response and, COHSE whipped up a fervent campaign. Such tactics were themselves criticised however, Olsen (1980) claiming that the Nursing Mirror coverage of the Jay report was presented: "in a manner which precluded responsible professional debate." In similar vein, a nurse complained of the activities of his local COHSE branch: "This protest is just about protecting nurse managers who feel threatened by the report" (Nursing Mirror 5.4.79).

The DHSS (1980b) rejected the Jay report's proposals for an "immediate and fundamental" change to the structure of training, but established a working group between the GNC and CCETSW to consider training. This was denounced in many quarters as a "sell-out to the nurses [and] COHSE" and as: "a facade, a ritualistic offering which has little to do with asserting the rights of clients and promoting their interest. The big battalions will see to that" (Andrews 1980). These fears were realised when the working party produced its report in 1982, and despite being critical of both the CSS and especially the RNMS, got "cold feet" over joint training: "The creation of a new single form of training is simply ruled out on the grounds that it would tread on too many toes ...." (Hudson 1982). Once again, nursing interests appeared to prevail over the interests of mentally handicapped people.

Government policy in the 1980s

In 1980 the DHSS (1980a) reviewed its own policies outlined in the 1971 White Paper, and concluded that they provided a: "sound basis on which to plan the development of better services." The 1980 Review concluded that the lack of progress in achieving the 1971 targets did not stem from problems of policy but from problems of implementing the policy. Two
notable modifications to the 1971 guidelines were however made; no more
large hospitals of more than 200 beds should be built, as it was calculated
that each Health District would require approximately 150 beds only; and
that large hospitals were not considered a favourable environment for
children to grow up in. With these exceptions, the model of service
provision embodied in the 1971 White Paper has remained intact and has
continued to provide the basis of official Government policy.

The bulk of Government activity in the mental handicap field in the
1980s has focussed on changes to financial mechanisms. In 1981 the DHSS
published its "Care in the Community" consultative document, on transferring
resources from Health Authorities to Local Authorities and Voluntary
Organisations. It made seven specific suggestions for the transfer of
hospital residents and resources, including: extending joint finance; lump
sum or annual payments; transfer of buildings; pooling of funds;
earmarking of funds; and a single agency.

The Green Paper was warmly received, Fogarty (1981) observing that it
had been: "heralded as the only positive statement of social policy from
the Conservative Government." This was followed by disappointment however,
when the Government announced that it had only accepted the two least
radical of the seven suggestions: an extension of joint finance; and lump
sum or annual payments. The relaxation on joint finance was generally
welcomed, although its drawbacks remained, as it was still only a pump
priming mechanism, and hence was not designed for handling large numbers of
hospital discharges. Lump sum or annual payments were also welcomed, but
Health Authorities had always had the power to make such payments to Social
Services Departments (Crine 1982a).

That there were no extra resources attached to the proposals caused
"widespread dismay" (Fry 1982). The dismay stemmed from the need for double
funding, in the interim period prior to the total closure of a hospital,
while the hospital and community services are both operating. The
Government's stance was interpreted by many as a failure to exercise
leadership, in leaving "community care to the goodwill of health and local
authorities" (Crine and Whitehouse 1983), which was insufficient given the
resource constraints on Local Government.

The Government's approach was embodied in a Circular in 1983 (HC (83)
6): Has it been successful or have the fears of the critics been realised?
In the first year following publication of the 1983 Circular: "Only 14% of DHAs reported that they had agreed to transfer resources to local authorities" (Wistow 1986b). Within some RHAs the resource transfer arrangements offered to Local Authorities have not been as favourable as those offered to DHAs (Wistow and Hardy 1985b). Such financial considerations have combined with a number of pressures on Local Authorities, resulting in a reluctance to accept new responsibilities, and on Health Authorities to develop their own community services. The result has been that: "policies designed to facilitate resource transfers could just as easily end up reinforcing local authority unwillingness to take patients from long-stay hospitals, and strengthening the NHS tendency to seek to retain health monies within the health system" (IBID.). It would appear that the critics' fears of the Government approach have been realised, Wistow and Hardy (1985a) concluding: "The initiative's underlying emphasis has proved too narrow and limited, both in its concentration on the patient transfer route and its self financing assumption." The former has neglected people already living in the community, hence there is a danger of a two-tier service: underfunding of services for those in the community co-existing with better funding for ex-hospital residents (Wistow and Hardy 1985b). To remedy the latter, the Select Committee on the Social Services (Community Care) recommended in 1985 that a "central bridging fund" be established, to meet the requirements of double funding and thus to get "over the hump" (IBID.).

In addition to the resource transfer initiatives, the Government has developed financial mechanisms to promote the involvement of the voluntary and private sectors. An example of the former was the "Pound for pound" scheme, promoted in 1980 to facilitate the discharge of mentally handicapped children from hospital, by providing £1 million to match money raised by charities. Mencap considered the sum to be "derisory," and were disappointed that Local Authorities had not been given sole responsibility for the care of mentally handicapped people (Howie 1980). Another example was the 1984 "Helping the community to care" initiative (ARVAC 1984).

While trying to cut expenditure on Social Services, the Government has provided short-term finance through the voluntary sector to tackle specific problems (Berstein 1984). The long-term security of such schemes is in doubt however, particularly as it is unlikely that Local Authorities will be
able to absorb them, since that would increase the likelihood of Central Government penalties. The other consequence has been that voluntary organisations have been tempted by "easy money" with the result that their role has been skewed from innovation to mainstream provision, but without secure funding.

Inducements have been made to the private sector also. Changes in Supplementary Benefit regulations have enabled the DHSS to fund placements in voluntary and private organisations, when Local Authorities are unable to fund individual placements: "Hence DHSS offices nationally have virtually been given a free hand to advance the cause of privatisation at a time when health and local authority services are being severely pruned" (Durrant 1984). The growth in private care has been most marked for the elderly (Vistow 1986c), although this growth has spilled over into the mental handicap field (CMH 1984).

A "dual system of welfare" has emerged, with Local Government and Central Government-funded services as "competing welfare systems" (Herbert 1984). There has been little public debate about the Central Government funded route, and the private sector has been very quick to avail itself of the new money, so much so that Durrant (1984) fears an extension of the "Bournemouth syndrome" comprising "acres of privately run boarding houses and hostels ...." One of the anomalies of the dual system is differences in assessments between Social Services Departments and Social Security officers (Herbert 1984).

One criticism of private homes for mentally handicapped people has been that they are too large (CMH 1984). Most concerns have focussed on the monitoring of standards, which was made easier by the 1984 Registration Act. Although it failed to focus on the rights of residents (Bartlett and Browne-Ross 1986) it did enable Local Authorities for the first time: "to impose conditions on private homes on a national basis" (Community Care 3.1.85). The registration and inspection functions of Social Services Departments were tightened up and a code of practice was produced by an official working party. This was not legally binding however, and a lack of resources to implement and enforce the regulations has resulted in a questioning of the Government's commitment to raising standards in private residential care. These fears have heightened as DHSS offices appear to have increased the number of maximum payments entitled to registered homes, to homes which are
unregistered (Doorly 1986), whilst the inability of officials to monitor private residential homes adequately was highlighted by the Oriel Lodge episode (Hencke 1986, Veitch 1986).

Community Care: policies and realities

The DHSS has used the term "community care" differently through time: in the early 1960s it referred to Local Authority services as opposed to care in hospitals; in the late 1960s and early 1970s it was associated with domiciliary services; and in the late 1970s it became identified with the voluntary sector and informal care (Hambleton 1981). Alongside these changes, the three assumptions which have traditionally underpinned community care are increasingly being questioned: it is a cheaper form of care; it is better for and more popular with the service users; and it involves a shift in care from the Health Service to Local Authorities (Wistow 1986c).

Community care has traditionally been seen as the "cheap alternative to institutional care" (Ayer 1984) despite recent pronouncements by Government ministers that community care is not a "cost-cutting exercise" (Fry 1984). Nevertheless the DHSS has expected many community care policies to be developed within existing resources, as with the "care in the community" programmes. The Commons Social Services Committee (community care) has attacked this both as "naive" and "inhumane" (Wistow 1986c). Further, the recent emphasis on voluntary and informal care has been partly motivated as a perceived opportunity to cut costs: the Government using the existence and breadth of informal care as a justification for cuts in Personal Social Services (Walker 1982b); while "substitutability" between professionals and volunteers has become a "political reality" (Grant and Jenkins 1986).

At the same time, many parents of mentally handicapped people in hospital have disputed the notion that life in the community would necessarily be better than life in a hospital for their sons and daughters (Brass Tacks 1986, Morris 1985, Wigmore 1986). As a result they have set up their own pressure group, RESCARE, to argue for the continuation of mental handicap hospitals. On the financial side, the increasing use of Joint Finance by DHAs, coupled with their take-up of "care in the community" monies suggests that a fundamental shift from Health to Local Authorities is not being achieved. Thus each of the three assumptions underpinning
community care have been challenged in recent years, hence Wistow (1986c)
has argued that the concept is back "in the melting pot."

The term "community" has probably never been out of the melting pot.
It is usually used rather loosely, conveying any one of a number of meanings. It is a "cosy" word, its appeal stemming from its use as: "a counterpart to impersonal modern life" (Barnes R. 1981). Moreover, the term has been so abused, that it has become "deprived of meaning" and obscures "an enormous degree of heterogeneity and conflict" by according issues a "specious sense of coherence" (Beresford 1984). However feminists have started to challenge it as a "gender-loaded concept used to oppress women" (IBID).

Traditionally, community has derived its meaning as a sense of geographical locality, but in many areas: "the geographical community has only a weak existence, and membership in various communities-of-interest unrelated to geographical propinquity is much more significant" (Jones 1981). Clarke (1981) has argued that there are two elements in communities of interest: solidarity, or a "we-feeling," and a sense of significance.

The majority of mentally handicapped people do not live in institutions, and most of their care is undertaken by their families (Grant and Jenkins 1986). Family care has predominantly been female care (Ayer 1984, Grant and Jenkins 1986, Wilkin 1977), with fathers and siblings generally participating little in "personal care" and "household chores." Further, the same studies have shown little help from relatives, neighbours and friends indicating that care "in" rather than "by" the community would be the more apt description, although Grant and Jenkins (1986) argue that communities may be respecting the norms and values devised by the families rather than simply not caring. Nevertheless, family care may be more "fragile" than it appears, particularly because primary carers would prefer to ask professional services to undertake personal care tasks rather than other members of their own family if they themselves were indisposed (Webb 1986).

The fragility of family care is further emphasised from being based on an outdated model of the "family", which accounts for only: "a very small proportion of all families" (Rossiter and Wicks 1982), because of recent increases in: divorce rates; re-marriages; female employment; male unemployment; and social mobility. The social division of labour both in
the labour market and at home is currently being renegotiated between men and women, the resolution of which will determine the future of family and community care (Walker 1982b).

Much research has been conducted into the costs of caring for a mentally handicapped dependant. However, early research tended to make too many assumptions regarding the burden of mentally handicapped people on their carers and tended to be methodologically unsound also (Wilkin 1977). Recently, the research has become more sophisticated, for instance Quine and Pahl's (1985) study of the causes of stress in families with mentally handicapped children. To meet the costs imposed by caring for a mentally handicapped person, Bayley (1973) found that families developed a "structure for coping," and this has been found subsequently by other researchers, for example Grant and Jenkins (1986) and Hunter (1980).

Despite the costs and coping structures, families with a mentally handicapped member should not be regarded as "curiosities" because: "these families resemble others, and most of their roles and values are drawn from and sustained in a flow of life events similar to that experienced by other families" (Burkitt 1977). Wilkin (1977) concurs, urging that the "normal family model" is applicable rather than the "pathological" model.

It is important also to avoid an exclusive focus on the families' costs of caring. Both Browne (1983) and Hunter (1980) have discussed the satisfactions as well as the costs of caring for a mentally handicapped dependant, while observing that families differ in their responses. One parent described her feelings towards her mentally handicapped child thus: "I would wish that she were normal but I think that she's taught me so much - and I think we've gained a great deal from having her" (Coping 1984). For siblings also, it is important not to assume that there will be atypical problems from having a mentally handicapped brother or sister, as experienced by Cantouzino (1984), as there can be many benefits (McConachie 1983). Indeed the founder of SIBS also argues that the problems should not be over- emphasised (Fairbrother 1984).

The "normal family model" would not appear to be so appropriate for families incorporating a mentally handicapped adult. Many mentally handicapped adults have continued to live with their parents, often because of a dearth of acceptable alternatives. As a result, both the individual and the family fail to follow the typical pattern, with the parents'
marriages in danger of becoming "threesomes" rather than "twosomes" (Wertheimer 1981).

Despite the equation between community care and family care, Government policies have focussed on "buildings rather than family support services" (Wistow 1984). This reflects Ayer's (1984) contention that there has been an ambiguity in the definition of community care, with a resultant confusion over whether it should substitute or support families. In practice: "community care has been defined as a substitute not a complement for family care" (IBID). The partial understanding of community care advanced in the 1971 White Paper would appear to have been perpetuated, with the result that family support services have been overlooked. Unfortunately it is not surprising that one of the biggest initiatives in this field, the extension of the Invalid Care Allowance to married women who comprise 84% of female carers, had to be imposed on the British Government in 1986 by the European Court on the grounds of sex discrimination.

The Government's interpretation of community care is further limited by its priority to hospital discharges. Mittler has called this a "major defect in official thinking" (Brass Tacks 1986a) because it fails to acknowledge the needs of people already in the community, and hence fails to establish services which could help prevent the need for admission to hospital. The pressure being applied on DHAs to close hospitals is causing further concern, particularly because of the slow growth in community services. A Social Services Director has argued: "Somehow it is important to help ministers understand that the rate of hospital closure must be determined by the development of an alternative range of provision" (Francis 1985). Others fear that the tone and emphasis of Government policy has become unbalanced, failing to acknowledge individuals' needs in the rush to empty the hospitals (Fleming 1986).

Philosophies of Care and Leader Responsibilities

The current debate over models of care has grown out of the "hospital - no hospital" debate of the 1960s, which provided the context for the 1971 White Paper (Wistow 1984). Hudson (1980) has argued that the future of mental handicap hospitals is based on three broad options, each of which represents a different model of care:
1. Retrogression, urging a continuation of specialist Health Service provision, and in effect a defence of the medical model of care;

2. Equivocation, based on the notion that people can be divided according to the level of their handicap, with hospital care considered appropriate for the most severely handicapped and community care appropriate for the less severely handicapped, as in the 1971 White Paper;

3. Abolition, based on the "social" model of care, and viewing "mental handicap hospitals as wholly inappropriate establishments for any mentally handicapped people."

This model, incorporated in the Jay report, is based on an assertion of rights and on integration, neither of which hospitals are seen as upholding.

The roles of Psychiatrists and specialist mental handicap hospitals have been questioned increasingly, particularly as mental handicap is not an illness susceptible to cure. Hudson (1980) for example has argued that the medical model is inadequate because "the overwhelming majority of first admissions to hospital for the mentally handicapped are for 'social' not medical reasons"; and because very traditional attitudes are engendered among staff. The Royal College of Psychiatrists has maintained that mental handicap is a "sub-speciality" of psychiatry, and hence mental handicap services should remain under the control of Consultant Psychiatrists (Tyne 1982). Further, hospitals have been justified as centres of excellence, providing a unique type of care unavailable elsewhere.

The debate on models of care has been fuelled by developments in the principles of "normalisation" and "an ordinary life," both of which have strengthened the arguments of the abolitionists.

The credit for promoting the principle of normalisation to centre stage rests with Wolfensberger (1980a) who has defined it in a number of ways, the most succinct being: "The use of culturally valued means, in order to enable people to live culturally valued lives." Hence the theory encompasses all devalued groups, and incorporates an emphasis on both the means and the outcome. Deviancy is considered not to rest within the person, but to be "culturally defined," and consequently the result of attitudes, beliefs and ideologies. A consequence of this is the "vicious
"circle" of a "deviancy career," wherein a person is devalued, for example in terms of "dehumanisation," "age inappropriateness" and "isolation," and subsequently acts in a more deviant manner which reinforces others' devaluing responses (O'Brien and Tyne 1981).

There has been much confusion surrounding normalisation mainly from misunderstandings arising from its derivation from the term "normal." The advocates of normalisation acknowledge that it is not problem-free: "A major stumbling block .... is .... that different normalisation implications may clash with each other ..." (Wolfensberger 1980b). An example of such a "clash" might be between the culturally normative right to choose, and a choice which is inconsistent with normalisation principles, for example ill-fitting clothes.

Wolfensberger's work has attracted broader criticism however: "Wolfensberger's history .... lapses into moralism, situating the problem in the minds and hearts of people, rather than in the relations among them" (Burton 1983). From this failure to consider the impact of structural determinants on ideologies, for example of economic structures, Burton considers that there will be additional problems when implementing a normalisation philosophy: he questions the capacity of communities to care, given that social fragmentation, alienation and privatisation are "chronic" under "welfare capitalism"; and observes that there are limits on the positive valuation of people who have a lack of success in the labour market.

Despite these reservations normalisation has become: "an internationally influential human service paradigm" (Flynn and Nitsch 1980). This is partly because of its application to the evaluation of service provision, through the PASS (Program Analysis of Service Systems) programme. Further, normalisation principles have been operationalised in research, for example by Hull and Thompson (1981) who constructed an "environmental normalisation scale."

The Kings Fund produced a project paper in 1980 entitled "An Ordinary Life" based upon the normalisation philosophy. It was an attempt to produce an alternative model of residential care to the 1971 White Paper and the Community Units promulgated by the DT. Underlying its recommendations were three "fundamental principles": mentally handicapped people have the same human value and rights as other people; mentally handicapped people have a
right and a need to live like others in the community; and services must
recognise the individuality of mentally handicapped people. From these were
derived a number of service principles, for example that services should be
comprehensive, flexible, and as "least restrictive" as possible, which in
turn were used to determine the components of a "comprehensive community
service."

The DHSS (1980a) has acknowledged the debate over competing models of
care, but has not contributed to it significantly. Neither has it adopted
the principles of normalisation or an ordinary life as the basis for its
policies. Consequently, the Government has been criticised for focussing
too heavily on financial mechanisms, and too little on the ideologies
underpinning community care policies (Kirk 1983). A comparison of the Jay
and Warnock reports on the one hand, and Government policy embodied in the
1971 White Paper and 1980 Review on the other, is instructive: the former
are based on a clear philosophy and a commitment to individuals' rights,
both of which are lacking in the latter.

The failure to enter into the models of care debate represents a lack
of firm leadership by the Government. This is currently representing itself
as an "incremental drift" (Wistow 1986c) in which new initiatives, such as
the increase in private sector care, are accomplished with little public
debate and without explicit reference to an existing set of priorities. A
further consequence has been the continuation of a divided two-tier service,
dictated since the equivocation of the 1971 White Paper, in which people are
labelled "hospital dependency" or "social services dependency": "as if the
distinction lay in the natures of mentally handicapped people themselves
rather than simply in the administrative arrangements which are made for
them" (Tyne 1982).

The lack of Government leadership in this field has suited the
occupational interests of the service providers. The Government's
acquiescence to the nurses' view of the Jay report extended most strikingly
the "policy making by compromise" so evident in the 1971 White Paper. The
Government has also failed to tackle the role of medical specialists in
mental handicap, despite their existence leading to a marginalisation of
mental handicap within the Health Service (Hudson 1980), waiting instead:
"for uncertainty and natural wastage to carry out a slow attrition of the
ranks of Consultants" (Tyne 1982).
The lack of leadership shown by the DHSS is thrown into sharp relief by its sister Department, the Welsh Office. Prior to the early 1980s mental handicap services in Wales had had no guiding strategy, as many initiatives such as the DT had been confined to England (Humphreys and McGrath 1986). In March 1983, the All Wales Strategy was announced by the Secretary of State.

Three principles underlay the strategy: mentally handicapped people have a right to normal patterns of life within the community; mentally handicapped people have a right to be treated as individuals; and mentally handicapped people will require additional help from their communities and from professional services (All Wales 1982). This strategy therefore emphasises the rights of mentally handicapped people more unequivocally than the DHSS, and is based on principles akin to normalisation and an ordinary life.

At the forefront of the strategy is an acknowledgment of the need to support the families of mentally handicapped people. Additionally, there is an attempt to break the "cycle of dependence on institutional care," as "the only option to families who can no longer cope on their own" (Edwards, cited by Murray 1983). As Blunden (1984) has observed: "The All Wales Strategy is not about flashy new buildings but about networks of support." To achieve this, Social Services Departments have been given the primary responsibility for developing community-based services, and £26 million per year is being made available over a 10 year period so that community-based services can be built up prior to the closure of hospitals. Wistow (1984) has concluded that the All Wales Strategy contains: "many of the elements missing from the English approach: political leadership; commitment to real change; an unambiguous philosophical base; and additional resources."

**Local initiatives in the development of services**

Is it appropriate that the Government exercise firm leadership? Russell (O. 1983) thinks not, arguing that: "many of the key initiatives in the development of mental handicap services took place not as a consequence of official policy statements but as a result of informal initiatives or grass roots action." He continues by claiming that such initiatives have: "generated far more exciting ideas than a decade of White Papers. Maybe
that is as it ought to be. Maybe we should discourage the DHSS from producing policy initiatives."

The Kings Fund (1980) also emphasises local initiatives in its "ordinary life" deliberations: "real innovation depends on sustained local action. Services will only improve through the initiative of local people and their success in mobilising support." Such a stance clearly fits neatly into the approach adopted by this study, which acknowledges both Bottom-up and Top-down processes, and which attempts to explore the interplay between policy and practice without prior assumptions regarding their relationship. A comprehensive picture of local initiatives is beyond the scope of this study, hence only a brief sketch is attempted.

Local initiatives in the development of services: Children

Parents respond differently to being informed of their child's disability, but they have some common needs, for example for information, support and practical advice (Ward 1982). In Leicester, Newall (1984) found a marked improvement over a ten year period to 1981 in how parents were informed. The changes included greater privacy and a greater tendency for both parents to be present. Support from other parents can be valuable, perhaps the best known early support scheme being the one in Southend initiated by Mencap (Pugh 1981). Parent visiting has recently been undertaken by a Contact-a-Family group in Ealing, and the Wandsworth group have produced a booklet entitled "Who can help for under 5s" (Contact 1985).

Early intervention has been the focus of a study at the Hester Adrian Research Centre, which provided Health Visitors with specific training. The Health Visitors were then able to provide families with the support and practical advice they required (Cunningham 1983). Portage is a rapidly expanding form of home visiting, in which parents and professionals work together to help the child reach developmental milestones (Pugh 1981, Scaife and Holland 1984, VCHC 1979b). Many of the schemes have been the subject of research studies, which have shown that the children made some developmental gains. However, it is not clear whether they would have made these gains in any case.

In addition to home visiting, there are assessment centres in many areas which help the parents become involved in education and development programmes (Armstrong et al 1980, Beveridge 1983, Rubissow 1976, Saunders
Mentally handicapped children were integrated into ordinary playgroups within the Barnardo’s Chorley project, with volunteers supporting the children (Shearer 1978). The Chorley project also provided a toy library, an aspect of service provision common in other areas, either under the guise of the Education Authorities or voluntary organisations.

To improve home-school links, Smith (B. 1983) has proposed an A to Z of parent-teacher collaboration, from assessment to zeal. Parent workshops have been a particularly effective means of improving home-school collaboration, and operate in many areas (VCHC 1979a). The extent of integration in education between children with and without mental handicaps has been patchy, although in a few areas mentally handicapped children as a whole receive all their education in normal schools: for example in Bromley up to 8 years old; and at secondary level in a part of Derbyshire (Hegarty 1984). Play-schemes are becoming a regular feature in school holidays, and are often organised by voluntary organisations, for example: Barnardo’s in Chorley (Shearer 1978); Mencap in Leicestershire (Cupples 1984); Contact-a-Family in London (Contact 1985); and parents groups (Collins 1976, Presland and Roberts 1983). In Sheffield, disabled children have been integrated into ordinary playschemes by an organisation called SKIP (Leicester 1984).

In a survey of residential short term care facilities for children, Oswin (1984c) found some “appalling” child care practices manifested by distressed children, worried parents and harrassed staff. There has been a trend to increase the provision of short term care through fostering rather than residential care, although the central emphasis of both remains separation, with the danger of "confirming the child as a 'burden' on the family" (Campbell 1983). Nevertheless fostering is considered the more desirable option, with schemes in many parts of the country (VCHC 1982b). Other forms of relief care bring services to the home, and appear in many guises, for example a sitting scheme in Chorley (Shearer 1978); Mencap’s Welfare Visitor service (Parents 1983b, Presland and Roberts 1983); and Family Support Services (Inskip 1981) and Crossroads schemes (Ward 1982) using care attendants.

Reflecting its greater prominence in mainstream child care, fostering is playing a larger part in accommodating mentally handicapped children in the longer term. To the schemes outlined by the VCHC (1982a) can be added...
one in Leicestershire (Burgess 1984), and a scheme in Sussex which attempts to find foster homes for multiply handicapped children (Taylor 1982). Camden Social Services Department turned fostering on its head when they rehoused three mentally handicapped teenagers from a children's home: "rather than get children in someone's home we got a home for the children and then got them carers" (Campbell 1984). Ordinary housing has also been used for children formerly in hospital (Allen et al 1982, Shearer 1981a, Weekes and Brandon 1984).

**Local initiatives in the development of services: adults**

Adult Training Centres (ATCs) have been the mainstay of service provision for the occupation and training of mentally handicapped adults. They have however attracted a lot of criticism, for "confused" aims, a "high institutionalising potential" and "low efficiency" (Bender 1983). As a result there have been calls to phase them out (Boyce 1984, Rose 1983). However, many ATCs have radically altered their functioning, for example by discarding labels such as "special care" (Semp 1983) and dispensing with contract work for its own sake (Crine 1983). Underlying these changes has been an attempt to make systems fit individuals rather than vice versa. Another experiment has been the "rural ATC" in North Yorkshire, using a bus (James 1984).

There has been relatively little use of Adult and Further Education facilities by mentally handicapped adults (Phillips and Smith 1983, Hegarty 1984). Nevertheless, two London boroughs, Hillingdon and Islington, have organised "A New Way" in which volunteers accompany mentally handicapped adults to ordinary Further Education classes. In Cardiff, training has been brought into the home in the NIMROD scheme, which employs Domiciliary Care Assistants to provide a home teaching service for clients who live with their families or in group homes.

Employment initiatives for mentally handicapped adults have faced increasing difficulties, with growing unemployment and the failure by many organisations to abide by the recommended 3% quota of disabled employees. Nevertheless, a few projects such as Mencap's Pathway Scheme (Ward 1982) and the Shaw trust have been conspicuously successful in finding employment for mentally handicapped adults. Even in successful schemes however, integration with the workforce may still be only "partial" (Davidson 1978a).
Open employment is at one end of a range of initiatives, which also includes: work experience placements, as organised from the Birkbeck ATC for example (Crine 1983); work preparation units, the Birmingham Employment Preparation Unit being one example; and sheltered placements for both individuals and small groups under the MSC's sheltered placement scheme. A scheme which has caused much controversy is Islington's Community Aide programme, in which mildly mentally handicapped people act as carers for physically handicapped people (Whitehouse 1984). The controversy stems from whether or not two deprived groups are simply being lumped together.

Relief care to families of mentally handicapped adults can be divided between care in and out of the home. Short term care in hospitals and hostels has recently been supplemented by placements within families, for example in Camden, North Yorkshire, Gateshead (McLernon and Fenwick 1984) and Newcastle (Whitehouse 1983). Services in the home mirror provision for families with children, for example Care Attendant schemes. Many mentally handicapped adults do not leave their family home until the death of their carer. To prevent them having to suffer this double loss at the same time, Mencap and MIND in Barnsley have formed a group to support them in their own home during bereavement (Oswin 1984b).

Over three-quarters of housing projects in housing association or housing department property are unstaffed group homes (Ritchie and Keegan 1983), making provision for approximately 2,000 mentally handicapped adults. The extent of voluntary organisations input to Group homes has been remarkable, for example by Mencap in Waltham Forest (Sowerby 1983) and in Slough (Race and Race 1979) and by MIND in Winchester (Sines and Wigley 1985). Voluntary organisations have initiated such projects, from a fear that the growth of community-based provision is too slow, and in some cases following the innovation have handed the responsibility for their support to Social Services Departments.

Many lessons have been learnt about group homes, for example: their establishment can prove time and energy consuming (Sines and Wigley 1985); careful selection and preparation are important (Chant 1977), particularly as the residents' behaviour (Malin 1980) and compatibility (Rose 1979) are important factors in determining the success of the group; it is easy to over-protect the residents (Rosen 1973), particularly as organisations such as Social Services Departments fear failure (Atkinson, D 1983); the size of
the home should be conducive to a "domestic atmosphere" (Rose 1979); individuals' needs should not be overlooked if they are expected to function as an "integrated family unit" (Ritchie and Keegan 1983); and needs change, hence it is unrealistic to plan for a permanent home, as at the Waltham Forest Housing Group, where: "after eight years, all the original group in the first home have moved - and with one exception, all into single person flats or flatlets" (Sowerby 1983).

Some group homes have been established as part of core and cluster schemes. Such a scheme is operating in South Bristol, in which the cluster consists of a "network of different residential options," and in which the core consists of staffed houses (Ward 1983). This scheme is part of an attempt to develop a comprehensive community-based service, and is guided by the "ordinary life" philosophy. Elsewhere however, there has been much misunderstanding of the core and cluster as a concept: "To rename a hostel a 'core home' and add on a couple of group homes, does not create a core and cluster model" (Parker and Aloe 1984).

Several projects providing staffed accommodation in ordinary housing have been tied exclusively to hospital discharges (see above) although this has not been the case in the NIMROD project or for Mencap Homes Foundation developments (Capewell 1984). Boarding out schemes for adults have become more popular for long-term as well as short-term placements, for example with schemes in Hampshire, North Yorkshire (Chilton 1983, Penfold 1983), Bedford (Parents 1983b) and Sussex (Crine 1982b). The Sussex scheme placed 17 mentally handicapped hospital residents in only 18 months.

With so much emphasis on the training and accommodation needs of mentally handicapped adults, their leisure needs have been relatively neglected. The majority of leisure activities engaged in by mentally handicapped adults are "passive," with little participation or social interaction (Jeffree and Cheseldine 1983, Walsh 1985). The Path project has helped mentally handicapped adolescents acquire new skills, resulting in a decrease in solitary leisure activities and an increase in "skilled interactive pursuits" (Jeffree and Cheseldine 1983). This is important for promoting social integration, a benefit also derived from befriending schemes (Walsh 1985). The key to both is the use of facilities available to the general public rather than segregated facilities. Other projects have focussed on increasing the expression and self-awareness of mentally
handicapped people through art, drama and music, for example the recreational arts project organised by a Mencap Development Officer (Cuppes 1984).

Themes in service development

Three themes have begun to emerge in the development of local services: planning according to individuals' needs; parental participation; and self advocacy.

1. Planning according to individuals' needs.

Individual programme plans (IPPs) are becoming a more common feature of service provision, particularly in the schemes which attempt to provide a comprehensive community-based service such as in Bristol (Ward 1983) and at NIMROD (Humphreys et al 1981), or in schemes involving a large scale transfer of residents from hospitals to alternative accommodation, as in South Derbyshire (Byrne 1985). The following is the working definition of an IPP used in South Derbyshire (1985): "The Individual Programme Plan is a written plan of intervention and action that is developed and modified at frequent intervals with the participation of all concerned. It specifies objectives and goals and identifies a continuum of development, outlining projected, progressive steps, and the developmental consequences of services."

Unfortunately, it is likely that: "many professionals pay lip-service to [IPPs] without understanding the true concept of them" (Spencer 1984). Nevertheless, IPPs in principle can help improve the co-ordination of service delivery to an individual, and promote the accountability of service providers. In adopting a holistic approach, IPPs can help ensure that services reflect an individual's needs, but also more broadly for the client group as a whole, by highlighting gaps in service provision.

The growing awareness of the unmet needs of many mentally handicapped people has prompted a rapid growth in the number of registers (Cubbon 1983). Registers have varied enormously, for example in terms of their sponsoring agency and format, and have fulfilled a number of functions (Cubbon 1984). Despite their general popularity, some registers have encountered problems of up-dating and are in danger of lapsing, because of shortages of staff, resources, or time. In other areas, they are only seen as one-off exercises
so as to minimise their cost, although this would appear to limit their capacity to become "firmly rooted in operational work" (Cubbon 1983).

2. Parental participation

a. Parent - service provider co-operation

A continuum can be drawn up, from communication to collaboration via consultation, to signify the strength of parent participation at strategic, operational and individual levels. Before parents can be consulted the Authorities have to know who they are, hence the significance of registers. Further, surveys and registers can represent parental perceptions of the services provided or required on a global basis. The joint management partnership in Newcastle, local development groups in Derby, the St. Helens Trust (Adams 1983), Nimrod's Consumer liaison group (Lowe et al 1986) and the Standing Conference on Voluntary Organisations in Wales (Blunden 1984) are all attempts to involve parents to a greater or lesser degree in service planning at a strategic level.

Parental participation at this level is not easy to achieve, as many parents have reached a "delicate homeostasis" in their care, and hence seek "quiet waters" to avoid change (Humphreys 1984). Tyne (1976) presented an unpromising picture regarding Health Service planning: "The RHAs were not, in the main, making excessive efforts to involve the public, or parents, or mentally handicapped people, in planning services." Indeed, an Association, RESCARE has been formed because of the lack of consultation between Health Authorities and parents over the decision to close hospitals, and for the parents to register their disagreement with this decision.

The extent of parental participation at the operational level is much less well documented. There is a parent representative on the Sanderson Centre CMHT who has attended business meetings and working groups, which has been welcomed both by the representative and other CMHT members. The parent representative described this as: "a rewarding experience and extremely interesting, although it has also been very time consuming" (Sanderson 1983b). There are parent representatives on other CMHTs also, for example a parent attends the business meetings of the Normansfield CMHT (Sines 1983).

Consultation and collaboration between parents and service providers at an "individual" level has attracted most attention. Collaboration is often seen as desirable, Mittler and McConachie (1983) for example advocating a
partnership between parents and professionals, based on the following essential elements: mutual respect and recognition of equality; sharing of information, skills, feelings and the process of decision making; and recognition of the individuality of families and the uniqueness of the handicapped child. It is clear that these elements do not always exist, as a group of parents acknowledge: "In our experience, parents know a great deal about their children - often much more than they themselves recognise and certainly more than many professionals give them credit for" (Family 1982).

IPPs have provided a useful forum for promoting the involvement of parents in the decision making processes affecting their son or daughter. Parental participation in the assessment of their child has been formally enshrined in the 1981 Education Act (Mittler and Mittler 1983). Parental participation in education and training programmes has also been promoted, for example through Portage schemes and child development centres. The training of parents in behaviour modification techniques has been particularly popular, on the basis that: "parents can be trained to effectively modify their childrens' behavioural disorders" (Cunningham 1975).

Consultation and collaboration between residential services and parents have been patchy. Under the Sheffield Development Project for example, parents had: "relatively small influence .... over their next-of-kin once they were admitted to residential care" (Armstrong et al 1979). Elsewhere, a parent had to involve the ombudsman to have any influence over a hospital's treatment of her daughter (Dyer 1984). Similarly there have been examples of a lack of consultation and collaboration between day centres and parents (Humphreys et al 1983, Wertheimer 1981).

Collaboration between parents and professionals can be problematic. Many parents experience social and environmental constraints which undermine their participation in development programmes (Saunders et al 1975), while other problems can include stereotyping (McCormack 1979) and divergent objectives (Saunders et al 1975). A partnership with parents of adults may be less appropriate than with parents of children because: "such a close involvement on the part of parents may in fact reinforce rather than diminish dependency" (Mittler and Mittler 1983). Fundamentally, professionals should acknowledge that some parents will want to participate
to a greater extent in the development of their children than others. Hence parents must be allowed to choose not to be closely involved, which may in turn lead to guilt feelings that professionals should be "sensitive to" (Blackburn 1986).

b. Services provided by parents

Parents groups began in the 1940s as a forum for mutual support but have since become a catalyst for service development. As Cook (1983) notes: "Often their main purpose was simply to share their experiences with each other, or to develop and provide services for their children or relatives where none existed. Many groups have since begun to redirect their efforts and to press for the provision of services by statutory agencies, as well as for the legislation which will support that initiative."

Self-help groups can be classified as follows: formal, including Mencap; institutional, for example parent-staff associations; service groups, for play schemes, toy libraries and social clubs for example; and parent groups, for a range of activities including mutual support and campaigning. A survey of the Northern region found that parent groups were a recent phenomenon, while formal and institutional groups were most prominent in the 1960s, but since 1975 there had been a "rapid growth" in all four types of group (Cook 1983).

The contribution to service development of formal groups such as Mencap has already been noted, for example through their visiting services and in accommodation projects. Traditional parent-staff associations have been supplemented by workshops involving parents and professionals jointly, for example between parents and school teachers (Gardner 1983) and parents and ATC staff (Flower and Oliver 1983). The Kith and Kids group (Collins 1976) could be categorised as a service group, as it has organised playschemes and "two-to-ones," although it has also achieved much more, through campaigning and promoting parents' participation in their children's development programmes. Mutual support and self-help parent groups have been established in many places, within umbrella organisations such as Contact-a-Family (Millar 1984, Smallwood 1982), and elsewhere more independently (Presland and Roberts 1983, Pugh 1981).

The conclusion of the joint parent-professional advisory committee in the Northern region is a salutory one and a fitting conclusion to this section: "Offering people with handicaps and their families an opportunity
to get together in a structured event which combines sharing of information and experiences with the learning of skills is a powerful way to offer support. It is quite clear that more people request help in dealing with service systems than in dealing with the person who has a disability" (Cook 1983).

3. Self Advocacy

The self advocacy movement in Britain developed out of "participation" conferences organised by CMH in the early 1970s, involving both mentally handicapped people and service providers (Ward 1982). The self advocacy movement: "aims to enable handicapped people to take their own decisions and exercise control over their own affairs" (Ward 1982). To achieve this, certain skills have to be acquired, notably in communication and interpersonal relationships: "the concept of self advocacy is [like] a circle divided into two halves, - the development of relevant skills (and) the use of relevant skills" (Willis 1985).

Most self advocacy groups have been based in ATCs, where the students come together in committees (Ward 1982). Indeed, there are such committees in more than one in four ATCs (Mittler and McConachie 1983). Less common are committees of residents of hostels or hospitals, although there are a few. Most of the issues considered by such committees concern specific details of the operation of the Centres or residential units. In a few areas, broader issues have been tackled, for example the Avro Centre committee has begun to: "pursue much wider and political issues" (Ward 1982). In Camden an "independent" (i.e. of an ATC) self advocacy group secured an apology from London Transport over bus passes, and in Islington self advocacy resulted in the term "mental handicap" being dropped by the Social Services Department.

The discussion group has been the primary vehicle for self advocacy, although it rests heavily on verbal communication and can result in domination by the most articulate individuals. Self advocacy need not be straitjacketed in this way, but could use other vehicles such as play and drama where appropriate (Willis 1985). This approach emphasises self advocacy as an orientation rather than as a compartment of work separate from others.

A further lesson has been that self advocacy "flourishes" where expectations of mentally handicapped people are high (Williams 1982).
Nevertheless, many professionals feel "threatened" and "uneasy" regarding self advocacy, particularly as it raises questions about their own role (Crawley 1986). Indeed some professionals have "abused" self advocacy. For example, one ATC committee was manipulated by the staff to influence the manager because management-staff relations were so poor. Similarly, there can be conflicts of interest between parents and their mentally handicapped dependents. It is possible that the two recent trends towards parent participation and self advocacy will clash, where the views and interests of mentally handicapped people and their parents differ. To resolve such disputes within IPPs in Derby, an "Appeals" mechanism has been established, although it is "a bit messy" (Byrne 1985).

