**CMHTs for older people: Team managers’ views surveyed**

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**Acknowledgements:**

The authors are grateful to the CMHT managers who participated in this research. This paper presents independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research scheme (RP-PG-0606-1109). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

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**ABSTRACT**

**Purpose:** To identify features of community mental health teams (CMHTs) for older people valued by their managers, and those they would most like to change.

**Approach:** Content analysis was used to analyse ‘free text’ responses to open questions from a national survey about CMHTs’ organisational structures and processes. Responses were sorted into statements which were categorised into content areas and higher level dimensions.

**Findings:** Free text information was provided by 376 teams (an 88% response rate). Eight higher level dimensions were identified. One related specifically to integration with social care services, whilst several more included material about other aspects of intra-team integration (e.g. documentation and location). The largest proportion of statements related to staffing and teamwork. Statements about inter-personal and inter-professional issues were largely positive, whilst statements about resources, bureaucracy and integration with social care services typically detailed desired changes.

**Practical implications:** Four key issues emerged comprising a high level of support from managers to develop integrated practices; a need to define the focus of CMHTs for older people and to be fully resourced; and the importance of a nurturing and supportive team environment.

**Originality/value**: The methodology provides a bridge between qualitative and quantitative research, exploring the volume of statements on particular topics and their meaning.

**Key words:** Content analysis, community mental health teams for older people, integration, teamwork, multidisciplinary working

**Article classification:** Research Paper

**Introduction and aims**

The development of specialised and comprehensive mental health services for older people, integrated across health and social care, is a key UK policy directive (Cm 8378, 2012). Government support for such integration is proffered on the basis that this approach enhances efficiency and improves outcomes for service users. Whilst outcome evidence is limited, recent findings do suggest that service integration may have benefits for both organisations and service users (Cameron *et al*., 2014). The narrative regarding the need for specialist older people’s mental health services is complicated with policy statements supporting access to services on the grounds of need alongside professional opinion promoting “strong specialist” services designed for and targeting older people (Royal College of Psychiatry [RCP], 2006, p4). Community mental health teams for older people (CMHTs) are at the heart of these services, providing specialist assessment, treatment and support directly as well as working with other agencies to improve recognition and management of mental illness in older people in non-specialist settings (Department of Health [DH], 2001). Guidance recommends that CMHTs have an integrated structure, that all professional health and social work staff undertake initial assessments, and that teams operate a single point of accessand a single data management system (DH and Care Services Improvement Partnership, 2005; RCP, 2006; National Institute for Excellence/Social Care Institute for Excellence, 2007). A survey of all CMHTs for older people in England in 2009 however found varying arrangements within teams although the majority had at least some of these features (Wilberforce *et al.,* 2011; Abendstern *et al.,* 2012).

The variety of practices found within CMHTs also includes the type of service user targeted, the length and intensity of involvement, the range of services delivered, the extent to which outreach is provided to non-specialist services and whether staff work as specialists or undertake generic roles (*Tucker et al.,* 2014 Wilberforce *et al.,* 2014). Such diversity accentuates the need to know what works well and what features constrain good practice in order to ensure the appropriate targeting of resources and support for positive approaches. The current paper considers the views of CMHT managers who, as part of a national survey were asked to comment on the way their teams worked. In particular it aims to identify the main areas highlighted by respondents as being of importance to the delivery of good practice. Free text data from a nationally representative sample was analysed, bridging the gap between purely quantitative studies, which traditionally provide breadth and qualitative case-study approaches providing depth; making it possible to generalise the findings to the sector as a whole.

**Method**

A national survey was conducted in 2009 to elicit information about team structures and processes. The survey included two open questions:

1. What do you feel are the best aspects of the way in which your team’s staff andtheir work are organised? (subsequently referred to as ‘positive’)
2. What aspects of the way in which your team’s staff and their work are organisedwould you most like to change? (subsequently referred to as ‘negative/change’)

The findings from these questions form the focus of this paper.

The methodology was influenced by the work of Begay and colleagues (2004) whose data were similar to the current study – a large representative sample of short statements - and who recognised the value of drilling down into the meaning of responses in addition to counting the frequency of their appearance. Data collection was part of a larger anonymous service evaluation which received National Research Ethics Service approval. Content analysis, providing a systematic and replicable means of rendering large quantities of text into specified categories was used to analyse the data (Holsti, 1969; Stemler, 2001).

