Integration of social care staff within community mental health teams

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## Glossary of terms/abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADSS</td>
<td>Association of Directors of Social Services</td>
</tr>
<tr>
<td>AMHP</td>
<td>Approved Mental Health Professional</td>
</tr>
<tr>
<td>AOT</td>
<td>Assertive Outreach Team</td>
</tr>
<tr>
<td>ASW</td>
<td>Approved Social Worker</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community mental health team</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CRHTT</td>
<td>Crisis Resolution and Home Treatment Team</td>
</tr>
<tr>
<td>CRT</td>
<td>Crisis Resolution Team (sometimes used to mean CRHTT, sometimes without home treatment)</td>
</tr>
<tr>
<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
</tr>
<tr>
<td>CUES</td>
<td>Carers’ and Users’ Expectations of Services</td>
</tr>
<tr>
<td>CWI</td>
<td>Centre for Workforce Intelligence</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EIS</td>
<td>Early Intervention in Psychosis Services</td>
</tr>
<tr>
<td>EIT</td>
<td>Early Intervention Team (usually means the same as EIS)</td>
</tr>
<tr>
<td>FACS</td>
<td>Fair Access to Care Services</td>
</tr>
<tr>
<td>FTE</td>
<td>Full time equivalent</td>
</tr>
<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcome Scores</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Pathways</td>
</tr>
<tr>
<td>Karasek JCQ</td>
<td>Karasek Job Content Questionnaire</td>
</tr>
<tr>
<td>MANSA</td>
<td>Manchester Short Assessment of Quality of Life</td>
</tr>
<tr>
<td>MHN</td>
<td>Mental Health Nurse</td>
</tr>
<tr>
<td>MLM</td>
<td>Multi-level modelling</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NPMS</td>
<td>National Psychiatric Morbidity Survey</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<td>---------</td>
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</tr>
<tr>
<td>NSF</td>
<td>National Service Framework for Mental Health</td>
</tr>
<tr>
<td>NSIP</td>
<td>National Social Inclusion Programme</td>
</tr>
<tr>
<td>OSCA</td>
<td>Outcomes of Social Care for Adults</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PREM</td>
<td>Patient-reported experience measure</td>
</tr>
<tr>
<td>PROM</td>
<td>Patient-reported outcome measure</td>
</tr>
<tr>
<td>PSSRU</td>
<td>Personal Social Services Research Unit</td>
</tr>
<tr>
<td>QOC</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>QOL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>STR</td>
<td>Support Time &amp; Recovery Worker</td>
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<tr>
<td>SUQ</td>
<td>Service User Satisfaction Questionnaire</td>
</tr>
<tr>
<td>SWB</td>
<td>Subjective well being</td>
</tr>
<tr>
<td>WACDS</td>
<td>Wales Alliance for Citizen Directed Services</td>
</tr>
<tr>
<td>WAG</td>
<td>Welsh Assembly Government</td>
</tr>
<tr>
<td>WDQ</td>
<td>Workforce Dynamics Questionnaire</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WRT</td>
<td>NHS Workforce Review Team</td>
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Contributions of Authors:

Professor Peter Huxley: PI and lead investigator, involved in the conception, design, execution and writing up of the drafts and final reports.

Professor Steve Onyett and Professor Nick Gould replaced original applicants when the proposal was made from Kings College in London and then moved to Swansea. They participated in meetings about the direction of the research, and then contributed to the interpretation of the results drawing on their professional expertise in relation to community mental health teams and social work respectively. They have provided advice at key stages of the projects as well advising on all drafts of the three Phases of the research, and approving the final version of the report.

Dr Sherrill Evans, Co-investigator was involved in the conception, design, execution and writing up of the drafts and final reports. She was also responsible overseeing the production of the survey instruments, supervising research staff, and conducting the statistical analysis with advice from experts cited in the acknowledgements.

Dr Christine Baker, was the senior researcher who worked with two other research staff to arrange for the data to be collected and entered into SPSS. She has contributed to the interpretation of the data and to the writing of drafts and the final report.

Jo White was one of the research staff who conducted the telephone interviews and went to the locations to arrange for data collection. She was
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Sally Philpin was one of the research staff who conducted the telephone interviews and went to the locations to arrange for data collection. She was also involved in data entry, interpretation of the results, and in the drafting of the draft and final reports. She also managed relations with the Research and Development bodies of the responding Trusts, and completed regular update reports.

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Executive Summary

Background

Multidisciplinary community mental health teams (CMHTs) have been the central organisational feature of the delivery of mental health care for decades. New teams (early intervention, home treatment and crisis resolution, assertive outreach) have been introduced in England and their composition has largely been left to local services to determine. Previous research has suggested that services can have better outcomes when delivered by multidisciplinary teams, and that new teams may have better outcomes than CMHTs for certain people. The rationale for team composition has never been explored systematically. Team composition varies considerably in terms of the proportion of the team made up of social care staff (social workers and social support workers) as opposed to health care staff. Previous research has not focused on the social care component of teams - which will arguably become more important as services attempt to implement government policy that emphasises public mental health.

Aims

The aim of the present study is to provide evidence about team composition, in particular the extent of the social care component, and whether composition influences the culture and climate of the team and whether this makes a difference to the service users.