There are two realities that self advocacy can help to improve: choices are denied to mentally handicapped people, and mentally handicapped people want to exercise greater choice. James (1985) has illustrated the different strategies professionals use to prevent mentally handicapped people deciding where they want to live, and more broadly, professionals can suffer from "case conferencitis" (Crawley 1986). Parents too can deny choice to their mentally handicapped dependant, which results in maintaining their dependence (Staples 1983). The net result of the denial of choice is that mentally handicapped people "exert less influence on their environments" than non-handicapped people (Speake 1985). When they have been asked, mentally handicapped people themselves claim that they want more choice and greater independence in their lives (London 1976) and complain of not being listened to and treated like children (Open 1985).

Denial of choice is closely related to denial of feelings. For example, during bereavement many mentally handicapped people are "protected" from a fear that they will not be able to handle their emotions (Oswin 1984b). Similarly with sexuality and relationships: "We can keep repeating facts and figures, yet some will still find reasons why the mentally handicapped should be denied the same sexual rights as normal people" (Staples 1983). This nettle is beginning to be grasped, Crafts' (1982) work helping to raise the profile of this issue. Recently more guidance has been forthcoming for service providers, such as the course developed by Slater and Whittles (1986), while Robbins (1984) has outlined the legal guidelines relating to sexuality and mental handicap.
Underlying the issues of self advocacy, choices and feelings, is the question of rights. The United Nations (1971) has issued a "Declaration on the Rights of Mentally Retarded Persons." In practice however, it is all too often the case that: "Rights which other people have are, for mentally handicapped people relegated to the status of 'privileges'" (Borden 1983). Indeed, as a society we do not automatically accord mentally handicapped people the right to live: "Two cases in 1981 grimly underscored this different status by failing to make it clear whether a mentally handicapped child with Down's Syndrome in fact has the same right to life as any other" (Tyne 1982).

Citizen Advocacy is an attempt to promote the rights of mentally handicapped people, and has grown alongside self advocacy as: "new products in our service market" (Crawley 1986). It was launched in this country in 1981 by Advocacy Alliance, and began with hospital residents, although subsequent schemes have not been confined in this way, for example the Sheffield advocacy project (Hoban 1984). The Advocacy Alliance (1981) has defined an advocate as: "an ordinary person who befriends a mentally handicapped person on a one-to-one basis and learns to represent that person's interests as if they were her or his own." Unfortunately, many professionals have responded to citizen advocacy in a similar manner to self advocacy, viewing it as a "threat" rather than as an "ally" (Crawley 1986).

Perhaps an apt conclusion to this section is provided by a group of mentally handicapped adults who attend Pyenest ATC in Harlow. At the second of the 1983 participation conferences in London, they sold badges with Mencap's "Little Stephen" logo. They disapproved of the logo as they considered it to portray too pathetic an image, and hence they attached captions which were incongruous with such an image, for example "Make love not bird boxes" (Borden 1983).
SUMMARY: A WAY FORWARD

Service planning and provision for mentally handicapped people have been briefly explored in this chapter. The role of Central Government in the planning of mental handicap services was examined and was found wanting in the exercise of effective Top-down leadership. Nevertheless different aspects of Government policy have filtered down to the localities, such as the encouragement of the private sector and tighter restrictions on Local Authority expenditure. Such trends formed the backcloth in Notts to the development of the CMHTs.

The models of care debate also helps to contextualise the emergence of the Notts CMHTs. It seemed unlikely that the teams and other local service providers would be able to opt out of that debate in the same way as the Government. Local initiatives in the development of services were also examined, together with the trends and themes which have evolved within these. These initiatives help to locate the Notts CMHTs' development role, since although the developments were new to Notts, in most cases similar examples were operational elsewhere.


CHAPTER 8
COMMUNITY MENTAL HANDICAP TEAMS

Introduction

As a review of community-based developments, the last chapter was incomplete as it omitted CMHTs, an omission which is rectified in this chapter. A lack of Government leadership was pointed to in Chapter 7, although it will be seen that the concept of the CMHT was initially developed by quangos established by Central Government. This chapter also covers the operation and experiences of CMHTs, including a discussion of both external and internal cohesiveness.

A national model

The concept of the CMHT was initially promoted by the NDG (1976), which advocated "joint working in the actual delivery of services" to complement "collaboration in strategic planning." The NDG (1977) first used the term "CMHT," whilst discussing the need to improve domiciliary support to families. Building on the "light of experience in different parts of the country" it proposed three specific functions for a CMHT:

i) To act as the first point of contact for parents and to provide advice and help;

ii) to co-ordinate access to services;

iii) to establish close working relationships with relevant local voluntary organisations.

If CMHTs were to work with both adults and children, the NDG recommended they serve a population of 60 - 100,000. Regarding membership, it distinguished between a small core of two to three full-time members, with back up from a wider range of professionals on a part-time or sessional basis.

The DT (1978) has subsequently developed the CMHT notion, alongside that of the Community Unit, as its two "essentials of Local NHS services for the mentally handicapped." Similarly to the NDG, the DT considered the CMHT to be a suitable vehicle both to improve the co-ordination of
services, and to provide a direct support service. Its support was aimed at assisting families to continue caring for their mentally handicapped dependant, and was to incorporate the following elements:

i) Specialist advice, counselling and support for parents in coping with:
   a) Trauma experienced by the families;
   b) Attitudes of relatives, siblings and neighbours.

ii) Specialist advice on day to day management to include:
   a) Overcoming any special feeding difficulties;
   b) Methods of attaining developmental milestones: e.g. sitting, standing, walking;
   c) Training in the use of remnants of vision and hearing;
   d) Programmes of training for the achievement of self-help skills, including feeding, toileting and dressing;
   e) Overcoming behaviour problems.

The CMHT's practical support role has since been emphasised: "we lay particular stress on the domiciliary nature of the service ...." (Mittler and Simon 1978). Following the NDG approach to membership, the DT distinguished between "regular" and "other" members, with: CMHNs, Social Workers, Consultant Psychiatrists, Clinical Psychologists, Occupational, Physio and Speech Therapists in the former category; and Specialist Health Visitors, Paediatricians, Child Psychiatrists, General Practitioners, Community Physicians, Medical and Clinical Assistants in the latter. Community Units were seen as suitable bases for CMHTs, which would be serving populations of 80 - 100,000. This model of CMHT was promoted by the DT in the late seventies and early eighties: "In this sense, therefore, the work of the Development Group and Team provided a national model for community mental handicap teams" (Wistow 1986c).

**District Handicap Teams (DHTs)**

At the same time as the NDG and DT were recommending the establishment of CMHTs, the Court Report (1976) recommended DHTs in an attempt to improve the quality and co-ordination of child health services for handicapped children. The DHT's "clinical" functions were
to include the provision of a "special diagnostic assessment and treatment service for handicapped children and advice and support for their parents." In addition the DHT was seen as undertaking "operational" functions, including the monitoring of services, surveys of need and acting as an information resource centre about handicap.

As blueprints there are some obvious differences between CMHTs and DHTs, notably that CMHTs were envisaged as covering mentally handicapped people of all ages and DHTs were intended solely for children. Further, CMHTs would deal with mental handicap only and DHTs with all forms of handicap. But who should work with children with a mental handicap and adults with a physical handicap? The Court committee foresaw DHTs working with all severely mentally handicapped children, an advantage being that DHTs would be better able to keep mentally handicapped children in touch with generic services, thereby postponing the "process of segregation" (Plank 1982). If the DHT were responsible for all handicapped children until school leaving age, CMHTs would be responsible for mentally handicapped adults only.

The DT and NDG maintained however that the DHT would not be able to meet the needs of all mentally handicapped children, particularly the small number with the: "most severe and complex disorders of development and behaviour" (Kittler and Simon 1978). For this reason they argued that the CMHT should complement the DHT as a second tier, providing more specialist services. The acceptance by the DHSS (1978a) of both models of team did little to resolve the confusion. CMHTs were accepted: "to support mentally handicapped people and their families in circumstances where the DHT for a variety of reasons may not be able to provide the help required." Such help was not specified however, and this stance was particularly remarkable given that DHTs were intended to: "provide a framework within which all the needs of the relatively few children with severe handicap both physical and mental can be met ...." (IBID).

Consequently Gilbert and Spooner's (1982) summary is apposite, that there exist: "inherent conflicts in ideology and government thinking as to who should work with mentally handicapped children." It is indeed ironic that two models of team were accepted by the DHSS, both of which
were attempting: "to provide a 'single' door to improve the co-
ordination of services" (Cotmore 1986).

Teams in practice

The national pattern of teams is constantly changing. For example, in her 1981 survey, Plank (1982) found 71 CMHTs, although Brown (S. 1986) has estimated that there are currently between 250 and 300 CMHTs in England. Plank found that the confusion in policy surrounding DHTs and CMHTs was reflected in practice as: 30% of Health Districts had DHTs only; 20% had CMHTs only; 25% had both; and 25% neither. The composition and structure of CMHTs varied enormously, one team consisting entirely of Speech Therapists! The composition of the teams was as follows, and is supplemented by data from a sample of 27 teams studied by Brown (S. 1986).

Table 8.1 CMHT membership

<table>
<thead>
<tr>
<th>Professions represented %</th>
<th>Plank (1982)</th>
<th>Brown (S. 1986)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 81</td>
<td>n = 27</td>
</tr>
<tr>
<td>Social Worker</td>
<td>81</td>
<td>67</td>
</tr>
<tr>
<td>CMHN</td>
<td>80</td>
<td>78</td>
</tr>
<tr>
<td>Psychologist</td>
<td>67</td>
<td>70</td>
</tr>
<tr>
<td>Consultant in mental handicap</td>
<td>64</td>
<td>44</td>
</tr>
<tr>
<td>Specialist Therapist</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Educational</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>30</td>
</tr>
</tbody>
</table>

The two sets of results are strikingly similar, the most marked change being the decrease in the position of the medical profession. This has been reinforced in a number of ways, for example by a reduction in their role in the convening of team meetings (Brown S. 1986). Both surveys found that teams were relatively small, two-thirds consisting of four or fewer members. Plank (1982) found that the Social Worker and CMHN were the "mainstay" of most CMHTs: "several teams have only these two professionals and in many other teams they are the only members employed full-time on the team." The number of specialist Social
Workers and Community Nurses in post has continued to rise, for example the DT (1982) found an increase in the number of CMHNs from 50 to over 300 in the five year period up to 1981. Cubbon (1983) has observed: "Generally, CMHTs have not been formed simply by increasing contact between professionals already in post. Usually their creation has accompanied the appointment of professionals with new roles such as specialist Social Workers and Community Nurses."

CMHTs' functions

Plank's (1982) survey showed that CMHTs commonly adopted a similar function, that of: "providing a practical support service to families with a mentally handicapped member...." More recently, however, it has been suggested that the teams' diversity of structure is reflected in a diversity of function: "Crudely, there is a division between teams involved primarily in some sort of direct service to people with mental handicaps and those concerned with planning or developing services" (Mansell 1986).

One explanation for such diversity is that many CMHTs work without operational policies from their employing agencies: "a coherent management policy is by no means the most common model" (Craft and Brown 1985). In some cases this was done "deliberately" so that team members were left to define their own objectives, activities and working methods (DHSS SWS 1979). This had both advantages and disadvantages in that services could evolve according to need and greater informality was generated, but on the other hand it was more difficult to weave the teams' activities into existing systems, and re-inventing the wheel was rather "time-consuming." More commonly however, it is likely that a lack of operational policy stems from the teams' establishment representing a "token gesture" by management, without "real thought" about what they would do (Brown H. 1986).

A further explanation for the diversity between teams is that they are at different stages of their "natural history" (Mansell 1986): with no clear operational policy, new cases are found, hence teams work at an individual level; this work generates new statements of need; which in turn leads to an impetus to develop services. The trend to developing
services has been reinforced by the pressure on Health Authorities to close mental handicap hospitals, several of which have looked to CMHTs, as professionals with the most appropriate expertise, to undertake this task. Mansell continues by claiming that the next logical step is to employ basic grade direct care staff and thus the team adopts a managerial role.

Arising from their "natural life" CMHTs are exposed to three separate demands:

i Gatekeeper/co-ordination which is: "probably the function most existing community mental handicap teams see as their primary role ..." (Mansell 1986). Ferlie (1984) views this as an attempt to provide a "magic mix" of care, with the CMHT: "providing a location for the mixing of the different ingredients."

Nevertheless, several commentators have observed that this function must be undermined by the small size of the teams, with many teams lacking representation from either Health, Education or Social Services (Brown S. 1986, Cotmore 1986, Plank 1982).

ii Casework, through the provision of a direct personal service. A problem is that it can easily become the total workload of the team even against explicit priorities, because of an "inherent attraction ... first because it is a tangible and valuable service with demonstrable effects and secondly it may serve to avoid awkward questions about what the team is doing" (Macdonald 1984a).

iii Development of services. This would appear to be compatible with the Government's current interest in statutory services adopting an "enabling role" (Fowler 1984). Nevertheless, the term "development" is rather ill-defined and used in a variety of ways, often as a "convenient organisational response," to criticism of existing standards, problems of organisational structure or an absence of new activities (Billis 1980).

Some of the problems encountered by Welsh CMHTs in undertaking a development role have been outlined by Humphreys and McGrath (1986). These include: a skills and knowledge gap; pressure from demands for casework; difficulties in translating expressed need into take-up of services, for example finding compatible residents for group homes; a
lack of guidelines on key issues, for example volunteers; the "siling up" of development work due to established developments requiring continued support; and overcoming prejudices and traditional attitudes could be time-consuming. Such attitudes were also displayed by professionals in their hostile reception to a presentation by two Nottinghamshire CMHT SSWs on their development role at the 1984 APNH conference.

The silting up of development work has been considered by Wistow and Wray (1986) as one of the constraints in a development process conceptualised as "a trajectory, plateau and spiral." Some development work is based on the assumption that it will follow the course of: "an ever-rising trajectory until, at some undetermined future date, an adequate range of services [will have] been established....." (IBID). Unless additional resources are found to support the newly developed services and to fund further developments, the trajectory begins to level out until it reaches a plateau. To overcome this Wistow and Wray (1986) suggest there is a need: "explicitly to create and sustain a development 'spiral': that is, to ensure that the teams' developmental capacities do not become silted up." This can be achieved either by employing additional CMHT staff to support the developments, or by transferring the support role to other agencies.

The above discussion of development is illuminating, but constrains development too narrowly, as simply the creation of new resources. Lewis's (1982) definition of a developmental role is wider: "to encourage and support existing day and residential establishments to broaden the scope of their activities and to research the need for and implement new initiatives in community support for the mentally handicapped." Lewis (1982) related several examples of a Social Worker's intervention in an ATC and a hostel, which resulted in changes in the regimes of both establishments, and in more flexible responses to clients' needs. As the result is an improvement in service provision, this broader concept of development appears appropriate.

The wide range of demands faced by CMHTs, notably for co-ordination, casework and development work, leads to problems of expectations (Cotmore 1985b). This has been high-lighted by the parent
representative on the Sanderson Centre CMHT: "An area which causes us
great concern is the amount of pressure placed upon the team to solve
'all' problems and the amount of time, therefore, they spend attending
meetings etc., which prevents them from helping the mentally handicapped
in the community and the families, directly" (Sanderson 1984).

A more restricted approach has been adopted in Derby: "The CMHT is
not the be all and the end all; there are far more people involved than
those in a CMHT - they're one cog in a bigger wheel" (Beswick 1984).
Further it may be more realistic to acknowledge that the three demands
of co-ordination, casework and development work cannot all be met within
one type of provision, as each requires a: "different sort of 'team'
than the community mental handicap team as conceived of by the
Development Team" (Mansell 1986).

**External cohesiveness**

Variation between CMHTs by function has so far been accounted for by
an absence of operational policies, and by their differential locations
within their natural histories. A further cause lies in the teams'
"external cohesiveness" (Craft and Brown 1985), that is their
relationships with their environments: "local demands and circumstances
affect the way that teams develop operational philosophies, the tasks
they perform and their relationships with the service system of which
they are a part" (Brown, S. 1986). In a case-study Brown has shown the
impact of the local environment on a CMHT, as its structures and
processes represented an attempt to solve problems stemming from the
manner in which it was established, and as it reflected trends in local
organisational politics.

As a team emerges into established systems and structures it has to
carve out a niche for itself, representing: "the scope of control (over
resources, over work, over relationships with the other parts of the
service system), which the team has negotiated" (Brown S, 1986).
Negotiation is clearly a key concept in this process, the negotiation
and bargaining undertaken by CMHTs within the All Wales Strategy,
described in Chapter 4, being a good example. Nevertheless, little
guidance typically seems to be given about "what one might see as a
central pre-occupation of a new team: how it should relate to the
structures and processes of the existing health and social services" (Mansell 1986).

Problems in relating to their management structures have been experienced by a number of CMHTs in London (Cotmore 1985a). They felt: that Health Authorities and Social Services Departments were unable to manage CMHTs effectively because they were so "amorphous" especially when boundaries are non-coterminous; senior managers tend to be "part-time in mental handicap" and hence committed to other services; and there is insufficient representation of CMHTs at management level. The CMHTs felt that their own decision making processes had been undermined, which in turn led to lower morale. Clearly these CMHTs lacked "external cohesiveness," their problems stemming from the organisational structures within which they were located.

Brown (H. 1986) has observed a trend to remedy this, however, with more CMHTs demanding from their managers a clearer set of priorities and objectives. Further, it was heartening to observe in Kent an acknowledgement of the need for CMHTs to have clout in their parent organisations, as District Planning Teams were urged to: "ensure that the information, advice and initiatives of the Community Mental Handicap Team are fully considered, supported and promoted" (Kent 1981).

**Internal cohesiveness**

Brown's (S. 1986) case study of a CMHT revealed the interplay between a team's external and internal cohesiveness, as its relationships with others partly determined its internal functioning. The importance of the internal cohesiveness of teams is increasingly being acknowledged, for example by BIMH's (1985) "Foundation course for CMHT members," which is based on the premise that professionals need to acquire skills in co-operation, in addition to their skills gained in professional training.

Structural arrangements can serve to undermine a team's internal cohesiveness however. This is exemplified by the frustration felt by the three "link" Social Workers (Areas 1, 2 and 5) to the Sanderson Centre CMHT, when considering their inability to "fully participate" in the life of the team compared to the two specialist social workers who are full team members (Areas 3 and 4, Sanderson 1984). Frustration was
also caused in the Normansfield CMHT when its two Social Workers were
given intake team responsibilities at the Area office. Consequently
the Social Workers could no longer accept referrals in the CMHT's
referrals meeting as before, since they had to run the gauntlet of the
intake team. The inability of the Social Workers to "commit" themselves
led to poorer relationships with the CMHNs on the team (Sines 1983).

An issue which has absorbed much negotiation within teams is that of
roles. The nature of the overlaps in roles of the two most common CMHT
members, CMHNs and Social Workers has been discussed elsewhere (Cotmore
1986), but the salient points are reproduced below.

CMHN

The CMHN service has developed since the mid-1970s, in a very
turbulent period for mental handicap nursing as it experienced the
"labour pains" of change to community-based services confronting the
question: "Will the nurses come out with the baby or will they be the
afterbirth?" (Kirk 1984a). CMHNs have been at the "forefront" (CMHNA
1984) of the nursing thrust into the community. Despite the rapid
growth in their numbers, Health Authorities have been confused about the
CMHN role, with the result that some CMHNs are working without job
descriptions (DT 1982). CMHNs themselves have written of the lack of
preparation they have received for their move from work in hospitals to
work in the community (Branch 1984, Short 1984).

Confusion over their role has left CMHNs vulnerable to falling into:
"the trap, like so many other services, of trying to provide for any and
every need" (CMHNA 1984). Consequently many nurses have adopted very
broad roles. Branch (1983), for example, suggested that they be renamed
"total family workers." Regarding their support function to families,
several CMHNs have described their counselling role, for example Thomson
(1980). Many CMHNs have tried to act as a "general information bank"
(Elliott - Cannon 1981) for families regarding other resources and
facilities. The support schemes in which CMHNs have become engaged are
very varied from toy libraries and playschemes for children (Crook 1984)
to accommodation and employment schemes for adults (Waldron 1984). Two
aspects of the CMHN role are often emphasised, helping to underline its
breadth, the practical nature of the help and support it provides, and
its flexibility: "The most advantageous aspect of the community nurse's role is that she is mobile and flexible. CMHNs are the health service equivalent of the SAS" (Branch 1984). It is not surprising therefore that some CMHN schemes provide a 24-hour intervention service. The RCN (1985), through its working party of the CMHN forum, has endorsed the appropriateness of a broad role for CMHNs.

Initially CMHNs adopted an "all and sundry" role, but more recently they have shown "greater selectivity" in establishing priorities within their work (Sines 1984). The RCN document, "typical of sloppy thinking" (Brown M. 1986) failed to provide such priorities, but the CMHNs' own association has attempted to. The CMHNA (1984) started from the premise that CMHNs have been undertaking many inappropriate tasks e.g. medical nursing care, crisis intervention, and a social work role. To rectify this, the CMHNA proposed that the CMHN role be based more closely on the nurse's skills, consisting of primary, secondary and tertiary roles.

The primary role is as an "educator" and in "health monitoring," the secondary role encompasses key worker, team worker, advocate and counsellor, while the tertiary role consists of "systems based activities". The CMHNA suggested that the education role would require intensive visiting, and hence a small caseload, while the establishment of priorities should aid the management of referrals and caseloads. Further: "The overriding rule is to stick to well planned work and avoid being diverted and diluted."

To summarise, CMHNs appear to have defined their roles in two ways: one seeks to respond openly to the vast expanse of unmet need, while the other seeks to define more closely which aspects of that need it is appropriate for nurses to respond to.

Social Worker

The DT has specified three areas in which they see a social work input as appropriate in the mental handicap field:
1. "Social work where there is mental handicap is essentially family work..." (Simon 1981). The basis of this claim is the Social Worker's understanding of family dynamics, and a "family-centred approach" providing "a balance to the 'official' view of handicap which focuses
primarily on the needs of the mentally handicapped child alone" (Browne 1982).

2. Information bank: "The Social Worker's knowledge of the wider range of services, statutory and voluntary, that now exist will ensure that the family are made aware of services and resources that are available." (DT 1978).

3. Community attitudes. As Browne (1982) states succinctly: "One of the functions of the Social Worker is to interpret to the community the needs of the handicapped and their families and to mobilise all the forces that will encourage and facilitate the handicapped and their families to participate in and contribute to community life."

In addition to these three functions, development work has been undertaken by some Social Workers, for example in: supporting independent living (Atkinson 1982); establishing a family placement scheme (Penfold 1983); establishing self-help groups (Presland and Roberts 1983); running playschemes and supporting and influencing day, residential and fieldwork services (Lewis 1982). Frequently overlooked is the social work role with mentally handicapped people themselves. Browne (1982) suggests: "Direct individual or group work with mentally handicapped people who need help with problems of social functioning."

Examples would include a workshop on Sex Education, and the use of Behaviour Modification techniques.

The 1971 White Paper (CMND 4683) and the Jay report (CMND 7468 1979) have argued that the Social Worker is the best placed professional to co-ordinate mental handicap services, and others have agreed (Browne 1982, Glendinning 1978, Shearer 1978). Despite this, a large number of studies have revealed how little support families and their mentally handicapped dependants receive from Social Workers (Bradshaw 1977, Glendinning 1978, Humphreys et al 1983, Phillips and Smith 1979, Wertheimer 1981, Wilkin 1977).

Often, only a crisis service is offered, as Social Workers only become involved when the family can no longer cope (Ayer 1984, Wilkin 1977). In addition, parents have been critical of the quality of social work support they have received (Ineichen and Russell 1980, Phillips and Smith 1979, Wilkin 1977).
The low level of social work support can be attributed to the low priority mental handicap has been accorded within Area Social Work teams (Ayer 1984, DT 1982). This has manifested itself in a number of ways, for example, in Social Workers not employing the skills used with other client groups: "i.e. 'generic' skills were not being applied generically" (Lewis 1982) and in a lack of imagination in their mental handicap work (Browne 1982).

Formal specialisation has increasingly been seen as necessary, to boost the priority to the mental handicap client group, and this has been supported by a number of studies (Armstrong et al 1980, Glendinning 1978, Lewis 1982). Nevertheless, organisational problems need to be resolved, notably how to locate specialists within existing structures. Problems can arise over their status (Adams 1981) or from isolation with little mutual learning between specialist and generic workers (DHSS SWS 1979). Further: "there are obvious dangers in maintaining this division, both in terms of hiving off handicapped clients from the rest of the population and of considerably restricting the field of recruitment of future specialists" (IBID).

Role overlap and negotiation

It is clear from the discussion above that there is a lot of potential for overlap between the CMHN and Social Worker roles, for example in counselling, as an "information bank" and in "development work". In practice, role overlap within CMHTs is frequently found (Brown S. 1986, Cotmore 1985a, DHSS SWS 1979). A CMHN and a Social Worker have argued: "it is clear that many roles in a community mental handicap team are interchangeable. There is no reason why any of the members could not practice behaviour therapy or family therapy given adequate training - social histories and nursing assessments have no particular mystique and arrangements for short-term care in the ideal community unit could probably be done by any team member" (Gilbert and Spooner 1982).

Overlaps between roles occur within the broader debates above, regarding priorities and organisational arrangements. For example if CMHNs are directed to adopt the priorities embedded in the CMHNA's (1984) approach, there will be a lot less overlap with the social work
role. Similarly, if priority to the mental handicap client group is boosted in social work by specialisation, less "role uncertainty" would be experienced, possibly leading to greater confidence in areas such as social skills work, and hence to a greater overlap of roles with CKHNs.

These debates operate not only at the level of "who performs which task?" but also at a broader level of the scope and remit of the different occupations. This applies to other occupations also, for example Consultant psychiatrists in mental handicap. There is some debate as to whether they should focus solely on the provision of psychiatric care to mentally handicapped people, or adopt a broader role with: "a wider and less parochial understanding of human problems than that of other professions" (Harris 1981). A consequence of such a broader view, combined with tradition could result in Consultants seeing themselves, and being seen as the natural leaders of multidisciplinary teams. For the present, however, their position within teams seems to have been increasingly challenged and Brown (S. 1986) has shown that their position in CMHTs has become weaker.

These broader trends in the renegotiation of roles and leadership functions form the backcloth for local negotiations over roles between team members. Sines (1983) has urged that roles should be negotiated locally rather than nationally. Ashton and Young (1984), a CMHN and Social Worker themselves, have taken a similar view: "any resulting definition of roles is often worked out on the basis of existing resources and the personnel working in any geographical area." Experience of Social Workers and CMHNs in multidisciplinary CMHTs suggests that it may "take time" for them to feel comfortable with each others' roles, and that this is facilitated by their being based together (IBID). In some teams, different foci have been adopted: CMHNs focusing primarily on the needs of the mentally handicapped person, and Social Workers on the needs of the family (Joinson 1979).

The degree of role flexibility achieved is a function of the team's "cohesion" and "maturity" argues Wilson (1979), whereby: "professionals are confident of their own role and areas of expertise [and] ... are able to be flexible about roles as they know each other's strengths and weaknesses." If local negotiations over roles result in such
"cohesion," the strengths of all team members and their different occupations should be exploited.

**SUMMARY: A WAY FORWARD**

This study's two principal concerns with implementation and teamwork have been touched on in this chapter with specific reference to CMHTs. The lack of operational policies has necessitated many CMHTs to determine their own work. Further, negotiation was seen to be a key element in relationships between CMHTs and their environments. Several teamwork issues were considered, for example membership, structures and roles. Focusing on both teams' internal and external cohesiveness was helpful for exploring teamwork and implementation issues, particularly as an interplay between the two was shown. Consequently the distinction between internal and external cohesiveness will be maintained for the empirical research into the Notts CMHTs, the results of which are presented in Part IV.
PART IV

POLICIES, PROVISION AND TEAMWORK IN MENTAL HANDICAP SERVICES: THE LOCAL EXPERIENCE
CHAPTER 9

PLANNING FOR THE CMHTs IN NOTTS

Introduction

Following the overviews of the broad policy contexts in Notts SSD and AHA(T), which were provided in chapter 3, the account of the development of CMHTs in Nottinghamshire is resumed. The account unfolds around a number of key turning points, for example the DT's visit to Notts and the SSD's "windfall" of resources. As outlined in Chapters 2 and 4, it is hoped that a dimensions approach may overcome the sterility of the polarisation of the Bottom-up and Top-down models of implementation.

The dimensions will be based on the "five factors" identified by Hambleton (1983) and from which the following questions have been generated as a focus for the following analysis:

1. The policy message: what types of policy existed and at what levels? How were policies communicated and how explicitly?
2. Perspectives and ideologies: did appreciative gaps exist between agencies? Did mediating bodies help to bridge these?
3. Resources: what impact did resources, and resource constraint have on policy making and implementation activity?
4. Multiplicity of agents: what "mechanical difficulties" existed, if any, between co-operating agencies at the planning and service delivery levels? How joint was joint planning? How well co-ordinated were services?
5. Politics of planning: who were the principal actors and what were their goals? What currency did they use in attempting to achieve their goals: negotiation, game playing or power relationships?

Policy context (1): Notts SSD Policy and Provision

During the 1970s, Notts SSD did not have a coherent philosophy or set of policies regarding its mental handicap services, as acknowledged by the Deputy Director on the first day of the CMHTs' induction course. The SSD had failed to establish a county-wide service with common objectives and standards. An internal working group blamed the department's divisional structure, which they
considered to be: "particularly poorly resourced to maintain a sustained interest in the mentally handicapped" (Notts SSD 1979b). The establishment of Policy Planning Groups (PPGs) in 1982 was an acknowledgement that the SSD suffered from: "a fundamental lack of policy, lack of planning and lack of any sense of direction" (Senior SSD Officer 15.2.84).

The lack of broad policy was reflected by a lack of operational policy for hostels and ATCs. The SSD did possess an operational policy guide, updated in 1976, although it was so broad as to be of little value. As a result, managers of ATCs and hostels were very powerful in determining internal regimes, as the internal working group observed in 1979 (Notts SSD 1979b).

A decline in social work input and a build-up in physical resources also characterised Notts SSD's approach to mental handicap services in the 1970s. The adoption of the generic social work approach in the early 1970s was followed in 1975 by the introduction of a priorities system for Social Workers: "This has meant that apart from emergency work, there is comparatively little social work involvement with the mentally handicapped" (Notts SSD 1980b).

The number of ATCs increased during the 1970s, and was scheduled to rise still further in the 1980s, so that the "Better Services" White Paper target for day care would be met by 1991 (IBID). This contrasted with the vast shortfall of SSD residential provision for adults, using the same national norms, of 457 places in 1982. The SSD's response was that it needed a wider range of provision rather than more hostels, including: "more lodgings, group homes and what we call family group homes" (IBID).

This stance adopted by the SSD towards accommodation reflected a consensus within the Department concerning "community care," which is perhaps surprising given their lack of policy and dearth of operational policies for mental handicap services. The consensus view emphasised non-residential services and alternatives to traditional residential care. The SSD had had a limited amount of experience with such alternatives, notably with two group homes. This experience had taught them that a structure was required to plan and support new initiatives adequately, thereby removing the vulnerability of residents and schemes which had derived from ad hoc arrangements.

This philosophical commitment to a particular model of community care was underpinned by pragmatic considerations concerning resources. The SSD realised that it could not afford to meet its targets for provision of residential care.
through the traditional hostel route. Consequently, alternatives such as unstaffed group homes, adult fostering and lodgings, were attractive as low cost options to the SSD, which assumed that they would be "self-financing" through DHSS payments.

What came to be known as the "development role" was born out of these considerations, both pragmatic and from a particular model of community care. The question for the SSD became: how should the development role be implemented?

Policy context (2): Notts AHA(T) Policy and Provision

There was equally a lack of clear policy regarding mental handicap services within Notts AHA(T) in the late 1970s. Health Authority planners discovered this in 1980 having been asked by Administrators to prepare detailed proposals for the implementation of the existing strategy. Consequently there was an absence of detailed operational policy for hospitals and other Health Authority services. In the previous year the AHA(T) (1979) had stressed the importance of community care, and adhered to the DT proposal that 45% of mentally handicapped people in hospital were capable of living in the community.

There was less of a debate within the Health Authority regarding community care than in the SSD. It was generally used as a catch-all phrase to encompass everything other than hospital care including community units, and differed therefore from the SSD's use of the term. Despite their professed belief in community care, it was clear that the AHA(T) was pre-occupied with hospital provision. This was obvious from the eight issues the AHA(T) (1979) planners considered to need addressing.

In contrast to the SSD, the AHA(T) (1980b) calculated that using the 1971 White Paper norms, it would exceed its target of residential provision for children by 49 beds in 1988, and for adults by 121 beds in the same year. The AHA(T) suffered from a maldistribution of provision however, with a large majority of hospital places in only one of its four Health Districts. Further, there were other problems with the three hospitals involved including their location, age, condition and layout (Burkitt 1977, Notts AHA(T) 1980b). Consequently the relocation of hospital patients formed a major planning task for the Authority.
There was an absence of "grassroots" commitment among some Health Service professionals to Community Care to counteract the managers' preoccupation with hospitals. For example, an Administrator claimed that many Health Service professionals felt "threatened" by community provision: "We're trying to tell all of them that they have a role here in the community but much education is needed because they are .... still speaking about treatment in hospitals." He considered that such fears had been generated because work in the community cut across established work practices which had developed "on a hierarchical basis."

To overcome these fears about community provision would have required strong leadership, but the Consultants in mental handicap failed to provide it. This was partly because they were understaffed, partly because they too were preoccupied with hospital provision, and partly because there was little agreement between them. A member of the Development Team commented on the poor relationships between the Consultants: "There is the terrible thing between the two Consultants .... which Gerry Simon had to take on. He had to get them together and tell them things were so bad in [a hospital] that the parents of the patients would not meet us there .... When he told them that they were somewhat ashamed." Resulting from the doctors' failure to provide leadership, an Administrator contended that "the gauntlet was having to be taken up by Administrators."

Leadership was all the more necessary as the lack of unanimity between the doctors reflected a lack of consensus across different disciplines within the Health Authority. As an Administrator observed: "There is a lack of unanimity of view and this runs throughout the NHS, indeed it characterises it. This is because everyone approaches the problem from a different viewpoint." The examples he gave were the differing views of the Health Service professions to the development role proposed by the SSD: "The medical staff .... are not convinced, the nursing staff are open to persuasion, the occupational therapists and physiotherapists have no precedent, the psychologists have no staff, and the speech therapists are already doing it."

Initial proposals for teams
The seeds of the CMHT idea were sown early in Notts but they were slow in germinating. For example in 1978 Notts SSD argued the case for a county-wide team in a bid for joint finance. A team of Social Workers would have established and supported a range of "less sophisticated and expensive forms of
care" than traditional hostels, including group homes and lodgings. The team was not established although the bid did bear fruit with the creation of the Senior Professional Officer post within the SSD.

The Senior Professional Officer's brief was to research the need for developments in community-based services. His "main proposal" was for a County Development Team: "to explore and develop alternative residential day care and support services ...." (Notts SSD 1979a). In this way the development role was seen to extend beyond accommodation. An exclusive focus on accommodation returned in the report of the SSD's (1979b) internal working group which argued for a Community Care team. This team would acquire alternative forms of accommodation, prepare hostel residents for their transition, and support them once moved.

Despite some differences, all three reports had recommended a team to develop resources and to have a county-wide brief. A county-wide community team was approved both by the SSD and in the joint planning arena. The team was to be small and composed of Social Workers, led by the Senior Professional Officer with a brief to develop residential resources, as per the joint finance bid. The Social Workers' posts were lost however due to manpower controls imposed by the County Council despite the AHA(T) having agreed to fund them through joint finance. In spite of this setback, the notion of a development team had become firmly ensconced in the SSD's thinking. At the same time, the SSD became aware of the NDG's proposals for CMHTs: "the NDG put us onto something different from hostels and ATCs .... In effect we had two separate blocks of services and we began to think that we should consider having a third block of services" (Senior SSD Officer). But how could the SSD implement the third block of services given tight financial and manpower controls? Their response was to label their proposal for a CMHT as a pilot scheme, so that no further provision would be made until the results of the pilot scheme were known.

Bassetlaw was chosen as the pilot area for a number of reasons including coterminosity of boundaries. The proposal for the Bassetlaw pilot CMHT was embodied in a paper by the Senior Professional Officer (Notts SSD 1980a). Of the existing situation in Bassetlaw he pointed to a lack of support for families and poorly co-ordinated services. His proposals included multidisciplinary assessments and reviews and individual programme plans. The CMHT was envisaged as being involved in these areas, particularly in assessment and in
co-ordinating advice and support, although its role was not teased out and stated explicitly. The use of terminology was somewhat ambiguous, particularly the term development, but what was later known as the development role was not mentioned.

Team membership was considered in detail, with recommended staffing for the core team as follows: "Health Visitor (1); Social Worker (2), one being a Senior Social Worker; Community nurses (2); pre-school teachers (2)" (IBID). The question of leadership was alluded to by mention of the Senior Social Worker. The pilot scheme document was generally well received, both within Bassetlaw, by the CHC and Area Social Services office for example, and in the rest of the County. Only the Education Department, concerned with overlaps with their "statutory duties," and the South Nottingham Health District confused with overlaps with their proposals for a District Handicap Team, were less than enthusiastic. Comments and criticisms were incorporated by the Senior Professional Officer into a second draft proposal, although in the meantime the DT had visited Notts.

Visit by the DT to Notts

The DT's terms of reference were worked out to encompass both long-term and more immediate issues. The most pressing specific issue at this time was the need to make improvements at one particular hospital. Following its visit in November 1980 the DT issued separate reports to the AHA(T) and the SSD. In its report to the AHA(T), the DT (1981a) was critical of: the joint planning mechanisms; the lack of clear objectives and operational policies; the lack of "positive multidisciplinary leadership" within hospitals; and of standards of care in particular hospitals.

The DT made a host of recommendations, including changes in: the JCPT sub-group's membership; management structures; and increases in the establishment of Consultants. The model of Health Service provision for Notts recommended by the DT was drawn from their national model, with three tiers:

1. CMHTs: 13 in total with catchment areas based on SSD Area boundaries, and with 1 CMHN in each;
2. Community Units: 10 across the county, using existing buildings where possible;
3. Base hospitals: 2 were considered sufficient, providing a total of 350 places between them.
In its report to the SSD the DT (1981b) considered the SSD's management structure to be too "centralised." Further the DT was critical of the lack of operational policy and of the low priority Social Workers were required to give mental handicap cases. To remedy the latter the DT recommended the establishment of CMHTs as per the recommendations to the AHA(T), across the County as a whole rather than in one pilot Area. Further they did not consider new staff to be required for the teams, as existing Nurses and Social Workers could be used. The DT also disagreed with the SSD's proposals for a County-wide team, preferring instead that the "development of services" function be located within a Development Officer post based at County Hall.

The DT made a large impact on Notts AHA(T). This was most obvious by the improvements secured at the hospital over which there had been most concern. More broadly the DT had put a spotlight on services for mentally handicapped people, and the AHA(T) established a steering group in January 1981 to ensure that the implementation of the DT's recommendations would not be delayed by the impending Health Service reorganisation. The SSD did not accept the DT's criticisms of its proposals however, and by the time they had received the DT's report their position had shifted: to incorporate both the development role and the family support role within the pilot CMHT and to drop their proposal for a County Development Team.

The SSD had two "basic disagreements" with the DT over CMHTs, as enunciated by the SSD's Director (1981). First, he claimed that the DT model was too "narrow" and "limited" in failing to acknowledge the need to develop alternative forms of accommodation, both: "to prevent mentally handicapped people needing residential or hospital care and to facilitate the rehabilitation of those already in hospital or residential care." Second he argued that the "primary responsibility" for community-based service provision should lie with the SSD, which he considered not to coincide with parts of the DT's report. As a consequence of these differences over the CMHT function, the SSD also rejected the DT's recommendations for one Development Officer because of the size of the County.