***Coding and analysis***

Coding employed a multi-staged approach involving periodic review of earlier decisions. Three researchers were involved in this process. Themes emerged through a system whereby responses were divided into statements referring to specific topics or “content areas” which were then grouped under a number of higher level “dimensions”. Strict coding rules were applied using key words or phrases to support objective decision making, keeping assumptions to a minimum, and statements assigned to single mutually exclusive content areas. Statements were coded as being related to integration with social services only where this was explicitly stated or if respondents referred to working with social services/social workers, capturing manifest (observable) as opposed to latent (underlying) content. Three content areas spanned both the integration dimension and one other, as illustrated in Figure 1. For example, some statements about the content area “Skill mix/MDT” related to integration with social services whilst others referred to various healthcare staff. These statements were coded separately to retain clarity during the analysis but are brought together in the findings in order to reduce repetition. Numbers of statements in each content area were summed to illustrate the level of importance given to particular issues. The grouped statements were then analysed qualitatively to ascertain dominant themes.

Analysis of the survey data reported elsewhere revealed that sixty percent of teams included at least one social worker. Teams were also classified into high (n=95), medium (n=234) or low (n=39) integration levels (Wilberforce *et al.,* 2011). These categories are referred to in the findings in relation to the nature of the respondents’ statements regarding integration but not in relation to other issues.

**Findings**

The response rate to the survey was 88 per cent representing 376 teams of which 357 (95%) provided at least one positive and 324 (86%) at least one negative/change statement. Respondents were predominantly team managers (73%) with a minority being either higher-level managers or team members (15% and 11% respectively). The majority of responses were short, including between one and three positive and/or negative/change statements (85% and 90% respectively) with 24 per cent making positive statements on a single issue and 40 per cent making a single negative/change statement.

Content areas clustered around eight dimensions (see Figure 1) with the largest proportion of statements relating to staffing and teamwork. In four dimensions: staffing and teamwork; team processes; models; and management and supervision; respondents made more positive than negative/change statements. In contrast respondents were far more likely to make negative/change statements about resources, documentation and integration with social services. The latter represented the second largest category of negative/change statements overall.

Further detail is illustrated in Figure 2 where the percentage of respondents making negative/change (-) and positive (+) statements within each content area is noted. The spread of the comments was wide. Overall, most positive statements were made about interpersonal and inter-professional relationships, followed by referral issues; whilst most negative/change statements referred to staffing resources, bureaucracy and general statements about integration with social services. A description of the content of these statements is provided within a summary of the dimensions below.

*Figures 1 and 2 about here*

***Staffing and teamwork***

Three issues dominated this dimension: staffing levels, support from colleagues, and the roles and functions of different professions. The impact of having too few staff was mentioned by over 18 per cent of respondents who commented on either the stress within the team that this created, due to “constantly … working to full capacity” with no time for reflection (e.g. “I would like more staff as we are all overworked … and sometimes feel overwhelmed with urgent referrals”), or to the frustration due to not being able to provide the service they felt the community required. For example:

More staff [needed] so that we can develop services which I feel meet client needs and are truly indicative of what a community mental health team should be/provide

Almost one third of respondents included a statement about the supportive nature of interpersonal relationships within their teams. The importance of such support was highlighted through statements about team building (e.g. “Good, cohesive team - efforts have been made re team building in past that have contributed to good team”) and shared team approaches to decision-making. As one respondent put it, this approach “doesn't leave clinicians feeling vulnerable”. Another manager commented that they had “developed a system for co-working high risk/complex cases which … provided a lot of support for staff”. Fourteen percent of respondents commented on the role of consultant psychiatrists. Positive comments noted consultants to be responsive, approachable, supportive and valuing of other team members. One manager noted that they worked with “consultants who believe in the team … trust their judgements and support each other”. Where consultants were experienced as dominating the way the team worked this was not welcomed.