Methods

Phase I: a national survey of Trusts providing mental health services in England and Wales to describe the number of teams and their composition, the rationale for that composition and the social care component and the drivers of any contemplated changes in teams configuration. Referred to hereafter as ‘The National Survey’

Phase II: a staff survey in four locations selected purposely for their differently constituted teams. Two locations were in England and two in...
Wales. Standardised instruments were used to assess team culture and climate and its relationship with team composition. Referred to hereafter as ‘The Staff Survey’ in four Trusts.

Phase III: **Interviews with service users** in two of these locations that had contrasting climate and cultures in the teams, using standardised instruments and a satisfaction questionnaire, to determine whether service user outcomes are related to team composition, culture and climate. Referred to hereafter as the ‘service user interviews’. The sample size was small, underpowered for quantitative analysis, and results can only be regarded as indicative not substantive.

## Results

### The National Survey

42/79 Trusts responded (53%) covering 381 teams staffed by 6646 people of whom 19% were social workers and 10% were social support workers. Nurses formed one third of the workforce. The average team size was 17.7 (sd 5.5). There were no significant differences in workforce numbers and types of team between responding and non-responding Trusts.

Social care composition ranged from 0% to 88% of the team. Social work staffing levels were lower where the funding was entirely in the hands of the local authority. Staffing deficits remained (compared to policy guidance figures) in social support staff, psychiatrists, occupational therapists (OTs) and psychologists.

The most common rationale for overall team composition was historical (46%) followed by policy guidance, demand factors and financial resources.

A third of the rationales for the social care component of the team involved the need for integration or multidisciplinarity.

With regard to planned changes to teams, extensive policy guidance was very influential on management decisions. One consequence has been the redeployment of CMHT staff to new teams; smaller Trusts with smaller existing teams were more likely than larger Trusts to be considering redeployment of staff.

The findings support previous research that suggests workforce composition is determined more by supply and historical factors than by demand or need factors.
The staff survey

300 staff from two Welsh (18 teams) and two English Trusts (24 teams) completed the Workforce Dynamics Questionnaire (WDQ) and the Karasek Job Content Questionnaire (JCQ).

Ninety percent of CMHTs responded and 60% of new teams. The individual staff response rate was 46%. There were no differences in response rate by professional group, country or Trust.

The main factor determining team composition was again historical (50%), but resources played a greater part than in the National Survey (26%) as did multidisciplinary (52%).

Almost one-fifth of teams had fewer than 10% social care staff, and only seven per cent had over 60%. Six teams had no social care input at all, five were in Wales.

New teams are smaller than CMHTs and have only 19% social care staff compared to 31.6% on average in CMHTs. More than one third of new teams have no social workers and 52% have no social support workers. Twenty-nine percent of new teams (n=4) had no social care input compared to 7% of CMHTs (n=2).

Where budgets were pooled the proportion of social care staff was significantly higher.

WDQ Multivariate results

The final regression models explained a modest amount of the variance of perceived integration (29.6%), perceived Quality of Care (48.5%), overall job satisfaction (46.1%) and intention to leave (37.6%) but 68.5% of teamwork.

Better integration scores were associated with new teams (which have a lower social care component), better management, and the ‘other’ staff group (OT, psychologist, psychiatrist etc) who were in short supply and often worked on a sessional basis. Support workers’ integration scores were higher where the social care component of team was higher.

Teamwork scores were predicted by higher (better) scores on role perception and flexibility, better management, more social support in the team, fewer job demands and not being co-located.

Perceived Quality of Care scores were significantly related to better teamwork, better management, and higher social care composition (over 60%), to a lesser extent less autonomy (p=0.057).

Job satisfaction was related to fewer job demands, working closely with nurses, better management, more decision latitude, less overlap with nursing roles, better training and more uncertainty about the future of the service.
Intention to leave was more prevalent among social workers than among nurses, less likely in CMHTs, and in larger teams and where job satisfaction was higher.

There were no significant differences between the four locations in terms of the JCQ subscales (decision latitude, social support and psychological job demands) quality of care, job satisfaction and uncertainty about the future. Uncertainty was highest in the Trust seeking Foundation status.

One Trust (C) scored consistently higher, and one Trust (D) consistently lower than the others in terms of teamwork, autonomy, management style, training and access to IT. Both of these teams were in England.

Social care workers are the most likely to want to leave, especially where they are working in a team with low social care composition.

**Service user interviews**

The size of teams in the selected locations (A and D) were similar, but the numbers of nurses significantly higher in A, and social care workers significantly higher in D. Forty five service users completed standardised interviews one of which allowed free text responses, which were analysed thematically. Because of the small sample size these results, in particular the quantitative analysis (which is underpowered) need to be treated with caution.

Excellent care was cited by 50% of users in A but only 39% in D (but not statistically significant).

Almost all needs were met for 62% of users in A compared to 33% in D (p=0.001).

Only two people were in work, and 46% had no leisure activities at all. The CUES, MANSA and free text results are consistent with each other, suggesting that satisfaction with mental health, not working and having no leisure is low, and satisfaction with friends, family, safety and accommodation are all high.

Quality of life scores were all similar, except for family relationships, which were significantly better in A.