Despite these differences, senior SSD officers conceded that the DT had promoted CMHTs as a third block of service to complement ATCs and hostels. Further, they felt that the DT's visit had forced them to make their own suggestions to overcome the unsatisfactory situation. To that extent therefore the DT had helped the SSD clarify the reasons for its dissatisfaction with the
DT model. Nevertheless, the DT had failed to provide a blueprint around which consensus could be formed, and consequently it was unsuccessful in bridging the appreciative gap between the AHA(T) and SSD.

One reason for this lack of success was the different relationships the AHA(T) and SSD enjoyed with the DT, as a senior SSD officer explained: "... we told the DT to push off, and that's one of the strengths of local government which crown servants can't do. Because of this we have no sense of awe of the DT which the Health Service had." He explained such awe as follows "... the Health Service ... are responsible to the same masters as the DT and some awkward questions could get asked."

The steering group

The steering group comprised over 30 members, of whom a large majority were Health Service representatives. Its terms of reference were: "To co-ordinate action within the Area during 1981 and to pass on to future District Health Authorities a clear statement of progress and outstanding action" (Notts AHA(T) Steering Group 4.3.81). The steering group had been established by the AHA(T) rather than jointly with the SSD, in anticipation of the DT's report and in an attempt to push through change, especially in the Health Service which was about to be re-organised. To what extent did the steering group achieve a "Clear statement of progress" for CMHTs?

The SSD's new model of CMHT was aired in the second draft of the pilot Bassetlaw CMHT proposal, written by the Senior Professional Officer. The CMHT's functions were identical to the support/co-ordination role outlined by the DT (1978), with the addition of a third function: "the development of alternative forms of residential care for mentally handicapped people and ..., a direct or indirect support role to such developments" (Notts SSD 1981a). Similarities to the DT's approach continued with recommendations for the team base, which closely resembled a community unit, and for team membership and roles. The prickly issue of team leadership was broached, with the SSW proposed as team leader. To make this palatable to the other agencies, leadership was defined primarily as a co-ordinating function.

Little emphasis was placed on the development function in this paper, as it was slipped in behind the support/co-ordination functions, and no account was taken of how it might affect roles within the team. The development role was given more prominence in the letter by the Deputy Director which
accompanied the paper to the steering group. He criticised the DT model for being too limited, from failing to acknowledge the need to develop new services in addition to co-ordinating existing ones. The steering group considered differences in models to be of "tactics" rather than "strategy," and did not discuss the development role specifically.

Proposals for a CKHT in Nottingham were embodied in a paper by a Health Service Administrator, and presented to the second meeting of the steering group: "There is now such widespread support for the concept of Community Mental Handicap Teams, it seems superfluous to further rehearse the argument about their value" (Nottingham DHA 1981a). The teams' objectives were skated over very briefly, and adhered to the DT guidelines without incorporating a development role. The SSD were prepared to accept the scheme, considering it a useful comparison with the "rural based" Bassetlaw pilot scheme. Nevertheless they indicated that the Bassetlaw team would be the SSD's "first priority" and that it was impossible to forecast a timetable for the Nottingham scheme.

There was growing frustration among Health Service representatives however, at the length of time it was taking to establish the Bassetlaw pilot CKHT. The responsibility for the delay was laid at the SSD's door, especially after the SSD had indicated that additional staffing resources would not be available until autumn 1982: "particular concern was expressed at the inability of the Social Services Department to provide additional resources within a reasonable timescale" (Notts AHA(T) Northern Working Group 18.6.81). This frustration resulted in agreement to consider establishing a CKHT in Mansfield employing existing resources in the AHA(T) and SSD in order to test what could be achieved quickly.

Thus by mid-1981 the steering group had agreed to the establishment with additional resources of two different types of CKHT: in Bassetlaw with a development role and in Nottingham without. Further, it had agreed to consider establishing a third team within existing resources at Mansfield.

The SSD's "windfall" of resources

The new County Council levied a supplementary rate in 1981, as described in Chapter 3. This was levied as a matter of principle followed by a brief exploration of needs, rather than using need as the starting base from which to calculate the scale of supplementary rate required. In turn it failed to
facilitate rational planning within the SSD as decisions on how the money would be spent had to be taken within three months.

There was a lot of hunting around within the SSD to find projects which could be implemented, reflecting their opportunism. Regarding CKHTs specifically a senior officer claimed that the SSD were "jammy" in their timing, as they had already decided on their desired model of CKHT. What impact did the extra resources make on the SSD's plans for CKHTs? It transformed the scale of their thinking: from establishing one pilot CKHT 15 months later, to establishing three CKHTs within three months. This served to expose the rationale behind the proposals for a "pilot" CKHT. One senior SSD officer called it a "stalking horse" and claimed: "We were going to use the wedge tactic, whereby we do what we want on a small scale and then get others to apply political pressure to expand the service. But now we can do what we like. Under the Tories one daren't overspend, but under Labour the exact reverse is true."

The three CKHTs were based on the boundaries of the three DHAs, with the exception of the Nottingham team which would cover the north of the area only (Notts SSD 1981b). The teams would be composed of Social Workers, line managed by the Divisions at County Hall and with support from the Senior Professional Officer. The proposals played down Health Service input, arguing that it was: "not an essential prerequisite that the teams are multidisciplinary."

The objectives for the teams were explicitly developmental: "The major task is to develop and support alternatives to residential care ...." This was reinforced by the claim that the teams would not take over services: "conventionally .... provided by Area offices," even when such services were inadequate. Nevertheless a door was left open: "Depending upon progress with the major task and resource availability, the teams may subsequently broaden their role into providing other services e.g. for people living at home ...."

The Area Social Services offices opposed the establishment of separately constituted CMHTs, preferring instead to be given the manpower themselves. Having received the SSD's (1981b) paper on CMHTs however, Area Directors realised that the teams would be established no matter what they felt, hence they focussed on the issue of control. For example the Bassetlaw Area Director argued that the CMHT should be line managed through the Area rather than County Hall, because of the Area's "valuable contacts" and "knowledge," and to help integrate the CMHT's work with the Area's. The Bassetlaw Area Director
was successful in forcing this concession from senior managers. This reflected the large degree of power Area Directors were generally considered to hold, as a senior SSD manager observed: "Area Directors ..... are very powerful in this county .... they can subvert anything they want to ...."

The Areas' response to the establishment of the CMHTs was part of a bargaining game between themselves (the localities) and County Hall (the centre). Indeed the initial decision by senior SSD managers to base the teams on Health District boundaries was also part of this process. Senior managers feared that if the new posts were organised through the Areas rather than through free-standing teams, the development role would be diluted by a conventional casework service: "Adhering to Area boundaries is both narrow and restrictive in that it would .... almost certainly force such a worker into a narrow Social Worker role" (Notts SSD 1981b).

Yet worse from County Hall's perspective was that it seemed unlikely that the specialist posts would have remained 100 per cent devoted to mental handicap, as a senior officer observed: "..... our whole departmental history is littered with specialists getting under way and then getting swamped with generic tasks." The use of Health District boundaries therefore was an attempt by the Centre to by-pass the localities so as to implement particular objectives.

What was the AHA(T) 's response to the SSD initiative? Some disquiet was expressed over a number of issues, notably the exclusion of the conventional social work casework role, and the role of casework-oriented Health Service professionals within teams "Dealing mainly with planning issues" (Notts AHA(T) Steering Group 10.9.81). The SSD's response was to interpret "service" more broadly than casework and to emphasise the importance of multidisciplinary teamwork.

There was a lot of concern within the AHA(T) that they were being pushed along by the SSD, with little consultation. Indeed, by the time the steering group discussed the SSD (1981b) proposals, the SSD had already advertised the new posts. The SSD had been able to do this because the resources were their own, unlike joint finance which would have necessitated a lengthier bargaining process with the AHA(T) holding the purse strings. With the extra resources at their disposal and with no external strings attached to them, the SSD clearly felt that they could implement their model without compromises. This factor,
combined with the speed which was required to spend the resources, led to the SSD forging ahead.

To summarise, the SSD attempted to seize the opportunity provided by their sudden influx of resources to establish CMHTs with a development role by bypassing the Area offices. The haste with which they moved undermined joint planning processes with the AHA(T). Was the steering group able to surmount the uphill task of achieving a compromise between the SSD and AHA(T)?

SSD and AHA(T): Reconciliation?

Much effort was expended late in 1981 to achieve a compromise between the SSD and AHA(T). The primary instigator of this effort was a Health Service Administrator, thereby supporting the contention that Administrators rather than doctors had taken up the leadership gauntlet. His efforts resulted in two papers, the first of which (Nottingham DHA 1981b) showed that a lot of agreement had been reached between the AHA(T) and SSD, on boundaries and membership for example. Regarding the teams' objectives he argued that there was only "a slightly different emphasis" between the DT and SSD models, thereby seeking to impute (as subsequent events fully demonstrated) a consensus over objectives that did not exist.

The second paper (Nottingham DHA 1981c) was written following a meeting with SSD representatives and was more honest in acknowledging "some significant differences" between the SSD and DT proposals, notably that: "The NDT concept does not include as a major task, the development of alternatives to traditional residential care." There was a strong developmental thrust within the paper, but also an acceptance of the need to support mentally handicapped people living with their families, as per the DT model: "Both of these dimensions are important if we aim to provide a service, prevent people going into hospital and ultimately begin to move people from hospital." This balance was reinforced by the suggestion that "some" of the Social Workers should undertake a development role "in the first instance." A compromise would appear to have been struck between the two agencies therefore, stemming from an acknowledgement of the importance of these two dimensions of community care.

The DT revisited Notts and attended the final steering group meeting in December 1981. It has become commonplace to talk of the Notts and DT models of CMHT as if they were diametrically opposed. It is surprising therefore that the DT's Director and Associate Director appeared to approach the Notts proposals very differently. This was most noticeable over the CMHTs'
development role, which the Associate Director accepted. The Director's only comment on this issue however was to observe that: "the Health Service policy for CMHTs was in line with the NDT's policy." Clearly he was much less willing to accept this variation on a theme from the DT's national model than his colleague.

Was the compromise that appeared to have been reached between the AHA(T) and the SSD reflected in the Steering Group's "statement of progress" (Notts. AHA(T) (1982) passed to the new DHAs? The paper opened with an acceptance of the importance of CMHTs, and on the agreements reached over team composition. The paragraph on the CMHTs' "task" has been reproduced in full because it summarised succinctly the differing views of the AHA(T) and SSD: "The National Health Service view of the primary task of the Team is that it would provide a wide range of support and advice on an individual basis to all mentally handicapped people within its catchment area. The Social Services view is that, whilst accepting the concept of individual support as the long term role of the Team, of necessity the Team's first task would be to attempt to stop any further patients being admitted to hospital and that their next objective must be to facilitate the transfer of existing patients out of hospital. In order to do this, the Teams initially have to spend time in providing additional facilities not only in terms of residential accommodation but also in terms of day centre, training units, domiciliary support, fostering arrangements etc., and then to use these facilities to aid people currently in the community, to prevent admission to hospital, and when that has been achieved, to start the process of discharge into the community. The logic of the Social Services approach is accepted with some reluctance and it is the intention to press both from outside the Team and through National Health Service involvement in the Team to ensure that this initial phase is as short as possible."

The tone and nature of this paper are somewhat different to the two previous papers (Nottingham DHA 1981b, 1981c) which had striven for compromise. However this statement of progress lay bare the differences between the AHA(T) and SSD, and made no attempt to conceal the differences in viewpoints. The impression given was of the AHA(T) having to accept a situation not to its liking, both because of the SSD's model and because of its own lack of resources, as the report was peppered with statements indicating that the ideal service was not achievable and that they would have to make do.
What impact did this lack of agreement have on the development of operational policies for the CMHTs? Despite the stance adopted in the Steering Group’s final report, which differentiated between two different approaches and expressed the different Health Authority and Social Services priorities quite bluntly, several Steering Group members felt that little progress had been made in determining specific priorities and procedures. A Health Authority Administrator considered that: "The Steering Group has left things very much in the air. Indeed the papers were simplistic generalizations.... The papers that were specific were knocked out, no ground rules were laid down at all." A Senior Officer in the SSD agreed, in claiming that despite the Steering Group, the CMHT was: "still a very woolly concept." A colleague agreed about the "woolliness" but claimed that this was desirable: "The Steering Group has left things very much in the air and very woolly - but that's the way we want it .... It must be left to team leaders .... to develop their own modus operandi." In similar vein, a Health Authority Administrator claimed that as a result of the divergence in objectives between agencies: "The staff in the posts will create their own ground rules."

**An evaluation of the Steering Group**

As a forum for joint planning, how well did the Steering Group fare on both sides of the equation: jointness and planning? The steering group lacked jointness both in terms of focus and composition. With the exception of CMHTs and registers, it was preoccupied with Health Authority issues, particularly the role of base hospitals, hospital transfers and community units. It neglected a range of issues of joint concern, such as the co-ordination of day care and short-term care. The steering group's composition included a vast array of Health Authority representatives with very few from the County Council. Further, there was very limited participation from agencies other than the AHA(T) and SSD, such as the Education and Housing Departments and the voluntary sector. The lack of jointness in approach was highlighted by the SSD's unilateral actions following their windfall of resources. The outcomes from the steering group as a planning mechanism were limited also. Regarding CMHTs in particular, the steering group failed to bridge an appreciative gap between the SSD and the AHA(T).

The SSD were enthusiastic about the incorporation of the development role within the remit of CMHTs because of resource considerations and also its
philosophical congruence with their approach to community care. Further, they enjoyed an element of excitement and pride in acting as innovators with this experimental type of team and from being able to reject the standard DT model. Within the SSD, the prime mover on the teams was the Deputy Director, who became widely associated with the model. It was largely from his authority and commitment that the SSD refused to shift from the importance of the development role.

The AHA(T) clung to the DT model of CMHT. One explanation posited above was that both bodies were accountable to the same agency (i.e. central government). There may also have been an element of the AHA(T) playing safe, as it recognised that the DT model of CMHT was being implemented elsewhere, and thus appeared a less risky option. More broadly, the DT model of CMHT was attractive to the AHA(T) as it could take the other constituent parts of the DT approach off the shelf, namely the community unit and base hospital. The community unit was considered to be part of the community care strategy, thereby highlighting the differences with the SSD strategy which emphasised non-residential services and alternatives to residential care.

The Steering group's lack of success over CMHTs was mirrored in its other failures: to achieve agreement on the role of community units and to dispel the confusion surrounding the problem of hospital transfers. Moreover, what progress it did make on the issue of registers was dissipated by the Health Service reorganisation. Its most conspicuous success was in achieving agreement on the role of base hospitals. A senior SSD officer attributed the steering group's limited outcome to the nature of the forum: "The steering group is not really a planning meeting because people have made their decisions beforehand. It has always reminded me of Parliament, in the sense that people go in and spout their departmental viewpoints whether or not they answer the question." He continued by observing that the appreciative gaps between the AHA(T) and SSD were compounded by a lack of unanimity within the Health Authority as noted above. Of representatives at the steering group he claimed that this was: "most notable between Administration and Nursing representatives. The result is a certain wooliness, in that even when decisions are taken different meanings are attached to these by the different people involved."
SUMMARY AND PRELIMINARY ANALYSIS

At the beginning of the chapter, five dimensions were listed with accompanying questions. These questions can be addressed here:

1. The policy message. Neither the SSD nor the AHA(T) had coherent philosophies or sets of policies regarding their mental handicap services. The SSD did enjoy a consensus view on community care, emphasising non-residential services and alternatives to traditional residential care. The AHA(T) was preoccupied with hospital provision, despite a professed belief in community care. The lack of broad policy was reflected in both agencies by a lack of operational policy. A consequence of this dearth of Top-down policy was that there was much scope for Bottom-up initiatives by the units of service. Managers of ATCs and hostels were powerful in determining internal regimes for example. Further, it was accepted in both agencies that a consequence of the "woolly" operational policies for the CMHTs would be that the teams would in large part determine their own objectives.

2. Perspectives and ideologies. Appreciative gaps existed between the SSD and the AHA(T) over models of community care. The Health Authority used community care as a catch all concept to encompass everything other than hospital care, including institutions such as community units. The SSD on the other hand emphasised non-institutional services. These different models reflected their different priorities: while the AHA(T) was grappling with the management of hospitals and patient relocation, the SSD wanted to build a network of alternative forms of accommodation to supplement existing hostels.

Differences in perspective filtered down to the role of the CMHTs. As presented starkly in the steering group's final report: the AHA(T) favoured the DT model of CMHT, whereas the SSD wanted the CMHTs to undertake a development role. Appreciative gaps existed within as well as between the agencies. It was suggested for example that a lack of unanimity characterised the approaches of the different disciplines within the Health Service, and that this applied to the CMHT issue. Within the SSD there was disagreement between the Areas and senior managers over the objectives, organisation and line management arrangements of the CMHTs.

Were the appreciative gaps bridged? The DT achieved a number of changes including improvements at hospitals, but did not succeed in bridging the differences between the SSD and AHA(T). Little progress had been made towards achieving a consensus within the Health Authority on the question of CMHTs,
despite the impression of a unanimous view given in the final steering group report. Within the SSD the Areas forced some concessions over line management arrangements from senior managers, but otherwise their viewpoints remained opposed.

3. Resources. Until mid-1981, the scarcity of resources at the disposal of the SSD and AHA(T) hindered Top-down implementation of their plans for CMHTs. The AHA(T) were not slow to berate the SSD for an apparent lack of commitment. The SSD's "windfall" of resources transformed the scale of their thinking however from one CMHT in 15 months to three CMHTs in three months, and the "pilot" CMHT was exposed as a wedge tactic. That the SSD was forging ahead with their own plans disturbed the Health Authority, but there was little they could do given that the SSD were using their own resources and had to do so quickly. Hence the windfall of resources facilitated the implementation of the SSD's policies, but at the expense of joint planning processes.

4. Multiplicity of Agents. The Steering Group replaced existing joint planning mechanisms. It was however limited regarding both the jointness and the planning sides of the equation. It was not established as a joint initiative, but by the AHA(T). This lack of jointness was further reinforced by the lack of balance in its composition, and by its focus on issues predominantly of concern to the Health Service. The lack of jointness in the AHA(T)'s approach was mirrored by the SSD's unilateral actions following their windfall of resources. The steering group's planning outputs were limited also, in failing to achieve agreement on a number of issues in addition to that of the CMHTs. Various factors may help to account for this, including appreciative gaps within and between agencies, and the nature of the forum.

5. Politics of Planning. Leadership in policy-making and planning for mental handicap services within the AHA(T) was rarely exercised by doctors for a number of reasons, including under-staffing and conflict between themselves. Instead that gauntlet was accepted by administrators, with the Deputy Sector Administrator being a particularly active actor. For example, towards the end of 1981 it was he who spearheaded the Health Authority's attempts to reach a compromise with the SSD.

Within the SSD the Deputy Director was committed to the incorporation of the development role within the CMHTs and became closely associated with the teams. The Senior Professional Officer clearly influenced the establishment of the CMHTs also, through his initial report and his two draft proposals. His
impact was at a detailed level as he worked within guidelines supplied by the Deputy Director.

Senior SSD managers' excitement with their innovatory model of CMHT made them less willing to compromise, particularly with the AHA(T). They were unable to implement their initial plans fully however, because they could not circumvent the Area offices. The Areas managed to force some concessions over the line management arrangements of the CMHTs, although they were still unhappy with the teams' organisation and objectives. The concessions represented gains by Bottom-up inputs into a Top-down policy making process.

Prior to the CMHTs' establishment therefore, there was much scope for Bottom-up initiatives within both the AHA(T) and the SSD because of the vagueness or non-existence of policies. The establishment of the CMHTs was largely a result of a Top-down policy, albeit not a joint one between the two agencies. The focus now turns to the CMHTs themselves, and an exploration through an "Action perspective" of their development.
CHAPTER 10

THE ESTABLISHMENT AND DEVELOPMENT OF CMHTs IN NOTTS

Introduction

The adoption of an "Action perspective" requires some simple questions to be asked regarding the development of the CMHTs. For example, what was the composition of the teams and how was it determined? Where were the teams based and what were their boundaries? What did the teams do? A problem immediately presents itself: how to classify action? Little guidance is offered in the literature, even by proponents of the Bottom-up model of implementation who argue that action should be the primary focus. A partial solution was adopted for this study: the classification of the teams' activities. This is somewhat narrower than a classification of action, focussing primarily on the question of what? rather than on the question of how? and when? although these questions are touched on below. A modified version of a framework devised by Notts SSD (Deputy Director 1982c) for the analysis of the teams' activities has been employed.

Teams' composition, bases and boundaries

The Social Services contingent of the first three CMHTs was as follows:

Table 10.1 Teams' initial composition

<table>
<thead>
<tr>
<th>Bassetlaw CMHT</th>
<th>North Nottingham CMHT</th>
<th>Central Notts CMHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SSW</td>
<td>1 SSW</td>
<td>1 SSW</td>
</tr>
<tr>
<td>1 SV</td>
<td>3 SW</td>
<td>2 SV</td>
</tr>
<tr>
<td>1 SVA</td>
<td>1 SWA</td>
<td>1 SVA</td>
</tr>
<tr>
<td>1 Clerk</td>
<td>1 Clerk</td>
<td>1 Clerk</td>
</tr>
</tbody>
</table>

The full Social Work complement of the Bassetlaw CMHT was in post by the beginning of January 1982. The SSW, SVA and one of the SWs of the North Nottingham CMHT also took up post in January 1982, but thereafter the SSW described the progress of team-building as "strangely slow." They "struggled" to find their extra two SWs, and their team Clerk was "also difficult to find." In addition, the SSW had to undertake part of his former role as Senior Professional Officer until
July 1982, regarding agency placements and admissions to hostels because of industrial action within the SSD. The Central Notts CMHT SSW was appointed in May 1982, but was the only team member for three months, describing himself as "lonely" and "isolated" for this period. The primary reason for this was the difficulty of finding suitable applicants for the SW posts.

With the exception of the Bassetlaw CMHN, who was appointed in mid-1982, membership from other disciplines resulted from negotiations stemming from the workers' own initiative. The Bassetlaw Pre-school Teacher Counsellor described how she joined the CMHT: "I approached County Hall and the Special Schools Department and asked if it would be all right to join the CMHT. They replied saying it was but I received a very flat letter which virtually gave me permission, and was not very excited about it. This letter reminded me that my main priority was to the Education Department."

The Senior Speech Therapist's description of the negotiations surrounding her becoming a North Nottingham CMHT member in mid-1982, applies also to the CMHN who joined the Central Notts CMHT in April 1983: "I said to my boss that 'I wanted to do it, I see it as an appropriate role for myself,' I gate crashed."

Where were the teams based? The first two teams had been established so quickly that their accommodation was not ready and temporary arrangements had to be made. The Bassetlaw CMHT Social Workers were located in the Area Social Services office for a couple of months. It had been intended that the CMHN be based jointly in a Health Centre and with the CMHT, although very quickly she regarded the CMHT as more of a base than the Health Centre.

The North Nottingham CMHT Social Workers spent their first two months based in County Hall, before moving to a large suite of offices half a mile from the centre of the city. The acquisition of this property annoyed Health Service administrators, who claimed that Social Services had acted unilaterally without consultation: "There has been no jointness..... they told us nothing. Indeed the first I heard was from [the CMHT SSW] saying that they had got it. They wanted to use the rest of the building for a team for the mentally ill but I wrote to them
saying that we had agreed that the building should be joint financed and for them to send me the bill. It's now going to cost us an extra £20,000. But what do we do? We either abandon ship or say that it's done and live with the consequences."

The Central Notts CMHT was based in a District Council house in Rainworth. The CMHT SSW was "unhappy" with the office accommodation, because it was part of a "mental handicap ghetto," and was very inaccessible to centres of population.

A fourth team was established with responsibility for that part of Nottingham DHA not covered by the North Nottingham CMHT, corresponding to the South Nottingham Health District. The following bid for staffing for the South Nottingham CMHT was approved by the Social Services Committee in January 1982: 1 SSW, 4 SWs, 1 SWA and 1 Clerk. This team was based in the same building as the North Nottingham CMHT. The SSD also decided to establish a fifth team in Newark composed of: 1 SSW, 1 SW, 1 SWA and 1 Clerk. Initially this was to have been a sub team of the Central Notts CMHT, but according to a senior SSD officer the Deputy Director wanted to "appease the Area Directors." He decided therefore that Newark should be a separate team line managed by Newark Area office. This arrangement mirrored that in Bassetlaw and also resulted from the exercise of power by Area Directors. Table 10.2 shows the CMHTs' boundaries and territories.

It is clear that their territories vary enormously, for example regarding their size and populations. The CMHTs were initially to have been coterminous with the DHAs and despite the addition of the South Nottingham and Newark CMHTs, the teams all still fell within DHA boundaries. The situation is more complex on the Social Services side, however, where the CMHTs cut across Divisional and even Area boundaries. This is most noticeable for the North Nottingham CMHT, which relates to all 3 Divisions and is particularly problematic as it is line managed Divisionally through City Division.
Table 10.2 CMHTs' boundaries and territories

<table>
<thead>
<tr>
<th></th>
<th>Bassetlaw</th>
<th>North Nottingham</th>
<th>Central Notts</th>
<th>South Nottingham</th>
<th>Newark</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIZE: HECTARES</td>
<td>66,000</td>
<td>16,000</td>
<td>17,000</td>
<td>53,000</td>
<td>66,000</td>
</tr>
<tr>
<td>POPULATION</td>
<td>100,000</td>
<td>240,000</td>
<td>177,000</td>
<td>370,000</td>
<td>104,000</td>
</tr>
<tr>
<td>D.H.A.</td>
<td>Bassetlaw</td>
<td>Nottingham</td>
<td>Central</td>
<td>Nottingham</td>
<td>Central</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Notts</td>
<td></td>
<td>Notts</td>
</tr>
<tr>
<td>SSD Areas and</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Divisions</td>
<td>Bassetlaw</td>
<td>North &amp; N. Mansfield</td>
<td>N.West,</td>
<td>Newark</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(North)</td>
<td>East (City) &amp; part of West,</td>
<td>(City)</td>
<td>(South)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gedling (S) Ashfield</td>
<td>South &amp; S.West</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hucknall (North) part of (City)</td>
<td>Rushcliffe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ashfield</td>
<td>Broxtone &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(North)</td>
<td>Rushcliffe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMHTs' Activities: Framework

To follow the "Action perspective", an outline will be given of the main activities undertaken by the CMHTs in the first 18 months of their existence. These activities will be discussed within the framework devised by the SSD (Deputy Director 1982c, see Chapter 13): Accommodation; Home services; Away from home services. To these have been added a section incorporating activities not directly targetted at clients, entitled: support services.

Table 10.3 shows the CMHTs' activities located within the framework described above. A brief outline will be given of the constituent parts of the table, followed by a summary of the similarities and differences between the CMHTs in both the scope of and balance between their activities.
### Table 10.3 Framework for CMHTs’ Activities: 1992 - June 1993

<table>
<thead>
<tr>
<th>BSSEX LAW CMHT</th>
<th>CENTRAL NOTTS CMHT</th>
<th>NOTTINGHAM CMHT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. ACCOMMODATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i ADULT PLACEMENT SCHEME</td>
<td>Involved in Planning</td>
<td>Involved in Planning</td>
</tr>
<tr>
<td>ii &quot;UNSTAFFED&quot; GROUP HOMES</td>
<td>- Support to 1 house - 4 residents, - Agreed future support role to 2 adjoining houses with 3 residents each following discharge from hostel.</td>
<td>- Support to 2 residents in flat following hostel discharge. - Agreed future support role to 2 groups of 3 residents following move from hostel. - Training and preparation of hostel resident prior to discharge, and future support role. - Training and preparation of group in local hospital unit prior to discharge, and future support role.</td>
</tr>
<tr>
<td>iii STAFFED ACCOMMODATION</td>
<td>- Planning with Mencap and Housing Association for staffed group home, - Planning with Housing Association for staffed accommodation in 2 houses, total of 8 residents, - Involvement in Health Authority planning for staffed accommodation, including community units.</td>
<td>- Planning with Housing Association for a &quot;sheltered housing&quot; scheme.</td>
</tr>
</tbody>
</table>

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2. HOME SERVICES

i, SITTING/RELIEF CARE
- Review of Relief care to children, with plans to extend it to a sitting service for mentally handicapped children.
- "Community Care" scheme approved, to provide a sitting service and a service of practical help to families.
- Increase Family Aide service offered to families with a mentally handicapped member.
- "Care Call" scheme approved; an emergency service to provide help to families to prevent their mentally handicapped member having to be admitted to residential care.

ii, CASEWORK
- CMHN holds approximately 30 cases.
- CMHT Social Workers hold several cases.

iii, INCONTINENCE
- Research by CMHT into need for suitable incontinence material.

iv, SURVEY AND WORK FROM SURVEY
- Yes
- Yes
- Yes
<table>
<thead>
<tr>
<th>SERVICES</th>
<th>BASSETLAW CMHT</th>
<th>CENTRAL NOTTS CMHT</th>
<th>N. NOTTINGHAM CMHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii. DAY CARE, EMPLOYMENT, TRAINING WORKSHOPS</td>
<td>- Help establish new course at FE college for mildly handicapped adults.</td>
<td></td>
<td>- Working group to consider sheltered workshop for the more able. - Social skills group. - Communication and relationships group.</td>
</tr>
<tr>
<td>iii. SOCIAL CLUBS; LEISURE</td>
<td>- Establish a Social Club</td>
<td></td>
<td>- Social skills group for Group home residents.</td>
</tr>
<tr>
<td>iv. PARENTS GROUPS</td>
<td>- Support to: Toy Library and 3 parents groups</td>
<td>- Support to 1 parents group</td>
<td>- Support to 4 parents groups, one of which the CMHT helped to establish. - Parents' committee formed in Hucknall following parents' meeting stimulated by CMHT.</td>
</tr>
</tbody>
</table>
4. SUPPORT SERVICES

i. REVIEWS;
   CASE CONFERENCES

   - Attendance at some hospital conferences;
   - School leaver reviews;
   - Review of agency placements.

   - Attendance at hospital reviews where discharge is possible;
   - Some hostel reviews;
   - Review of agency placements.

   - All team members attend case conferences in an "advisory capacity";
   - All hostel residents reviewed regarding their future accommodation needs;
   - Review of agency placements.

   - Wide circulation.

ii. NEWSLETTER

   - Relatively little; some work in schools.
   - More with other projects.

   - Relatively little; some.

iii. COMMUNITY EDUCATION

   - Register being developed.
   - Compilation of relevant literature.

   - Library being developed, of relevant literature.

iv. RESOURCE CENTRE

   - Consultation service to Area Social Workers.
   - Attendance at Mencap meetings.
   - Liaison and referral point for other establishments.
   - Health Care Planning Team and multidisciplinary meetings.
   - MENCAP special interest group.
   - Meetings with senior SSD officers.

   - Advice and support to Area Social Workers.
   - Work in local ATC.
   - Representation on Mencap and another voluntary organisation.
   - SPIG special interest groups.
   - Meetings with senior SSD officers.

   - Advice and support to Area Social Workers, ATC and hostels.
   - Regular links with Mencap.
   - Meetings with senior SSD officers.
   - Multidisciplinary meetings.
   - Hospital project group.

v. LINKS; SUPPORT

- 165 -
1. Accommodation

1. Adult Placement Scheme

All the CMHTs were committed to the establishment of an Adult Placement Scheme, as it fell clearly within their brief to develop alternative forms of accommodation. To this end they convened a working party in December 1982 with a representative from each of the five teams. Their report was ready at the beginning of March 1983. It stressed the importance of the scheme as an addition to the range of accommodation provided and for its flexibility in providing both long-term care and short-term care. The CMHT's role was envisaged as the recruitment and selection of care families, their continued support, and the matching of clients and carers. The assessment of carers prompted a lot of debate between CMHT members, several of whom felt the selection criteria were "insulting." The placement procedure and support structure for clients were ironed out, with agreement on trial placements of three months, followed by six monthly reviews. The scheme's finances also attracted much debate. It was finally agreed that a small charge be levied on the handicapped person for short term care, with the CMHTs' development budget used to pay families offering short term care placements.

Following such extensive work and negotiations, the CMHTs were keen that the Adult Placement Scheme be implemented quickly. There was a strong feeling amongst them that it was clearly part of the CMHTs' role to undertake such research and planning, and that as a consequence the SSD should approve the scheme. There was some annoyance therefore when the Development Officer proposed that the CMHT working party's document be presented to the Policy Planning Group (PPG), as the CMHTs felt that senior managers would only cover ground already covered by the CMHTs. This was rather a naive view, showing a failure to grasp how the SSD's planning machinery operated, particularly as the Deputy Director had outlined to the CMHT SSWs in March 1983 the route that the document would travel: the PPG; Assistant Directors' group; and the Social Services Committee.

In April 1983 the Deputy Director revealed to the CMHT SSWs that the SSD would struggle to find sufficient funding for the scheme, and hence it was unlikely to be implemented until the new financial year, almost a
year later. This delay was compounded by a delay in securing approval for the Adult Placement Scheme. One of the CMHT working party members claimed in October 1983 that they had been waiting for a meeting at County Hall on the Scheme "for several months," and that this was a good example of the CMHTs being "ineffective in dealing with planning systems." As a result of these delays, the CMHTs were informed that the Adult Placement Scheme would not be operational until the Autumn of 1984, a full 18 months after the production of the CMHT working party's report.

ii Unstaffed Group Homes. The North Nottingham team was supporting considerably more residents in group homes than the other two teams. This was because such accommodation existed already in their area: in four out of their five group homes, the CMHT became involved after the residents had moved in. Prior to the CMHT, the main support role to these four group homes had been undertaken by each of the following: an ATC, a hostel, a hospital, and the Senior Professional Officer prior to becoming CMHT SSW. The support role was broad and included the management of the household as well as support to the residents. Further, the CMHT co-ordinated other inputs, home-helps and befrienders for example, or the "support groups" which had been formally constituted for two of the group homes. In addition, the CMHT's role in the fifth group home included the preparation and training of the prospective residents prior to their move.

Planning for the first group home in Bassetlaw was well underway by the time the Bassetlaw CMHT was formed. Nevertheless, the CMHT undertook a central role both prior to and following the residents' moving in. The CMHT instigated the three month training and preparation period for the prospective residents before they moved, as well as recruiting and training volunteers. A co-resident lived at the house for several months, and the CMHT supported him. The team also agreed to undertake the support to six residents in adjoining houses, who were to leave a Health Authority hostel.

The Central Notts CMHT did not "inherit" group homes as the other two teams had done. As a result, the majority of their work at this time was in the training and preparation of people prior to their moves. This work was carried out jointly with residential establishments.

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iii Staffed Accommodation. The CMHTs became very involved in planning for staffed accommodation which would provide an alternative to more traditional forms of residential accommodation, although none got off the ground at this time because of the lengthy duration of the planning phase. Most of this planning was undertaken with Housing Associations and in North Nottingham this was brought within the umbrella of Mencap Homes Foundation. In Bassetlaw the CMHT made an input in the joint planning arena to the Health Authority plans for staffed accommodation.

2. Home Services

i Sitting/Relief Care. The Bassetlaw team used results from the survey to argue the case for the "community care" service, in which a co-ordinator would be employed to recruit and support paid carers in providing a sitting service or "practical help" to families. Care Call was also to be a new service which the CMHT had planned jointly with Bassetlaw CVS and Mencap, and which would recruit a Community Programme worker. Unlike these two schemes, the relief care scheme had operated for a number of years, but the CMHT helped to review and expand it. The CMHT had also been instrumental in increasing the amount of Family Aide time devoted to mental handicap, and was arguing for an increase in Family Aides through Joint Finance. In a similar way to Bassetlaw, the Central Notts CMHT used results from the survey to justify the need for a sitting service, which they jointly established with MIND. The scheme used volunteers, but MIND dropped out at the CMHT's insistence on paying them.

ii Casework. The CMHNs on both the Bassetlaw and Central Notts CMHTs held sizeable caseloads. The Social Services personnel differed between CMHTs regarding casework: only one casework referral had been accepted by the North Nottingham team. The Social Workers and SWA on the Central Notts team each held three or four cases, while the number of casework referrals accepted by Social Services members of the Bassetlaw CMHT, including the SSW, was larger: rising from ten in May 1982 to 21 in February 1983.

iii Incontinence. Entitled the "seepage project", the Bassetlaw CMHN undertook a small project into the needs of mentally handicapped people for suitable incontinence material.
iv Survey. The CMHTs established their own working party consisting of a member of each of the first three CMHTs. In mid-1982 a CMHT SSW claimed that the aim of the survey was to provide as much information as possible about clients, particularly about their residential needs. This would help to determine priorities for service providers and for CMHTs in particular. A further significance for the CMHTs stemmed from its being a high-profile exercise.

The CMHTs' Working Group established a circular working definition of "mental handicap" as: "those people receiving or likely to require specialist services for the mentally handicapped." Locating appropriate respondents proved to be a problematic and laborious task, particularly the sifting of old files. It was most difficult in the city of Nottingham because of the greater mobility of its population.

The design of the survey questionnaire form proved to be time consuming, much to the frustration of CMHT members. The survey form consisted of five sections: personal details; services used and/or needed; ability assessment; financial position; and general comments. The survey aimed to elicit respondents' subjective perceptions, for example regarding abilities, rather than undertaking an objective "professional" assessment. Respondents were the principal carers rather than mentally handicapped people themselves.

Starting from the end of November 1982, the CMHTs were hopeful that the survey would be completed by Easter 1983, particularly following the appointment of temporary workers attached to each team to work solely on the survey. This timescale proved to be wildly over-optimistic, particularly for the two Nottingham teams who had to cut short the surveys after a year. This is reflected in their lower proportions of respondents surveyed as shown in Table 10.4.

Table 10.4: Numbers surveyed per population

<table>
<thead>
<tr>
<th>Bassetlaw</th>
<th>N. Nottingham</th>
<th>Central Notts</th>
<th>S. Nottingham</th>
<th>Newark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8</td>
<td>2.1</td>
<td>2.9</td>
<td>2.1</td>
<td>2.9</td>
</tr>
</tbody>
</table>

n/1000 population

SOURCE: Notts County Council SSD Research Unit (1984b)

One reason for the CMHTs' under-estimation of the length of time the surveys would take was their cathartic impact on respondents. An observer noted: "The CMHTs have not found themselves able to walk in
and leave quickly, because in some cases they're the first Social Worker to have visited for years." Another explanatory factor, and a less positive one, was contained within the teams' experiences of conducting the survey. Many team members became "bored" with the survey. Boredom was combined with a "loss of heart," which was partly generated by the difficulties of continuing to offer the survey a high priority over such a long period of time. One CMHT SSW claimed, for example, that the survey had "diluted" the team's development work.

A further problem for the CMHTs in undertaking the survey was one of frustration. Despite some examples of the survey being used before its completion to initiate developments, the teams felt they had to wait for the full results to be fed back before they could pursue other developments or argue for particular changes in practice or policy. Another form of frustration was recorded by an observer: "There was .... a feeling of frustration by workers, many of whom had social work experience and training, that they could not get involved in more long term casework."

In addition to team members' experiences of undertaking the survey, several other issues arose which will be highlighted briefly.

a. Register. The survey was conceived without reference to the establishment of a continuously updated register. There was some criticism, notably from a Development Officer, that it was a mistake to conduct the survey without agreement at the beginning to update it. He partly blamed "insufficient Health Service-Social Services co-operation."

b. Inconsistency. One observer noted that: "The CMHTs have been uneven in filling it in. Newark for example explained in detail to respondents the different residential schemes, but this was not done in Bassetlaw...." There was some evidence also that the teams were inconsistent in coding the survey forms for computerisation and that boredom contributed to this.

c. Work arising from the Survey. The most common form was Welfare Rights advice. For example, the South Nottingham CMHT gave assistance to 34% of respondents. Other types of work included finding out about particular resources and referral to appropriate agencies. Overall
Though, most CMHT members felt they had undertaken little follow-up work. One team member explained that despite a lot of work being created initially from having to unearth answers to queries, once they had been found the first time they created less work when they arose again.

d. Use of Survey material. The teams used information they had collected from the surveys before they were all completed. The team who did this most extensively was the Bassetlaw CMHT, who made a big impact on the local ATC by providing them with lists of people in wheelchairs who would like to attend an ATC (previously there had been no wheelchair access to the ATC), and of older mentally handicapped people who might be appropriate members of the Centre's elderly group. In addition, they used the survey information to gauge the demand for new services, a social club being one example. These uses of the survey made a large impact on the teams' morale, as they could see the survey being of some value.

e. Analysis. The teams were much clearer about the information they wanted than about how they might analyse it once they had collected it. They did not consult the SSD's own research section about the survey until they had virtually decided on its format and design. The researchers found inclusion at such a late stage "frustrating." An example of a possible improvement concerned the "abilities" section, which the teams devised by "borrowing" questions from different schedules. By its nature, therefore, an integrated package of dependency assessment was problematic although the CMHTs had decided it would be useful by the time the surveys were completed.