More than a fifth of respondents referred to aspects of inter-professional working and the extent to which this was thought to provide a more flexible and holistic service to the public. Strong opinions emerged regarding the work that different professionals within multidisciplinary teams should undertake, the majority favouring the maintenance of distinct roles, described as supporting the best use of the various skills and expertise present in the team (e.g. “each discipline is encouraged to utilise their particular skills/knowledge and joint working is often further forward”) as well as aiding the respect of one discipline for another. Negative/change statements referred to the need for more clarity around professional roles within multidisciplinary teams, and a desire for “roles to be more streamlined and not generic”. Within integrated teams – those with a range of health and social care staff – role blurring was sometimes regarded as wasteful of skills and expertise. For example:

Nursing team model keeps role as a practising clinician and not have time taken away from this in doing a social work role. Avoids dilution of mental health nursing skills, facilitates team to provide service to primary and secondary care

However, this often appeared to be linked to resources rather than principle, suggesting that if teams were properly resourced role blurring might have been less problematic for managers. For example, relating back to earlier comments about tem capacity, one respondent noted:

We have tried mixing and matching social workers and nurses however due to staff shortages we have gone back to doing what we know best

# Team models and processes

These dimensions were chiefly concerned with team boundaries and the efficiency of their access and referral processes. Around a quarter of respondents made at least one positive statement about their team in relation to its remit, philosophy, interventions or service delivery model. The operation of a holistic or person-centred approach, taking account of individual and community needs and aspirations, and the adoption of the recovery model, dominated these responses. There was a strong desire amongst those 15 percent making negative/change statements to develop the work of their team to include more therapies, group work, preventative approaches, within-team memory services, and long-term involvement, as well as a wish to move away from what was perceived to be the dominance of a medical model. Negative/change statements also pointed to concerns about a lack of clarity about their core business and whether this should be a focus on the most vulnerable or a wider remit including more mental health promotion and education with no consensus on this issue. One manager stated that s/he wanted the team to “become more proactive with promoting positive mental health and working beyond the restrictions of just seeing people who have very high need and high risk”. Another wanted to achieve the opposite, developing primary care knowledge of mental health in order to “allow [the] CMHT to work more intensively with fewer service users and carers”.

Forty-five percent of managers reported positive aspects of their team’s processes whilst 23 percent reported a need for improvement. Both strengths and concerns were dominated by views on referral and access practices. Systems that supported the provision of a swift and appropriate response, including the operation of a single point of access (SPA) to reduce duplication, and a duty or triage system which led to the “prompt allocation of referrals” were frequently cited. One manager noted that their SPA along with “the combined assessment documents developed for this service, coupled with a truly interdisciplinary team” enabled them to deal with referrals efficiently. Multidisciplinary referral systems were reported to result in “the most appropriate professional … get[ting] allocated from the start”. There were also positive statements about the operation of extended opening hours, which had led to a service that was more “responsive to client need”. Negative/change statements were largely the mirror image of positive ones with respondents noting that an SPA would improve the work of the team, as would having an out of hours service, a daily allocation system and a ‘better duty’ system. In relation to assessment, statements referred to either the need for several staff from different disciplines to be involved in order to provide “best practice joint assessments at the first point of contact” or for all staff to undertake holistic assessments themselves, so that services could be provided that met “service users’ and their carers’ emotional, social and physical needs”.

## *Management and supervision, documentation and location*

The importance of unity within teams is highlighted within these dimensions which focus on the need for a single team manager, database, and location. Team management issues were the subject of statements by 11 percent of teams. These were largely related to the importance of strong, clear and accessible leadership and in particular to the strengths of having a single manager responsible for the whole team. This was seen as enabling a flexible response with the best use of everyone’s time and expertise. Many negative/change statements simply noted that not having a single team manager was the aspect that they would most like to change about their team. Management of integrated health and social care teams was described as “difficult” and “messy” where a single management structure for the whole team was not in place. Almost all statements regarding supervision were positive, focusing on the fact that it should be regular, structured, and include both clinical supervision and workload management.