The experience of stigma was better in D, but qualitative findings revealed that much of the stigma experienced stemmed from the service, rather than the public. The reverse was true in A.

The integration subscale of the WDQ was unrelated to any of the user measures.

Workers overall job satisfaction was associated with the level of choice experienced by users and their satisfaction with the choice available to them. These results should be regarded as indicative and not definitive, until a suitably powered study can be conducted.
Conclusions

The results suggest that more work needs to be done on workforce planning and better linkage is needed between supply, demand and resource factors.

In the implementation of future mental health policy initiatives consideration needs to be given to whether the social care component of teams and the skills associated with community social work, employment work and support work are adequately available in team members.

The term integration continues to be used rather loosely. Workers’ perceptions of integration may be related to a secure professional group identity, where teams are less mixed (leading to higher integration scores on the WDQ). The presence of a greater proportion of social care staff in the team is associated with higher perceived quality of care among staff.

A larger study involving additional outcome measures is needed in order to definitively address the question of the influence of team level factors on user outcomes. The present study results suggest that this ought to be achievable with a larger sample.
The Report

1 Introduction

Multidisciplinary community mental health teams (CMHTs) have been the central organisational feature of the delivery of care for decades. The rationale for team composition has never been explored systematically. Team composition varies considerably in terms of the proportion of the team made up of social care personnel (social workers and social support workers) as opposed to health care staff. New teams (early intervention, home treatment and crisis resolution, assertive outreach) have been introduced in England and their composition has largely been left to local services to determine. Previous research has tended to confirm that services can have better outcomes when delivered by multidisciplinary teams, however little attention has been paid to the social care components of such teams. Some people have suggested that integration of health and social care in CMHTs may lead to better outcomes, and new teams have advantages over the CMHT. None of this research has focused on the social care components, which will arguably become more important as services attempt to implement the New Horizons policy(1) with its emphasis on public mental health.

Phase I of the study (The National Survey) draws upon national survey data provided by senior managers in NHS Trusts in England and Wales in 2007, to illustrate the workforce planning arrangements for community mental health teams (CMHTs). The focus is on what influences decisions about team composition, particularly decisions to employ social workers or social care support workers (usually untrained non-professionals) alongside psychiatrists, nurses and other health care staff, and what changes to team composition are planned and why.

Mental ill health is associated with a range of social causes but also has considerable social consequences in terms of peoples’ ability to work and so maintain an adequate and stable financial situation, their ability to form and maintain friendships, engage in local communities and community activities etc. Social workers have historically adopted an holistic approach to mental health care looking at the wider needs of the person rather than just the person’s illness. New mental health policies in England and Wales are based on a public mental health approach, in which social work skills such as those relating to community engagement and promoting social inclusion will be more in demand.
1.1 **Aims and objectives (from the original protocol)**

**Phase I: The national survey of Trusts**

The composition of mental health teams appears to be determined by factors other than the need to integrate health and social care professionals. Mental Health Mapping Data\(^2\) shows that there is enormous variability in team composition, with some teams operating with no social care staff at all. We need to understand the factors that determine this situation. This will provide us with an insight into current workforce planning and provide evidence about the key determinants of team structure and inputs. This will be of general value to health and social care workforce planners.

**Phase II: The staff survey in four locations**

We also need to know, however, whether variability in team composition makes any difference to the way that these teams operate. The evidence produced may show that the social care component needs to be at a certain level in order for team climate to be positively affected, or it may show that having too many social care members interferes with team functioning in an unhelpful way. In either event, this is useful information for those who plan the teams, and for those who manage them.

**Phase III: Service user interviews**

Finally, does the composition or characteristics of the teams, relate in any way to outcomes for service users. As one referee of the original proposal pointed out, without an understanding of whether the structure and the processes make a difference to outcomes, the exercise would be far less worthwhile and fail to address a key issue. We therefore need to interview service users, using standardised instruments to see if the differences in structure and process can be identified at the outcome stage. As this Phase was not in the original proposal, the resources that could be devoted to it were less than ideal. Service user researchers conducted the interviews in two of the locations.

The report begins with an introduction to the policy and practice contexts in which the study took place, and the conceptual terminology used, bearing in mind that the terms ‘integration’ ‘climate’ and culture’ are contestable constructs. We explain the rationale for our approach to these topics in the next Chapter.

\(^2\) Mental Health mapping data was collected by Durham University on behalf of the DH. It was based on managers’ annual returns covering the number and type of services offered by the Trust, and the numbers and types of staff employed. It transferred to Mental Health Systems of Salford.
2 Contexts and concepts

In this Chapter we consider the context in which this study took place. We look at the policy context in terms of workforce planning, and the policies that affect mental health service delivery and organisation, specifically in relation to community teams. In this Chapter we also attempt to address the vexed question of the definition of integration, culture and climate, as well as associated terms.

2.1 Contexts

It has been argued that the global health workforce and the behavioural health workforce in the USA are in crisis\(^3, 4\). Mental health services around the world are experiencing shortages across staff groups\(^5\) not only within psychiatry\(^6, 7\) and nursing\(^8\). In this context and in an era of worker migration workforce planning has become a global issue\(^9, 10\). Following the first worldwide forum on Human Resources for Health (HRH) governments have been called upon to determine the appropriate health workforce skill-mix and to institute coordinated policies for the community health workforce\(^3\). The World Health Organisation (WHO) and Global Health Workforce Alliance have since produced an HRH Action Framework\(^11\) to inform the development of best workforce planning practice. As in the past, social care workforce planning is at risk of being forgotten as part of this process.