3. Away From Home Services

i. Playschemes. The North Nottingham CMHT learnt in Spring 1982 that arising from a lack of co-ordination, there were to be no playschemes for mentally handicapped children that summer, and decided therefore to provide one. A playscheme had been held for many years in Bassetlaw, although help was required to plan and organise it, to which the CMHT responded. From their survey visits, the Central Notts team felt that there was a need for an Easter playscheme, and ran one during the Easter holidays. The CMHTs' involvement in the Summer 1983 playschemes was largely a function of their involvement in 1982 or
Easter 1983. In addition there were some spin-offs, with a team member from both the Central Notts and North Nottingham CMHTs who were interested in play becoming more broadly involved in play organisations not specific to mental handicap.

ii. Day care, employment, training, workshops. Arising from the inappropriate day-time placement of a few of her clients, the Bassetlaw CMHN approached a local FE college. The upshot was the development of a new course for mentally handicapped adults. The CMHT used their survey visits to provide the college with a list of people who might benefit from such a course, and the college ran the course from September 1983.

The Nottingham CMHTs were concerned about inappropriate placements: of mildly mentally handicapped people in ATCs. They established a working group to consider the possibility of a sheltered workshop for the more able, and were spurred on by the availability of premises, although no firm proposals were ready by Summer 1983. The team also engaged in some specific training. For example, a Social Worker ran a social skills group for a small number of hostel residents. In addition the Speech Therapist and a Clinical Psychologist jointly ran a communication and relationships group.

iii. Social clubs, leisure. From the survey results, the Bassetlaw team found a lot of demand for a Social Club for mentally handicapped adults on the Worksop side of Bassetlaw. Following negotiations with Leisure Services and Mencap, and an open parents' meeting, it was agreed that Leisure Services would fund a leader and the CMHT a deputy. The club started meeting on a weekly basis towards the end of 1983.

The North Nottingham CMHT ran a social skills and leisure group for group home residents, which was started by a Social Work student on placement with the team. In addition, the CMHT SWA had very close links in the leisure field with the voluntary sector.

iv. Parent groups. The Bassetlaw CMHT SW helped the Pre-school Teacher Counsellor to run the Toy Library, and the team as a whole supported a number of parents' groups through regular attendance. In a similar way the Central Notts team supported a parents' group on a regular basis. The North Nottingham CMHT helped to establish a parents' group, in addition to supporting existing ones. A CMHT SW adopted a "low-key" role in encouraging Area team SWAs to establish a parents'
group. He made the following observation on a consequence of his approach: "It's easy to do yourself out of a job.... At the last meeting, the Area Director told me how committed and good the Social Work Assistants were and yet I had been the catalyst. Therefore you're almost angry that you're being denied, but pleased that subversively you've been successful."

4. Support Services

i. Reviews - Case conferences. All CMHTs attended case conferences and reviews. In the majority of cases, they were for adults, and often it was because alternative accommodation was required. The exception was the Bassetlaw CMHT which regularly attended school reviews on children.

ii. Newsletter. The North Nottingham CMHT developed one jointly with the South Nottingham CMHT, initially because of a dispute over the circulation of the minutes of multidisciplinary meetings. Thus the newsletter was intended to improve communication and information sharing between "all persons involved in the care of and planning for mentally handicapped people."

iii. Community Education. Despite much talk of the importance of Community Education during the CMHTs' induction course, the teams acknowledged that they did little of such work explicitly. Nevertheless they did feel that it was incorporated within a number of their projects, for example the use of volunteers on playschemes.

iv. Resource Centre. This was promoted the most by the North Nottingham CMHT in conjunction with the South Nottingham CMHT, with whom they shared a building.

v. Links, support. Many links were well developed, as the CMHTs realised that the success of their developments was partly dependent on other service providers, and that the support of other service providers was a legitimate development activity in itself. Links with senior Health Service and SSD managers involved discussions of policy issues primarily (see Chapter 13).
SUMMARY AND PRELIMINARY ANALYSIS

The foregoing outline and Table 10.3 reveal a number of similarities and differences between the CMHTs, but also a variation in the extent to which the admittedly very broad brush objectives for the CMHTs are reflected in their activities. All three teams undertook a lot of work on "Accommodation" services. Similarities included the Adult Placement Scheme and their planning with Housing Associations. The teams varied in the number of unstaffed group homes they supported, this difference stemming from historical factors. The biggest difference between the teams was in the "Home Services" category. The Bassetlaw team had a range of sitting and relief projects planned or in operation, in addition to holding the largest caseloads of the teams. However, the North Nottingham CMHT had no such schemes and had accepted only one casework referral. Differences appeared in the "Away from home" services section also, where the Central Notts team engaged in fewer activities, although the Bassetlaw and North Nottingham teams were more similar. The "support services" section shows a lot of similarities between the teams.

It would appear that, of the three teams, the Central Notts CMHT was undertaking the narrowest range of activities, although this was partly accounted for from being the youngest of the three teams. The Bassetlaw team appeared to be undertaking the broadest range of activities, and this was reinforced by a fact not immediately obvious from Table 10.3: the Bassetlaw team, and to a lesser extent the Central Notts team, were working with children in addition to adults, while the North Nottingham team had a more exclusive focus on adults.

The Bassetlaw team's work with children and their families included the relief care scheme; casework; incontinence project; support to a Toy Library and two parents' groups specifically for parents of children; regular attendance at school reviews in addition to school leaver conferences; play schemes; and surveys. With the exception of these last two, the only work undertaken by the North Nottingham CMHT with children and their families occurred in parents' groups, where one Social Worker attended a parents' group for parents of young children, and some parents of children attended the other parents' groups with a CMHT input. Not only were there differences in the range of activities
and development work undertaken by the CMHTs therefore, but there were also differences in emphasis between different client groups.

It is not possible from the description of the teams' activities above to assess implementation processes, without considering their environments. This latter issue is taken up in Chapter 13. Nevertheless some indicators can be teased out. The principal one is the Bottom-up processes indicated by the large extent to which the CMHTs decided on what work to undertake and on the nature of that work, as with the playschemes for example. Similarly with the survey, which they had also begun to use in helping to initiate new developments, thereby reinforcing Bottom-up processes.

The team membership of Health Service and Education Department professionals is best explained by Bottom-up processes, as it was their own initiative followed by negotiation with the CMHTs which resulted in their joining the teams. By contrast, they were joining teams which had been established initially by the SSD as a Top-down policy. The politics of planning, one of Hambleton's (1983) five dimensions, is useful for highlighting the means rather than the end. For example one team member described how he had acted subversively in establishing a parents' group. A consequence of such subversive actions is that Bottom-up processes are more easily masked, despite their significance. The concession forced by the Areas from senior SSD managers, that the line management of the Newark CMHT should mirror the arrangements for the Bassetlaw CMHT, is a good example of Bottom-up processes within the SSD. This example is also highlighted by the politics of planning dimension.
CHAPTER 11
CMHTs' TEAMWORK FACTORS (1)

Introduction

An exploratory approach was adopted to the study of teamwork, which attempted to discover CMHT members' experiences and perceptions of cooperation and teamwork. The exploration was focussed by templates which comprised the key issues from the literature reviews. For example, the investigation of trust incorporated the distinction between trusting attitudes and trusting behaviours, and the different components of trusting behaviours and trustworthiness. The seven factors which were considered significant to the process of cooperation in Chapter 6 were explored with team members. A further two factors will also be reported: membership, to determine the boundaries of the teams; and a broad category entitled "experiences," in which team members discuss their feelings about their teams and their work.

Four facets of cooperation will be discussed in this chapter: membership; objectives; roles; and leadership. The next chapter will focus on the other five facets: communication; decision making; conflict; trust; and "experiences." The picture of teamwork generated by team members' experiences can be used to test the explanatory power of the models and frameworks outlined in the literature review in Chapter 5.

Membership

In only one of the three CMHTs was total agreement on the team's membership reported: the Central Notts CMHT. This team was the only one of the three to consist solely of full-time members. The other two CMHTs included "part-time" members also, but such a status raised questions of identity. In the Bassetlaw CMHT, half the team members saw the Pre-school Teacher Counsellor as a part-time team member, but the other half did not. Several team members changed their opinions during a six-month period, including the Teacher Counsellor herself, who claimed initially that she was not a team member, but six months later claimed she was, albeit a "part-time member."
The nature of the Teacher Counsellor's work, and her "style of working" were mentioned by respondents who felt she was not a team member, while the Teacher Counsellor used the nature of her work to account for being a "part-time" member only. There was agreement therefore within the team that she was not a "core" team member, but the uncertainty lay in whether she was a part-time member of the team or simply another professional that the CMHT had to maintain contact with.

The situation in the North Nottingham CMHT was more complex, with questions surrounding the identity and team membership of three people: Speech Therapist; Clinical Psychologist and a Social and Recreational Officer (SRO). All Social Services CXHT personnel regarded the three as team members. They agreed that the Speech Therapist was a team member, even though she only worked two days a week, also had a base at the local hospital, and worked with another CHHT as well: "she's only part-time but very much identifies with the team." There was some feeling among the CMHT Social Services members that while the Speech Therapist was a "full CMHT member," the Clinical Psychologist and SRO were situated more to the periphery of the team. In this way, the question of team membership was not regarded in a strict either/or way, but as a range of degrees.

How did these Health Service professionals regard the question? The Speech Therapist considered herself a member of the CMHT but neither the Clinical Psychologist nor the SRO considered themselves to be team members: "I work with the CMHTs rather than as a member of them." The Clinical Psychologist cited the following explanations: not attending team meetings; not at the CMHTs' base very often; and not involved in the CMHTs' decision making processes. The SRO on the other hand attended team meetings and spent the majority of his time at the CMHTs' base. Indeed he spent a greater amount of time there than the Speech therapist, and attended team meetings more fully.

The question of identity might help to unlock these complexities. Two different strategies were undertaken by the Speech Therapist on the one hand, and the Clinical Psychologist and SRO on the other:

1. to join the Social Services-dominated CMHT and to try and make it broader;
2. to accept the CMHT as a Social Services-dominated team, and to be content working with it rather than as part of it.

In practice, the impact of the two strategies could be similar, as the physical presence of a Health Service professional could be enough to make the team consider the Health Service in addition to Social Services. Nevertheless, there was an important difference between the two strategies in that the Speech Therapist, in pursuing the first strategy, accepted a responsibility for trying to influence the team and broaden their thinking, whereas such a responsibility was not imposed on the Clinical Psychologist or SRO who were pursuing the second strategy.

A seemingly small problem for Health Service CMHT members, but one which struck at the heart of the issue of identity, was that of headed note-paper. The CMHT's paper had the name and address of the Director of Social Services at the top. One CMHN found this useful as it offered more "protection," but the other CMHN and Speech Therapist disagreed, arguing that it was "misleading." The Speech Therapist fought for a joint logo at the top of paper, although this did not materialise. The CMHN used Health Authority paper, but with the CMHT's address.

Team members from the three CMHTs all saw their teams as small in size, with the exception of a couple of North Nottingham CMHT members who considered their team to be medium-sized. There was agreement concerning the advantages and disadvantages of working in small teams. The advantages were seen to be: more intimacy; easier communication; and less tendency to have sub-groups and factions. The disadvantages were: a limit to flexibility; feelings of isolation; and an over-emphasis on problems because there were too few people to soak them up.

There was a consensus that in a smaller team relationships could be more intense. The consequences of this intensity and intimacy could be both positive and negative: "In a small team personalities become too much of an issue .... The opposite is true also though - if personalities gel it can work effectively. It needn't necessarily be one or the other, since at different times it can be both."

Within the Central Notts and Bassetlaw CMHTs there was some feeling that the teams were unbalanced in composition between males and females. In both teams there was one male only, and in both cases they were the SSWs. Indeed it was noticeable at this time that all five CMHT SSWs

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were male, and all five Clerks were female and were located within a Social Services Department that was a male-dominated hierarchy. In the Bassetlaw team one (female) member asked: "What would it be like with (another) man in the team? It might balance the team a bit more." In the Central Notts team, a female member made a similar observation regarding balance of composition: "The weakness is that we're all women which is not so bad now that (the CMHN) is here."

Objectives

Table 11.1 shows CMHT members' replies to two open-ended questions: What are the CMHTs' objectives? and what role is the CMHT fulfilling? These questions had been asked to ascertain whether there were any differences between team members' perceptions of their teams' aims and their roles. There are some interesting differences between these two sets of replies. All team members regarded the development of services as an objective of their CMHT, but the majority of members of the North Nottingham and Bassetlaw teams did not include this in their replies regarding their team's role. It is difficult to determine whether this was because team members regarded service development as a long-term objective which they had barely touched upon or, more mundanely, whether they felt it to be self-evident from discussion of the earlier question.

Such a mundane explanation may also account for the small number of responses indicating that research into needs was a role of the teams (a higher score would have been expected given that they were conducting the needs survey at this time). The majority of the Central Notts CMHT felt they were supporting other services although only one team member had claimed this was a team objective; the majority of the other two teams also saw this as part of their team's role. Support to mentally handicapped people and their carers may have attracted so few responses because it implied casework and the holding of cases, although of course the teams were undertaking such support in other ways (for example group homes and parents' groups) in addition to the cases they held.
Table I. CMHTs' objectives

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>BASSETLAW CMHT</th>
<th>CENTRAL NOTTS, CMHT</th>
<th>N. NOTTINGHAM CMHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop Services</td>
<td>8</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>To support existing services;</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Co-ordinate; Resource Centre</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>To Research/Identify Needs</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Community Education</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Support mentally handicapped people</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>and/or carers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Discharge people inappropriately</td>
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<td></td>
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<tr>
<td>living in institutions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>3</td>
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</tbody>
</table>

n = 8
n = 6
n = 7
How did the CMHTs interpret their developmental objectives: broadly or narrowly? All three teams interpreted the term "developmental" very broadly. One Bassetlaw team member claimed: "developmental covers pretty well everything." The Central Notts CMHT SSW argued: "I'd almost go as far as to say that we would get involved in anything which would improve the lot of the mentally handicapped..." Another member of the team concurred: "We shouldn't be limited to alternative residential accommodation - we should be doing other schemes to help individuals manage." The North Nottingham CMHT adopted a similarly broad view of its developmental objectives, one team member considering them to incorporate: "Just about anything really - it's one of the problems since developmental is so wide - you could do anything, literally anything." In a similar manner to the other teams, several team members mentioned the need to develop more broadly than accommodation: "That means not just houses, but the whole life plan ..."

That the development role was so broad was referred to by a North Nottingham team member above as a "problem." To overcome this, this team had a more visible and structured set of priorities, as the SSW explained: "You can't develop all these at once and therefore you need priorities - the priorities are seen to be in meeting the residential need - to set up a network of alternative residential situations which offer the chance of meeting the needs of individuals with more than one solution." This greater emphasis on Accommodation schemes helps to explain why the North Nottingham CMHT had engaged in fewer "Home Services" than the other two teams, as was shown in Chapter 10. Indeed this difference was reflected in the debate within and between the CMHTs, over the question of: should the CMHTs accept casework referrals?

Bassetlaw and Central Notts CMHT members felt it was appropriate for their teams to hold cases, whereas the North Nottingham team thought not. The arguments used by the Bassetlaw and Central Notts teams were almost identical: to keep workers in touch with mentally handicapped people and their families; casework was inevitable, hence the question becomes "how far, not whether or not"; the existing casework service was inadequate; and casework improved the morale and credibility of the
teams. Whilst using the same arguments in favour of casework, the Bassetlaw team embraced casework more openly, while the Central Notts team was more cautious, and stressed the need to let the survey determine their priorities.

The North Nottingham team was in one accord that CMHT Social Workers should not accept casework referrals: because casework would squeeze out development work, which would be detrimental as casework had a more limited impact in the longer term. Further, the team questioned whether they could establish meaningful criteria for the acceptance of cases to prevent confusion amongst others, particularly Area Social Workers.

Despite this stance however, team members agreed that they were undertaking casework, through support of their developments and the survey. There was support from within the team that this issue was one of "packaging": "You don't stand on a stool and tell the Areas that you're a casework service .... There are different ways of picking up cases and I believe that the way we're doing it has helped to clarify the team's position." The difference between the teams on the casework issue was not whether or not the teams undertook any, because all three teams did, but that the North Nottingham CMHT Social Workers' casework arose from their development work, while the other two teams were more (Bassetlaw) or less (Central Notts) willing to accept casework referrals which were unrelated to their development work.

The North Nottingham CMHT clearly gave "Home services" less priority than the other two teams, but even regarding "Away from home services" in which they had undertaken a lot of activities, there is some evidence that they gave them a lower priority than the Bassetlaw team. Concerning the first playscheme, for example, one team member candidly admitted: "To be honest, we were a bit short of work at the time - the team was looking around for things to do." The North Nottingham team differed from the other two teams by withdrawing from direct involvement in playschemes to a co-ordinating role. This was seen as appropriate because of the nature of development work: "we should be hit and run therefore we should get in there, stimulate, and set it up so that it can continue without us." More broadly regarding leisure services, the Bassetlaw CMHT SWA was more successful in gaining her team's support for her venture, a Social Club, than was the North Nottingham CMHT SWA for
his, work with the Disabled Sports Association. The North Nottingham CMHT did wish to give employment a higher profile, particularly a sheltered workshop for mildly mentally handicapped people, although they received a "directive" from the Development Officer stating that this was not a priority for the team. The Development Officer was described as "cautious" in his response to this project, although he became more "enthusiastic" after the working group had met several times.

How much scope did the teams feel they had to determine their own objectives and priorities? All three teams felt they had a lot of freedom, for example the Central Notts CMHT SSW claimed: "Within the broad heading of developmental work, I have full rein." As this quote shows however, the teams' freedom to determine their own objectives was delimited by a broad Top-down policy. It is clear that throughout the duration of this study, the framework became less broad for the North Nottingham CMHT as the Development Officer imposed a narrower set of priorities on the team, revolving around accommodation and the survey. Examples include his directive regarding sheltered employment, and his insistence that: "leisure services are of minimum importance." As a result, the North Nottingham CMHT attributed less of a priority to Away from Home services. The Bassetlaw CMHT's development objectives were constrained differently through line management relationships. Their work was skewed to Home services, and more especially casework, as a result of Area office pressure to accept casework referrals. The CMHT was keen to accept these, one reason being to boost their credibility with the Area office. The CMHTs therefore placed different emphases on their objectives and organisational arrangements helped to bring these about.

The teams' objectives have been discussed as though they were held uniformly within teams, but was this the case? All Bassetlaw CMHT members claimed that they were happy with the team's objectives, although three of them found it difficult to continue to give development work such a high priority when the casework service was so inadequate. These feelings were gradually being resolved however: by the CMHN's involvement in casework, and by a greater acknowledgement of the importance of development work by the Social Services members of the team. By June 1983 therefore, team members were more committed to
development work, although they still felt it important to maintain their caseloads.

While three Central Notts CMHT members claimed they were happy with their team's objectives, three expressed qualifications: that the team should act as more of a pressure group, and that casework and community education should be higher priorities. The SSW claimed that there were particular consequences of having such broad objectives: "I think all of us question where we go and none of us are sure but one or two may be a bit more disillusioned than others.... it's not a matter of disagreement, it's a question of finding your way."

Towards the end of 1982, all North Nottingham CMHT members considered themselves to be happy with their team's objectives. The Speech Therapist did not consider the Social Workers' development objectives to be her own priorities, but felt her objectives did coincide with theirs'. By June 1983 however, there was some reaction from within the team against the narrower focus on development being adopted: "There's no point in concentrating on their housing if they're miserable and therefore you have to look at day, leisure and employment services. That's not in accordance with the CMHT's aims."

It is clear that, during this study, there was some uncertainty regarding objectives, or some change in the degree to which team members were happy with those objectives in all three teams. Despite this, team members felt there was a broader guiding philosophy which unified them. For example, a Central Notts CMHT SW claimed: "The ethos of the team is strong so we've got people who wouldn't strongly disagree with the objectives or the philosophy." The North Nottingham CMHT SSW talked in a similar fashion of the "new philosophy," in establishing a "foundation for a new residential service ... in other words a complete revolution." He claimed that this "imbued" the team: "It is like a new religion." Team members felt therefore that they were aiming in the same direction, even if they disagreed over the details.

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Roles
Role Derivation

With the exception of the North Nottingham CMHT Speech Therapist who felt her role to be "clear cut," CMHT members in all three teams felt that they had helped to determine their own roles: "We're given a very broad brief: a lot of loose rein. If you have a particular interest within the broad brief, you get on and do it: it's great." Several team members observed that discussion and negotiation were crucial to the evolving nature of their roles. This situation was not limited to Social Services team members, as an SSW observed of a CMHN: "she has been given no brief at all but she has given herself a role which is in sympathy and in line with what we do...."

The Clerks' roles too incorporated some scope for evolution, for while the clerical parts of their roles were imposed, they did more than clerical work, for example advice giving, attendance at meetings and joint visits. On returning from illness, one Clerk had a backlog of work and had to concentrate on the clerical side of her work, hence the extent to which team Clerks could become involved in extra-clerical activities, was in part determined by the amount and pressure of the clerical aspects of their work.

CMHT members felt the imposition of roles occurred in two ways: framework and delegation. Several team members considered their roles to have evolved, but within a framework: "To some extent it is imposed because of the job description....There is therefore an accepted framework but it is a vast area and you can gouge out for yourself a particular role." Delegation involved the allocation by team leaders of particular tasks to team members, although team leaders did not usually take such decisions autocratically without discussion or negotiation.

In what way did roles evolve? One team member offered the following insight: "Evolved - because they are very much a function of the personality of the workers, and they have been negotiated within the team." The Bassetlaw CMHT discussed in a team meeting how different their current SWA was from their previous SWA, differing in personality, interests and skills. The SSW observed: "People work to their ability rather than to their job description." The SWA concurred, noting the determinants of her role which she saw as important: "The role has
developed around my interests and personality." As a result, team members were often able to justify the pursuit of their particular interests within the broad heading of development work.

It was because the notion of development work was so broad, and because the SSD and Health Authorities had failed to specify closely the CMHTs' objectives and priorities that team members had so much scope to determine their own roles. This could be a double-edged sword however, as team members enjoyed such freedom but there was also much uncertainty. The following extract from a discussion between two North Nottingham CMHT SWs illustrates some of the uncertainty which was created by the development role:

"What confuses me are my skills as a Social Worker, as they're being used at this moment of time. I don't feel I'm a Social Worker: I feel I'm something else. It's more a community work model."

The group that felt most unsettled by the vagueness of their role were the CMHT SVAs. This was exacerbated by feelings of vulnerability, since they felt they were assuming responsibility which was far greater than indicated by their title as appropriate. This may in turn have led to undue sensitivity. For example, one SWA was annoyed because a SW had done some work on one of her cases while she was away: "It comes back to being a Social Work Assistant, subconsciously, you never forget that you're a Social Work Assistant, but my personal opinion is that a qualification doesn't make you a better Social Worker. I felt my role as Social Work Assistant was questioned..."

**Roles: Evolution and Overlaps**

Within the Social Services members of the teams there was a lot of overlap between SWA and SW roles, to the extent that the SSWs considered the SWA post "an irrelevance." There was discussion about the SWA role as early as the CMHTs' induction course, in which the CMHTs acknowledged that SWAs: "will be doing a lot more than they are paid to." Despite being wary of "being ripped off by the Department," the SWAs were generally keen to accept extra responsibility for reasons of professional development: "If you stuck to the basic SWA job description you'd be bored."
The nature of role overlap between SWA and SV varied between the teams. There was a consensus within the Central Notts CMHT that the SWA's role overlapped the SWs' to a large degree: "We do much the same." The differences that did exist, tended to be generated by others' (especially the SSD's) perceptions of who should do what. Such differences included "legal" things, for example fostering applications, and liaison responsibilities, where others might be insulted that only a SWA was representing the CMHT or confused about their level of responsibility.

By the end of 1982 the North Nottingham CMHT SWA considered himself to be "almost a Social Worker" and other team members thought likewise. Nevertheless, there were several examples in the first year of the SWA role being limited in comparison to a SW's. The SWA had been given less of a role regarding the 1982 playscheme than he'd wanted and support to the first group home was given to a SW because the team: "didn't think [the SWA] was going to be involved at that early stage." In addition the SWA was "disappointed" that he had not been asked by his SSW to attend case conferences, but rationalised it as follows: "perhaps it's me wanting too much."

A further difference between the SWA and SWs was in the level of involvement by the SSW in their work, with the SSW taking more "direct responsibility" for the work of the SWA, through more frequent supervision sessions and joint visits for example. These differences stemmed from expectations from within the team, rather than expectations from outside the team, as with the Central Notts CMHT SWA. By mid-1983 the North Nottingham CMHT SSW acknowledged that he viewed the SWA role more broadly than before, and there were consequent changes, for example the SWA attended case conferences.

The Bassetlaw CMHT SWA tried to limit her own role due to a lack of confidence. For example, she did not warm to the task of writing reports, preferring the SW and SSW to do this even if she had done all the background research. Despite this, her role expanded more broadly than she had considered possible. For example, she was the main instigator of the social club. At several points she wished to withdraw for the SSW to take over, but he felt it more appropriate that she
continue. The extension of her role therefore resulted partly from the SSW pushing her to take on extra responsibilities.

It has been seen that in all three CMHTs there was a lot of overlap between the SW and SWA roles, although the nature of the overlaps and the dynamics which brought them about varied between the teams. Within the Social Services cohorts however, the SSW role was seen to be "quite different from the rest of us." The SSWs had a greater responsibility for leadership, co-ordination, management and supervision. In addition, SSWs were seen to have a greater responsibility to "attend meetings" aimed at establishing the CMHT in the "Health Service-Social Services order of things."

Two CMHNNs were in post during this study: one each in the Central Notts and Bassetlaw CMHTs. In the Central Notts CMHT all of the fieldworkers thought that there were role overlaps between CMHNNs and SWs. The main differences that were mentioned were that the nurse's role included medication and management of the handicap, while the SWs had a greater emphasis on counselling, developing services and welfare rights, although there was an acknowledgement that the CMHN's role included some counselling and social work. Despite this, the Social Services cohort of the team felt that they would have little overlap with the CMHN because of different foci in their work, between development work and casework. This was borne out initially, as the CMHN undertook little development work, instead working in a more "traditional casework" relationship with clients.

In the Bassetlaw CMHT, there was a marked change between December 1982 and June 1983. Initially all team members perceived a lot of overlap between CMHN and SW roles: "[The CMHN] is doing quite a lot of counselling and social work." Indeed, the SSW admitted that he had been: "trying to push [the CMHN] along to work like this." The advantage he perceived was that she was more likely to accept a referral than the Area Social Services office. In this way the CMHN role was skewed, which led to confusion within the team, and differences of opinion over how much overlap there should be. This confusion over roles lasted for several months, and was exacerbated by the relationship between the SSW and the CMHN, as other team members thought he was her
line manager. Resolution was further hindered by the CMHN being in a separate room, which led to her feeling "cut off" from other team members and vice versa. Through the Spring of 1983 the CMHN's role changed: "The behaviour side of my work is coming more to the fore, especially since people have seen the work that I've done." These changes were accompanied by changes in other team members' perceptions of the CMHN's role. As a team member acknowledged: "...if it's a behaviour problem, I would look to a Psychologist but perhaps I should approach our Community Nurse more because she has been trained in that field. At first I didn't see a Community Nurse doing that sort of thing but now I do; I've learnt."

A circular effect was created: a change in the CMHN's role led to changed perceptions of that role, which led to a change in the nature of referrals to the CMHN, which reinforced the initial change. This process was supported by changes in the CMHN's organisation of her work, for example by closing more cases. Allied to this process was a greater assertiveness on the part of the CMHN, which derived from having a clearer picture of her own role: "In the beginning I had things pushed on me but now I won't accept them."

As a result of changes in emphasis within the CMHN's role, there was less role overlap with the Social Worker's and this was perceived throughout the team. Nevertheless, there was still some role overlap, as the CMHN was involved in some aspects of development work, for example in helping to establish a course at the local FE college, and in supporting developments such as the group home. Further, her input to some of her cases continued to include emotional support, counselling and welfare rights.

It has already been seen that the Clerks enjoyed some scope for extra-clerical activities, and in the North Nottingham CMHT the Clerk was selected because of her capacity for such activities, as the SSV acknowledged: "We also wanted an anchor, to take on responsibilities over and above just being a receptionist."

The Clerk's role is a good example of the importance of expectations in determining roles, whereby Clerks played a different role according to the team member, as one acknowledged: "If certain workers don't want my opinion or want me just to do the clerical side then that's what I do..."
but if another wants to stop and chat and get my opinion then I do that and therefore my role varies between the team members."

Potentially, a lot of tasks could be shared between different levels of Social Worker and between Social Workers and CMHNs, and even Clerks. But to what extent did team members' roles impinge upon each other through joint work? Bassetlaw CMHT members felt that they engaged in a lot of joint work, and gave several examples: SW and SWA on the playscheme; SWA and CMHN in supporting the group home; and the SSW, SW and SWA had all held cases jointly with the CMHN. One team member observed: "A lot of development work is joint work - the planning and thinking is a joint activity." The SWA gave as an example the Social Club, for which she had undertaken a lot of the "leg work," but she felt that: "it has been a team effort.... I've been working separately but it's a team decision making process and that's similar for others too: they do the work and the research and then bring it back to the team - no-one just goes out on a limb." In this way the team felt that a shared rather than an individualistic model underlay their work, even where that work was undertaken by an individual. This was despite some criticisms from within the team of the SSW, who at times preferred a more individualistic way of working.

When asked about joint work, Central Notts team members felt that they had undertaken none or very little: "we're all doing different things." Despite this, several examples of joint work were cited, for example a SW and SWA on the playscheme; joint visits between a SW and the CMHN; and joint meetings regarding the development of group homes between the two SWs. There was a change of opinion within the North Nottingham CMHT over a six month period from the end of 1982. Initially with only one exception, all team members felt that there had been joint work. Six months later however almost all team members replied "not really" when asked if they had undertaken any joint work with other team members, and several appeared to have engaged in more joint work with professionals external to the team.

Why was so little joint work undertaken, particularly in the Central Notts and North Nottingham teams, and what might account for the changes in the North Nottingham CMHT? Several factors can be cited, the first of which is the nature of the CMHTs' work. In contrast to the Bassetlaw
team, a North Nottingham team member claimed that development work militated against joint work, because the team's function was one of stimulating rather than taking over, and it was easier for the team to withdraw if fewer team members were involved.

Covering more than one Social Work Area and a number of establishments, both the North Nottingham and Central Notts CMHTs allocated the responsibility for particular liaison duties to different team members. This in turn developed into a patch system in the North Nottingham team, albeit not a rigid one, whereby team members became responsible for all developments for their given areas. Such a system is likely to have militated against joint work, as the following quote illustrated: "How [CMHT SW] runs her Hucknall project only affects [CMHT SW] and Hucknall and therefore even if I disagreed violently with something she was doing, unless it impinges on me I don't get involved."

The third factor militating against joint work concerns the issue of role derivation. It has already been seen that team members felt that their roles had largely evolved around their abilities and interests, and as these varied between team members, they became involved in different projects. Models of teamwork is the fourth factor. In the North Nottingham team some team members preferred to work in an individualistic fashion, as witnessed by the card index system devised by one team member for her private use. One Central Notts team member commented about the rest of the team: "Although they're a team, you still work as individuals."

Any or all of these factors may have accounted for the lack of joint work in the North Nottingham and Central Notts teams. It is likely that the second and third factors accounted for the change in the North Nottingham team, as the Patch system became firmer through time, and as team members became more comfortable in attempting to pursue their own interests within the broad heading of development work.
Leadership

The CMHT SSVs were the designated leaders of the Social Services cohorts of the teams. In addition, their authority relationship with Social Services team members was a "managerial" one, whereby they were accountable for their work. Health Service team members were subject to a "dual influence" relationship however, with responsibilities to both the CMHT and to their own professional and management structures external to the teams.

There was some confusion within the teams as to the meaning of concepts such as leadership, management and co-ordination. For example, several team members felt that leadership included management functions incorporating some degree of control, while others argued that management was a separate function, and that leadership consisted of co-ordination and direction-giving. Interestingly, team members defined leadership narrowly, focusing almost exclusively on instrumental functions, with only one team member mentioning an expressive function, that of support and encouragement to other team members.

CMHT members found co-ordination to be a more manageable concept. Its key was seen to be in discussion and consultation. Team members pointed to differences in the relationship with other team members between a leader and a co-ordinator: "A leader is much more out on his own - at the front with a line behind him, rather than being sat in the middle." There was some disagreement in all three teams as to whether they needed a leader or co-ordinator. This was marked in the two teams which had a Health Service member for the duration of this study, in other words the multidisciplinary nature of these teams brought the issue to the fore.

Arguments for co-ordinators or leaders were similar in all three teams. Proponents of the case for a co-ordinator argued that leadership through a designated leader was redundant, as: "we tend to co-ordinate ourselves ...... and we see everyone as equal." This view regarded designated leadership suspiciously, as encroaching on participative and shared decision making. Further, some felt also that designated leadership was inappropriate for a multidisciplinary team, as it would stifle the contribution of members from other disciplines. Others disagreed however: "overall there is a need for a leader - someone
needs to have responsibility for the ideology of the team and to make sure that people are working within an ideological framework, that requires more than co-ordination." In addition, some felt that an important role for a leader was as a "public figure" particularly with the host agencies.

CMHT members discussed the question of leadership narrowly, not just in instrumental terms, but also primarily in terms of designated leaders. Only a minority mentioned that leadership need not be vested in one person. The failure of the designated leader of the Bassetlaw CMHT to allow a greater degree of situational leadership caused resentment and conflict within the team. He acknowledged this as follows: "Sometimes I'm not a good delegator, and others have pointed that out to me: I do tend to hold onto the reins a bit." Conversely, it was this SSW who encouraged the CMHT SWA to undertake a greater leadership role, regarding the development of a Social Club, than she had initially wanted. Consequently, it was not that he uniformly failed to stimulate situational leadership, but that he failed to develop it consistently.

The conditions for situational leadership within the CMHTs were ripe because of the large degree to which team members could determine their own roles. The other two CMHT SSWs were praised by team members for allowing such leadership to develop. The support role to a group home was cited by a SW from the North Nottingham CMHT: "it was our first need for real liaison with [a hospital] and to let [the SWA] do it was very impressive of [the SSW] - it shows his ability not to want to be in control."

In addition to leadership functions, CMHT SSWs were responsible for managing the Social Services components of the teams. Arrangements for supervision varied between the three teams. There were very structured systems in the Bassetlaw and North Nottingham teams as these SSWs felt that they were simply following their job descriptions, but the Central Notts CMHT SSW felt that Notts SSD had gone overboard on "Social working the Social Workers." As a result there was a very unstructured system in the Central Notts team, in which the SWs had only received a couple of formal supervision sessions.
The Central Notts CMHT SSW did not encourage team members "to save things for supervision," and operated an open door policy of informal reviews. Within such a system, it was important that team members considered the SSW to be approachable, and they were of one mind: "You know that you can approach [the SSW] any time." The other two SSWs were described by their team members in a similar fashion, and one pointed out that the informal process extended beyond the SSWs: "If I have a problem or want information ..., I go to whoever is around at the time and I get their attention. Some things just can't wait for supervision."

The Bassetlaw CMHT SSW observed that supervision sessions could perform a range of functions, depending on the worker and the issue: consultation, as a two-way learning process; teaching; and monitoring. The SSWs may have found it a strange experience supervising development workers rather than caseworkers. A Bassetlaw team member felt for example that his formal supervision sessions had "fallen a bit flat" because they had concentrated too heavily on his caseload, which was only a small part of his overall workload. A further problem for the SSWs was in supervising the team Clerks, which they clearly felt uneasy about, as witnessed by the absence of any regular work review for two of the Clerks.

There were no effective systems for the work review of Health Service team members. The Central Notts CMHN derived most of his support from the CMHT and had become used to working on his own initiative, although he hoped for an improved monitoring system in the newly emerging management structure. He had never met with the CMHT SSW to review his work, unlike the Bassetlaw CMHN who met on a fortnightly basis with the CMHT SSW, which constituted the only "formal" review of her work. The CMHN claimed: "I don't know what I'd do without those sessions." In these sessions she tested out new ideas with the SSW, and he helped her to examine her work objectively. It was because of the regularity of their meetings that other CMHT members erroneously thought that the CMHT SSW could line manage the CMHN.
CHAPTER 12
CMHTs' TEAMWORK FACTORS (2)

Introduction

Following the last chapter, five facets of teamwork are discussed in this chapter: communication; decision making; conflict; trust; and "experiences." Team members' perceptions and experiences of those issues were sought as part of an exploratory approach. As noted in Chapter 11, the exploration was focussed by templates comprising the key issues from the literature reviews and the picture of teamwork that is generated will be used to test the explanatory power of the models and frameworks outlined in Chapter 5.

Communication

With one exception, all team members replied positively when asked if all relevant information had been passed to them within their team. The exception was the Central Notts CMHT Clerk, who claimed that: "sometimes they only tell me as much as they think I need to know." There were also several qualifications to the positive responses indicating that failures in communication did occur, but that such failures were accidental rather than intentional: "you're bound to have problems in communication - it's a fact of life, but we do quite well."

To consider how successful communications were between team members, they were asked how aware they felt they were of other team members' roles, in addition to the question on relevant information. All Central Notts team members felt sufficiently aware, and one observed: "probably more so than in a generic team." Only half of the members of the Bassetlaw and North Nottingham CMHTs felt sufficiently aware of their colleagues' roles however. A North Nottingham team member accounted for it thus: "I think we shut ourselves off a little bit." Noticeably, in both teams there was a reciprocal feeling of too little awareness of roles between Health Service and most Social Services team members. The North Nottingham CMHT Speech Therapist blamed this on only working part-time. The Bassetlaw CMHT SSW was very aware of the CMHN's work through "supervision" sessions, but the SV and SVA were much less aware.

When asked how they had become aware of other team members' roles, team meetings and informal chat figured prominently in the replies of all three
teams. There was agreement across the teams regarding the impact of their size. One respondent claimed: "informal chat, because the team’s small it works and it’s more reliable." Sharing a room made an impact on role awareness in all three teams. Central Notts team members claimed that office sharing had helped them to get to know each other better, in addition to a greater awareness of each others’ work.

In the Bassetlaw team the CKHN was in a different room to the SW and SWA, and this had obviously hindered a resolution to the role confusion that had occurred. In May 1983 the SW and SWA offered to let the CKHN use their office, and she accepted on a temporary basis although she maintained her own room, as she found it easier to work in a separate office than in a shared one. The Clerk and SSW had separate offices but felt very aware of other team members’ work, hence sharing was not the only mechanism, but the SW and SWA who shared an office clearly felt that they had "learnt" from each other as a result. The SW saw both sides of the argument: "It’s a problem having a number of people in the same office because you get less work done and you end up chatting more but the advantages outweigh the disadvantages - it leads to better working relationships."

Three Social Services members of the North Nottingham CMHT shared an office, while other team members each had separate offices. The shared office was regarded as a "team room" to which: "People wander in and out a lot." Having a separate or shared office appeared to make little impact on Social Services members of the team in their awareness of others’ roles or in informal contacts. Health Service team members however were not only in separate rooms but on a separate floor of the building. One team member observed: "We have the Health Service on a different floor and therefore we’re in danger of cutting them off." Consequently Health Service team members, especially the Speech Therapist, had to make a conscious effort to counter their isolation.