Perhaps not surprisingly, the majority of statements about documentation were negative (22% vs. 5%). The lack of shared systems between professional groups, combined with the amount of paperwork and/or computer data entry required, were the most commonly cited criticisms. The effect the latter had on staff morale was highlighted by terms such as ‘frustration’, ‘worry’, ‘nightmare’ and ‘desperate’. For example:

Complete nightmare for all practitioners remembering to ensure that all assessments, reviews, reassessments etc are entered on both systems for the purpose of stats

The lack of a single shared database system was said to create inefficiency and extra work, particularly for social workers who potentially often had to input data onto two systems. As one manager put it:

Having to record on different systems takes away from time available to spend on clinical work, particularly for social workers, having one system of recording patient information is preferable to ensure all patient information is in one place and reduce the level of recording

The positive statements described the systems desired by others. For example:

All information and case notes are on one system that can be accessed by all of mental health and social care to ensure a more seamless approach to clients’ care

The importance of team members being co-located was emphasised by 12 per cent of respondents who noted that this “fundamentally assist[ed] communication” and aided mutual support and understanding. Not sharing a single base was described as putting a strain on team management, team cohesion and support. For example:

Difficult to manage in so many locations and communications between team members can be a problem as can be peer support

# Integration and interface with other services

These dimensions focus on the way in which teams work with social services and on their relationships with health services in their localities. Integration with social services was manifestly commented upon positively by 13 percent of respondents whilst 28 percent made negative/change statements. Importantly, the latter were mainly expressions of a desire for more integration, demonstrating general support by team managers. Moreover, it was observed that positive and negative/change statements on integration with social services were not equally distributed across all teams. Among those with low/medium integration, 10 percent reported positive features of integration whilst around 30 percent desired changes in this area. In contrast, among the highly integrated teams, positive and negative/change issues were reported in equal measure by 21 percent of teams. Negative/change statements among the latter tended to focus on the desire to further improve aspects of integration such as sharing of records and documentation.

Almost one fifth of statements on integration with social services were of a general nature (e.g. “Would like to be integrated or at least work more closely with social services”). A number of statements reflected a broader management view of the direction that CMHTs for older people should be taking and the belief that they were beginning to achieve this. For example:

Recent integration measures are working very well in terms of multidisciplinary relationship. Team support each other and work well together - a lot more joint working. Things feel to be heading in the right direction

The team…has grasped the ideals of integration and is working hard to develop systems and processes which reflect the new ways of working

Finally, approaching a fifth of negative and slightly fewer positive statements referred to the interface between the CMHTs and a range of healthcare agencies and related services, indicating concerns about the difficulties resulting from poor coordination with primary (usually general practitioners (GPs)) and secondary (usually in-patient) healthcare services (e.g. “better communication from the wards [needed] to improve CPA and discharge”). There was also frustration over the lack of time to commit to supporting non-specialist services. The minority of positive statements that expanded on their good working relationships with other agencies noted that these had been achieved through the development of formal links between CMHT staff and other services. This was particularly noted in relation to GPs (e.g. “CPNs work to specific surgeries-enabling strong links”).

**Discussion**

***Methodological considerations***

This article provides a unique overview of the lived experiences of managers of CMHTs for older people at a point in time when their boundaries were in question (Hilton, 2012). The data remains relevant despite being collected in 2009. Integration at both agency and professional levels in the field of adult health and social care continues to be a key policy goal (e.g. DH, 2013) whilst researchers and commentators continue to remark on its progress and its complexities in a range of settings (e.g. Glasby *et al.,* 2011 and 2013; Clark *et al.,* 2013; Kennedy, 2014). Whilst the nature of the data cannot offer the richness provided by more typical qualitative data, its properties offer a degree of generalizability not equated with the former. Coding decisions proved challenging and it is likely that the deliberately conservative coding rules applied resulted in an under-representation of statements about integration. It is probable that at least in some instances where statements included terms such as ‘multidisciplinary’, ‘single point of access’, and “co-location” integration with social services was being referred to. If so, it would suggest that the theme of integration is considerably more important to CMHT managers than the raw figures imply. On the other hand, the coding strategy could also be perceived as a strength as the findings revealed that integration mattered without recourse to additional assumptions about content meaning. Furthermore, although individual statements were read in context, they were divided into positive and negative statements before this process. This may have disrupted the level of understanding achieved and led to a further underestimation of statements related to integrated working with social services. Finally, the article also made only limited use of the team integration classifications. However, analysis (not shown) revealed that only in the case of integration related responses did patterns emerge that could be linked to team integration levels.