Workforce planning has three main elements\(^12\) relating to the demand for staff of different types, the supply of these staff and the balance between the two. The extent to which the planning process connects with and influences funding allocation decisions about staffing levels and mix is more critical in determining impact on national policy and local service delivery than workforce planning itself\(^12\). The present study attempts to examine that relationship with regard to CMHTs.

The need for better workforce development planning is now acute given the ageing population\(^6\), and ageing mental health nursing\(^8\) and social work workforces\(^13, 14\). For example, 42% of the UK social work workforce were aged over 50 in 2003\(^14\), and in the USA 62% were over 40 years old in 2006\(^13\). Unlike the US where there is a planned 30% growth rate for social workers (from a base of 310,000 of whom about half work in mental health), the growth in mental health social work in the UK is unplanned, small and slow. One report\(^15\) identified a need for a 120% increase in the number of social workers, starting from a small base of about 4,000
workers. The UK growth rate in social work contrasts considerably with community mental health nursing, which benefited from 70% growth between 1990 and 1996\(^{(16)}\), and a further 13% growth between 1999 and 2003\(^{(17)}\).

Criticisms of the state of UK health and social care services and of workforce planning in particular\(^{(12, 18-20)}\) have continued despite an overhaul of workforce planning in the NHS in England\(^{(21)}\). The House of Commons Health Select Committee report\(^{(20)}\) was particularly scathing describing workforce planning in the NHS as a ‘disastrous failure’, and pointing to a lack of strategic planning, insufficient workforce planning capacity, poor integration and coordination between workforce and financial planning, constant re-organisation, and short-termism as associated factors. Neither social care nor mental health are current priorities for the UK NHS Workforce Review Team (WRT) despite recognition of the need ‘to bridge the gap between health and social care provision’\(^{(22)}\) (p3) and to pilot work on integrated care organisations that connect health and social care\(^{(23)}\).

### 2.1.1 New Horizons and beyond

New Horizons\(^{(1)}\), the Labour government’s plan for mental health and social care services from 2010 onwards is firmly based on the NHS Next Stage Review\(^{(23)}\) thinking and principles. The emphasis is on the strengthening of mental health in a broad sense, reducing inequalities and increasing participation with a firm focus on related outcomes such as quality of life, recovery and social inclusion. The new Health Secretary has recently outlined a vision for locally led NHS service changes that continue to support this approach and emphasise the need to ensure that patient outcomes, clinical evidence and a person-centred approach are at the heart of any changes to health services\(^{(24)}\).

> "When they need it, all patients want care that is personal to them. That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way."\(^{(p 15)}\)

The move to the New Horizons agenda requires an emphasis on non-medical and non-clinical interventions. It is a new approach to mental health that brings together a wide range of voluntary and statutory agencies as well as communities and individuals to work towards a situation where people understand that their mental well-being is as important as their physical health. It also sets out the benefits, including economic benefits, of maintaining good mental health. It aims to cover a person’s lifetime, from childhood, through to maintaining resilience in older age. New Horizons\(^{(1)}\) also emphasises the importance of prevention, early intervention, effective treatment and recovery.

This new approach may have implications for professional groups working in mental health and the necessity to review current working practices. For example, the Chief Nursing Officer undertook a review in 2006\(^{(18)}\) to ask the
question ‘How can mental health nursing best contribute to the care of service users in the future?’ and recommended:

“Mental health nursing should take a holistic approach, seeing service users as whole people and taking into account their physical, psychological, social and spiritual needs. This means that MHNs need to widen their skills to improve service users’ physical well-being through better assessment and health promotion activities and provide more evidence-based psychological therapies.” (p 4).

Whilst recommendations for change to fit with this approach are mentioned within nursing, acknowledgement of the current working practices and principles of social work has been described by The British Association of Social Workers as “disappointing.” It is suggested that social workers are able to make a valuable contribution to this way of working.

“The four guiding values of equality and justice, reaching full potential, being in control, and valuing relationships, are some of the guiding principles of New Horizons that fit well with a social work approach.”

Planning for team composition is more than getting the correct numbers of team members but also ensuring that staff have the necessary skills to provide high quality care to mental health service users. However it has been shown that nurse workforce planning in the UK tends to be led not by demand and need but rather by supply factors. Buchan suggests that supply, demand and finances need linking in a way that they are not at present. Similarly, the House of Commons Health Committee was highly critical of NHS workforce planning and highlighted some of the underlying problems that drove these failures, including a lack of alignment between workforce planning and service/financial planning, and inadequate workforce planning capacity. In 2008, the NHS Next Stage Review called for service providers and local commissioners to take a leading role in workforce planning. A Centre for Workforce Intelligence (CWI) has since been set up to provide leadership to help improve the quality of forecasting and provide expert support in workforce planning across the health and social care system.