Team meetings as a forum for communication

The North Nottingham CMHT held its team meetings fortnightly initially, although the frequency was increased to weekly because of the volume of items discussed. Central Notts CMHT meetings were also held fortnightly while the Bassetlaw CMHT met weekly. Most team members were happy with the frequency of their meetings, although two members of the Bassetlaw team
would have preferred shorter meetings. As Table 12.1 shows, the average length of a Bassetlaw team meeting was almost 1\frac{1}{4} times that of a North Nottingham team meeting.

Table 12.1 Team meetings

<table>
<thead>
<tr>
<th>Team</th>
<th>Average Length of Meeting</th>
<th>Range from shortest to Longest Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bassetlaw</td>
<td>112 minutes</td>
<td>20 minutes to 2 hours and 55 minutes</td>
</tr>
<tr>
<td>Central Notts</td>
<td>93 minutes</td>
<td>45 minutes to 2 hours and 40 minutes</td>
</tr>
<tr>
<td>North Nottingham</td>
<td>76 minutes</td>
<td>40 minutes to 2 hours and 30 minutes</td>
</tr>
</tbody>
</table>

The length of their meetings was a constant source of concern to the Bassetlaw team. An agreed time limit had been set although this was continually broken. The greater length is partly accounted for by the meetings' structures, as the Bassetlaw team engaged in a more comprehensive review of the previous meeting's minutes. In addition the Bassetlaw CMHT SSW relied more heavily on the team meeting forum than the other SSWs, who used alternative mechanisms more freely, for example informal chat. The Central Notts CMHT introduced a feedback section to their meetings in response to two specific lapses in communication. The practice of both the Bassetlaw and Central Notts teams regarding topics or themes differed from their intentions, as they found it difficult to prevent "business" items from squeezing them out.

In only one of the three teams, the Central Notts CMHT, did all team members attend the majority of meetings: 8 out of 13. The Bassetlaw CMHT failed to achieve a full attendance at 13 of its 22 meetings and in addition there were five meetings where team members left early and/or arrived late. In only four team meetings therefore were all team members present for the whole meeting. It was a similar picture in the North Nottingham CMHT, with a full attendance in only two out of 16 meetings.

Initially North Nottingham team meetings were uni-disciplinary, and the issue of inviting Health Service personnel impinged on the purpose of the meetings, which had centred around: "Social work things pertinent to our
domestic tasks - things we couldn't discuss in multidisciplinary meetings." Nevertheless the CHHT SWs wanted to involve the Speech Therapist and did not wish to appear conspiratorial, and consequently she was invited to attend. Following this the Clinical Psychologist and Social and Recreational Officer were invited to attend, although only the latter accepted the invitation.

The Bassetlaw and Central Notts CKHT meetings were chaired by the SSWs and both pursued a very active form of chairmanship. For example, the Central Notts CHHT SSW guided discussions between items, asked key questions within items, tried to resolve disagreements, made the largest contribution in terms of volume overall, and made the largest input to decision making. This active form of chairmanship combined with their large contribution and inputs to decision making, led to team meetings feeling as if they were "dominated" by the SSWs. At an early meeting the North Nottingham CKHT decided to have a rotating chair. Nevertheless, the SSW continued to chair the large majority of meetings, almost by default, as team members forgot at the end of each meeting to choose the chairman for the following meeting. When chairing a meeting, the SSW pursued an active role similar to the other SSWs.

How did the rotating chair modify other team members' contributions to team meetings? Very little. As chairman, one of the SWs was very active in co-ordinating the meeting, and in making a large contribution, but he had a tendency towards these already, hence the chair just gave him a bit more free rein. The chairmanship role for the other SWs and SWA however, resulted simply in their calling out the next items on the agenda, and at the end of each discussion asking if there were any other comments. Hence the rotating chair did little to instruct team members in the finer points of chairmanship and co-ordination, such as the facilitation of decision making and conflict resolution, and left leadership and decision making structures intact.

Table 12.2 shows that the SSW in each team introduced the largest number of items. In one meeting the Bassetlaw CKHT SSW introduced every single item, and on no occasion did any other team member introduce more items than him. The SSWs' dominance was less marked in the other two teams. The majority of items raised by all three teams were "organisation structure maintenance," as shown in Table 12.3. The Central Notts CKHT was a younger team, which might help to account for the higher proportion of "primary
goals" items discussed as the team was in the early stages of addressing its objectives and new projects. Regarding accommodation, a large proportion of items discussed by the Bassetlaw CKHT are accounted for by one particular group home for which they were responsible. Discussions, which included the co-resident, tended to be extremely detailed, and often very "practical." This may also have been because most team members made some input to the home, so team meetings provided a forum for the co-ordination of decision making. It is odd that the North Nottingham team discussed group homes much less, even though they supported a larger number. This was probably because each team member was responsible separately for a group home, hence there was less need for a co-ordination of inputs, and team meetings were not seen as the appropriate forum for detailed decision making. This is an example of the Bassetlaw CKHT communicating and working in a more shared or joint fashion than the other two teams. Nevertheless, it provides a contrast to their consideration of casework which was discussed proportionately much less often.
The "internal" and "external" organisation structure maintenance items are equally balanced in the Bassetlaw and Central Notts teams, but the North Nottingham team discussed a much larger proportion of "external" items. This is explained by a higher score for "other CKIITs," as they shared their base with the South Nottingham CKIIT, and by a higher "Health Service management and provision" score, as CKHMs were a burning issue, and as they strove to make their team multi-disciplinary.

Table 12.3 Nature of Items %

<table>
<thead>
<tr>
<th></th>
<th>Bassetlaw</th>
<th>Central Notts</th>
<th>North Nottingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY GOALS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accommodation Schemes</td>
<td>11.8</td>
<td>14.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Support Schemes</td>
<td>16.5</td>
<td>19.3</td>
<td>16.5</td>
</tr>
<tr>
<td>Survey; Planning for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs</td>
<td>5.3</td>
<td>8.0</td>
<td>8.3</td>
</tr>
<tr>
<td>Casework</td>
<td>2.5</td>
<td>5.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>2.6</td>
<td>1.1</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>SUB-TOTAL</strong></td>
<td>38.7</td>
<td>48.8</td>
<td>36.2</td>
</tr>
<tr>
<td>ORGANISATION STRUCTURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAINTENANCE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>27.2</td>
<td>24.6</td>
<td>21.0</td>
</tr>
<tr>
<td>External</td>
<td>26.7</td>
<td>25.1</td>
<td>36.3</td>
</tr>
<tr>
<td>Other</td>
<td>3.0</td>
<td>0.5</td>
<td>3.9</td>
</tr>
<tr>
<td><strong>SUB-TOTAL</strong></td>
<td>56.9</td>
<td>50.2</td>
<td>61.2</td>
</tr>
<tr>
<td>OTHER</td>
<td>4.4</td>
<td>1.0</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

There were variations between different designations of worker regarding the nature of items introduced, as the SSWs and Clerks introduced a greater proportion of organisation structure maintenance items than the SWs and SWAs. The high proportion of such items introduced by the SSWs may be accounted for by their management role, with responsibility for the functioning of office systems for example, and from feedback from meetings.
with their managers and external bodies. The Clerks tended to raise administrative issues most frequently.

**Team meetings' functions**

During their induction course in February 1982, team members felt that team meetings should fulfil the following functions: mutual support; discussion of policy issues; decision making; and feedback. These all featured again in team members' responses to the question: 'What functions did CMHT meetings actually perform?'

**Table 12.4 Team meeting functions - interview responses**

<table>
<thead>
<tr>
<th>FUNCTIONS</th>
<th>Bassetlaw</th>
<th>C.Notts</th>
<th>N.Nottingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information exchange/feedback</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Discussion of issues</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Educative benefit deriving from discussion</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>To get everyone together as a team</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Mutual support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision making</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>To remind the team of its objectives</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>No functions</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total No. of Responses</td>
<td>18</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Total No. of Respondents</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Observations showed that the North Nottingham CMHT discussed the purpose of their meetings most often, arising from the issue of whether or not to invite Health Service team members. Information exchange was seen as an important function of team meetings in all three teams, and tended to be closely linked to the function of "team togetherness": "Team meetings are
very necessary if the team is to function as a team. We need to know what everyone else is doing.....” The Central Notts CMHT Clerk felt that team meetings performed no functions: “That’s because everything that’s been said has been said beforehand.” Decision making was not considered to be the primary function of team meetings in all three teams, and this is reinforced by the team meeting analysis instrument which examined the overt purpose for the introduction of each item, as shown in Table 12.5.

Table 12.5 Purpose of items

<table>
<thead>
<tr>
<th>CMHT</th>
<th>To Give Information</th>
<th>To Discuss Information</th>
<th>To Seek Information</th>
<th>To Make Decisions</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>39.2</td>
<td>30.2</td>
<td>13.7</td>
<td>16.9</td>
<td>100</td>
</tr>
<tr>
<td>C. Notts</td>
<td>43.9</td>
<td>30.0</td>
<td>6.4</td>
<td>19.8</td>
<td>100</td>
</tr>
<tr>
<td>N. Nottingham</td>
<td>46.7</td>
<td>31.4</td>
<td>14.0</td>
<td>7.9</td>
<td>100</td>
</tr>
</tbody>
</table>

How effective did team members consider team meetings to be in fulfilling their functions? Table 12.6 shows that, with two exceptions, members of all three teams felt that team meetings were either effective or very effective.

Table 12.6 Effectiveness of team meetings - Interview responses

<table>
<thead>
<tr>
<th>TEAM</th>
<th>Bassetlaw</th>
<th>C. Notts</th>
<th>N. Nottingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very effective</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Effective</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Equally effective and ineffective</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Ineffective</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Very ineffective</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL No. of Respondents</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Three North Nottingham CMHT members attributed the success of their meetings to the relaxed atmosphere, with implications for team members' participation, as one respondent noted: "because this meeting is less formal and more relaxed, people are much more forthcoming about ideas for the agenda .... Also because of being more relaxed people take more risks."
The effectiveness of team meetings was undermined however by the less than full attendance of team members outlined above. This threatened all of the team meeting's functions, notably getting together as a team, communication and decision making. For example, the SW's absence from the Bassetlaw CMHT meeting on 3.11.82 resulted in the decision making on one topic being deferred, and the postponement altogether of another topic.

**Decision making**

Central to a lot of the decision making undertaken in the teams were the SSWs, primarily because of their leadership and management functions. All three SSWs reserved some decisions for themselves, as to a certain extent they could commit the teams to accepting new work. Interestingly, the North Nottingham CMHT felt much more constrained by SSD managers than the other two teams, as was borne out in the objectives section above. The CMHT SSW claimed: "The bug-bear is the administration at County Hall who may or may not help us, which is a big frustration. Having decided what to do we then have to put it through to another level."

Each SSW adopted a range of decision making styles from autocratic to participative according to the issue. These different styles often appeared within the same meeting. For example at the Bassetlaw CMHT meeting on 30.6.83, observation revealed a lot of decision making through discussion and consensus, over administrative systems and the survey for example. The SSV decided that they should not re-employ the temporary Clerk however, even though the rest of the team wanted to. Following the meeting, the team was unhappy and wondered why the SSW had made that decision, as he had not given them a reason. At the same meeting it was noticeable that the SSW's decision making style was more participative on issues over which he sought help or advice from other team members. Similarly at previous meetings he had raised topics such as joint finance and accommodation so that team members could express their views thereby influencing his presentation to
external agencies. It may well be therefore that a number of factors such as the SSW's grasp of the issue, or the strength of his viewpoint on it, or of others' stances towards it, may determine the nature of the decision making process as much as the nature of the issue itself.

The North Nottingham CMHT SSW readily admitted that he had not found the consultation process an easy one to handle and confessed that on occasions he had consulted for "consultation's sake." The Central Notts CMHT SSW concurred, observing that he sometimes appeared to be operating democratically, but that the team simply agreed to what he had already decided. The SSWs could be very subtle in manoeuvring decision making so as to appear consultative and participative. For example, at a Bassetlaw CMHT meeting, although the decision regarding the team's input to a group home appeared to evolve from discussion, the SSW was very active in the discussion, waiting until the suggestion he liked was forthcoming. The CMHT SW realised this: "He does consult us on occasions. He actually sees himself as consulting us, but he tends to take the decision beforehand and in a team meeting accepts the view which is closest to his own."

One member from the North Nottingham CMHT and a couple from each of the other two felt that the SSWs should be more consultative, while all other team members were content with the SSWs' decision making styles. Even those who wanted more consultation offered some qualification to this, for example a Central Notts CMHT SW claimed: "I would like the group discussion more, but it is a problem in terms of time and getting people together."

There was some feeling within the Bassetlaw CMHT that the SSW's decision making style had become consultative: "There has been a change in [the SSW's] style, he has mellowed." The SSW acknowledged that he had become "better at consulting people." This can partly be attributed to feedback to the team from the first round of interviews from this study. Team members felt by the second round of interviews in June 1983 however, that the SSW had become more autocratic again: "At the moment however he's working on his own and presenting things as fait accompli. His style seems to vary over time." This was most likely because the team was very busy at this time and the SSW appeared to feel a more autocratic style appropriate in order to ensure things got done.
Decision making in team meetings

It has already been seen that decision making was not considered to be the primary function of team meetings, although Table 12.7 shows that a greater number of decisions were taken than the "purposes" (see communication section above) would have indicated. The Bassetlaw and Central Notts teams took decisions on approximately one-third of items, while the North Nottingham team took decisions on one in four. The majority of decisions were at the "Action" level and of a routine nature in all three teams, with a much smaller number of non-routine decisions, and an even smaller number of decisions at the level of "goals".

Table 12.7

<table>
<thead>
<tr>
<th>CMHT</th>
<th>NO DECISIONS</th>
<th>DECISION(S)</th>
<th>DECISION(S)</th>
<th>DECISION(S)</th>
<th>DECISION(S)</th>
<th>DECISION(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CR DECISIONS</td>
<td>DECISIONS</td>
<td>DECISIONS</td>
<td>DECISIONS</td>
<td>DECISIONS</td>
<td>DECISIONS</td>
</tr>
<tr>
<td></td>
<td>DEFERRED</td>
<td>GOALS</td>
<td>ACTIONS</td>
<td>ACTIONS</td>
<td>ACTIONS</td>
<td>COMBINATION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PROGRAMMED</td>
<td>PROGRAMMED</td>
<td>PROGRAMMED</td>
<td>PROGRAMMED</td>
<td>LEVELS</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>66.8</td>
<td>33.2</td>
<td>1.4</td>
<td>24.1</td>
<td>5.1</td>
<td>2.6</td>
</tr>
<tr>
<td>C. Notts</td>
<td>63.1</td>
<td>36.9</td>
<td>2.1</td>
<td>23.0</td>
<td>5.4</td>
<td>6.4</td>
</tr>
<tr>
<td>N. Nottingham</td>
<td>73.8</td>
<td>25.2</td>
<td>3.9</td>
<td>16.2</td>
<td>4.8</td>
<td>1.3</td>
</tr>
</tbody>
</table>

There were variations in outcome between items introduced by different designations. Most interesting is the large proportion of items introduced by Clerks and SWAs on which decisions were taken. Nearly all of the decisions on the Clerk-initiated items were of a routine nature, but the SWAs, two of them in particular, initiated items resulting in "non-programmed actions" decisions proportionately more often than the SSYS and SWs. Conversely nearly all of the decisions at a "goals" level were initiated by SSYS and Level 3 SWs.

There was some variation in outcome also according to the nature of the issue. A proportionately larger number of decisions were taken on primary goals items than organisation structure maintenance (OSM) items. There was also a tendency for organisation structure maintenance items to attract a
greater proportion of routine decisions. The only issue which had decisions taken on more than half of its items in all three teams was that of team meeting organisation, for example in fixing the dates for future meetings.

Team meetings played a number of different roles in the decision making process. They could provide a forum for: the sowing of seeds at an early stage of the decision making process, as at the North Nottingham CMHT meeting on 21.4.83; explorations of issues and questioning of assumptions, as in the Bassetlaw CKHT's consideration of its input to a group home; and the validation or confirmation of a decision, as in the Bassetlaw CKHT's decision to establish a Social Club.

The SSWs dominated decision making within team meetings and again subtle manoeuvres were employed. For example, at a Bassetlaw CKHT meeting, the CMHT's case presentation attracted very little interest, but that was because she introduced it after the meeting had already lasted for 2½ hours. It was introduced so late on because the SSW had relegated it within the agenda, so as to follow his many items of feedback. Therefore not only did he influence the decisions that were taken, but also the framework and structure within which they were taken.

In the Bassetlaw and Central Notts CKHTs team meetings were an important forum for work allocation. Table 12.8 summarises the section of the interviews which focussed on team members' workloads, and shows that the decisions that Bassetlaw and Central Notts CKHT members would work on particular schemes were taken in team meetings, with the exception of the schemes on which SSWs worked, which were chosen by themselves. The allocation of cases provides an interesting contrast as team meetings did not feature in this. Instead, a dual process evolved in both teams, first whereby the worker took a case (usually from the survey) to the SSW, they discussed it and took a joint decision, and second where the referral came to the SSW from outside and he allocated. Allocation by the SSW still allowed for discussion and argument: "it's still open to challenge". Nevertheless, some team members did intimate there were times when it would have been difficult to say "no."

It is not clear why the allocation of cases should have been handled so differently from the allocation of other work. One reason might have been that greater negotiation was required between the worker and the SSW, and
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Team</th>
<th>Team Member</th>
<th>Forum of Decision Making</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>APS Working Party</td>
<td>B</td>
<td>SSW</td>
<td>Self</td>
<td>Had already worked on Workshop scheme</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>SW</td>
<td>Team meeting</td>
<td>Interested. Other team members involved in other working groups.</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW</td>
<td>SSW decided</td>
<td>SW interested, no-one else interested</td>
</tr>
<tr>
<td>Play-Scheme</td>
<td>B</td>
<td>SW &amp; SWA</td>
<td>Team meeting</td>
<td>SW decided on input, with agreement from SSW</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>SW &amp; SWA</td>
<td>Team meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW</td>
<td>Self and SSW</td>
<td></td>
</tr>
<tr>
<td>Liaison with Area Social Services offices</td>
<td>B</td>
<td>SSW</td>
<td>Self</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>SW, SW &amp; SWA</td>
<td>Team meeting</td>
<td>Decision informally, first; verified in meeting</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW, SW, SWA</td>
<td>Team meeting</td>
<td></td>
</tr>
<tr>
<td>Group Homes</td>
<td>B</td>
<td>SWA</td>
<td>Team meeting</td>
<td>Meeting of CMHT Social Workers only</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>SW &amp; SW</td>
<td>Special meeting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW</td>
<td>SSW allocated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW</td>
<td>SSW allocated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SWA</td>
<td>SSW asked SWA</td>
<td></td>
</tr>
<tr>
<td>Parents Groups</td>
<td>N</td>
<td>SW</td>
<td>Self and SSW</td>
<td>SW approach SSW; SSW agreed.</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>SW</td>
<td>Self and SSW</td>
<td>SSW approach SSW; SW agreed.</td>
</tr>
<tr>
<td>Liaison hospital</td>
<td>C</td>
<td>SW</td>
<td>Team meeting</td>
<td>SW had previously worked in a hospital</td>
</tr>
<tr>
<td>Liaison hostel</td>
<td>N</td>
<td>SW</td>
<td>Self and SSW</td>
<td>SW approach SSW; SSW agreed.</td>
</tr>
<tr>
<td>Newsletter</td>
<td>N</td>
<td>SW</td>
<td>Special meeting</td>
<td>SW elected in meeting</td>
</tr>
<tr>
<td>Sitting Scheme</td>
<td>C</td>
<td>SW</td>
<td>Team meeting</td>
<td></td>
</tr>
<tr>
<td>FE Course</td>
<td>B</td>
<td>CMHN</td>
<td>Self and Team meeting</td>
<td>Decided by self; verified in team meetings</td>
</tr>
<tr>
<td>Social Club</td>
<td>B</td>
<td>SVA</td>
<td>Team meeting</td>
<td>SWA's initiative; others too busy</td>
</tr>
</tbody>
</table>

B = Bassetlaw  C = Central Notts  N = North Nottingham
that they felt this should be conducted more privately. On the other hand, Social Services members of the teams may have been conscious that casework should not be a primary role for them and consequently they sought a more private method of allocation. Alternatively, they may have felt that their development work schemes impinged more greatly on the rest of their teams than casework, and consequently that a team forum was more appropriate for the allocation of such work.

Very little work allocation was undertaken in team meetings in the North Nottingham CMHT. For Social Services members of the team, a dual process had evolved, similar to the process for casework in the two teams above; the SSW approached team members and allocated; and other team members took the initiative and approached the SSW with their ideas. The outcome of both was that decisions were taken by the worker and the SSW, but not with a team meeting as the forum. One team member explained: "In some ways we don't make team decisions.... but people are involved wherever they need to be." Individuals were therefore seen to work separately on projects, and the allocation and decision making process reflected this.

Most team members had a lot of freedom to take decisions on their work when in progress. Often CMHT SWs met their SSWs for support of their decisions rather than for decision making per se, although the SSWs tended to be involved in the "bigger" decisions which might involve policy issues. Generally, the SSWs adopted a low key role on Social Workers' work, preferring to facilitate the SWs' own decision making. A North Nottingham CMHT SW commented: "[the SSW] doesn't encourage people to get him to make decisions for them - he tends to clarify your thoughts rather. You don't go along consciously thinking that someone else will make a decision for you."

CMHT SWs were slightly more circumscribed than the SWs, although they took decisions on a "practical" level: "in everyday social work, you make decisions on your own." The "big" decisions and future planning were done jointly with the SSW. The Clerks' roles were much more tightly circumscribed, although there was some room for initiative, for example the North Nottingham CMHT Clerk devised the survey card with the SSW. Further, each of the Clerks had managed to extend their roles into extra-clerical activities, in which there was greater scope for decision making. Both CMHTs took all decisions on their work by themselves, although the Bassetlaw nurse was greatly influenced by the SSW through their regular supervision.
sessions. The North Nottingham CMHT Speech Therapist took the decisions on her work allocation and on her work when underway. She was unaware of the decision making processes affecting other team members' work, but felt sufficiently involved when team decisions impinged on her or her work.

Conflict

Although this is a discrete section, conflicts have cropped up in the previous sections, for example, regarding objectives, roles, leadership and decision making styles. In addition there were personality clashes to a greater or lesser degree in all three teams, and more specific items which attracted some conflict, for example: over a team member's organisation of work in the Bassetlaw CMHT; involvement by a SW in a SWA's case in her absence in the Central Notts CMHT; and non-recognition of a contribution and a breakdown in communication in the North Nottingham CMHT.

Of the three teams, the most overt conflict was observed in the Bassetlaw CMHT, which at times almost appeared to be pre-occupied by its internal conflicts. The North Nottingham CMHT appeared to experience the least conflict of the three teams. One team member attributed this to their model of working, which was more separate in nature: "if we discuss things about the handling of cases for example, I'm sure we'd have different ideas but we don't really do it." That there was little overt conflict in the North Nottingham CMHT is supported by Table 12.9 which shows it to have had the smallest proportion of items in team meetings to attract conflict, although it also shows that there were disagreements on very few items in all three teams.

Table 12.9 Conflicts

<table>
<thead>
<tr>
<th>CMHT</th>
<th>No Conflict</th>
<th>Some or much conflict</th>
<th>Unresolved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Bassetlaw</td>
<td>95.8</td>
<td>2.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Central Notts</td>
<td>94.1</td>
<td>4.8</td>
<td>1.1</td>
</tr>
<tr>
<td>North Nottingham</td>
<td>98.7</td>
<td>1.3</td>
<td>---</td>
</tr>
</tbody>
</table>

- 209 -
The patterns of conflict across different types of decision varied between the Bassetlaw and Central Notts teams. The majority of conflicts in the Bassetlaw team occurred on decisions at a "goals" level, on non-programmed activities and at a combination of levels; indeed of the six items with decisions taken at a goals level four of them attracted conflict. The large majority of conflicts in the Central Notts CMHT however, including both of the unresolved ones, occurred on programmed activities, and no conflict was recorded for any of the decisions at the goals level.

Only one heated argument was observed in a team meeting during the course of this study and it occurred in an early Central Notts CMHT meeting. The issue was a very minor detail of the survey, but the argument became quite personal in nature. After a lengthy discussion it was the SSW who suggested a compromise. The SWs were so willing to accept it that they'd agreed to it before he'd finished his sentence, although the exact details and wording were not decided upon. The disagreement had been heated, and they were glad a compromise had been reached, such that they each laughed over the following item. The rest of the meeting was quite jovial, in fact it felt a bit too forced, with the SWA acting as the "scapegoat" about which the whole team could laugh.

The Speech Therapist's attendance at the North Nottingham CMHT meetings made little impact on the extent of conflict therein, although it took the rest of the team a little while to feel comfortable discussing Health Service issues when she was present. At one meeting for example, the SW hedged his criticism of the local hospital where the Speech Therapist also had a base, but she commented: "It's OK, I'm not sensitive about [a hospital]."

While there was little overt conflict in team meetings, there was some evidence of conflict avoidance. For example, at one Central Notts CMHT meeting, there was a curious failure to make a decision, resembling the "Abilene paradox," whereby they failed to decide who should help the SW with the sitting scheme following her request for help. After the meeting the SW asked the SWA why she had not volunteered, because she had wanted her to. The SWA replied that she had wanted to, but felt that the SW may have wanted the other SW to help.
Team members could use conflict avoidance to avoid hurting themselves and each other. The confusion over roles in the Bassetlaw CMHT was a good example, where there was a high degree of collusion between team members, with the aim of avoiding an open discussion between the team as a whole. The issue was discussed in small groupings only and not by the team as a whole for several months. The avoidance only led to increasing resentment and a spiralling downwards in trust between team members, and in the quality of their relationships generally.

Conflict resolution

Many conflicts were resolved through discussion. A good example occurred at the Bassetlaw CMHT meeting on 2.2.83. The SSW and SW felt that the CMHT should not attend a hospital reviews, although the SWA thought they should, calling the hospital patients "the forgotten people." Her contribution was a forthright one, the SSW calling it "impassioned." The discussion resulted in the SSW and SW modifying their position. A ploy that was occasionally used, would be to address the team as a whole, even though criticisms were intended for one individual in particular. Team members regarded this as a fair and valid way to broach conflicts, as it depersonalised the issue. A Bassetlaw CMHT member pointed to the key in the resolution of their conflicts: "we all have our opinions in discussions but they're usually humorous: that's what keeps this team going, the humour."

It was clear by their high profile in conflict resolution, that the SSWs felt they had a responsibility for ensuring some form of agreement was reached. As with other forms of decision making, the SSWs' style varied. In the conflict over the survey in the Central Notts CMHT above, the SSW made proposals which could be accepted or rejected by the team. In a disagreement at another meeting over two questions in the survey, he rejected the Clerk's proposed compromise for the first question, but accepted her argument on the second question, and used that agreement to act as a compromise in itself for the rejection of her first proposal, and hence over these questions he was more directive.

Underpinning some of the conflicts was the question of "style." In the Bassetlaw CMHT, some of the conflicts could be traced to the leadership and decision making style of the SSW, and to other team members' dislike of these. The result was that team members occasionally felt they wanted to outsmart him. Conflicts generated by team members' personal styles proved
difficult to resolve. Regarding an issue discussed by the North Nottingham CMHT for example, although one of the SWs could accept the position adopted by others, indeed by the team as a whole, she liked to let other team members know that she would have preferred otherwise, with the result that the issue failed to die down until long after it might have done. The personality of some team members also tended to result in their being the focus or the butt of others' jokes. It is noteworthy that one member from each team (two SWAs and one CMHN) tended to fulfil this role, and whilst most of it was in good humour, it was not always clear that those team members liked providing the others with their amusement.

Trust

When asked to describe levels of trust within their team, North Nottingham CMHT members replied that it was at a high level, with the exception of the clerk who replied "medium." That the Speech Therapist was part-time received comment from a CMHT SW, who observed that this might make it more difficult for her to trust the rest of the team. In responding to the question herself, the Speech Therapist commented: "I'm almost talking about impressions as an outsider." There was a greater emphasis within the replies of the other two teams on variations in the levels of trusting attitudes within their teams. A Bassetlaw CMHT member observed: "I would trust the whole team. Between some individuals however, trust is not as strong as it should be." Similarly, a Central Notts CMHT member replied: "Generally high, although there may be the odd low area - that would be as a result of individuals' ways of working."

The questionnaire on team members' perceptions of their colleagues' trustworthiness was not sufficiently flexible to record the variations in attitudes which existed, as it asked for perceptions of the team as a whole rather than of individual members. Table 12.10 shows the results of the questionnaire, and shows that the trustworthiness of team colleagues was perceived to be high. The same exercise had been completed with just the North Nottingham and Bassetlaw CMHTs six months previously at the end of 1982, and there were only very small changes in the replies. Faith in others' intentions and team members' reliability were the two indicators over which there was most agreement and the highest scoring. In two of the teams it was the Clerk who gave their team the lowest rating of
Table 12.10  Indicators of Team members' trustworthiness, June 1983

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TEAM</th>
<th>QUESTION</th>
<th>VERY HIGH</th>
<th>FAIRLY HIGH</th>
<th>MEDIUM</th>
<th>FAIRLY LOW</th>
<th>LOW</th>
<th>VERY LOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faith in Team members' Intentions</td>
<td>B</td>
<td>a</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>B</td>
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</tr>
<tr>
<td></td>
<td>C</td>
<td>a</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>b</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
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<td></td>
<td>N</td>
<td>a</td>
<td>5</td>
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<tr>
<td></td>
<td>N</td>
<td>b</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Team Members' Reliability</td>
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<td>2</td>
<td>2</td>
<td>1</td>
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<td>Team Members' Knowledge</td>
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B = BASSETLAW
C = CENTRAL NOTTS
N = NORTH NOTTINGHAM

* It is possible that these responses are inaccurate, with the respondents failing to realise that the statements were negatively worded, as they are completely out of line with their other responses.

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trustworthiness, and in the Central Notts CMHT this was part of a pattern in which the lower the formally-designated status of the (Social Services) team member, the lower the rating of trustworthiness of the rest of the team.

**Trusting behaviour**

Three indicators of trusting behaviour were explored: the willingness to pass on information and communicate, the degree of mutual influence and the degree of mutual control. The information variable has already been considered in the "communication" section, but to recap, with only one exception members of the three CMHTs felt that all relevant information had been passed to them, and any failures in communication were not attributed to other team members' unwillingness to pass on information.

There was almost total agreement within the Bassetlaw and North Nottingham CMHTs that mutual influence had been exerted between team members. Bassetlaw CMHT members felt that there had been a high level of such influence, and that it was not a one-way process: "I think we've all been able to influence each other." Several North Nottingham CMHT members felt similarly: "Team members have shared a lot and gained from each other." An example given by one team member was the SWA's interest in leisure: "He has made us more aware of it than we would have been if he hadn't had such a strong interest."

Despite the sharing and information exchange, one North Nottingham CMHT member pointed to the model of teamwork as a limiting factor on the extent of influence: "Our practice has not really been put on the line as far as everyone is concerned but [the SSW]. No-one else ever sees my work and therefore they don't know for example why I chose a particular approach."

There was unanimity in the Central Notts CMHT that there had been little or no mutual influence between team members, and a number of explanations were posited. First, that team members had "fairly forceful personalities" which made influence difficult. Second, because of involvement in different projects: "it seems to me that we go off and do our own things and there's not much influence." Related to this, the third explanatory factor was team members' preferences for individualistic patterns of working, with the result that: "there's not much general discussion about each others' work."

Team members found control a very difficult concept to discuss, particularly in distinguishing it from influence. In all three teams, there
was some control in line management relationships, although there was agreement that the SSWs preferred to exercise influence rather than control.

The exercise of control outside line management relationships is more relevant for the study of trust. The majority of Central Notts and Bassetlaw CMHT members and half of the North Nottingham CMHT claimed that such control was exercised. It appeared to be less common than influence within the three teams, and when team members spoke of it, they described it in a rather vague manner. This may have been because it manifested itself most often in under-hand ways. For example one team member admitted to being unaware if or when other team members had controlled her, but confessed to using "devious ways" to control others.

Control was seen as undesirable by a Central Notts team member, because she associated it with subordination: "If I'd been a bit weak, I could have been controlled - but I'm not." That there was so little control was explained by team members in a similar way to their explanations for the exercise of influence. For example, Central Notts CMHT members mentioned their model of teamwork in which: "we tend to work independently," a concomitant of which was that control was more difficult to exercise and less relevant.

To summarise, faith in intentions and reliability were the highest scoring indicators of trustworthiness within the teams. Regarding trusting behaviours, control was the least common on the basis of team members' own accounts, although neither control nor influence appeared to be common in the Central Notts CMHT. What of the relationship between trusting attitudes and trusting behaviours? This is a difficult question to answer because the variables were operationalised poorly, as measures were taken of trustworthiness instead of trusting attitudes, the trustworthiness questions were insufficiently sensitive as they related to the whole of the rest of the team rather than to each individual, and a mixture of research methods were employed in an uncoordinated fashion making it impossible to compare reliably the results for trustworthiness, trusting attitudes and trusting behaviours.

In spite of these shortcomings, the results throw up an interesting finding: that the model of teamwork employed by team members appears to play an important role regarding trust, possibly as a mediating variable between trusting attitudes and trusting behaviours. For example, Central
Notte CMHT members felt that their preferences for individualistic patterns of working accounted for their low levels of trusting behaviour (with the exception of information), despite high trustworthiness scores in the questionnaire. In other words, team members felt a cognitive state of trust towards their colleagues but the model of cooperation they employed made it difficult or inappropriate to translate this into trusting behaviours. The relationship between trust and the model of teamwork will be explored more fully in the last chapter.

Experiences

Team members' likes and dislikes of working in their teams fell into two categories: work and team. The experiences across the three teams were very similar. Both general and specific aspects of their work were mentioned by team members when outlining their likes. The community orientation of the teams was appreciated by all team members, in addition to the broad developmental objectives. For example one team member referred to the "whole pioneering business," while another described the development of new services as a "challenge," and claimed to like the vagueness of the team's role and the resulting lack of structure.

Regarding specific aspects of team members' work, the variety of work was generally welcomed, as well as the opportunity to specialise and the freedom and autonomy to create their own roles: "I have the freedom to do what I want to do which I could not do in the Areas; that was the cream you could not do but here it is part of the job." Indeed Area office work, particularly statutory child care, did tend to come off much worse in comparisons. There were several consequences to this degree of autonomy, one team member claiming for example that it helped to increase his "personal sense of worth," while another claimed that his skills had developed substantially: "I felt my wings were clipped in the other job; I can try them out now."

Team members had both broad and specific likes regarding their teams. Several referred generally to their team's atmosphere: "the team as a whole is a very nice team and I enjoy working in it." "Informal" was the term most often used to describe the atmosphere of their team. A couple of respondents claimed to feel a "sense of belonging" to their team, while others commented on how friendly and supportive other team members were.
The smallness of the team received favourable comment in the Bassetlaw CMHT, and several team members from both the Bassetlaw and Central Notts CMHTs claimed to like working in multidisciplinary teams. A result of the atmosphere and the high level of mutual support was an increase in mutual respect, claimed a North Nottingham CMHT member: "One of the nicest things is that people seek out my opinion, they seem they really want to know—they appear interested: it's smashing, it's nice they value comments I make."

It is noteworthy that some of the "work" and "team" likes were also regarded by team members as dislikes. The variety of work had been mentioned as a like for example, but one team member also cited it as a dislike because he felt his job had become "fragmented" as a result of being involved in so many different things. "Frustrating" was the term used by several team members to describe the pace of development work, and the cause for this was located outside of the teams in their parent agencies, particularly the SSD.

Frustration is evident in the following quote from a Central Notts CMHT member, which is also a good example of the same factor being both a like and a dislike: "I dislike most it's vagueness and the lack of structure; and the fact it's role isn't clearly defined; sometimes at the end of the week you can ask: what contribution have we made to the service for the mentally handicapped? ...... It may seem strange but I also like that. I like the idea of getting new services, I think I'm impatient." The "lack of structure" could be a problem not only for the CMHTs however: "people don't know what to expect, especially clients and other agencies tend to question what we do - it's good because we're kept on our toes but it can be uncomfortable." As a consequence the teams could feel more "vulnerable," and hence sensitive about their credibility.

A common dislike in all three teams was their isolation from other members of their disciplines. A Bassetlaw CMHT member felt that a separate office from Area SWs was "fragmenting workers from their roots." This feeling was even more pronounced in the other two teams which related to more than one Area. Further, the Bassetlaw and Central Notts CMHNs were based separately from other nurses, and were the only CMHNs in their areas.
Both this chapter and the previous one have focused on specific facets of cooperation. They have been discussed as if they were simply discrete entities. It is clear from this study however that they are interwoven in a complex set of dynamics, similar to Bruce's (1980) "medical syndrome." The conflict over the Bassetlaw CMHN's role is a good example, as it impinged on many facets of cooperation, including: objectives; leadership; decision making; communication; use of office space; morale; and trust.

It will be a task of the final chapter to integrate the foregoing material with the models and frameworks of cooperation and teamwork discussed in Chapter 5. A couple of observations can be made at this point however. There were significant variations within teams on a number of variables, including joint work and decision making. As a consequence, global classifications may become problematic. For example, instead of asserting that team 1 is an integrative team, it may be more realistic to argue that team 1 is an integrative team in certain circumstances, and a co-ordinate team in others. In addition, the model of teamwork employed would appear to act as a mediating variable in the relationship between trusting attitudes and trusting behaviours. A cognitive state of trust will only be converted into trusting behaviour if the preferred style of team working allows for this. This was an unexpected finding as it modified the initial assumption that a more direct relationship between trusting attitudes and behaviours would be found.

The second point concerns the role of identity in determining a team's boundaries. This was most obvious in North Nottingham where the Speech Therapist regarded herself and was regarded by others as a CMHT member, despite having less contact with the rest of the CMHT than some network members. The question of identity was at the heart of this, as she felt committed to the CMHT as part of her "professional identity" (Macdonald 1984a). In other words she had identified herself with the CMHT as part of her working consciousness, unlike other service providers, even though they had a greater amount of contact with the CMHT. The issue of identity would appear to be important therefore in determining if and when a team is a team.
CHAPTER 13

CMHTs' EXTERNAL COHESIVENESS

Introduction

The focus must now change from the CMHTs' internal machinery and operation, their internal cohesiveness, to the nature of the relationships between the CMHTs and their environments, their external cohesiveness. An exploration of the teams' external cohesiveness is required for a fuller understanding of implementation processes. An attempt will be made to examine the relationship between policy and action in an open manner, without prior assumptions regarding causality. It is hoped that this openness will be able to draw on the insights of the 'Bottom-up' and 'Top-down' models, while overcoming the sterility of the polarisation of these models.

It is also hoped that a dimensions approach may reconcile the two basic models and focus more sharply the exploration of implementation issues. The five dimensions outlined by Hambleton (1983) are again used, as above in Chapter 9, as pegs on which to hang the details of the relationships. The questions which emerge from these dimensions are:

1. The policy message: what types of policy existed and at what levels? How were policies communicated and how explicitly?

2. Perspectives and ideologies: did appreciative gaps exist between agencies? Did mediating bodies help to bridge these?

3. Resources: what impact did resources, and resource constraint have on policy making and implementation activity?

4. Multiplicity of agents: what "mechanical difficulties" existed, if any, between co-operating agencies at the planning and service delivery levels? How joint was joint planning? How well co-ordinated were services?

5. Politics of planning: who were the principal actors and what were their goals? What currency did they use in attempting to achieve these goals: negotiation, game playing or power relationships?
The repeated use of these dimensions is an acknowledgement of the continuity of implementation processes, before, during and after the establishment of the CMHTs.