# What do the findings reveal?

Taken as a whole the positive and negative/change comments demonstrate a complex picture of arrangements within which teams operated. Four issues stand out: concern about the proper focus of CMHTs for older people; the importance of a nurturing and supportive team environment; the need to be fully resourced; and support for multidisciplinary working and integrated practices amongst managers in order to provide a holistic service to the communities served. These issues are considered in turn below.

A number of studies have shown that effective teamwork requires clear goals (Poulton and West, 1999; Borrill *et al*., 2000) and that improved team functioning is related to the pursuit of common purpose (Cashman *et al*., 2004). The current findings suggest that some teams were unsure of the parameters of their role and that they would like further clarity regarding this. Teams operate in local environments with differing resources so that the nature of what is undertaken by them individually will necessarily vary. However, in line with previous research (Onyett *et al*., 1997), the current study findings suggest that they are likely to operate more efficiently and in collaboration with other teams and services if they have a clearly defined and distinct role within their local context. At a time when in some places CMHTs for older people are being merged with CMHTs for working age adults leaving small dementia specific teams for older people this issue is highly topical (Sikdar and Warner, 2013).

The extent of comments referring to interpersonal relationships within teams should not be underestimated. Previous studies have stressed the importance of positive interpersonal relations in helping to achieve a constructive working environment of mutual respect, trust and support (Cook *et al*., 2001; Molyneux, 2001). However, a survey of working age adult CMHTs found that whilst working as part of a team was seen as particularly rewarding, relationships with others and working as part of a dysfunctional team could be very stressful (Harper and Minghella 1997).Most comments in the current study are positive, pointing to the presence of strong and supportive relations in many teams. This encouraging finding will require nurturing, particularly during times of budget cuts and service restructuring, conditions known to increase stress (Thomas, 1997), if the positive environments achieved by teams are not to be lost.

Respondents’ comments also highlighted the need for sufficient resources to offer high quality services that do not result in staff burnout. Staffing levels, systems of recording, access arrangements and co-location of teams were all aspects raised by managers that affected the quality of service delivery, echoing previous research findings. A review of the literature on stress and burnout in community health nursing (Edwards *et al*., 2000) found that increases in workload, administration and lack of resources were amongst the most frequently cited factors leading to these symptoms. Staff in many teams in the current study appeared to be under pressure to see more people due to staff shortages. A commitment to the provision of appropriate staff support including reducing the burden of recording might contribute to ensuring this skilled and dedicated workforce are not overwhelmed.

Overall, comments suggested that managers supported the idea of integration, wanted to see its further development and were critical where this was not happening. Respondents were looking for solutions to difficulties within an integrated framework rather than the dismantling of this structure. Some of the most vociferous negative comments from integrated teams referred to difficulties of information sharing due to the lack of shared databases. The implication is that whilst integration is a desired and valued concept and practice, its presence – in a variety of forms – brings new challenges. This suggests that messages from the literature regarding the benefits and challenges of integration are supported by managers experientially. Wistow (2012) suggests that purposefully integrated care offers a needs-led, person-centred service that is easily accessed and delivers support “in the shape of the “right” services at the “right” time from the “right” person and in the “right” place" (p110). The comments made by the respondents within the current study are testament to CMHT managers’ desire to provide exactly this type of service and indicates the relevance of these data to the larger integration debate. Whether fully integrated teams and services are deliverable in the current financial climate however remains in question. Cultivating and protecting the positive relationships between individuals and different staff groups within teams that presently exist might become even more important in this environment.

Acknowledgements

(Removed for blind review)

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**Figure 1: Proportion of teams providing evaluative statements in eight different content dimensions**



Based on: +n = 357 teams, -n = 324 teams

**Figure 2: Proportion of teams commenting on individual topics (content areas)**

 (-) Would most like to change / (+) Best aspect of team.

 *Percentages refer to number of teams making statements on individual issues* *based on: +n = 357 teams, -n = 324 teams.* SSD = Social Service Department, VCS = voluntary and community sector