A more recent report considered the extent to which NHS workforce planning in England is likely to support the delivery of a workforce fit for the future. The Report warned that there will be a risk that the current workforce planning system will continue to drive investment towards ‘more of the same’ which maintains the supply-led, single-profession approach that has previously dominated the NHS and contributed to its inefficiencies (and which is evident in the results of the present study).

The authors of that report concluded:
"There is a need for new thinking based on the recognition that the workforce should have the skills and potential to respond flexibly to a population with changing health care needs, be able to work effectively in teams to deliver new models of care, and be able to work with new technologies. These should be core policy objectives at any time but, in the constrained funding situation that the NHS will be in for the foreseeable future, they must become key factors in ensuring its survival." (p 28)

The authors questioned how planning could be better integrated across different professional groups when funding and planning remain divided between the medical and ‘non-medical’ workforces. The report recommended that in consideration of the prospects of reduced funding during the present economic climate there should be more focus on integration by linking financial and workforce planning, particularly in the light that the NHS may not be able to afford the number of doctors or nurses currently being supplied and planned. There will remain however, serious obstacles to overcome, for instance in the form of the different terms and conditions of the health and social care workers.

2.1.2 A new outcomes orientation

In England, the NHS Next Stage Review (23) makes it clear that there is going to be an increasing reliance on outcomes performance. Under the Commissioning for Quality & Innovation (CQUIN) scheme (27) providers will be rewarded in the first year for submitting outcomes and quality data and then from 2010, payments will reward outcomes under the scheme. The World Class Commissioning programme (28) is designed to raise ambitions for a new form of commissioning that delivers better health and well-being for the population, improving health outcomes and reducing health inequalities. In addition, NHS commissioners will be held to account for the quality of health outcomes that they achieve for the populations they serve, including the most vulnerable or excluded people with complex care needs. The Outcome Framework for Mental Health Day Services (29) followed by the Outcomes Framework for Mental Health Services (30) for example, have been devised to help commissioners and providers to monitor, evaluate and measure the effectiveness of day services for adults of working age with mental health problems.

In Wales, a series of Welsh Assembly Government (WAG) papers and announcements confirm the need for adult social care services to be based on available evidence and aim for efficiency and effectiveness in producing the best outcomes for service users (31, 32). Designed for Life (33) for instance says the government will ‘ensure that changes are based on evidence of what works’ in health and social care,(p14) and that ‘establishing an evidence base for health and social care ... is a vital component’ of the strategy (p32). The evidence base for health is better established, as are the means of assessing outcome. As a result of the Wanless Review (34) the Assembly intends to measure health outcomes using the Health Gain
Targets for Wales for 2012, but no similar measure exists for the outcome of social care over the same period.

Fulfilled Lives, Supportive Communities\(^{(31)}\) expects social services in Wales to become outcome orientated. The vision is of social services, which are strong, accessible, and accountable, in tune with citizens’ and communities’ needs and promote social inclusion, citizens’ rights and good outcomes (1.6). All parts of social care services are expected to improve outcomes for service users, including adult service users (3.21). In adult services it is recognised that improved outcome measures are needed and that the universal standards for social services must incorporate training and performance of staff in the use of research evidence. Joint strategic outcomes for health and social services will also be developed as part of this work (4.21). These themes continue in the more recent document ‘Better Outcomes for Tougher Times’\(^{(35)}\) that sets out a plan to improve public services in Wales within the current pressure on public finances and an increasing demand for services and action. The approach calls for the needs of citizens to be met through local and regional collaboration and partnership rather than competition, improving performance by shifting the balance from reliance on targets to focus more on outcomes and providing better information and evidence through the use of surveys and performance indicators. This document recognises the need for better workforce planning in public sector services.

There has been a general move towards self directed services in creating person-centred care in the UK. Personalised and integrated care planning supports World Class Commissioning\(^{(28)}\) and the aims of Putting People First\(^{(36)}\) and recognises there are needs other than medical that can impact on a person’s total health and well-being. A full range of issues are considered including ethnic and cultural background, health, personal, social, family, educational and the mental health needs of a service user. The approach is a holistic process with a focus on outcomes to ensure people have choice and control over their support arrangements. Patients do want to be more involved in individual decisions made about their own treatment and generally participate much less in these decisions than they would wish.\(^{(37)}\)

Several recent documents in Wales subscribe to this way of giving service users control over their lives including Putting People First\(^{(36)}\); One Wales: A progressive agenda for the government of Wales\(^{(38)}\); Fulfilled Lives, Supportive Communities\(^{(31)}\); and Adult Mental Health Services: Stronger in Partnership 2\(^{(39)}\). The Wales Alliance for Citizen Directed Services (WACDS)\(^{(40)}\) was launched in June 2010 in support of developing a Welsh approach to increased choice and control for service users.