The external cohesiveness of two of the CMHTs was studied: Bassetlaw and North Nottingham, and four aspects of their environments are isolated and discussed: Social Services Department; District Health Authorities; local service providers; and parents of mentally handicapped people. Similarities and differences between environments are considered, as are the CMHTs' responses to these differing contexts. The foregoing material is then located within the dimensions approach.

1. Social Services Department

In an attempt to develop a "comprehensive package of policies" for mental handicap services, as well as an operational policy for the CMHTs, the Deputy Director (1982c) produced a consultative document in July 1982. It was divided into three sections: accommodation, incorporating individual and group living situations; home services, for example good neighbour and sitting schemes; and away from home services, including short term fostering and sheltered employment. CMHTs' responsibilities within each area were outlined.

The CMHTs suggested a number of revisions which were incorporated in a second version (Notts SSD Deputy Director 1982d). They were content that a balance had been struck between being given responsibilities, but with sufficient flexibility. They were dismayed however when the PPG discussed the document and appeared to dilute their responsibilities. The Deputy Director felt the CMHTs' alarm was "too great," preferring to keep arrangements "fairly open" for the purposes of flexibility, although he did agree to reword the document in a couple of places to make it more explicit. The revised document was not re-issued however, hence the CMHTs did not receive an operational policy that was widely accepted within the Department, and consequently had to rely on local negotiations to a greater extent.

Regarding the CMHTs' objectives, the Deputy Director acknowledged he had "shifted ground" in arguing that the CMHTs should undertake casework as well as development work. In a paper sent to Area offices (Notts SSD Deputy Director 1982a) he argued that two broad "concepts" underpinned the CMHTs' establishment: "The NDT concept" of providing a comprehensive service for
clients living with their families; and the SSD's development role. In conversation with the North Nottingham CMHT SSW in January 1982 he explained that his change from an exclusive focus on the development role resulted from pressure from Area Directors who considered CMHTs to be a "luxury service" in comparison with their struggling teams. This compromise was an example of the power of Area Directors, in addition to the compromises they had forced over line management arrangements.

The Bassetlaw Area Director, accountable for the work of the Bassetlaw CMHT was happy that the CMHT accept casework referrals, both because his Area teams were under pressure and to prevent the CMHT from becoming "too removed." In contrast, the North Nottingham CMHT experienced different pressure from their line manager, a Development Officer. Three such posts were created, one for each Division, although the Development Officer (City Division) who was appointed in March 1982 was alone for a year before the other two posts were filled.

The Development Officer role was very broad, incorporating line management of hostels and ATCs, as well as the social work components of the CMHTs. The CMHT SSWs had a number of misgivings about the Development Officer role, notably the large degree of overlap with their own. Further, they were unhappy that the Deputy Director increasingly regarded the Development Officers as "the key people" in the planning and development of mental handicap services, interpreting this as another example of the "centralist" organisation of the SSD: "It retains power at County Hall .... it's a narrow view of what should be a multidisciplinary approach."

The Development Officer (City Division) agreed with the North Nottingham CMHT on the relative importance of development work and casework: "Teams will be judged on the alternatives they develop, not on their small amount of individual work." He adhered to the SSD's original understanding of the development role however, focusing almost exclusively on accommodation, which did not coincide with the CMHT's broader interpretation.

The Development Officer was fairly directive in trying to reorient the CMHT, as revealed by this intentional slip in a description by a CMHT member of a meeting held between the Development Officer and the two Nottingham teams in May 1983: "it was [the Development Officer] telling us, or should I say discussing with us, what our aims were." As a compliance strategy
this was a much less subtle and successful moulding of the team's normative structure than in Bassetlaw, where the CMHT experienced an atmosphere in which casework was construed positively. This was coupled with Area office game strategies to entice the CMHT to accept casework referrals (see section below on local service providers).

To what extent did the CMHTs influence senior SSD managers and policy-making? The saga of the development of the adult placement scheme related above in Chapter 10, revealed how naive the CMHTs were initially in thinking they could bypass existing planning mechanisms. This naivete was reflected on by an Area Director, who made the following observation regarding a CMHT SSW: "He was a shade naive about political processes and the way that Local Authorities work. Development work has brought him face to face with those realities."

This naivete resulted in frustration for the CMHTs, as their initial expectations went unfulfilled. A further cause of frustration was the length of time it was taking the teams to complete their survey. For the duration of this study the survey's full results were unobtainable, hence the CMHTs were deprived of a potentially valuable data base, both for influencing policy making processes and specific policies.

The CMHTs were generally regarded as having good access to senior SSD managers, particularly to the Deputy Director whom the SSWs met on a six-weekly basis. They failed to use this access effectively however, because initially they were in "awe" of the Deputy Director. Consequently they failed to take sufficient initiative, resulting in meetings they acknowledged to be unstructured and ill-focussed.

From early 1983 onwards, the CMHTs' frustration was compounded by feelings of isolation within the SSD, as they became aware of the ground lost by the Deputy Director in power battles with the Assistant Directors' group. A senior SSD officer explained the Policy Planning Group's perceived lack of effectiveness in its first year as the result of these power battles: "there has been much argy-bargy at senior manager level. [The PPGs] are chaired by [the Deputy Director] and therefore others have tried to make them ineffective." Similarly another senior officer argued: "the Assistant Directors' group is in the process of isolating the [Deputy Director]."
The CMHT SSWs began to question the value of their meetings with the Deputy Director, feeling that they were no longer seeking to exercise influence in the right place. They requested contact with the Assistant Directors' group and representation on the PPG, both of which were denied. The Deputy Director argued: "Issues around community care .... you've been better consulted about those than any other groups in the Department. We don't always consult Senior Social Workers in Areas; you're 'getting involved and influencing." The CMHTs might have replied that in spite of their inputs to the community care documents, they still did not have an operational policy.

Another issue over which the CMHTs were keen to exercise influence was the SSD's future hostel provision. The PPG wanted to explore the alternatives to 24-bed hostels and each CMHT SSW submitted a document. There were some common themes between the documents, for example the separation of short term and long term care. The Deputy Director informed the CMHTs that a working group would be established, incorporating a CMHT SSW and a Development Officer: "so your views will be very influential in terms of what the Assistant Directors are told." A CMHT SSW replied: "I was sceptical about our ability to influence anything. It's pleasing."

The teams' feelings of frustration and isolation led to an acknowledgement of the importance of learning "how the machinery operates." The development budget provides a good example. Despite a first year underspend, the CMHTs felt the development budget was far too small, as a SSW observed in October 1983: "Next year our budget is £27,000 but estimates of our proposed schemes are £180,000." As a consequence the budget was not large enough to meet substantial revenue commitments, and hence was being used primarily for one-off projects.

The CMHT SSWs felt the budget's small size reflected a lack of understanding of their development role by senior SSD managers, which itself was couched within a broader lack of commitment to community-based services: "Despite the developments they still need convincing that a community programme is relevant for the mentally handicapped: they're not convinced."

With some feeling a CMHT SSW argued: "We have a developmental brief, but no tools. Our direction in the long-term may be: back us or sack us."

At the CMHTs' joint meeting in October 1983 a CMHT SSW observed: "It's a political game - we're part of that and we must play it." Their chance
came the following year when requested by the Deputy Director to submit proposals for schemes. He was fearful of a change in political control of the Council following the forthcoming elections and thought the development budget would sustain a cut more easily if it was bigger. The CMHTs colluded in this, and submitted proposals totalling £200,000, although only "hoping for an extra £5000." As a result the development budget was increased from £28,000 for 1983/4 to £69,000 for 1984/5. It is noticeable that it had taken the CMHTs two years to learn such a lesson and to apply it, in which time they had suffered much frustration.

The issues regarding mental handicap services confronted by the Bassetlaw and Nottingham DHAs post-NHS reorganisation reflected their situations more broadly. Bassetlaw DHA was a small District with few resources and this applied to its mental handicap services. It was therefore trying to establish services such as an Assessment unit, community units and long-term accommodation. Nottingham DHA was a much larger Authority with more resources, but was facing problems of revenue consequences from capital-led developments. This problem manifested itself most notably in its mental handicap services, by a hospital with unopened wards. Both DHAs were having to grapple with historical legacies of shortages in residential provision for mentally handicapped people, and were considering at this time how best to accommodate so many transfers from other hospitals. Several of the issues that had confronted the steering group therefore, were being faced by the newly established DHAs.

The Bassetlaw CMHT SSV used the joint planning machinery as the vehicle through which to influence DHA policy-makers. The joint planning mechanisms were activated quickly with the establishment of Health Care Planning Teams (HCPTs). However there was a lack of jointness initially as the DHA failed to inform senior SSD managers of the HCPT (mental handicap) meetings. Further the JCC started to meet without input from the SSD, to which the SSD protested "in the strongest terms." In addition the HCPT (mental handicap) was initially composed entirely of Health Service personnel with the exception of the CMHT SSV, and considered DHA plans almost exclusively in an attempt to firm them up before being submitted to Trent RHA.

The Bassetlaw CMHT SSV felt he had made a large impact on the DHA's plans, particularly by using interim results from the survey. For example,
he used survey material to support the HCPT in arguing for the opening of the second wing at their children's unit. He also used survey results to argue against Health Authority proposals for DT-style community units. He accused them of "planning in the dark" when proposing: "a 24 place community unit - they've been bandying around the numbers. I said how do you know, whether 16 places? 8 places? I said to them: use some planning information, we'll provide you with it."

The basis for this dispute over community units lay in differences in models of provision. The CMHT felt the DHA was obsessed with "institutions" and the medical model. A CMHT member advised the SSW: "You have to try and get them to think of the mentally handicapped as people and not commodities." The SSW's main protagonist was the newly appointed Consultant Psychiatrist (mental handicap), who had restored medical leadership to mental handicap services within the DHA. The SSW's description of an early HCPT meeting is notable for showing their disagreement, as well as the importance of game playing:

"[The Consultant] was on one side, I was on the other, and [the DMO] was playing games; no one else mattered. [The DMO] kept saying: 'The CMHT is the expert, we should listen to them.' This was to try and isolate [the Consultant] who was putting the case for institutions .... [the DMO] enjoyed putting [the Consultant] down."

The SSW and Consultant developed their own game playing strategies. To the SSW's assertion in a multidisciplinary meeting that an assessment unit be no larger than 12 beds, the Consultant replied: "I've got my own ideas" and to his proposal for ordinary housing to supplement the assessment unit the Consultant's reply was: "I may agree." The protagonists used such phrases as a means with which to deflect opposing arguments, although as a result differences were not resolved.

The games involved points scoring, as when the Consultant asked if he could have a copy of the CMHT surveys conducted on hospital patients, as had been agreed with the Central Notts CMHT. The CMHT SSW replied: "It depends on what parents say about the use of information - its confidentiality. If they've said 'yes,' then there's no problem." The SSW was clearly attempting to rebuff the Consultant, while attempting to cover the iron fist with a velvet glove. Their relationship was widely perceived as a power...
struggle, in which the purpose of forums such as HCPT and multidisciplinary meetings was: "to find out who has got more power."

The North Nottingham CMHT was deprived of joint planning machinery as a route through which to influence Nottingham DHA, because of its tardy development. The first formal joint meeting was held over a year after the Health Service re-organisation, and it was a further nine months before the mental handicap sub-group of the Joint Planning Team was established. The Nottingham CMHTs tried to form a bridge with the Health Service, as a CMHT SSW claimed in October 1982: "The Health Service are keeping in touch through us." He also observed however that he had had his "wrists slapped" by senior SSD managers and was told to keep out of negotiations with the Health Service in future.

The Nottingham CMHTs became frustrated by the absence of joint planning arrangements, which resulted in a failure to resolve a number of issues, most notably concerning CMHNs. The steering group had agreed to the creation of two CMHN posts for the North Nottingham CMHT, and three for the South Nottingham CMHT. This did not prove to be a contentious issue until the appointment of a new District Nursing Officer (DNO) following the Health Service re-organisation. He questioned the appropriateness of the RNMS qualification and of nursing in different contexts: "You cannot convert them [i.e. nurses] to a quasi-social worker/community worker." He argued that he: "would rather give Health Service money to Social Services ..... than not use it effectively."

At a meeting in September 1982 at which the DNO expressed these views, he agreed to receive submissions on the CMHN issue before December. Following that meeting, a DHA planner acknowledged that it was a "welcome and refreshing change" for a Nurse to play such a dominant role in policy discussions. In effect the DNO had accepted the leadership mantle, which he was to continue to hold. That the steering group decisions were being overturned however, annoyed many service providers, and there followed a vigorous exchange of correspondence between the Consultant in mental handicap and the DNO.

The Nottingham CMHTs (1982) submitted a paper to the DNO by the deadline, arguing for the CMHN posts agreed by the steering group. At this deadline the DNO announced that he was commissioning a survey of all mentally handicapped people in the Highbury hospital catchment area, to
assess the numbers requiring either CMHN or Specialist Health Visitor services. The CMHTs were unhappy with this survey, considering it both ill-conceived and unnecessary, particularly as it threatened to duplicate their own survey. The survey report was completed in mid-1983 by the specialist Health Visitor, but as she acknowledged, the DNO had "pre-empted" her report by deciding to employ three more Health Visitors.

Against almost total agreement on the desirability of CMHNS the DNO had stood firm. An Administrator commented: "I don't know whether [the DNO] is being devious or just obstinate." Certain factors point to the former, notably the survey, particularly in not waiting for its results before reaching a decision. The Administrator admitted to being devious himself in his support for CMHNS. The motivation for his support was that they would influence the work undertaken by the CMHT Social Workers: "I thought the CMHNS would get the Social Workers' hands dirty. They would therefore have a valuable role in diverting Social Services from their intentions, to providing a service to patients. I therefore had a subversive political aim."

The North Nottingham CMHT (1983) SSW argued that "the absence of Health Service staff" proved to be: "The main barrier to progress towards a multidisciplinary community service." Indeed there was so much frustration and resentment within the CMHT, that one team member suggested removing "Nottingham DHA" from the sign at the front of their base, which displayed both the County Council and DHA logos. The CMHT considered the only avenue to the resolution of the CMHN issue to be the reconstitution of joint planning machinery, to which end they started lobbying senior SSD managers.

Neither the Bassetlaw nor the Nottingham DHA appeared to understand fully or approve of the CMHTs' development role. Both equated it with planning which they viewed negatively as they felt it failed to offer sufficient direct help to mentally handicapped people and their families, particularly as they approved of the DT model of CkET. In Bassetlaw for example a doctor argued: "Social Workers spend too much time planning and not in doing." Similarly an Administrator in Nottingham felt that: "The political realities are that the CMHT Social Workers are fanning around doing a planning role."

Bassetlaw DHA did not pursue this, as the CMHT SSW acknowledged: "They have never said what they expect us to do. They are interested but they..."
have not tried to influence us." Nottingham DHA increasingly tried to influence the North Nottingham CMHT over its objectives however, through the CMHN issue for example. This is revealed in the DHA's (1983) progress report: "One of the principal decisions needed over the course of the next year will be the pattern of working of the Community Mental Handicap Teams in Nottingham. On this decision will depend the Health Service support. The role may be that of a multidisciplinary community services management team, which the present research based activities would suggest, or that of a full field-work team."

This statement shows very clearly that Health Service support for the CMHTs became contingent upon their perceptions of the CMHTs' objectives. The "support" most sought after by the CMHTs was additional personnel, CMHNS particularly, but also a range of therapists and clerical support. Despite wanting the extra personnel, the CMHTs resisted changing their objectives to suit the tastes of the DHA.

iii Local service providers

There were several examples from both areas of units or services working in isolation from each other or suffering from poor relationships, when dealing with the same clientele. In Bassetlaw relations between the Health Service unit for children and special school were not positive, as evidenced by the number of reviews in either setting to which staff members from the other unit were not invited. The Work Orientation Unit's perception of the ATC was one of mild contempt, while a more open hostility raged between Social Services and Health Service Occupational therapists, as a CMHT member observed: "Ne'er the twain will meet; they're at loggerheads."

In North Nottingham, staff at the local Health Service unit for children admitted that their relationships with the Paediatric Assessment Unit had been marked by "rivalry" and that there was still room for improvement. An adult was offered a place in an ATC the day after being offered a place in Health Service day care. This lack of co-ordination is the inevitable outcome of poor relationships and communication, as a day centre nurse observed: "The right hand doesn't know what the left hand is doing."

Poor co-ordination was reinforced by stereotyping. There was some evidence of this in the views of residential workers towards field social
workers. Their criticisms included: not being honest with residential staff; not knowing their clients well enough; and "dumping" their clients without revisiting. The stereotyping process involved a transition from legitimate criticism of some Social Workers through a negative spiral to a broad dismissal of all Social Workers, a point reached by this hostel worker: "I think all Social Workers go to the same school where they learn the same patter."

This process was evident in the views of some Health Service workers who felt that Social Services and hostels in particular, were too "choosy" in whom they accepted: "Hostels won't take them unless they've got 'perfect' stamped on their back." This was linked to a belief that the only expertise in caring for those with behaviour and medical nursing problems existed in the Health Service. The consequence for the CMHTs as a new unit of service was that they were initially judged within these existing frameworks, as teams of fieldworkers, and of predominantly Social Services personnel.

Did the CMHTs contribute to improved service co-ordination? This was a major plank of the DT's approach to CMHTs although the Notts SSD model with its development role had played it down. In both areas the CMHTs' decisions to accept casework referrals had led to greater confusion both because it provided yet "another door," and because the criteria by which they accepted cases was unclear to others. A Bassetlaw Area SW claimed: "I got a case at the time [the CMHT] came - a difficult one - I thought that they should do it - they're the Social Workers and specialists. The CMHT SSW offered to do a joint visit - but I felt that was inappropriate; they should have had the case in the first place."

The North Nottingham CMHT SWs only accepted one casework referral during this study, but it was a good example of the resulting confusion. An Area SW stated: "I thought - 'Good, the CMHT is consultancy,' but then they take on a case. [CMHT SW] didn't consult, but went on and did things without telling me...." There were other instances where service providers felt the CMHTs had not facilitated the provision of a co-ordinated service. The input of the North Nottingham CMHT to a hostel for example, was criticised by hostel staff for undermining their approach and hostel policy.

Nevertheless there were several examples of the CMHTs attempting to achieve a better co-ordinated service. The Bassetlaw CMHT supported the
case for a paediatric assessment unit in Bassetlaw. Further, they argued for joint reviews between the Health Service unit for children and the special school. The CMHT pointed to several examples of the separate reviews being held close together, which had been an "ordeal" for parents and child, and their content had been very similar. The CMHT was unsuccessful in its bid to unify the reviews because of professional territoriality, and the poor relationships between the two units.

Both CMHTs tried to convey themselves as resource centres and foci for mental handicap services, particularly the North Nottingham team, hoping thereby to improve communication and co-ordination. In assessing whether the CMHTs contributed to a greater co-ordination of services therefore, their impact could best be described as "mixed."

The CMHTs had to contend with some confusion over their objectives. For example in Bassetlaw many service providers saw the CMHT purely as a casework agency when asked, and did not refer to the CMHT's development brief at all. Several respondents who mentioned development work found it difficult to specify, admitting to being "confused" and "foggy" about it. There was some confusion over the development role in North Nottingham also. Despite being able to outline a number of the CMHT's activities several respondents still felt uncertain regarding the team's objectives and priorities.

The CMHTs' survey was a high profile exercise of which most other service providers were aware. It enjoyed a mixed reception. Some argued that it was "essential" because: "unless you know the numbers and types of problems, you can't plan services and interventions." Others expressed more ambivalence however, particularly those whose workload had been affected by the survey, including an Area Social Worker: "We'd never suggested things because we knew we didn't have the resources - there are now a lot of 'jumping beans' all over the place ..... The [survey] is turning over stones which we haven't bothered unturning - the stuff's coming our way, but we won't get resources unless we know about all this...." Because of uncertainty over the development role there was confusion among many service providers as to how the CMHTs would follow the survey: "I'm not clear what happens after the survey: whether they become ordinary Social Workers or planners/co-ordinators."
Approximately half of the respondents in both areas were unhappy with the CKHTs' role, and for the same reason: they wanted the CMHTs to undertake more casework. This response arose partly from the Area social work and community therapy services being over stretched, and consequently they found it more difficult to accept teams which had so much freedom to determine their objectives. An Area Director observed: "There is an area of resentment between Areas and [CMHTs]. It is that they do the good stuff and we have to get on with the graft."

Others objected to the model of team and its focus on development work preferring the DT model of CMHTs, as did a Consultant Psychiatrist (mental handicap): "They shouldn't concentrate on one thing and ignore others, since it doesn't help parents and clients much, who look for immediate help ...." This raises the question of timescale as a lot of the CMHTs' development work was long-term in nature. The survey was a good example, as its results were not available for the duration of this study. Nevertheless both CMHTs did pass the survey's interim results to others, notably ATCs, in an attempt to effect some change both at an individual level and more structurally, and with some success. For example the North Nottingham CMHT observed that an ATC manager had followed up some of the criticisms of the Centre that had been passed to him from the team.

The CMHTs became aware that the long-term nature of their work did not coincide with the timescales that other service providers were working to, particularly those working at crisis level. An Area Social Worker claimed: "They're planning for two to three years ahead but that's no good for our present work." This lack of fit between timescales resulted in the CMHTs' work failing to impinge directly on others' work. Consequently in their early months the CMHTs found it difficult to influence others' practices.

Issues of timescale were compounded by the intangibility of some of the teams' work. Indeed on occasions CMHT members were acting "subversively," and hence as inconspicuously as possible. This made the teams more sensitive to their credibility. The Bassetlaw CMHT for example, discussed in a team meeting how "concrete" examples like group homes (no joke intended) were necessary to persuade others of the viability of their development work, which otherwise appeared as ill-conceived and the "soft option."
It is not surprising when asked about the CKHTs' achievements that the majority of service providers' responses incorporated activities which were tangible or pertinent to themselves: support to professionals and parents in Bassetlaw, and support to professionals and the survey in North Nottingham. The North Nottingham team was able to rely on the credibility of their SSW, who had established a positive reputation in his previous post as Senior Professional Officer. The Bassetlaw team's response to their credibility problems was to accept a higher number of casework referrals from the Area Social Services office.

Casework referrals became the currency in a game played between the Bassetlaw CMHT and Area office. An Area Social Worker claimed: "When the CMHT came here, files were passed to and fro, from us to them and back again, that no work was getting done." The objective of the passing the referral game was to secure acceptance of the referral by the other party. A refusal by one party to accept a case put the other under greater pressure to accept it. The game continued until the resolve of one side weakened, and was played within the compliance strategy used by the Area office of moulding the CMHT's normative structure.

Other relationships between the CKHTs and service providers were marked by game playing. The power games between the Bassetlaw CMHT and the Consultant Psychiatrist (mental handicap) described above are a good example. More broadly the CMHTs were careful to temper their input to other service providers, sensitive to the degree to which they had been "accepted." A good illustration was the North Nottingham CKHT's input to three hostels. The team considered that the hostels employed different models: innovative; transitional; and traditional. Their relationships with the hostels varied according to these models: much more open with the "innovative" hostel than with the "traditional" hostel, to which they decided to make further input only "under the Development Officer's wing."

Parents of mentally handicapped people

Both CMHTs attached a lot of importance to their work with parents through organisations such as Mencap, or through smaller parents groups which they supported or had helped to establish. Local Mencaps were regarded as fairly "dormant" by the CMHTs although they continued to keep communications open. The proposal that the Nottingham Mencap have a
development worker was welcomed by the North Nottingham CMHT as a chance to build bridges between the statutory and voluntary agencies.

The CMHTs regulated their approach to parents' groups and organisations according to the nature of the group. They were particularly sensitive about the divide between statutory and voluntary and consequently adopted a "cautious" approach so as not to appear "imposing." Covertly however the CMHTs acted more subversively, as in the North Nottingham CMHT's attempt to generate change within the local Mencap: "The new parents' group, the small committee, we were trying to push them to take over the [Mencap] AGM, it'd change the face of it." Another Social Worker from the same team admitted to working subversively within a parents' committee: "Decisions are taken by the parents' committee, for example the house we had in mind, I wanted the parents' approval but if they hadn't approved it I would have worked hard to have persuaded them. I think [ATC manager] thinks likewise and therefore we take decisions and try and make the committee think that they are taking decisions."

An obvious way in which the CMHTs felt they were working with parents directly was through the survey. The teams acknowledged its weakness as a planning tool in not including an objective assessment of needs. They felt that this was more than balanced however by unearthing parental perceptions of needs and service provision, thereby promoting the consumer's voice in planning. It has already been seen for example that an ATC manager made some changes as a result of feedback of parental perceptions from the survey. In addition the CMHTs used interim survey results to determine the need for some of their own developments, for example the Bassetlaw CMHT and the Social Club.

A further example of a CMHT attempting to promote parental participation, was the Bassetlaw CMHT's informing the Consultant Psychiatrist (mental handicap) that parents were not involved in programmes devised at the local Health Service unit for children. This led to a worsening in relations between the service providers involved for a period, but succeeded in bringing the issue to the fore.

The North Nottingham CMHT was under the greater pressure from parents' organisations, most clearly from a parents' group based at the local Health Services unit for children. The parents' groups started a campaign for more facilities for mentally handicapped adults, and won the support of the CHC.
This forum commanded the attention of both the SSD and DHA, and in an atmosphere "hostile" to representatives of these organisations, a Health Service Administrator promised an extra eight short term care beds for the summer of 1983.

The CMHT SSW regularly attended these meetings and found them "uncomfortable." He felt that the lesson for the CMHT was: "the need to do more than the survey, we need to keep the developments going." In mid-1983 the CMHT SSW revealed that the CMHT had been criticised by an ATC's parents' association, for concentrating too exclusively on accommodation for the least dependent, particularly unstaffed group homes. This criticism encouraged the team to focus its thoughts more keenly on ways of providing community-based accommodation for people with higher levels of dependency.

**SUMMARY AND PRELIMINARY ANALYSIS**

There were some striking differences between the teams' environments: they were subject to divergent pressures within Social Services line management relationships; they enjoyed differential access to their respective DHAs, and were subject to differential amounts of pressure from them; and the North Nottingham CMHT received the greater pressure from parents' organisations. Similarities between the teams' contexts included both teams experiencing: frustration with and isolation from the SSD's broad policy making processes; and credibility problems with local service providers, although their responses to this latter problem varied.

Using the foregoing material it is possible to address the dimensions and questions listed in the introduction to this chapter.

1. The policy message

The CMHTs witnessed in the first 18 months of their lives several attempts by the SSD to operationalise the concept of "community care." The CMHTs were given the green light by the Deputy Director early in 1982 to undertake casework as well as development work, reflecting the SSD's understanding of community care as embracing services for clients living with their families as well as services for clients unable to live at home.

The long running saga of the community care document showed some refinement of the issues and was significant both as a first step to developing a package of policies for the SSD's mental handicap services, and
as an attempt to develop an operational policy for the CMHTs more specifically. However, it failed to become "official" policy, with the result that the CMHTs did not receive an operational policy for the duration of this study.

The issues regarding mental handicap services confronted by the Bassetlaw and Nottingham DHAs post NHS re-organisation reflected their situations more broadly, as Bassetlaw DHA was a small District with few resources and Nottingham DHA was facing problems of revenue consequences from capital-led developments. Several of the issues that had confronted the Steering Group were being faced by the newly established DHAs, most notably the relocation of hospital patients. Regarding CMHTs, there was little difference between the DHAs' viewpoints and that expressed on behalf of the AHA(T) in the Steering Group's final report: that a DT model of CMHT was favoured, with greatest emphasis placed on helping families care for their mentally handicapped dependents in the community.

2. Perspectives

i. CMHTs and SSD

In the CMHTs' first 18 months, they worked hard to act as Bottom-up influences on the thinking of senior SSD managers, for example over the Community Care document and future hostel provision. They were denied a valuable source of influence however as the survey's full results were unavailable in this period. It was generally felt that the CMHTs had ready access to senior managers, but the CMHTs felt increasingly isolated from decision making processes within the SSD. These feelings of isolation generated frustration among the teams which was compounded by their belief that senior managers lacked commitment to community based services for mentally handicapped people. The CMHTs felt that they themselves enjoyed a strong ethos but that there was an absence of any guiding philosophies within the higher echelons of the SSD. After their first 18 months, the CMHTs gradually adopted a stance in which they accepted the need to educate their own Department.

Concerning their own objectives the CMHTs were happy that the SSD did not have a detailed operational policy for the teams, because they enjoyed the freedom of determining their own objectives and work. This proved to be a double-edged sword however, as the lack of clearly defined responsibilities created problems of credibility for the teams. Their
freedom to determine their own work denotes bottom-up processes, but these were constrained differently within line management relationships: on the North Nottingham CMHT to define the development role more narrowly; and on the Bassetlaw CMHT to accept casework referrals.

ii CMHTs and Health Authorities

The Bassetlaw CMHT SSW made a large impact on the DHA's plans for mental handicap services, by using interim results from the survey and by advocating an alternative model of provision. The North Nottingham CMHT were denied the avenue of influence used by the Bassetlaw CMHT, joint planning forums, and became frustrated by the failure to resolve a number of problems, most notably the CRRN issue.

Neither DHA appeared to understand or approve of the CMHTs' development role. Both equated it with planning, which they viewed negatively as they felt it failed to help mentally handicapped people and their families sufficiently. Bassetlaw DHA did not pursue this, so that the CMHT did not feel the DHA had tried to influence the team's objectives or work. Nottingham DHA did try to influence the North Nottingham CMHT, through the CMHN issue. It became increasingly clear that Health Authority input to the two Nottingham CMHTs was dependent on the teams' objectives. As a result, where such input occurred it tended to derive from negotiations between individual professionals and the CMHTs.

iii CMHTs and local service providers

Both CMHTs had to contend with some confusion over their role. For example, in Bassetlaw many professionals saw the CMHT purely as a casework agency and there was confusion over the development role in both areas. The CMHTs found that the intangibility of development work caused credibility problems. It was not surprising that when other service providers were asked about the CMHTs' achievements, their responses commonly reflected activities which were either tangible or pertinent to themselves.

Problems of intangibility were compounded by problems of timescale, as the timescale for development work did not coincide with the timescales that many other service providers were working to. Consequently the CMHTs found it difficult to influence others' practices as their work did not impinge immediately and directly on that of others. The survey is a good example, as its full results did not materialise until after this study's completion, thereby depriving the teams of another source of influence. They did pass
the interim results to others however, particularly ATCs, which helped bring about some change both at an individual level and more structurally.

The CMHTs were conscious that they had a credibility problem but their responses differed. The North Nottingham CMHT relied heavily on the credibility the SSW had built up with other service providers in his previous position as Senior Professional Officer. The Bassetlaw CMHT on the other hand gave in to some of the demands to accept more casework referrals.

CMHTs and parents

In both areas the CMHTs regarded the local Mencaps as fairly dormant, although they continued to keep communications open. Both CMHTs worked with parents through a number of parents' groups and through the survey, and both fed parental perceptions of services through to service providers in order to effect change. Another example of the CMHTs promoting parents' interests was the Bassetlaw CMHT's informing the Psychiatrist that parents were not involved in programmes devised at the local Health Service unit.

Where the CMHTs were promoting parents' interests in an attempt to achieve change, they were facilitating Bottom-up processes. The teams themselves however were also subject to pressures from below, from parents. The greater pressure from parents was applied on the North Nottingham CMHT, primarily through a parents group and the CHC. The CMHT felt the lesson was the need to forge ahead with the developments rather than just conduct the surveys. They also responded to criticisms from a Parents' Association by considering schemes for people with higher levels of dependency.

3. Resources

Despite an underspend of the development budget in their first year, the CMHTs found the budget too limited thereafter, not containing the capacity for projects with large revenue consequences. The CMHTs considered the budget limitations to show that the SSD had not fully understood the nature of their development role and felt frustrated as a result. It is an example of resource constraint limiting the operation of Bottom-up processes.

4. Multiplicity of agents

There was a lack of jointness in the Bassetlaw joint planning arrangements, particularly regarding membership and foci. The lack of jointness was even more acute in Nottingham where joint planning structures were established very tardily. As a result several problems went unresolved.
and the CMHTs' Bottom-up initiatives to resolve the CMHN issue proved insufficient. In lobbying for the establishment of joint planning mechanisms, the CMHTs were arguing for "sideways" pressure to be brought on the DHA.

At the service delivery level there were several examples from both areas of poor relationships between different services, and occasionally these were reinforced by stereotyping. A consequence for the CMHTs as new units of service was that they were initially judged within existing frameworks of expectations. The CMHTs' contribution to the co-ordination of service delivery could be described as "mixed." For example, the decision by both CMHTs to accept social work referrals caused confusion. The teams did however try to establish themselves as resource centres and foci for mental handicap services in an attempt to improve communication and co-ordination.

5. Politics of planning

Medical leadership was restored to mental handicap services in Bassetlaw DHA with the arrival of a new Consultant. He engaged in a lot of bargaining and game playing with the CMHT SSW. Their game playing formed an ongoing power struggle which revolved around scoring points at the other's expense. In Nottingham the leadership mantle was adopted by the newly appointed DNO who made a big impact on the planning of mental handicap services in the DHA. A notable example was the CMHN issue, on which he withstood a lot of pressure, including pressure from the CMHT. His approach would appear to have included some deviousness, for example in commissioning a survey but not waiting for its conclusions before deciding on a course of action.

Power battles were clearly evident within the SSD, for example between the Deputy Director and the Assistant Directors' Group, and between Area Directors and senior managers at County Hall. The Area Directors flexed their muscle in obtaining a further concession from senior managers over the CMHTs, that they should undertake casework. The CMHTs were generally regarded as having good access to senior SSD managers, but they failed to use it efficiently. This undermined their capacity for achieving change through Bottom-up processes, but in addition they had been initially very naive regarding the scope for Bottom-up initiatives within the SSD.
Feelings of frustration and isolation resulted, and led to the teams accepting the need to learn the "rules of the game."

The CKHTs were very careful to temper their input to other service providers, being very sensitive to the degree to which they had been "accepted." Negotiations in some of the relationships between CMHTs and other service providers were characterised by game-playing. Good examples include the "power struggles" between the Bassetlaw CMHT and the Consultant Psychiatrist, and the pass the casework referral game between the Bassetlaw CMHT and the Area Social Services office.

The CKHTs also regulated their approach to parents' groups and voluntary organisations, according to the nature of the group. They were particularly sensitive about the divide between statutory and voluntary. Nevertheless, there was some evidence of the CKHTs acting in subversive ways in work with parents. As a consequence the CKHTs were adopting different strategies: publicly they were working in partnership with parents or responding to parents' Bottom-up demands, but covertly they were trying to manipulate parents in more of a Top-down fashion.

It is a task of the next chapter to integrate this material with that in the previous chapters, to assess the explanatory power of the models of implementation discussed in Chapter 4, and to judge the effectiveness of the exploratory approach adopted for this study. Some points can be highlighted at this juncture however. First, that the balance between Top-down and Bottom-up processes was extremely complex, such that a uni-directional model, either Top-down or Bottom-up, would appear insufficiently flexible to incorporate the complexities.

The second point concerns the multi-levelled nature of both policy and action processes. The CMHTs found that policies could vary according to the level within the organisation from which they emanated. For example the North Nottingham CMHT was told by the SSD's Deputy Director that they should undertake casework, while being encouraged by the Development Officer to focus almost exclusively on development work. The relative nature of policy and action is pertinent here, and applies also to the CKHTs' work with clients. For example, it was noted above under 'politics of planning' that the CMHTs could adopt a Bottom-up or Top-down approach when working with parents, depending on the focus for change.
The final point also concerns the question of levels. When considering the CMHTs' environments, the Top-down and Bottom-up concepts have helped explain the relationships between the teams and their parent agencies and clients. But the question remains as to how to classify the "sideways" processes between the CMHTs and other service providers. Once again the unidirectional models are insufficiently flexible for the real world, which tends to be more "messy" than the models allow for.
PART V

SUMMARY AND CONCLUSIONS
CHAPTER 14

SUMMARY, ANALYSIS AND CONCLUSIONS

1 INTRODUCTION

An attempt is made in this chapter to integrate the fieldwork material with the models and frameworks from the literature on implementation and teamwork. Prior to this a brief mention is made of the broad approach adopted to the study of these two foci. An exploratory approach formed the basis of the empirical fieldwork. Regarding implementation for example, the relationship between policy and action was examined without prior assumptions, to combat the polarisation between the Top-down and Bottom-up models. Similarly an open approach was used with teamwork, where the primary aim was to ascertain team members' own perceptions and experiences.

This chapter addresses the outcomes outlined in the field work chapters above, to determine if they were congruent with a "policy was implemented" explanation, or an "action produced unplanned outcomes" explanation. It is important to be clear about the outcomes before proceeding to account for them. The research started with a policy initiative: developmental, multidisciplinary CKHTs. To what extent therefore, did the CMHTs prove to be: a) developmental? b) multidisciplinary? c) teams?

a) The CMHTs were primarily developmental in their work although the nature of developmental work itself was subject to debate between the teams. In addition the CMHTs differed as to the amount of casework they undertook.

b) The CMHTs did not become multidisciplinary in composition as originally intended, although all three had some input from Health Service professionals by the end of the study.

c) Once again the teams differed, although they were each imbued to a greater of lesser degree with a commitment to development work as a shared goal. In addition there were examples of complementary roles and shared information, although there were variations within as well as between teams.
The next two sections will attempt to explain these outcomes, by testing the explanatory power of the concepts and models identified in Chapters 4 to 6. The final section posits some broad conclusions and considers briefly the links between the study of teamwork and of implementation.

II IMPLEMENTATION

The aim of this section is to explain the outcomes and to examine the explanatory power of the Top-down and Bottom-up models. In addition the value of the five dimensions as bridging concepts will be assessed.

As a break from the tradition of the implementation literature, the Bottom-up model will be considered first: how far does it explain the CMHTs' actions? The lack of detailed operational policies left the CMHTs with some scope for determining their work at a detailed level. However the teams' initial expectation that they would implement their schemes with little reference to their parent agencies was soon frustrated. Initiatives such as the adult placement scheme increasingly had to be legitimised by the SSD, not least because of resource consequences. An advantage of focusing on the teams and their work without adopting a Top-down perspective exclusively, was that elements of the teams' environments other than their parent agencies were examined. Consequently the impact of the negotiation between the CMHTs and local service providers and parents could be more readily considered.

Although the CMHTs' action was not totally, or even primarily, determined by Bottom-up processes, this perspective can be mobilised in a second way: Could the CMHTs' action be a vehicle for Bottom-up processes, even if not a product of them? An example of the CMHTs trying to act as a vehicle in this way were their attempts to learn the "rules of the game" in negotiation with senior managers, so that "the game" would be played to their benefit. The particular issue the CMHTs were considering in this light was the size of their own development budget, but they also worked hard towards the development of a Community Care policy and on the design of future hostels. The survey's results were not ready until after the completion of this study, but the teams
hoped it would provide a database with which to influence both policy and policy making. Indeed the teams hoped that the existence of the developments themselves, such as group homes, would help to convince their managers that alternatives to traditional policies were viable.

How far does the Top-down model account for the CMHTs' actions? The decision by the SSD to establish the CMHTs and place them outside existing Area structures in an attempt to protect the development role represents Top-down policy making. That the CMHTs remained primarily developmental was in no small part due to the 'space' they enjoyed - not least the independence of the Areas which they generally enjoyed. Clearly, therefore, the Top-down model seems to provide a significant key in accounting for the operation of the CMHTs.

There was grassroots opposition to the original policy, notably from some Area teams who were successful in gaining some concessions regarding line management arrangements and casework. How compromised were the Centre's intentions by these concessions? Because of the lengthy timescale of some elements of development work it was impossible to answer this question after only 18 months of the teams' existence. Two points can be made however: the development role was not initially displaced in the Bassetlaw CMHT; indeed it was this team that adopted the broadest interpretation of development; but the Bassetlaw CMHT SWs accepted a significantly higher number of casework referrals than their counterparts in the other CMHTs. Given that line management, through the Area team, influenced the role adopted by the Bassetlaw CMHT (in accepting more casework referrals, particularly), a simple policy/implementation Top-down view has to be modified.

It is interesting to note that the most potentially disruptive force to the development role, from the AHA(T) and latterly the DHAs, was Top-down and not Bottom-up. There was not much conflict between the CMHTs and SSD over the broad policy goal of development, not least because the staff were chosen with such a commitment. In wanting to learn the "rules of the game," the CMHTs accepted the broad policy goal, but wanted to manipulate the system in order to influence decision making. In doing so they increasingly accepted the policy making structures they were located within, thereby according greater legitimacy to those structures. Ironically, the CMHTs were trying to exercise influence in
order to implement the approach selected at the Centre, but to which the SSD's management and structure proved to be insensitive and impermeable. The Bottom-up perspective is useful here for highlighting the importance of the CMHTs' response to barriers which could have impeded the implementation of a policy laid down from above.

The complex nature of the interplay between Bottom-up and Top-down processes has been touched on above but requires further discussion. The use of this dichotomy tends to assume a single "top" for any given policy issue. The Notts CMHTs were operating in a multi-agency field however, confronted by at least two "tops", the SSD and DHAs, which had divergent effects because of conflict over strategic policy. The term "top" requires further specification also, as most "tops" are "bottoms" in other hierarchies. For example the model of CMHT incorporating a development role devised by senior SSD managers would be considered a Bottom-up development by the Development Team.

The CMHTs were embroiled in a mix of upward and downward pressures, reflecting the multi-levelled nature of policy and action processes. They found that policies could vary according to the level within the organisation from which they emanated, between the SSD's Deputy Director and Development Officer for example. Even at the grassroots level there was a mix of pressures as the CMHTs sought to manipulate parents groups, while responding to parental perceptions of need through the survey. In short, action at the grassroots level can involve the use of power, authority and control, and can embody a significant Top-down component, even if covertly.

The two models have been helpful as metaphors, indicating in broad outline the general direction of processes. Necessarily they have been over-simplistic and other factors need to be introduced if the process of implementation is to be more fully understood. It was hypothesised that the five dimensions outlined by Hambleton (1983) could act as bridging concepts between the two models. To what extent have the dimensions illuminated the complexity of Top-down and Bottom-up processes? To address this question, the fieldwork material is briefly summarised under the five headings.
1. **The policy message**

The CMHTs received no detailed operational policies from either the SSD or the Health Authorities, a situation mirrored by other units of service. Departmental policies were very broad, with two consequences. First, Bottom-up processes were encouraged as the CMHTs had a large degree of autonomy to determine their own work and objectives, within boundaries defined by the broad Top-down policies. The survey is a good example of a project the CMHTs themselves decided to undertake.

The exact processes were dependent on the nature of the issue however, as the teams required approval from senior managers over issues which changed broad SSD policy or which had large financial consequences. The adult placement scheme is a good example, largely the initiative of Bottom-up inputs by the CMHTs, but which had to be accommodated within and legitimised by Top-down policy making processes. The second consequence of such broad policies was that there was much scope for multilateral negotiations lower down within organisations. Consequently the relationships between the CMHTs and their line managers became crucial. This was neatly illustrated by the different pressures experienced by the CMHTs through line management arrangements: on the North Nottingham CMHT to define the development role more narrowly and on the Bassetlaw CMHT to accept more casework referrals.

2. **Perspectives and ideologies**

Appreciative gaps existed between the SSD and AHA(T) prior to the establishment of the CMHTs. Differences in models of community care filtered down to differences over the role of the CMHTs. The AHA(T) preferred the DT model of CMHT and did not approve of the SSD's development role. In addition there were appreciative gaps within the agencies, as the Health Service was marked by a lack of agreement between different disciplines, and there was a lack of agreement between the Areas and senior managers within the SSD over several aspects of the CMHTs' functioning. These appreciative gaps were not bridged by the time the CMHTs were established, with the exception that the Areas had forced some concessions over line management arrangements from senior managers.

The CMHTs found that their relationships and negotiations with their respective DHAs were very different. The Bassetlaw CMHT did not come to feel pressurised by the local DHA, but the Nottingham DHA attempted to
exert influence on the North Nottingham CMHT by making Health Authority input to the CMHTs dependent on a change in the teams' objectives. The Bassetlaw CMHT made a large impact on its local DHA by using interim results from the survey and by advocating an alternative model of provision. The team used the joint planning forum primarily as the avenue for such influence, but such an avenue was denied to the North Nottingham CMHT because of the tardy development of joint planning machinery by Nottingham DHA. Consequently the North Nottingham CMHT was unable to exert bottom-up pressures as successfully on its local DHA.

The CMHTs were content not to have a detailed operational policy from the SSD although it created credibility problems for them. They worked hard to influence senior SSD managers regarding an operational policy, couched within a broader approach to community care. This did not become official policy however; their attempts to create a policy validated from the Top were unsuccessful. They felt they were being more successful regarding the issue of the design of future hostels. Towards the end of this study the CMHTs accepted that they would have to work harder to influence senior SSD managers because they perceived an absence of guiding philosophies among them.

Both CMHTs had to contend with some confusion over their role among local service providers. Some of the confusion stemmed from the nature of the development role, particularly its intangibility and timescales. These factors limited the impact of the CMHTs on local service providers and vice versa. Nevertheless the CMHTs did achieve some change, for example they passed interim survey results to ATCs which resulted in improvements in the Centres. Nevertheless the CMHTs were conscious they had a credibility problem, stemming from the nature of the development role, which they resolved differently: the North Nottingham team relying on the credibility of their SSW and the Bassetlaw team accepting more casework referrals.

The CMHTs promoted parents' interests on several occasions, thereby acting as a vehicle for bottom-up processes. However they were also subject themselves to pressures from parents. The greater pressure from parents was applied on the North Nottingham CMHT, which as a result felt a greater urgency over the pace of development work and considered accommodation schemes for people with higher levels of dependency.
3. Resources

Prior to the establishment of the CMHTs, the scarcity of resources until mid-1981 clearly impeded the implementation of the SSD and AHA(T) policy of establishing CMHTs. Following the SSD's "windfall" the SSD were able to implement their own plans, albeit at the expense of joint planning processes. However, once operational the CMHTs found their development budget far too restrictive. In short the availability of resources at a crucial juncture made it possible to enact a broad approach to development conceived at the centre, but subsequent restraint limited the speed and extent to which change was shaped and implemented at the grassroots.

4. Multiplicity of agents

There was a lack of jointness in approach between the SSD and AHA(T) prior to the CMHTs' establishment. This manifested itself in the steering group which was dominated by the AHA(T) both in terms of personnel and foci, and by the SSD's unilateral actions following their "windfall" of resources. This lack of jointness continued following the NHS reorganisation, most notably between the SSD and Nottingham DHA; as joint planning structures were slow to be established. As a consequence, several issues of joint concern remained unresolved, including the CMHN issue. The CMHTs' Bottom-up initiatives proved insufficient, hence they lobbied senior SSD managers regarding the importance of joint planning with the DHA. In so doing they were attempting to have "sideways" pressure brought on the DHA in the hope that a greater degree of jointness in Top-down policy making would help resolve the issue.

At the service delivery level there were examples in both areas of poor co-ordination in service provision arising from poor relationships between services. The CMHTs' contribution to the co-ordination of service delivery was "mixed." For example their decisions to accept casework referrals caused confusion although the teams did try to establish themselves as foci for mental handicap services in an attempt to improve communications and co-operation between service providers.
5. The politics of planning

Leadership strategies and power games were examined within the AHA(T), DHAs and the SSD. Within the AHA(T) the leadership gauntlet regarding the planning for mental handicap services had been taken up by Administrators. It was Administrators for example who expended most energy towards the end of 1981 in attempting to reach a compromise with the SSD over the CKHT issue. Medical leadership was restored in Bassetlaw DHA by a new Consultant Psychiatrist (mental handicap) who engaged in a lot of bargaining and game playing with the CKHT SSW. The DNO accepted the leadership mantle in Nottingham, and over the CKHN issue his approach included some deviousness.

Within the SSD the Deputy Director was particularly associated with the incorporation of a development role within the CKHTs' brief. His commitment to this model made him less willing to compromise with the AHA(T). He was forced to make some concessions to pressures from Area Directors within his own Department however, relating to the line management of two of the teams and an acknowledgement that they could be expected to undertake casework. Another power battle within the SSD occurred between the Deputy Director and the Assistant Directors.

The CMHTs had reasonable access to senior SSD managers but they failed to use it effectively in their first 18 months. For example they were in awe of the Deputy Director which prevented them from taking sufficient initiative in their meetings with him. This was compounded by a naivete concerning the working of organisations such as the SSD and DHAs. As a result their capacity for achieving change through Bottom-up processes was undermined. The teams also had to contend with their feelings of frustration when they realised how naive they had been and resolved to learn the "rules of the game."

The bargaining between the CMHTs and local service providers was sometimes characterised by overt game playing. Good examples include the "power struggles" between the Bassetlaw CMHT and the Consultant Psychiatrist and the "pass the casework referral" game between the same team and the Area Social Services office. In other cases the strategies were more covert, as with the North Nottingham CMHT SW's role in establishing a parents' group. In work with parents the CMHTs were sensitive to the nature of the divide between statutory and voluntary,
and attempted to respond to parents' demands. Covertly however there was some evidence that the teams worked subversively thereby manipulating parents in a Top-down fashion, for example the manipulation by a North Nottingham CMHT SW of decision making on a Parents Committee.

How helpful have the dimensions been in illuminating the relationship between Top-down and Bottom-up processes and in acting as bridging concepts? Each dimension has proved useful for highlighting a particular aspect of implementation processes and the dimension approach has encompassed very complex scenarios. It would appear however that the dimensions do not so much bridge the models as complement them. By providing greater detail at a micro-level, the dimensions reveal how oversimplified the models are, and are a useful specification of some of the other key features of a multi-factor explanation. The models and dimensions would appear to offer different levels of explanation: the models as metaphors, providing a high level of generality; and the dimensions at a detailed micro-level. They both have weaknesses if used in isolation: the former proving too simplistic, particularly if adopted rigidly; and the latter liable to hide the wood from the trees.

The existing dimensions suffer from a number of limitations however. As they currently stand they are simply descriptive. It should be possible however to use the dimensions to explain outcomes and to generate hypotheses. The Resources dimension would appear to lend itself most readily to this. For example, given that an initiative such as developmental CMHTs cannot be implemented without resources, it could be hypothesised that the "top" is dependent on new resources for implementing policies. It was also seen that the CMHTs complained that a lack of proper funding restricted their Bottom-up developments. Nevertheless the developments did not dry-up, but low cost developments appeared, for example work with volunteers and with parents groups. It might be hypothesised therefore, that where there is commitment and innovation at the grassroots, resource constraint may not strangle development, as opposed to change its nature.

The other dimensions could be used to construct hypotheses similarly. Examples include:

- The Policy message - the vaguer the policy, the more significant becomes multi-lateral negotiation;
Perspectives and ideologies - Appreciative gaps between agencies will stimulate pressure from below for the adoption of a uniform approach, where there is a shared commitment to objectives at the grassroots, and where action at the grassroots is largely the result of Top-down initiatives;

Multiplicity of agents - where mechanical difficulties are experienced within organisations, implementation and action processes are more likely to vary from original intentions at the "top". It should be noted that mechanical difficulties between the "tops" in Notts, combined with differences in perspective, did not impede the implementation of the SSD's policy;

Politics of planning - where action is the vehicle for Bottom-up processes, it will be more successful when the "rules of the game" at the "top" are understood and learnt. Further, both policy and action processes will be skewed where game-playing is pursued for its own sake.

A further limitation exhibited by the dimensions is that they illuminate policy more brightly than practice. For example the work undertaken by the teams is not portrayed systematically, particularly when compared with the consideration of policy. In addition, the external determinants of the CMHTs' work are encompassed more easily within the existing dimensions than factors from within the teams. This is because the existing dimensions treat the teams as sealed units and do not consider a micro-political perspective focussing on the teams' day to day operation.

A number of factors internal to the teams might help to account for some of their actions, not least of which is the question of composition. For example, because CMHNs and Speech Therapists have different roles, a team with a CMHN would undertake a different range of action to a team with a Speech Therapist. This is particularly pertinent given that Health Service professionals initially tended to negotiate their own membership of the Notts CMHTs. Roles can evolve within teams according to different processes. For example, after one of the SWAs had demonstrated his competence, the SSW allowed his role to broaden. In another CMHT however, the SSW virtually had to force the SVA to accept a broader role because she lacked confidence.
Consequently the range of action undertaken by both SWAs increased, but for different reasons.

Role evolution was also dependent upon team members' experiences of their work, which had consequences for their future work, including: the two Social Workers who worked on playschemes and developed broader interests in play; casework experiences which stimulated developments, such as the "seepage" project and the PE course; and the completion of the survey, which took much longer than anticipated, thereby diverting team members' energies from other projects and possibly delaying the implementation of other developments. This discussion has focussed on team members within teams rather than taking the teams as the unit of analysis. This focus on the internal processes within teams which help determine the scope of action undertaken should be a sixth dimension and entitled the micro-dynamics of operational action.

This sixth dimension is grounded within the concept of Action. Action has been a central concept for the Bottom-up theorists who have found it a useful rhetorical device, particularly in challenging the legitimacy and hegemony of the Top-down model. Its use as a concept in this study has helped to provide a counterweight to the concept of policy, by emphasising what happens in practice rather than what ought to happen. Two questions present themselves however: how to classify action? What does it mean? In this study a partial solution to the classification of action was adopted, by classifying the CHRTs' activities according to their focus. This was helpful for highlighting differences between the teams in their operationalisation of the development role. Many other aspects of action were overlooked however, including that of tasks, for example administering an injection. Tasks themselves could be broken into components to analyse how they were undertaken, for example by phone or face-to-face. It is clear therefore that Action remains a concept that is difficult to classify and as a result it tends to be rather amorphous and undifferentiated.

This fact poses the second question: if action is so undifferentiated, does it mean anything? It is a term that lacks theoretical weight or power, a neutral term to explain the dependent variable: outcome. It is rather vacuous because it is not trying to explain anything, being seized upon by the Bottom-up theorists as a
counter-weight to policy and in support of their normative model. This is not to argue against focusing on outcomes and day to day operation, far from it, but at present the concept of action is in danger of detracting from analysis rather than promoting it.

Negotiation and the policy/action continuum

The CMHTs developed their own interpretations of their objectives and of their work. This did not occur within a void however, but within action and policy contexts. Negotiation was clearly central to the relationships between CMHTs and their environments, as the teams tried to carve out a niche for themselves in the manner outlined by Brown (S.1986) and Mansell (1986). The CMHTs negotiated with senior SSD managers over their role through discussions on the Community Care document; they negotiated with their line managers over interpretation of their objectives; they negotiated with the DHAs regarding their broad policies, as well as CMHNs and the role of the CMHT in Nottingham. Further, the CMHTs were negotiating with service providers to sell themselves and gain credibility; and with parents, notably through work with parents' groups and organisations.

In this way, and mindful of the concerns over the concept of Action expressed above, the situation is even more complex than Barrett and Fudge (1981) indicated in the policy/action continuum, as the teams were having to work within a number of different continuums. Further, a problematic factor for the CMHTs was that the continuums did not coincide. For example the North Nottingham CMHT was facing opposing pressures from the SSD and DHA regarding its objectives.

Within negotiations therefore, the challenge to the CMHTs was to attempt to increase their external cohesiveness by reorienting their continuums, so that they were more compatible. The North Nottingham CMHT attempted to do this, by influencing the DHA to adopt a more favourable attitude towards the development role, although they were unsuccessful. Likewise the CMHTs' game playing with other service providers, "subversive" work with parents, and their acceptance of the need to "educate" senior SSD managers, represent attempts to shift continuums so that they are more congruent with their own objectives and perspectives.
Based on Barrett and Fudge's (1981) policy/action continuum, Figure 14.1 represents a compatible set of continuums as they progress in a similar direction and move closer together. In such a situation the CMHTs would not be subject to opposing demands or expectations and would be working in environments composed of elements which shared the CMHTs' ideologies and philosophies. The CMHTs faced constraints to achieving such compatibility however, notably that all of the other actors were also confronted by a number of continuums, of which the CMHTs were only one element. As a result, the CMHTs had to compete with others to exert influence, which limited their impact.
Some Final Thoughts

It would appear that the CMHTs experiences of the development role resembled closely those of the Welsh CMHTs as outlined by Humphreys and McGrath (1986), although the contexts are very different. CMHT members enjoyed enormously the freedom and autonomy they had to determine their own objectives and work. They liked the variety of work, viewed development work as challenging and felt that their skills had increased as a result. The issue of skills is a pertinent one: was it appropriate to employ Social Workers (as well as SSWs and SWAs) to undertake a development role?

In terms of planning and making an impact on the SSD, it took SSWs a long time to learn the rules of the game regarding negotiation and bargaining and to feel comfortable with these. In the interim they experienced a lot of frustration from not fully understanding the systems they were working within, and from naive assumptions regarding their potential impact. The Adult Placement Scheme is a good example of the CMHTs making a number of naive assumptions, not least in their estimates of timescales which were grossly over-optimistic. The CHHTs gradually learnt that development work was longer in timescale and slower in pace than they had expected.

The CMHTs' survey also highlights the issue of skills. It was primarily a research task for which the CMHTs were ill-equipped with resultant weaknesses in its design and implementation. Further, the Social Workers' training may have actually hindered them as they experienced frustration at not being able to accept all of the casework referrals thrown up by the survey. The CMHTs' development role proved to be a learning process for team members in acquiring new skills and in re-orienting their approaches. This may help to explain why team-building was initially slow, as teams found it difficult to recruit Social Workers with appropriate skills for development work and with sufficient flexibility to amend their approach.

The CMHTs found that the freedom and lack of structure they enjoyed proved to be a double-edged sword, as they also experienced feelings of vulnerability. Consequently they became more sensitive to their credibility. This was particularly an issue given the intangibility of
a lot of development work and its timescale not corresponding to that of others' work. The issue of credibility was particularly keenly felt by CMHTs because of the inadequacy of the social casework service to mentally handicapped people and their families. CMHT SWs faced a dilemma: as trained caseworkers they were trying to maintain a high priority for development work in the face of an inadequate casework and crisis service. Once again, therefore, issues of skills and training come to the fore.

III Teamwork

This section attempts to explain the teamwork outcomes, particularly through the integration of fieldwork material and theoretical concepts and models. Prior to this, a brief summary will be given of eight facets of co-operation within the CMHTs.

1. Membership

Compared to the CMHTs surveyed by Plank (1982), the Notts CMHTs were larger than the average size of CMHT. Further, it is notable that the Notts CMHTs had a high proportion of full-time members. Despite this, most CMHT members in Notts felt that their teams were small in size compared with their previous experiences, (for example, in Area Office Social Services teams). There was agreement among team members of the advantages and disadvantages of the small size of their teams: more intimacy and easier communication in the former category, and a limit to flexibility and over emphasis of problems in the latter. Notably, the greater intensity and intimacy could have both positive and negative consequences.

In only one of the three CMHTs was there total agreement on the team's membership: the team which consisted solely of full-time members. The other two teams included "part-time" members, but such a status raised questions of identity. Indeed, it would appear that the question of identity was a crucial one for determining team membership, possibly more so than the degree and nature of contact with other team members. For example the Speech Therapist was more integrated into the North Nottingham CMHT than the Social and Recreational Officer because she identified herself more closely with the team, despite having less contact with them.
2. **Objectives**

Unlike many other teams, including Social Services teams and Primary Health Care Teams, there was a lot of discussion over objectives and priorities within the Notts CMHTs. There was a degree of dissatisfaction and uncertainty amongst some members of all three CMHTs over their teams' objectives at some point, indicating that these were not always aligned with their own personal objectives. Despite some disagreement over specific goals however, team members felt that the ethos and philosophy of their teams was strong. All three teams interpreted their objectives very broadly, although the North Nottingham CMHT had the most structured set of priorities. The impact the teams' environments made on their objectives was examined above, under "implementation."

3. **Roles**

Bargaining and negotiation were at the heart of the evolution of Notts CMHTs members' roles, with personalities, interests and skills important determinants. Reflecting evidence from other studies, (Cotmore 1985a, Horwitz 1970, Schachor 1976) it was very much a case of the worker changing the role rather than vice versa, as shown by the Bassetlaw CMHT SWAs. With so much scope to determine their own roles, the CMHT members experienced a lot of freedom, but such freedom also resulted in their feeling unsettled, especially the SWAs who experienced role ambiguity. In addition the SWAs suffered from role conflicts, where their expectations of their role differed from other team members'. For example the North Nottingham CMHT SWA was not given as many Social Work-type jobs as he had wanted, while the Bassetlaw CMHT SWA felt she had been given too many. The Bassetlaw CMHN experienced both role conflict and role overload, as she found it increasingly difficult to reconcile the CMHT SWAs' expectations of her role with her own, until she became more assertive and changed the organisation of her work.

There appeared to be a lot of role overlap within the CMHTs, especially between CMHNs and SWs, and SWs and SWAs. Nevertheless, the extent to which team members impinged on each other through joint work appeared to be limited, with the exception of the Bassetlaw CMHT.
4. Leadership

There was some confusion among CMHT members over the concept of leadership, and whether or not it included management functions. In addition, there was a lack of consensus within the CMHTs as to whether they needed a leader or a co-ordinator, the multidisciplinary nature of the teams bringing this issue to the fore. Most commonly, leadership was defined narrowly, with a focus almost exclusively on instrumental functions. Further, CMHT members' understanding of leadership was also limited in referring most commonly to designated leadership, namely the SSWs. Nevertheless, the conditions for situational leadership were ripe, given that team members had so much scope to determine their own roles. The failure of the designated leader of the Bassetlaw CMHT to encourage situational leadership consistently, caused much resentment and conflict among other team members.

CMHT SSWs were responsible for managing the Social Services components of the teams, hence they had a managerial authority relationship. They discharged their responsibilities differently, for example in differing supervision arrangements. Health Service team members on the other hand were subject to a "dual influence" relationship, with responsibilities to both the CMHTs and to their own professional and management structures external to the teams. These arrangements whereby team members reported separately up vertical lines, are characteristic of a "functional structure." Change to a different structure incorporating greater flexibility or jointness was unlikely given the lack of agreement between the SSD and Health Authorities regarding the appropriate objectives for CMHTs, which mirrored a broader lack of jointness in approach between the two agencies.

5. Communication

CMHT members regarded communication as an important factor in teamwork. With one exception, team members felt that all relevant information had been passed to them, although half of the members of two of the teams did not feel they were sufficiently aware of other team members' roles. There was insufficient awareness between Health Service and Social Services members in both teams. Team members felt that the small size of their teams made informal chat particularly efficient as a
communication mechanism. Sharing of rooms also appeared to make an impact on communication, by facilitating mutual learning.

There were variations between the teams in the organisation of their meetings, for example in structure and length. Unlike the Primary Health Care Teams studied by Sachs and Forman (1980) the majority of items in all three CMHTs were organisation structure maintenance in nature rather than primary goals. The two types of team were similar however in not having decision making as the primary function of their meetings, this mantle being adopted for CMHT meetings by information sharing, with "team togetherness" close behind. The majority of CMHT members felt that team meetings were either effective or very effective in fulfilling their functions, although there was a danger they could be undermined by a less than full attendance. Such attendances are not unique to the Notts CMHTs as they are experienced elsewhere, for example by the CMHT based at the Sanderson Centre, Newcastle (1983a, 1983b, 1984).

6. Decision making

The CMHT SSWs made a large impact on team decision making, deriving from their leadership and management functions. Each SSW reserved some decisions for themselves, although the North Nottingham CMHT SSW felt the most constrained. They each displayed a range of decision making styles. Determinants of their style appeared to include the nature of the issue, the SSWs' grasp of it, and the strength of their viewpoint on it. The SSWs occasionally appeared more democratic than they really were, either because the team's viewpoint coincided with what they had already decided, or because their subtle manipulation remained hidden.

Within team meetings, decisions were taken on one in three or one in four items. Most decisions were routine in nature and at the level of actions, with very few non-routine decisions or decisions on goals. There were proportionately more decisions on primary goal items than organisation structure maintenance items, and the latter attracted a higher proportion of routine decisions. The team meeting forum undertook different roles in the decision making process, from the initial floating of ideas to rubber-stamping. In two of the CMHTs, team meetings were important forums for work allocation. This did not apply to the North Nottingham CMHT, possibly reflecting their preference for a
more individualistic style of working. As expected from the literature review, CMHT members experienced much freedom and autonomy to take decisions on their work when underway.

7. Conflict

In line with evidence from other studies, the CMHTs displayed little overt conflict. For example, conflict occurred on only a small number of items in the CMHTs' meetings, and there was only one heated argument in a team meeting for the duration of the study. There was some evidence of conflict avoidance however, with examples of avoidance of decision making and of discussions in small sub-groupings rather than in more open forums. Discussion was the key to the resolution of many disagreements. The CMHT SSWs had a high profile in trying to secure conflict resolution, feeling that their position as a co-ordinator, leader, manager, or a combination of these, dictated that they have a responsibility for this task. Conflicts which derived from a person's "style" however, were more difficult to resolve, particularly if it were the CMHT SSW's leadership and decision making styles which were the cause of the conflict.

8. Trust

There were variations in the levels of trusting attitudes within the CMHTs. Most team members felt their colleagues were trustworthy, with faith in others' intentions and reliability the highest scoring of the indicators. There were some differences between the CMHTs regarding the indicators of trusting behaviours. There was a willingness to pass relevant information to colleagues in all three teams, but there were differences in the extent of mutual influence, reflecting different models of teamwork. Control proved to be a slippery concept, and appeared to operate less than influence. It is impossible to determine the precise nature of the relationship between trusting attitudes and trusting behaviours in this study, but the results indicate the likelihood of the model of co-operation or teamwork acting as a mediating variable between the two.
The interrelatedness of facets of co-operation

The facets of co-operation are not simply discrete entities but are interwoven in a complex set of dynamics, similar to Bruce's (1980) "medical syndrome." Such interrelatedness is acknowledged in a new model of trust, illustrated in Figure 14.2. Within this model, trustworthiness and trusting attitudes are separated, as they should have been in this study. This model follows the general literature on trust in asserting that trusting behaviours do not require trusting attitudes as antecedents, and it is proposed that "commitment" is the other inducer of such behaviours. Commitment has been specified to refer to co-operation with another person or with a team or group as a whole. The relationships found by Cook and Wall (1980) between commitment, trustworthiness, and need satisfaction have been incorporated. It is suggested that a further determinant of commitment to co-operation are superordinate goals, two of which are particularly pertinent: commitment to client group and authority of relevance.

The acknowledgement of the interrelatedness of facets of teamwork is represented within the model by the "dynamics and model of co-operation". These are not constants but are themselves determined by a number of factors, for example the nature of the work, previous experiences of co-operation, and organisational constraints. It is likely that the different facets of co-operation will impinge on this model in a variety of ways. For example, one would predict:

- less trustworthiness during conflicts over roles and role overlaps;
- failures in communication will be forgiven if trust is high, otherwise they will be interpreted as distrusting behaviours reflecting distrusting attitudes;
- conflicting objectives and priorities, or a mutual lack of awareness of objectives will lead to distrust;
- differences in philosophies may lead to a lowering of trust and trustworthiness, possibly more so in a team than in a network;
- and in permanent team structures, discontentment with the designated leader, the extent of situational leadership, or with decision making processes would result in a lowering of
commitment and of trust.

It was suggested in Chapter 12 that the model of co-operation within the Notts CMHTs was a mediating variable in the relationship between trustworthiness and trusting behaviours. This study would indicate that the more a shared pattern of working is adopted rather than an individualistic one, the easier it is to engage in trusting behaviours, if appropriate. Interestingly, the model of co-operation can also be a dependent variable. For example, if A wanted to change the model of co-operation employed so that it was more "shared," he might exhibit greater trusting behaviours toward B, resulting in B's attitudes of A becoming more trusting. This change in their relationship might enable them to work more closely, wherein role boundaries became less important and with consequences for other facets of co-operation, for example communication and decision making.

Figure 14.2 Trust within teams
Models of Co-operation: Notts CMHTs

Which models of co-operation outlined above in Chapter 5 help to illustrate the working of the Notts CMHTs? Given that co-operation and teamwork are simply means to the end of providing a better service, a crucial question must be that of how the work is undertaken: in a shared or individualistic fashion? The "open" and "private" classifications used by the DHSS (1978b) for Social Services teams would appear apposite, as they relate to this question.

The Bassetlaw CMHT exhibited the greatest degree of joint work and shared responsibility, with team members feeling there had been a high degree of mutual influence. This was reflected in the use of team forums for detailed discussions and decision making. The North Nottingham CMHT on the other hand approximated more closely to the "private" end of the continuum, with fewer examples of joint work and shared responsibility, and less mutual influence between team members.

The Central Notts CMHT had engaged in a few more joint tasks than the North Nottingham CMHT, and most work allocation was undertaken in the team meeting forum. Nevertheless, the majority of tasks were undertaken by team members in a "private" manner and team members felt very strongly that they worked separately with little mutual influence. The team proposed "strong personalities" as an explanatory factor, while additional factors common to the North Nottingham CMHT were: liaison responsibilities which had more or less evolved into "patch" work; team members' roles had evolved around their interests and abilities, hence shared work presupposed a coincidence of these attributes; and the nature of development work was seen in some cases to be "hit and run" which was easier to accomplish with fewer team members involved.

A further explanatory factor was that some team members simply preferred to work in a more "private" fashion. Indeed, the CMHT SWs would most likely have been accustomed to such a model from their previous Area team experiences, and may have found it more comfortable to continue rather than change their pattern of working. This points to a complicating factor when classifying teams: team members differ in their preferences for shared or individualistic patterns of working. Classifications are even more problematic given that the CMHTs exhibited different patterns of working according to the task.
Both the Bassetlaw and Central Notts CHHTs had different processes for casework and development work, tending to be more shared in approach regarding development work. This was partly because of the nature of the work, in that some development projects required the input of more than one team member because of their size, for example the survey. There may also have been an element of uncertainty regarding the development role resulting in a lack of role confidence, and hence team members may have felt greater safety in numbers. In addition there were a number of examples of joint work on cases. As a result of differences between team members, and different patterns of working according to the task, any composite classification may be somewhat meaningless, merely representing a compromise between wide variations. It may be more honest therefore to replace a composite classification with a series of such classifications for each team, according to the nature of work for example. This could be applied to the Notts CHHTs in the following way:

Figure 14.3 Private - Open continuum

<table>
<thead>
<tr>
<th>PRIVATE</th>
<th>OPEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURVEY</td>
<td>B, C, N</td>
</tr>
<tr>
<td>GROUP HOME</td>
<td>N</td>
</tr>
<tr>
<td>CASES</td>
<td>B, C</td>
</tr>
<tr>
<td>ADULT PLACEMENT SCHEME</td>
<td>N, B</td>
</tr>
</tbody>
</table>

Key: B = Bassetlaw  C = Central Notts  N = North Nottingham
The survey was an example of the "open approach" and there were a number of examples of joint work on cases. Several Bassetlaw CMHT members made an input to a group home, which they regularly discussed together, unlike North Nottingham CMHT members, who made their inputs to group homes in a more "private" manner. Although a member of each CMHT participated on the Adult Placement Scheme working group, the representatives reported back to their teams differently, thereby involving their teams differentially in the decision making process: the Central Notts CMHT representative reported back to each team meeting; the North Nottingham CMHT representative reported back to the CMHT SSW only; and the Bassetlaw CMHT representative was the SSW, who reported back to the rest of the CMHT very rarely. The North Nottingham CMHT had become more "private" in its playscheme work between 1982 and 1983, reflecting perceptions from within the team that they had become less "open" in their approach more generally.

The other dimension to such a classification is that of interaction and the environment in which the work is undertaken. The interaction within the Notts CMHTs, similar to the Social Services teams in the DHSS (1978b) study was integrative in nature characterised by discussion, support and advice, thereby providing a supportive environment, but one in which team members worked separately.

The notion promoted by Bruce (1980) that facets of co-operation are closely inter-related would be supported by this study. Are his "modes of co-operation" similarly supported? It would appear that the collection of variables may be too diverse. For example, it is clear that regular personal contact is not always associated with mutual trust. Further, there were failures of communication in all three teams: the crucial issue was not whether or not they occurred but how they were interpreted, either as accidents or as distrusting behaviours.

Unfortunately, under the "service" category, Bruce has assumed what he should have been studying: the experience of the Notts CMHTs shows that despite "committed" co-operation between team members, they did not consistently improve the co-ordination of services. None of these criticisms invalidate Bruce's "modes of co-operation," but given the complexity of inter-relationships, the variables he has used need refining. It also has to be acknowledged that the limitations which
applied to the "open-private" continuum arising from differences within teams, apply to this continuum also.

**When is a team not a team?**

Using Webb and Hobdell's taxonomy of teams, the Notts CMHTs could be classified as complex teams, comprising Social Work, Health Authority and clerical members. Regarding field-workers only, all three CMHTs started as apprenticeship teams, with Social Services personnel only (homogeneous tasks) and SWAs as the apprentices (heterogeneous skills). The CMHTs became "complex" when staff from other disciplines joined, namely the CMHMs, Speech Therapist and Pre-school Teacher Counsellor.

A limitation to the taxonomy is that it does not delineate the team's boundaries, in other words it assumes the issue of team membership is straightforward. These boundaries are explored more fully in the debate over teams and networks. The key to Payne and Scott's (1982) approach is the intensity of interaction. Did the Notts CMHTs exhibit the four characteristics outlined by Payne and Scott?

1. Continuous interaction within the group:
   
   More so for full-time team members, than for part-time members.

2. The group will tend to have a long life:

   Yes, as the CMHTs are permanent team structures, and team members are part of the "group" until they leave.

3. The work of group members is visible to other members of the group: Only within the office, on the phone for example, otherwise no.

4. The whole group works together often:

   No. The nearest example was the Bassetlaw CMHT play-scheme which involved a majority of team members. Also the survey which all team members worked on, but separately.

It would appear from Payne and Scott's classification that the CMHTs were not "teams," although the characteristics used would appear to be better designed for residential and day care teams rather than fieldwork teams. Nevertheless, the concept of a network as a looser grouping than a team, incorporating interaction with a wider range of people and accommodating a wider range of values, approaches and goals, helps to
illustrate the CMHTs' relationships with other service providers. Interaction alone did not resolve the question of membership however, as there remained some confusion over the status of part-time CMHT members.

This was most noticeable in North Nottingham, where the Speech Therapist regarded herself and was regarded by others as a CMHT member, despite having less contact with the rest of the CMHT than some network members. It has been suggested above that the question of identity helps to account for this, as she had identified herself with the CMHT as part of her working consciousness, and was thereby committed to the CMHT as part of her "professional identity" (Macdonald 1984a). This study would support the differentiation between teams and networks therefore and in a similar way to Macdonald, point to the importance of "identity" for determining a team and its membership.

IV CONCLUDING REMARKS: LOOKING BACK AND FORWARD

The exploratory approach that was adopted for this study was useful for examining existing models and concepts from both the implementation and teamwork literatures. Regarding implementation, the exploratory approach succeeded in overcoming sterility from the polarisation of existing models and combined the insights from those models while avoiding over-simplification. In this way the rigidity of existing models was by-passed. The dimensions approach also helped to overcome rigidity and over-simplification. A sixth dimension was added: the micro-dynamics of operational action, although only a partial understanding of the broader concept of action was gained. The policy/action continuum was found to be useful and was elaborated to encompass the complexity of the CMHTs' environments. It must be an urgent task for research to explore and refine further our understanding of action and to determine more precisely the relationship between the dimensions and the two models.

The exploratory approach provided some useful insights into the teamwork issues regarding the Notts. CMHTs. It was important to focus clearly the exploration, particularly given the diversity and lack of integration of the teamwork literature. Consequently some key issues were identified from the literatures which provided such a focus. The
The issue of identity was found to be important for determining a team's membership. Because teamwork is a means to the end of service delivery, the question of how the work is undertaken is obviously an important one. The open/private continuum proved helpful and was elaborated to allow for complexities arising from differences within teams according to the task and the individual. Different facets of co-operation were seen to be closely inter-related and this was reflected in a model of trust that was devised. However, the precise relationships between different facets of co-operation were not fully explored, and this requires further study.

The final question concerns the relationship between the analysis of teamwork factors and implementation issues. So far, these two topics have been considered in parallel, but significantly, the study of one informed the study of the other. The very shape and composition of the teams were largely explained by implementation processes. They were not as multidisciplinary in membership as initially intended because of: a lack of resources; "mechanical difficulties"; and divergent perspectives between the agencies. Indeed in two of the CKHTs, Health Service input was negotiated between professionals at the service delivery level.

Implementation processes had a significant impact on other teamwork factors also. The lack of specificity with which the agencies outlined the CKHTs' objectives, coupled with structural arrangements within the agencies, resulted in the teams enjoying considerable scope for developing their own interpretations of their objectives. Other teamwork factors affected by the parent agencies included leadership and roles, as the SSD appointed designated leaders and both agencies issued job descriptions, although the lack of specific objectives facilitated role evolution around team members' strengths and interests. Focusing on the teams and on teamwork issues, provided material for the study of implementation. Team meetings which were initially attended on a regular basis for the purpose of analysing communication, leadership and decision making patterns within the teams, revealed many insights into team members' views of their parent agencies. Crucially, the focus on the teams unearthed the significance of internal processes in determining the teams' action, thereby revealing a gap in the existing
dimensions. In short, the study of teamwork factors generated the sixth dimension which has been added to the five originally advanced by Hambleton.

Clearly, being able to match the implementation and teamwork material strengthened the study of both issues. This cross fertilisation was aided by the adoption of the same exploratory, or organisational anthropological approach across both issues. The value of pursuing the micro-dynamics of processes within broader frameworks was demonstrated for both implementation and teamwork. Conversely, the generalisations of models in both fields were subjected to the results of this micro-analysis. A drawback is that hypothesis testing is limited, if not impossible with such an exploratory approach.

Nevertheless, it yielded several significant insights in this study. An example from the teamwork fieldwork was the possible mediating role played by the preferred model of teamwork in the relationship between trusting attitudes and trusting behaviours. Regarding implementation, the complementary relationships between the models and dimensions was explored, and the use of dimensions in generating hypotheses was considered. Therefore, while limited in hypothesis testing, the exploratory approach was able to generate a series of new hypotheses.
APPENDIX A

Team Meeting Analysis Instrument
<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>Columns 1, 2, 3, 4</th>
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<tbody>
<tr>
<td>CMHT</td>
<td>Column 5</td>
</tr>
<tr>
<td>1</td>
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</tr>
<tr>
<td>2</td>
<td>C. Notts</td>
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<tr>
<td>3</td>
<td>N. Nottingham</td>
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**Team Meeting Analysis Instrument**

<table>
<thead>
<tr>
<th>DATE OF MEETING</th>
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<td>TEMP. SV</td>
<td>CLERK</td>
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</tr>
<tr>
<td>7 TRAJECTOR</td>
<td>CMHN</td>
<td>TEMP. SW</td>
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<td>9 CO-RESIDENT</td>
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<td>THERAPIST</td>
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<thead>
<tr>
<th>V5 PART of MEETING</th>
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<tbody>
<tr>
<td>1 Matters Arising</td>
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<tr>
<td>2 Feedback/Go Around/AOB</td>
<td></td>
</tr>
<tr>
<td>3 Topic</td>
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<table>
<thead>
<tr>
<th>V6 SUBSTANTIVE ISSUE</th>
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<tbody>
<tr>
<td>1 Primary Goals of Team</td>
<td></td>
</tr>
<tr>
<td>2 Organisation Structure Maintenance</td>
<td></td>
</tr>
<tr>
<td>0 Other</td>
<td></td>
</tr>
</tbody>
</table>
Residential; accommodation
APS and Fostering schemes
Day Care: Education; Training; Occupation; Employment
Playschemes
Relief Schemes: STC; Sitting Schemes; Care-at-Home
Leisure
Non Statutory: Parents Groups, Committees, Voluntary Organisations
Identification of Need: Survey; Waiting Lists
Community Education
Casework, Case Conferences, Reviews
Welfare Rights
Primary Goals of Team: Other
Internal: Team members' learning processes, including meetings, conferences, workshops, talks
Roles of Team members, and of the Team
Team Meetings and their Organisation
Administrative arrangements e.g. Referrals; Float; Book Fund
Other mechanisms and arrangements e.g. Use of rooms; Supervision; Induction; Student placements
External: Other CMHTs and links and relationships with them
SSD Management, and links and relationships with them
SSD Provision e.g. ATC's, Hostels, Area Offices, and links and relationships with them.
Health Service Management and Planning; and links and relationships with them.
External: Health Service Provision, and links and relationships with them.
External: Education Service, and links and relationships with them.
External: Housing Departments and Associations, and links and relationships with them.
Voluntary Sector, and links and relationships with them.
Organisation Structure Maintenance: Other
Other
<table>
<thead>
<tr>
<th>Column 13</th>
<th>Column 14</th>
<th>Column 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Giving.</td>
<td>1. No Decision Taken/Appropriate.</td>
<td>1. No Conflict.</td>
</tr>
<tr>
<td>2. To Air or Discuss an Issue.</td>
<td>2. No Decision, but decision deemed appropriate or deferred.</td>
<td>2. Some or Much Conflict: Resolved.</td>
</tr>
<tr>
<td>3. Advice or Help Seeking.</td>
<td>3. Decision(s) taken: Goals.</td>
<td>3. Some or Much Conflict: Unresolved.</td>
</tr>
<tr>
<td>4. To Make (a) Decisions(s).</td>
<td>4. Decision(s) taken: Actions - Programmed.</td>
<td>4. Decision(s) taken: Goals and Actions - Programmed and non-programmed.</td>
</tr>
<tr>
<td>5. Information Seeking.</td>
<td>5. Decision(s) taken: Actions - Non-programmed.</td>
<td>5. Decision(s) taken: Goals and Actions - Programmed.</td>
</tr>
</tbody>
</table>
These notes of guidance have been drawn up to help overcome inconsistencies in completion.