As part of this process, service providers should offer service users the chance to be involved in drawing up their own care plan. Nevertheless, the issue of service user involvement in care planning has had a poor history and was one of the shortcomings identified by the Healthcare
Commission\(^{(41)}\). In a survey of 27,000 mental health service users on the Care Programme Approach (CPA), only 53% of all respondents said they had been given or offered a copy of their care plan. Forty-five percent of those on the standard care programme approach had been given (or offered) a copy of their care plan, although this increased to 71% amongst those on the enhanced care programme approach. Respondents who had been given or offered a copy were asked about their understanding of, and involvement in, their care plan. Fifty-eight percent of people said that they definitely understood what was in their plan. Of those who wanted to be involved in drawing up their plan 40% said that they definitely had been while 35% said that they had been involved to some extent and 25% said that they had not been involved. In addition, for personalisation to be successful, as well as service users being involved in developing their own plans there is yet no clear direction in the delivery of personal care planning as warned by Goodwin and Lawton-Smith\(^{(42)}\) in the following way:

“Personalised care planning appears to be an essential part of the design, yet it is clear that no specific vision exists for how this may be delivered. Little guidance as yet, has been put forward for how a holistic assessment of need should be made, who should take responsibility for coordination of the care package that results; and the skills and leverage that the care co-ordinator needs to be effective.” (p3).

Traditionally the focus for measuring the effectiveness of care has been mainly based on measuring clinical indicators. One exception has been an interest in patient based outcomes that have measured the impact of illness or healthcare interventions on the individual and how they live day-to-day.\(^{(43)}\)

Lord Darzi’s Report\(^{(23)}\) made quality of care and treatment a guiding principle and the basis for the future development of Health and Social Care services. The view of service users on the success of their treatment and the quality of their care through personal experience has now been given prominence.

“Patient experience. Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences.” (p 47).

Service users’ experience of treatment and care has become a major indicator of quality and there has been a recent expansion of different measures including patient reported experience measures (PREMS) which are used to understand patients’ views on their experience while receiving care, rather than the outcome of that care. Patient-reported outcome measures (PROMs) have also been used to provide a means of gaining an insight into the way patients perceive their health and the impact that treatment or adjustments to personal lifestyle have had on their quality of
life. Client centred care in mental health requires the collection of outcomes that are consequential to service users and clinicians. A study conducted to explore how services users understood and prioritised outcomes found that they placed a great emphasis on non-clinical and social outcomes.\(^{(44)}\)

Accordingly, the present study will involve a consideration of the views of service users in services with different levels of integration.

### 2.1.3 Multidisciplinary teams in mental health

Ovretveit\(^{(45, 46)}\) was one of the first to delineate models of multidisciplinary mental health team management and organisation describing teams in three dimensions: structure, process and integration. Structure refers to the composition of teams and how team composition is managed. Existing evidence suggests that the rationale for team composition is rarely well thought out, and highlights a need for more research to establish the optimal skill-mix within teams\(^{(47)}\).

A recent synthesis of reviews reported that multidisciplinary teams and integrated care changes impacted positively on symptom severity, functioning, employment, and housing of people with severe mental illness, compared with conventional services\(^{(48)}\). Others have found: team composition to be an important factor influencing inter-professional working\(^{(49)}\); that more stable teams produce more effective teamwork\(^{(49-51)}\); that teams with greater occupational diversity are more effective overall in terms of patient care\(^{(49)}\); that team functioning is better where mental health and social care are integrated\(^{(52)}\) and that the culture and climate of the host organisation needs to be supportive for the team to work effectively\(^{(49)}\).

There is long-standing evidence that different professional groups make unique contributions to teams: social workers are important for providing continuity of care; psychiatrists ensure easy access to hospital beds; occupational therapists offer practical help with activities of daily living and community mental health nurses provide the main full-time workforce\(^{(53)}\). All add value to the team, which is, after all, the rationale for multidisciplinary approaches.

Social workers often take a different stance on service delivery and have different skills to other team members. For example, mental health social workers (and to some extent psychologists) take a different view about the use of compulsory treatment to other health professionals\(^{(54)}\), and differ in their views of compulsory community supervision\(^{(55)}\), which suggests that team composition might influence the type of care received. Different professional groups also differ in their judgements of assessed need and case complexity, with nurses being less able than social workers to distinguish between critical and substantial social needs according to Fair Access to Care Services (FACS) criteria\(^{(56)}\).
In many countries, including Australia\(^{57}\), Ireland\(^{58,59}\), Indonesia and Singapore\(^{60}\) and Sweden\(^{61}\), policy and practice statements emphasise that social work is a core professional group for multidisciplinary teams. In most cases however, the balance of professionals within teams is not considered further resulting in radically different approaches towards developing the wider social care components of community mental health services worldwide, and workforce compositions that are disparate in the extreme\(^{13}\). For example, the mental health workforce is made up largely of postgraduate trained social workers in the USA, and community nurses in the UK; in the former Soviet Union the official state list of job titles did not include ‘social worker’, so trained social workers working in mental health could only be appointed to nursing posts\(^{62}\).

### 2.1.4 Previous research evidence on mental health team composition

The most comprehensive CMHT survey data available for England\(^{53}\) and Wales\(^{63}\) are now outdated but provide a useful baseline with which to compare CMHT composition pre and post introduction of new teams (sometimes referred to as ‘specialist’ or ‘functional’ teams; these are assertive outreach teams, early intervention in psychosis teams, and crisis resolution and home treatment teams). In the early 1990s the average CMHT in England hosted 11.4 (sd=6.3) full-time equivalent staff (FTEs) and 15 people (sd=7.4). The figure for Wales was 17.6 FTEs in 1997\(^{63}\).