VI ITEM NUMBER Issues arise which are often closely related or even "fused" together. While the primary focus or orientation of these issues is the same, then the item is counted as one:

- e.g. 1 Playscheme: Budget
  Work Allocation
- e.g. 2 Group Home: Training
  Co-Resident
  Team Input
  Money to Purchase small items
  Numbers of residents

In both of these examples, a number of facets of each type of provision is discussed, but the primary focus is the type of provision itself, as each of the facets is only considered in relation to it. In both examples, one item only was recorded: Playscheme and Group Home.

If issues arise out of an item that are either unrelated or only tangentially related to it, they will be counted separately against the initiator under "OTHER"

- e.g. 3 Group Home: Training
  ATC Training: Philosophy and practice

The first item included a consideration of the ATC's input into the Group Home, but then discussion turned to a consideration of the ATC internally. This requires classification as a separate item, as the orientation of the training is no longer to the Group Home, but with the ATC.

The Topics (see V5) discussed by Teams were occasionally very broad, and as in other cases, if a range of items were considered, each will be classified separately e.g. On 6.10.82, Bassetlaw CMHT's topic was a review of the operation of a number of non-statutory groups and the team's input into these. Each Group has been considered a separate item.

V4 INITIATOR of ITEM. This denotes the team member responsible for bringing the item to the team's attention. Where there is no agenda, it is the team member who mentions the item first. Where there is an agenda, it is the person who placed it on the agenda, hence not necessarily the person to mention it first, as this may simply be the Leader/Co-ordinator reading it from the agenda.

V5 PART of MEETING. The following classifications were devised:

"Matters Arising" i.e. from the previous meeting. These will usually arise from a consideration of the previous meeting's
minutes.
"Feedback" This refers not to the purpose of the item, but to the section of the meeting within which it falls.
"Topic" All 3 CMHTs had agendas, and Topic refers to items placed on the agenda prior to the meeting.
"Other" - an item not appropriately classifiable in any of the 3 categories above.

V6 SUBSTANTIVE ISSUE The responses in V6 and V7 should correspond e.g. If classified as a Primary Goal of the Team in V6, it must be classified between 01 and 12 in V7.

V7 SUBSTANTIVE ISSUE The Primary Goals of the Team include the CMHTs' developmental objectives, particularly 01 - 09. This does not mean necessarily that when classified as such, the CMHT is currently planning and creating them, or that the CMHT has planned and created them in the past, as these classifications include support to those services or resources, whether they were initiated by the CMHT, or by other agencies.

This is the variable on which there is the greatest potential for overlap and inconsistency, hence the need for the following very specific guidelines:

- EXTERNAL LINKS:

  When the focus is Development Work, classify according to the nature of the work e.g. Housing Associations: 101
  When the focus is soley on the external body, or on the links between that body and the CMHT, classify as an external link, e.g. Housing Associations: 224.

- USE OF VOLUNTEERS:

  If the issue is the use of existing volunteers on existing projects, classify according to the project e.g. Volunteers in a Group Home - 101.
  If the issue is a more general one, concerning ways to encourage volunteering for example, classify as Community Education: 109.

- REVIEWS of GROUP HOME RESIDENTS:

  For individual residents, classify: 110 (Reviews)
  For any management or operational problems, or for a review of the scheme as a whole, classify: 101 (Residential).

- CONSULTANT in MENTAL HANDICAP:

  In relation to DMT: HCPT etc. classify: 221 (Health Service Planners)
  If only a general mention is made of the Consultant; classify: 222
MEETINGS.

Meetings often cover a number of issues e.g. Joint Planning meetings. These should be regarded solely as forums in which issues are discussed, hence the issues should be itemised and classified separately. The exception is where the focus of the item is the meeting or mechanism itself, in which case it should be classified according to the type of meeting:

Joint Planning meetings and Joint Finance: 221
Meetings with SSD management: 219

V8 OSTEONIBLE PURPOSE:

Be sure to classify according to the purpose and not the outcome, e.g. if the purpose was to seek information, and a decision was taken, categorise as "5 Information Seeking.

V9 OUTCOME:

A decision was deemed to be taken if either a formulation for action or a viewpoint were adopted, or rejected.

Programmed decisions are repetitive and routine, and do not have to be treated de novo each time they occur.

Non-programmed decisions are more "novel, unstructured and consequential."

In making this distinction, Simon saw the two types not as a dichotomy, but as a continuum, hence one must ask: to which of these two types does the decision most closely approximate?

Goals refer either to the CMHT's goals, or to the goals of the service as a whole, or particular segments of it.

V10 CONFLICT

An issue may appear to be resolved but surface in the future, clearly unresolved. This is irrelevant, as the determining factor should be that the issue APPEARED to be resolved at that time, and that team members APPEARED to accept the resolution.

Resolution does not require that all team members' views coincide, but that the different views have been postulated, and a compromise or other form of resolution worked out. Hence an agreement to differ would be classed as "Resolved", as the agreement acted as a resolution, even though the viewpoints still differed.
APPENDIX B1

Interview Schedule for first interviews to Bassetlaw and North Nottingham CMHTs
Interview Schedule

1. What are the CMHT's stated objectives?  5

2. How effective has the CMHT been in obtaining and maintaining its objectives?
   SHOW CARD A
   Please illustrate

3. How far do your personal objectives coincide with or differ from the CMHTs?

4. Are there any differences between different members' objectives?
   YES 1  10
   NO 2

If YES, please say why.

5. (a) What role at present is the CMHT fulfilling within the system of care for the mentally handicapped?  5
   (b) Do you think the CMHT should adopt:
   SHOW CARD B
   If wider or less wide: in what way?
   (c) Is there agreement, outside the CMHT, about the CMHT's role?

6. (a) How did you come to join the CMHT?  5
   (b) (FULL-TIMERS) What role, at present, are you fulfilling?
   (PART-TIMERS) What role, at present, are you fulfilling, both within and outside of the CMHT?
   (c) Have you been undertaking any work with individual cases?
      YES 1  19
      NO 2

IF YES: With whom do you regard yourself as dealing primarily:

IF NO: If you did, with whom would you regard yourself as dealing primarily:

- 279 -
- The mentally handicapped person
- The family or environment
- Both person and family/environment?

(d) Within the CMHT, do you think you should be adopting:

SHOW CARD B

If WIDER or LESS WIDE; in what way?

(e) Has your role changed since joining the CMHT? YES 1

NO 2

IF YES; In what way?

7 (a) Does any overlap exist between the roles of the CMHT professionals?

YES 1

NO 2

IF YES; Between whom?

(b) Do all CMHT members work with the same client groups?

(i) children - adults
(ii) mildly HH - severely HH - profoundly MH
(iii) non-behaviour disordered - behaviour disordered

(c) Do all CMHT members participate in development work?

Do all CMHT members undertake work with individual cases?

(d) Are there any tasks that you perform that are also performed by other CMHT members?

(PROMPT: By members of other professions within the CMHT?)

(e) How in practice, have the boundaries of CMHT members' roles been drawn

(PROMPT: Through open discussion?)

8. What are the major strengths and/or weaknesses in the contributions that other professionals make to the CMHT?

9 How, if at all, would you differentiate between the terms: leader and co-ordinator?
10. Does your CMHT need a leader?  
   YES 1  
   NO 2  

IF YES: What role should he/she perform?  

11. Does your CMHT need a co-ordinator?  
   YES 1  
   NO 2  

IF YES: What role should he/she perform?  

12. (TEAM MEMBERS) To which of the following five styles does the CMHT leader/co-ordinator adhere to?  
   SHOW CARD C  
   (TEAM LEADERS/CO-ORDINATORS) To which of the following five styles do you adhere to?  
   SHOW CARD C  

13. Do you think the CMHT leader/co-ordinator should use a different style?  
   YES 1  
   NO 2  

IF YES: Which of the five styles should he adhere to?  

IF YES: Why?  

14. (TEAM LEADERS ONLY)  
   (a) Are there issues on which you reserve the decision for yourself?  
   YES 1  
   NO 2  

(b) IF YES: What are the issues, and how are those decisions taken?  

15. (TEAM MEMBERS ONLY)  
   (a) What system exists to review your work?  
   (b) How satisfied are you with this system?  
   SHOW CARD D  

- 281 -
16. (TEAM LEADERS ONLY)
(a) What systems of review exist for team members' work? 
(b) Do you regard this system to be

SHOW CARD E

17. (a) What functions do the CMHT meetings perform?
(b) How effective have the CMHT meetings been in fulfilling these functions?

SHOW Card A
(c) Do you think the CMHT meetings should be held: more regularly; less regularly; or at existing intervals?

IF MORE REGULARLY OR LESS REGULARLY: Why?

18. (a) How have you kept in touch with your parent agency?
(b) Do you feel that all relevant information has been passed onto you?

YES 1
NO 2

IF NO: Please specify

19. Have you had any disagreements with other team members? YES 1

NO 2

If yes: Over what issues did the disagreements occur?

20. (IF YES TO 19) How were such disagreements resolved?

21. Are you aware of any significant disagreements between other CMHT members in which you are not involved? YES 1

NO 2

IF YES: Over what issues did the disagreements occur?
22. Are you aware of any significant disagreements that remain suppressed within the CMHT?

<table>
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IF YES: Please specify.

23. (TEAM LEADERS/CO-ORDINATORS ONLY) What means do you pursue to resolve intra-team disagreements?

24. (a) How would you describe the level or levels of Trust between Team members?

(b) Do you trust some team members more than others?

25. What do you like and dislike most about working in this CMHT?

26. (a) What are the differences between this job and your previous non-multidisciplinary experience?

(b) Are any of the tasks different?

27. Have your professional skills developed since joining the CMHT?

<table>
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<th>YES</th>
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IF YES: Please specify how they have developed.

28. How viable in the light of your experience, do you regard multi-disciplinary teamwork and your CMHT as being?

29. (TEAM LEADERS/CO-ORDINATORS ONLY)

How far has the CMHT deviated from the objectives and the priorities of

(a) the SSD?

(b) the Health Service?

30. Has any pressure been exerted on you by the parent agencies to adopt their/the Joint Planning objectives?

31. What pressure and control are the parent agencies exerting on you to take on more cases and to have more client contact?
32. (a) What influence do you feel the CMHT has had on Departmental policy?

(b) What influence do you feel the CMHT has had on Health Service policy?
APPENDIX B2

Interview Schedule for second interviews to Bassetlaw and North Nottingham CMHTs
Interview Schedule

1(a) Who are the members of this CMHT?

1(b) What should the membership of a CMHT be?

2(a) What factors, in your view, lead to good teamwork?

2(b) What are the advantages and disadvantages of working in a team of this size?

3(a) What do you understand by the term “developmental”?

3(b) Is it possible to be developmental without holding caseloads?

4(a) What are the CMHT’s objectives?

4(b) How effective has the CMHT been in obtaining its objectives? (PRESENT CARD A)

4(c) How far do your personal objectives coincide with or differ from the CMHT’s?

5(a) What roles, at present, is the CMHT fulfilling?

5(b) Do you think the CMHT should adopt the same or different roles?

6(a) How aware do you feel you are of other team members’ work?

6(b) In what ways have you become aware of others’ work, and they yours?

(PROMPT: Informal chat? Team meetings?)

7(a) Have you undertaken any joint work with other CMHT members?

If yes: What?

7(b) Have you undertaken any joint work with other professionals?

If yes: What?
8. Do you feel that all relevant information has been passed onto you within the team?
   If no: Please specify.

9. To what extent have CMHT members influenced each others' thinking and practice?

10(a) Have you in any way attempted to control your fellow CMHT members' actions?

10(b) Have your fellow CMHT members attempted to control your actions?

11(a) Have you had any disagreements with other team members?
   If yes: Over what issues?
   How resolved?

11(b) Are there any suppressed disagreements within the team?

12. How, if at all, would you differentiate between the terms: leader and co-ordinator?

13. Does your CMHT need a leader?

14. Does your CMHT need a co-ordinator?

15. (TEAM MEMBERS): To which of the following five styles does the CMHT leader/co-ordinator adhere to?
   (SHOW CARD C)

   (TEAM LEADERS - CO-ORDINATORS): To which of the following five styles do you adhere to?
   (SHOW CARD C)

16. Do you think the CMHT leader/co-ordinator should use a different style?
   If yes: Which of the five styles should he adhere to?
   Why?

INDIVIDUAL: CASE LOAD

17. Do you have a case-load?

- 287 -
If no: Go straight to Decision Making

If yes:

18(a) How many cases do you hold?

18(b) Is your caseload all adults? all children? a mixture?

18(c) Do any of your mentally handicapped clients have additional disabilities or handicaps?

18(d) Do any of your clients exhibit any behaviour or psychiatric problems?

18(e) In what form of accommodation do your clients live?
DECISION MAKING

A. CASES
Do CMHT members have caseloads?
If yes: Which team members? How many cases?
How was it decided that team members should or should not have caseloads?
(Or: How was it decided that some team members should, and some should not have case loads?)
How was it decided that particular cases would be taken?
How satisfied are you with this existing situation?
If dissatisfied: How would you like it changed?

B. NEWSLETTER/POSITION STATEMENT
Does your CMHT have a newsletter/position statement?
If so: How is it organised? By whom?
How was it decided that it should be organised in that way?
How satisfied are you with the present system?
If dissatisfied: How would you like it changed?

C. PLAYSHEME
How many playschemes has your CMHT organised?
Who organised it/them?
Which team members made an input?
How was it decided that it/they should be organised in that way?
How satisfied have you been with its/their organisation?
(PROMPT: Frequency; duration; client group)
If dissatisfied: How would you like it/them changed?
How satisfied are you that playschemes are appropriate for your CMHT's involvement?
D. LIAISON WITH AREA SOCIAL WORK TEAM(S)

How is responsibility for this liaison organised within the CMHT?

How was it decided that the liaison would be organised in that way?

How satisfied are you with the present system?

If dissatisfied: How would you like it changed?

E. GROUP HOME

[Is your CMHT involved with (a) group home(s)?]

What has been and what is the CMHT’s input to the group home?

By whom is this input undertaken?

How was it decided that the input should be organised in that way?

How satisfied are you, with how the CMHT has organised its input?

(Prompt: Is the CMHT too involved? Is the wrong CMHT member involved?)
SAMPLE

If a case, ask questions A1 to A4 and then A9 onwards
If other work, ask questions A5 to A8 and then A9 onwards

Sample Number: ............

A1 Was any other agency involved in this case before the CMHT? If so, who?
A2 Why has the CMHT taken on the case?
A3 How was it decided the CMHT would take on the case?
A4 How was the case allocated to you?

NATURE OF WORK

A5 (WHERE APPROPRIATE): Has the CMHT been involved from the start of this work?
A6 Why has the CMHT taken on this work?
A7 How was it decided the CMHT should be involved?
A8 How was this work allocated to you?
A9 What tasks have you undertaken in this case/work?
A10 Have you had communication with fellow CMHT members about this case/work?

If yes: Please outline the nature of your communications with the CMHT professional(s) in this case/work:

- person(s) communicated with
  - nature of communications
  - number of communications
  - purpose of communications
  - mode of communications

  Was the purpose of the communication successfully achieved?

Has responsibility for the case/work changed as a result of
the communications?
A11 Have you had communication with professionals other than CMHT members about this case/work?

If yes: Please outline the nature of your communications:
- person(s) communicated with
- nature of communications
- number of communications
- purpose of communications
- mode of communications

Was the purpose of the communication successfully achieved?

Has the responsibility for the case/work changed as a result of the communication?

A12 How have decisions been taken with regard to your work on this case/work?

A13 (If a case): How will it be decided when to close this case?
Interview schedule for interview with Central Notts CMHT members
Interview Schedule

1(a) Who are the members of this CMHT?
1(b) What should the membership of a CMHT be?

2. What are the CMHT's objectives?

3. How effective has the CMHT been in obtaining its objectives?
   (SHOW CARD A)

4. How far do your personal objectives coincide with or differ from the CMHT's?

5. Are there any differences between team members' objectives?

6(a) What roles, at present, is the CMHT fulfilling?
6(b) Do you think the CMHT should adopt the same or different roles?
6(c) Is there agreement, outside the CMHT, about the CMHT's role?

7(a) Why did you join the CMHT?
7(b) What role, at present, are you fulfilling?
7(c) Have you been undertaking any work with individual cases?
    If no: Go to Question 8.
    If yes

7(d) How many cases do you hold?
7(e) Is your caseload: all adults? all children? a mixture?
7(f) Do any of your mentally handicapped clients have additional disabilities or handicaps?
7(g) Do any of your clients exhibit any behaviour or psychiatric problems?
7(h) In what form of accommodation do your clients live?
8. Do you think you should be undertaking different roles?

9. What factors, in your view, lead to good teamwork?

10(a) How aware do you feel you are of other team members' work?

    What impact has being in the same room with/in a different room to others made?
    
    IF UNAWARE: Would you like to be more aware?

10(b) In what ways have you become aware of others' work and they yours?

    (PROMPT: Informal chat? Team meetings?)

11(a) Does any overlap exist between the roles of the CMHT professionals?

11(b) Are there any differences in the client groups team members work with?

    (i) children - adults
    (ii) mildly MH - severely MH - profoundly MH
    (iii) behaviour disordered - non-behaviour disordered

11(c) Do all CMHT members participate in development work?

11(d) How, in practice, have the boundaries of CMHT members' roles been drawn?

    (PROMPT: Evolved or imposed?)

12(a) Have you undertaken any joint work with other CMHT members?

    IF YES: What?

12(b) Have you undertaken any joint work with other professionals?

    IF YES: What?

13. What are the major strengths and/or weaknesses in the contribution that other professionals make to the CMHT?

14. How, if at all, would you differentiate between the terms: leader and co-ordinator?
15. Does your CMHT need a leader?

16. Does your CMHT need a co-ordinator?

17. (TEAM MEMBERS): To which of the following five styles does the CMHT leader/co-ordinator adhere to?
   (SHOW CARD C)

   (TEAM LEADERS/CO-ORDINATORS): To which of the following five styles do you adhere to?
   (SHOW CARD C)

18. Do you think the CMHT leader/co-ordinator should use a different style?
   If yes: Which of the five styles should he adhere to?
   Why?

19. (TEAM LEADERS/CO-ORDINATORS ONLY): Are there issues on which you reserve the decision for yourself?
   If yes: What are the issues, and how are these decisions taken?

20(a) (TEAM MEMBERS): What system exists to review your work?

   (TEAM LEADERS/CO-ORDINATORS): What system of review exists for team members' work?

20(b) (TEAM MEMBERS): How satisfied are you with this system?
   (SHOW CARD D)

   (TEAM LEADERS/CO-ORDINATORS): Do you regard this system to be,...?
   (SHOW CARD E)

   (a) What function do CMHT meetings perform?
   (b) How effective have they been in fulfilling these functions? - CARD A
   (c) Do you think they should be: more regularly; less regularly same interval, why?

21(a) Do you feel that all relevant information has been passed onto you, both from outside, and within the team?

21(b) (WHERE APPROPRIATE): How have you kept in touch with your parent agency?

22. To what extent have CMHT members influenced each others' thinking and practice?
23(a) Have you in any way attempted to control your fellow CMHT members' actions?

23(b) Have your fellow CMHT members attempted to control your actions?

24 Have you had any disagreements with other team members?

If yes: Over what issues?
How were such disagreements resolved?

25. Are you aware of any disagreements between other CMHT members in which you are not involved?

If yes: Over what issues did the disagreements occur?

26. Are you aware of any disagreements that remain suppressed within the CMHT?

27. (TEAM LEADERS/COORDINATORS ONLY): What means do you pursue to reduce intra-team disagreements?

28(a) How would you describe the level or levels of trust between team members?

28(b) Is this extended to all team members?

29(a) What do you like and dislike most about working in this CMHT?

29(b) What are the advantages and disadvantages of working in a small team?

30. Have your professional skills developed since joining the CMHT?

If yes: Please specify.

31. How viable, in the light of your experience, do you regard multi-disciplinary teamwork, and your CMHT as being?

32. (TEAM LEADERS/COORDINATORS ONLY):

(a) How far has the CMHT deviated from the objectives and priorities of:

(i) SSO
(ii) health service?

(b) Are the SSO and health service exerting pressure on you to have more client contact?
(c) What influence has the CMHT had on SSD and health service policy?

DECISION-MAKING: A, B, C, D, E

SAMPLE: A1-A13
CARDS FOR INTERVIEWS

B1 _ B3
CARD A

VERY EFFECTIVE
EFFECTIVE
EQUALLY EFFECTIVE and INEFFECTIVE
INEFFECTIVE
VERY INEFFECTIVE

CARD B

A WIDER ROLE
THE SAME ROLE
A NARROWER ROLE

CARD C

ABSOLUTELY AUTOCRATIC:
The Leader makes decisions independently on the basis of his existing information, with neither consultation nor taking account of others' interests.

AUTOCRATIC:
The Leader makes decisions independently after other team members have collected the information defined by him to be the most relevant.

NARROWLY CONSULTATIVE:
The Leader makes decisions after receiving ideas from team members individually.

BROADLY CONSULTATIVE:
The Leader makes decisions after exploring issues with the team.

GROUP:
The problem is shared with the team, alternatives are discussed and a consensus is reached.

CARD D

VERY SATISFIED
SATISFIED
EQUALLY SATISFIED and DISSATISFIED
DISSATISFIED
VERY DISSATISFIED

CARD E

VERY SATISFACTORY
SATISFACTORY
EQUALLY SATISFACTORY and UNSATISFACTORY
UNSATISFACTORY
VERY UNSATISFACTORY
APPENDIX B4

Interview Schedule
for members of CMHTs' Networks
Interview Schedule

1. What role at present, are you fulfilling within the system of care for the mentally handicapped?

2. a. What role at present, is the CMHT fulfilling within the system of care for the mentally handicapped?
   
b. Should the CMHT be adopting a different role in any way?

3. a. Does any overlap exist between the roles of the professionals who work with the mentally handicapped in the community?
   
b. Are there tasks that you perform that are performed by other professionals?
   
c. Do Social Workers and CMHNs perform similar or different tasks?

4. a. Do you feel that any facilities other than those already provided should be available to the mentally handicapped?
   
b. Has the CMHT initiated any significant changes to services for the mentally handicapped?

CONTACTS WITH THE CMHT

5. During the last 12 months, have you contacted or been contacted by the CMHT?

6. Which CMHT members have you been in contact with?

7. How many contacts have you had with the CMHT within the last 12 months?

8. What is the nature of the Activity/ies on which you have had contact with the CMHT?

9. How have such contacts been made?

10. How would you describe the way in which the CMHT has worked with you?
    (Cue: In what capacity did the CMHT act? Advisers? Facilitators?)

11. How freely has information been exchanged between you and the CMHT?
    (Cue: Any problems of confidentiality?)

12. To what extent have you and the CMHT mutually influenced each others' thinking and/or practice?

13. Have you had any disagreements with the CMHT?
    If YES: Over what issues?
    How resolved?
CONTACTS WITH OTHER PROFESSIONALS

14. During the last 12 months which professionals have you been in contact with in your mental handicap work?

15. How many contacts have you had with these Other Professionals within the last 12 months?

16. What is the nature of the Activity(ies) on which you have had contact with Other Professionals?

17. How have such contacts been made?

18. How would you describe the way in which these Other Professionals worked with you?  
   (Cue: In what capacity did they act? Facilitators? Advisers?)

19. Have you had any Disagreements with these Other Professionals?  
   If YES: Over what issues? How resolved?

20. Are you in contact with the CMHT instead of other professionals or in addition to Other Professionals?

21. How viable do you regard a multidisciplinary approach as being?

22. How viable do you regard CMHTs as being?

List of Network professionals and managers interviewed:

- Bassetlaw: 2 Area Social Workers and 2 Area SWAs; 4 Health Visitors; 1 Health Service Administrator; 2 Consultant Psychiatrists (MH); 1 Consultant Paediatrician; 1 ESN (S) and 1 ESN (X) School headteachers; 1 ATC manager; 1 hostel officer in charge; 2 Educational Psychologists and 1 EPT Social Worker; 1 Work Orientation Unit trainer; 1 Physiotherapist; 1 hospital Nurse, and 1 Clinical Psychologist.

- North Nottingham: 4 Area Social Workers and 1 Area SWA; 2 ATC managers; 2 hostel officers in charge and 2 Residential Social Workers; 2 Educational psychologists; 1 specialist Health Visitor, 1 Health Service Administrator; 2 ESN (S) school headteachers; 1 Physiotherapist; 1 Clinical Psychologist; 2 CMHNs; 1 hospital Nurse; 1 Social and Recreational officer; 1 hospital Social Worker; 1 Development Officer.
APPENDIX C1

Questionnaire submitted to Bassetlaw and North Nottingham CMHT members to coincide with the first round of interviews
QUESTIONNAIRE

1. SEX: please circle as appropriate
   Male 1
   Female 2

2. AGE: please circle as appropriate
   20-25 years 1
   26-35 years 2
   36-45 years 3
   46+ years 4

3. PROFESSION AND STATUS:

4. PROFESSIONAL TRAINING:

5. PREVIOUS EXPERIENCE AND EMPLOYMENT:
   (a) In profession:

   (b) With the mentally handicapped:

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6. There are four statements below numbered A to D, each of which represents a different philosophy regarding services for the mentally handicapped. Please rank these statements from 1 to 4 in the boxes below, where 1 represents the statement you adhere to most closely, and 4 the least.

A. In order to meet the full range of problems posed by mental handicap, there is a need to provide both mental handicap hospital and community services. The existing balance between the two is just about right.
B. In order to meet the full range of problems posed by mental handicap there is a need to provide both mental handicap hospital and community services. The existing balance is not the appropriate one, however, since more mentally handicapped people could yet be discharged from the hospitals.
C. The mental handicap hospitals will always have a central role in providing services for the mentally handicapped. Not only is it a focus for specialist resources, but it is also an economical way of providing those resources.
D. All people, including those who have a mental handicap, have a right to enjoy normal patterns of life within their own community and have a right to be treated as individuals.

These statements cover a wide spectrum, but you may feel strongly about certain issues or alternatively wish to clarify your above rankings. If so, please comment below.

7. There are seven statements below numbered A to G, each of which represents a possible objective for your CMHT. Please rank these statements from 1 to 7 in the boxes below, where 1 represents the objective you think most appropriate for your CMHT, and 7 the least. If you think two or more of the objectives are equally appropriate for your CMHT, you may give them the same ranking.

A. To identify the need for different services.
B. To establish alternative forms of accommodation.
C. To change the community’s view of mental handicap.
D. To discharge mentally handicapped people who are inappropriately living in institutions.
E. To directly support mentally handicapped children who are living in the community, and their families.
F. To directly support mentally handicapped adults who are living in the community, and their families.
G. To stimulate informal care networks.
8. Please explain why you think that the objectives you have ranked 1 and 2 are the most appropriate.

9. Are there any other objectives about which you feel strongly?

   Yes 1
   No 2

   If YES, please give details.
10. Please indicate, by placing ticks in the appropriate boxes, which of the following professionals, if any, you would expect to perform each of the following tasks. You may tick as many boxes as you think appropriate but if you think none of the professionals would perform a particular task, please leave the corresponding boxes blank.

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<th>Task</th>
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<td>13. Development of training programs for the achievement of self-help skills; feeding, etc.</td>
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11. Indicate by circling the appropriate number how often you have felt your contribution to CMHT meetings to have been highly valued.

   - Very often 1
   - Often 2
   - Sometimes 3
   - Isolated instances 4
   - Never 5

12. (a) Circle the appropriate number indicating how each decision is taken within the CMHT.

<table>
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<tr>
<th>DECISION</th>
<th>INDIVIDUAL WORKER</th>
<th>CMHT MEETING</th>
<th>CMHT LEADER/COORDINATOR</th>
<th>CMHT LEADER/COORDINATOR AFTER CONSULTATION WITH CONCERNED OTHERS</th>
<th>DECIDED SEPARATELY BY ONE GROUP OF PROFESSIONALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spending of CMHT money</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Use of other resources</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Allocation of cases</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Allocation of other tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Case closure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Resolving administrative difficulties</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Review of Social Worker's work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Review of other team members' work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

You may wish to clarify your above rankings. If so, please comment below.

(b) Do you think any of the above decisions should be taken in a different way?
   - Yes: 1
   - No: 2

If YES, please outline which one(s) and your reasons why.
13. How satisfied are you with the influence you have been able to exert over issues in which you think your involvement appropriate?

<table>
<thead>
<tr>
<th>Response</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>1</td>
</tr>
<tr>
<td>Satisfied</td>
<td>2</td>
</tr>
<tr>
<td>Equally satisfied</td>
<td>3</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>4</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>5</td>
</tr>
</tbody>
</table>

Please give examples to illustrate your answer.

14. Please indicate by circling the appropriate number, how you would rate the morale of the CMU.

<table>
<thead>
<tr>
<th>Morale</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>1</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
</tr>
<tr>
<td>Very low</td>
<td>5</td>
</tr>
</tbody>
</table>

Why?

15. What level of friendship exists between the CMU members?

<table>
<thead>
<tr>
<th>Friendship</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>1</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
</tr>
<tr>
<td>Very low</td>
<td>5</td>
</tr>
</tbody>
</table>

16. What level of respect characterises team members' views of each others' roles?

<table>
<thead>
<tr>
<th>Respect</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high</td>
<td>1</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
</tr>
<tr>
<td>Very low</td>
<td>5</td>
</tr>
</tbody>
</table>
17. Is this level of respect extended to all CBT members?  

<table>
<thead>
<tr>
<th></th>
<th>Yes 1</th>
<th>No 2</th>
</tr>
</thead>
</table>

If NO, please illustrate with examples.

18. Can you indicate by circling the appropriate number, how much you agree or disagree with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes, I Strongly Agree</th>
<th>Yes, I Agree Quite A Lot</th>
<th>Yes, I Agree Just A Little</th>
<th>I'm not Sure</th>
<th>No, I Disagree Just A Little</th>
<th>No, I Disagree Quite A Lot</th>
<th>No, I Disagree Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can trust my fellow CBT members to lend a hand if I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2. Most of my fellow CBT members can be relied upon to do as they say they will do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3. I have full confidence in the knowledge and skills of my fellow CBT workers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<td>4. I can rely on my fellow CBT members not to make my job more difficult by careless work.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. I feel myself to be part of the CBT.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. I am proud to be able to tell people that I work for this CBT.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7. I'm willing to put myself out just to help the CBT.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8. Even if the CBT did not appear to be operating successfully, I would be reluctant to change to another practice setting.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>9. In my work I like to feel I am making some effort, not just for myself, but for the CBT as well.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10. I sometimes feel like leaving this CBT for good.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11. If I got into difficulties, I know my fellow CBT members would try and help me out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>12. I have full confidence in the competence of my fellow CBT members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. Our team has a poor future unless my fellow CBT members use their skills more efficiently.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. I cannot fully trust my fellow CBT members because they are not reliable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
<td>7</td>
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</tbody>
</table>
APPENDIX C2

Questionnaire submitted to Central Notts CMHT members to coincide with interviews
1. PROFESSION AND STATUS:

2. PROFESSIONAL TRAINING:

3. PREVIOUS EXPERIENCE AND EMPLOYMENT:
   (a) In profession:

   (b) With the mentally handicapped:
There are four statements below numbered A to D, each of which represents a different philosophy regarding services for the mentally handicapped. Please rank these statements from 1 to 4 in the boxes below, where 1 represents the statement you adhere to most closely, and 4 the least.

A. In order to meet the full range of problems posed by mental handicap, there is a need to provide both mental handicap hospital and community services. The existing balance between the two is just about right.

B. In order to meet the full range of problems posed by mental handicap there is a need to provide both mental handicap hospital and community services. The existing balance is not the appropriate one however, since more mentally handicapped people could yet be discharged from the hospitals.

C. The mental handicap hospitals will always have a central role in providing services for the mentally handicapped. Not only is it a focus for specialist resources, but it is also an economical way of providing these resources.

D. All people, including those who have a mental handicap, have a right to enjoy normal patterns of life within their own community and have a right to be treated as individuals.

These statements cover a wide spectrum, but you may feel strongly about certain issues or alternatively wish to clarify your above rankings. If so, please comment below.

There are seven statements below numbered A to G, each of which represents a possible objective for your CMHT. Please rank these statements from 1 to 7 in the boxes below, where 1 represents the objective you think most appropriate for your CMHT, and 7 the least. If you think two or more of the objectives are equally appropriate for your CMHT, you may give them the same ranking.

A. To identify the need for different services.

B. To establish alternative forms of accommodation.

C. To change the community's view of mental handicap.

D. To discharge mentally handicapped people who are inappropriately living in institutions.

E. To directly support mentally handicapped children who are living in the community, and their families.

F. To directly support mentally handicapped adults who are living in the community, and their families.

G. To stimulate informal care networks.
6. Please explain why you think that the objectives you have ranked 1 and 2 are the most appropriate.

7. Are there any other objectives about which you feel strongly?

If YES, please give details:

Yes 1
No 2
8. Please indicate, by placing ticks in the appropriate boxes, which of the following professionals, if any, you would expect to perform each of the following tasks. You may tick as many boxes as you think appropriate but if you think none of the professionals would perform a particular task, please leave the corresponding boxes blank.

<table>
<thead>
<tr>
<th>Task</th>
<th>Clerk</th>
<th>SH &amp; WA</th>
<th>SH &amp; SN</th>
<th>Area Based SN</th>
<th>Hospital Based Charges</th>
<th>Community</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Assessment of mentally handicapped adults' self-help skills.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Assessment of mentally handicapped children's self-help skills.</td>
<td></td>
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<tr>
<td>6. Assessment of mentally handicapped adults' physical abilities.</td>
<td></td>
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<tr>
<td>7. Assessment of mentally handicapped children's physical abilities.</td>
<td></td>
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<tr>
<td>8. Assessment of IEP and social quotient.</td>
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<tr>
<td>9. Specialist advice, counselling and support for parents in coping with the traumas experienced by the family.</td>
<td></td>
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<tr>
<td>10. Specialist advice, counselling and support for parents in coping with the attitudes of relatives, siblings and neighbours.</td>
<td></td>
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<td>11. Specialist advice on overcoming any feeding difficulties.</td>
<td></td>
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<tr>
<td>12. Specialist advice on methods of attaining development milestones: sitting, walking, etc.</td>
<td></td>
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<tr>
<td>13. Development of training programmes for the achievement of self-help skills: feeding, etc.</td>
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<tr>
<td>14. Training in the use of remnants of vision and hearing.</td>
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<tr>
<td>15. Specialist advice to parents on overcoming behaviour problems.</td>
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<tr>
<td>17. Advice on welfare rights and financial aid.</td>
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<tr>
<td>18. Review of hostel residents regarding the appropriateness of where they live.</td>
<td></td>
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<tr>
<td>20. Liaison with ESRI(S) Schools.</td>
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<tr>
<td>21. Liaison with AIC Managers.</td>
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<tr>
<td>22. Liaison and work with voluntary organisations.</td>
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<tr>
<td>23. Creation of fostering placements.</td>
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<tr>
<td>24. Devise a behaviour modification programme.</td>
<td></td>
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<tr>
<td>25. Implementing a behaviour modification programme.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>26. Changing the community’s view of mental handicap and the mentally handicapped.</td>
<td></td>
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<tr>
<td>27. Setting up of group homes.</td>
<td></td>
<td></td>
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<tr>
<td>28. Setting up of lodgings schemes.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. Support to group homes and lodgings.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>30. Assessment of clients speech abilities and defects.</td>
<td></td>
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</tr>
<tr>
<td>31. Training in speech development.</td>
<td></td>
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</tr>
<tr>
<td>32. Attempt to find less sheltered employment for the mentally handicapped.</td>
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</tr>
<tr>
<td>33. Participation in play schemes for mentally handicapped children.</td>
<td></td>
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</tr>
<tr>
<td>34. Liaison with mental handicap hospitals.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
9. Indicate by circling the appropriate number how often you have felt your contribution to CMHT meetings to have been highly valued.

- Very often 1
- Often 2
- Sometimes 3
- Isolated instances 4
- Never 5

10. How satisfied are you with the influence you have been able to exert over issues in which you think your involvement appropriate?

- Very satisfied 1
- Satisfied 2
- Equally satisfied and unsatisfied 3
- Unsatisfied 4
- Very unsatisfied 5

Please give examples to illustrate your answer.

11. Please indicate by circling the appropriate number, how you would rate the morale of the CMHT.

- Very high 1
- High 2
- Moderate 3
- Low 4
- Very low 5

Why?
12. What level of friendship exists between the CMH members?

- Very high 1
- High 2
- Moderate 3
- Low 4
- Very low 5

13. What level of respect characterises team members' views of each other's work?

- Very high 1
- High 2
- Moderate 3
- Low 4
- Very low 5

14. Is this level of respect extended to all CMH members?

- Yes 1
- No 2

If no, please illustrate with examples.
15. Can you indicate by circling the appropriate number, how much you agree or disagree with each of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes, I Strongly Agree</th>
<th>Yes, I Agree Quite A Lot</th>
<th>Yes, I Agree Just A Little</th>
<th>I'm Not Sure</th>
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<th>No, I Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can trust my fellow CMHT members to lend a hand if I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>2. Most of my fellow CMHT members can be relied upon to do as they say they will do.</td>
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<td>3</td>
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</tr>
<tr>
<td>3. I have full confidence in the knowledge and skills of my fellow CMHT workers.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>4. I can rely on my fellow CMHT members not to make my job more difficult by careless work.</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5. I feel myself to be part of the CMHT.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>6. I like other professionals to know that I work for this CMHT.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>7. I'm willing to put myself out just to help the CMHT.</td>
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<td>3</td>
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<td>8. Even if the CMHT did not appear to be operating successfully, I would be reluctant to change to another practice setting.</td>
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<td>11. If I got into difficulties, I know my fellow CMHT members would try and help me out.</td>
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<td>13. Our team has a poor future unless my fellow CMHT members use their skills more efficiently.</td>
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<td>4</td>
<td>5</td>
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<td>14. I cannot fully trust my fellow CMHT members because they are not reliable.</td>
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