Community psychiatric nurses (CPNs) and other nurses provided the largest full-time commitment, alongside generic support workers (although they were few in number); clinical psychologists, psychiatrists, other doctors and specialist therapists were not available full-time. CPNs, social workers and administrative staff were the most frequently occurring disciplines in CMHTs, followed by consultant psychiatrists; nevertheless, one-fifth did not report having a psychiatrist in their team and frozen or unfilled clinical psychology and occupational therapy posts were disproportionately high in both England and Wales. It is likely that the composition of UK CMHTs has changed since the new specialist teams have been introduced.

A more recent evaluation of the structure of psychiatric multidisciplinary teams in eight Irish Health Boards\(^{64}\), in which desirable team composition was expressed as the ratio of consultant psychiatrists to other team members suggested a minimum of 2.5 staff per psychiatrist (representing a full-time OT and social worker, and a half-time psychologist). Significant variations were observed between Health Boards, with 37.4% failing to meet this minimum standard. The team staffing ratio was strongly negatively correlated with admission rates per 1,000 population (\(r=-0.805\), \(p<0.001\)). Subsequent research, also in Ireland\(^{59}\) suggested that the
optimal size for mental health teams involved in making complex decision is about seven.

After decades of delivering multidisciplinary mental health care, evidence about how the balance of input from various personnel is decided upon and managed, is lacking. How do we decide what team composition provides the most synergy and best outcomes for consumers? Does composition have a bearing on team climate or culture and if so is this related to the service user experience? We remain a long way from answering these questions\(^{(65)}\) but the present study will begin to inform the evidence gap.

2.1.5 New community mental health teams

In England, the 1999 National Service Framework for Mental Health (NSF)\(^{(66)}\) and the NHS Plan (2000)\(^{(67)}\) provided significant funds and impetus to revolutionise the organisation and delivery of mental health services. Prior to the NSF\(^{(66)}\), small teams provided for all categories of mental health problem (from common to severe disorders). Since the NSF, attention has been refocused on to people with more severe disorders, and there has been extensive development of community based teams that include community mental health teams but now also include early intervention in psychosis services (EIS); crisis resolution and home treatment teams (CRHTT); and assertive outreach teams (AOT).

CMHTs interface with all of these types of teams as well as other services providing mental health and social care and as such may be affected by the introduction of the new types of team. It appears that when introducing a new team, insufficient thought has been given to the impact on the existing CMHTs and other mental health services as explained by Hannigan\(^{(68)}\):

> "Setting up and staffing crisis services had significant, wider, consequences. Some were foreseen (the closure of a ward to provide funding), others unforeseen (impossible-to-sustain initial shift patterns, the loss of experienced staff from other parts of the local service, increased workloads in other parts of the system)."\(^{(p5-6)}\).

The implementation of the different types of teams in England and Wales is geographically variable. Audit information revealed that whilst the Department of Health has met its target of creating 335 CRHT teams by the end of 2005 it also reported that a wide variation existed in the size and composition of the teams relative to the identified levels of local need.\(^{(69, 70)}\)

In Wales, an audit conducted in 2005\(^{(71)}\) reported that crisis intervention and home treatment services were in place or were being set up in only nine of the 22 Local Authority areas in Wales. In addition, early intervention and supportive outreach services were found to be poorly developed across the country. The failure to develop a comprehensive range of teams in
mental health services in Wales might highlight a capacity issue where some authorities representing very small geographical areas struggle to populate these new teams without impinging on existing provision. The following quote from the audit office report rather supports this view.

‘Very few areas have a dedicated early intervention and treatment service or team. A number of CMHTs report that they include early intervention as part of their remit, and in one area a limited number of CMHT staff have been identified and trained to provide an early intervention service.’ (1.39 p25)

Elsewhere, some CMHTs have been stripped of resources and many of their skilled staff have been recruited to the new, better funded teams which are said to have a clearer focus and purpose. (61) A recent survey of CRHTTs in England (72) reported that recruitment to these new crisis teams had been ‘relatively easy’ as staff simply transferred from hospitals and especially from CMHTs. Partly, as a consequence, 93% of CRHTTs reported delays in referring to local CMHTs that were seen as “poorly resourced, often burnt out and evasive of contact” (72) (p219). The recruitment and retention of social work staff in mental health is reported to be proving difficult, with high turnover arising from pressures on existing staff, job dissatisfaction, high stress and concerns about the disappearance of a distinctive social work role. (73)

In England, there has also been the introduction of ‘New Ways of Working” (74) that initially reflected concerns about the role of psychiatrists in the team, combined with concerns about the pressure of demand for services and an insufficient supply of some categories of professionally qualified staff. This was followed by ‘Creating Capable Teams” (75) which placed an emphasis on reviewing current working practices and exploring how existing roles can be extended and new roles created to improve the way that teams support users and families. New roles include Support, Time and Recovery Workers (76) and those arising from the Mental Health Act (2007) (77); the Responsible Clinician and the Approved Mental Health Professional (77). The emphasis on greater collaboration and integration has sparked concerns that the distinctive contribution of professions, particularly social workers, might be diminished. (78, 79)

In England, additional roles have also been established to address common mental health problems in primary care. These include Graduate Primary Care Mental Health Workers and the development of services under the new service model, Improving Access to Psychological Therapies (IAPT) (80), with workers providing guided support and/or cognitive-behavioural therapy in the management of depression and some anxiety disorders. These therapies are considered the preferred treatment of choice and a substantial amount of funding has been set aside for IAPT with the Comprehensive Spending
Review(80) allocating £33 million in 2008/09; a further £70 million to a total of £103 million in 2009/10; and a further £70 million to a total of £173 million in 2010/11 for this purpose. It is as yet unclear whether this allocation will be amended by the incoming government, but early evidence that suggests a lack of impact on social outcomes (i.e. those that demonstrate improvements in people’s daily functioning and lives) might make it a candidate for efficiency savings.

Extended roles also include those associated with the introduction of non-medical prescribing for nurses and pharmacists. All these developments have significant implications for CMHTs.

Social work membership of the new teams is lower than membership of CMHTs which, at the turn of the century was about 25%. In contrast, in England in 2004, social work membership of assertive outreach teams was 17%, and only 8% in early intervention teams. These changes have been accompanied by changes in the proportions of care workers in teams. It is not clear whether this picture arises from conscious workforce decision making, the shortage of social workers, or the ‘more appropriate’ use of the skills of other disciplines (Appleby personal communication) or simply downward substitution. Recently Huxley(81) reported that social work membership of the new community teams continued to remain low, and the proportion of social support workers continued to grow.

2.1.6 Previous research on the new teams

Several evaluations of the effects of the different types of teams have been conducted in the past few years but little attention has been devoted in this research to the question of team composition. It has been shown that patients in assertive outreach teams maintain better contact with the services(82) and crisis resolution teams (CRTs) can reduce hospital admissions in times of mental health crises.(83, 84) Joy et al.(85) found that CRHTTs reduced family burden and were a more satisfactory form of care for both patients and families. Similarly, studies of EIS show they are highly valued by service users and their carers(86), that they are cost-effective over the short to medium term(87) and also produce better clinical outcomes than generic CMHTs. (88) Friis(89) suggests that EIS invest a high level of personal engagement with patients which is not possible in the standard CMHTs. However Hannigan(68) warns that continuity of care is difficult to achieve in services with teams such as AOTs which are inter-professional and in which staff work in shift systems.

An assumption of the present study is that different team composition and the nature of integration may be related to the way that the culture and climate of the team develops, and this might have an impact on the service user experience. Next, we turn to the concepts of integration, team culture and climate.
2.2 Concepts

2.2.1 What is health and social care integration?

The failure of health and social care agencies and personnel to integrate policies, procedures and practices has helped to maintain the health and social care divide. A report on stroke and learning disability services concluded:

"There is no other group of people or sequence of events whose actions or experiences are in any sense continuous. Service providers come and go, and there is no consistent pattern of communication and feedback between any of the other parties involved in treatment and care." (p8).

This could be said of almost any client group in receipt of health and social care services. Lack of progress towards integration means it has remained a policy priority for decades.

Integration is said to have great potential to redesign care around the needs of patients rather than NHS structures, particularly for patients with long-term conditions. The creation of integrated mental health and social care providers in England and the Single Assessment Process in England and Wales are two examples of policy initiatives that aim to implement this transformation. It is frequently asserted that service users will receive a better service from integrated services in which multidisciplinary teams work together.

These groundless assertions are one of the two outstanding characteristics of the promotion of ‘integration’ of health and social care as an unquestionably good thing (for organisations, teams, efficiency, outcomes and user valued outcomes). It is more often asserted to be a ‘good thing’ rather than being supported by any evidence. Second, that which is ‘being integrated’ is poorly specified or not specified at all.

As Ramsay and Fulop (2008) wrote: “in many discussions, integration is not well defined but is suggested as a promising solution to the problem of fragmentation”. The situation appears to remain the same today, as indicated in recent research.

There are many dimensions of integration, including horizontal and vertical integration. The degree of integration in teams has been measured at two levels. First, at a structural level where integration refers to the nature of the team, its links with other services (e.g. GP/primary health services and other agencies). Secondly, integration is measured at a...
practical level that considers a number of factors such as shared assessment processes, shared client databases, shared points of referral and joint training. At its most basic it can be interpreted as the co-location of all team members. Management arrangements can vary even in co-located services. One manager may be designated as the health and social care co-ordinator - but the health and social care staff still are separately managed and are separately accountable to two different organisations with different priorities, procedures and practices. In some settings, even where there is joint operational management, separate professional management is retained. In others all management arrangements are now combined in a single structure. In very few cases budgets are also said to be ‘integrated’ that is combined or pooled, but this is not very common

Ramsay and Fulop\(^{(95)}\) argue that the effects of integration are experienced at three levels, micro, meso and macro. At the micro-level they relate to the individual service user experience. They suggest that here integration is synonymous with coordination, that is, the close collaboration between different professionals and teams required to deliver timely, efficient and high quality interventions. At a meso-level, integration describes organisational or clinical structures and processes designed to enable teams and/or organisations to work collaboratively towards common goals. Examples include integrated health and social care teams so they may share IT, administration and data systems that support processes (such as booking appointments) or information.

At a macro-level, integration describes structures and processes that link organisations and support shared strategic planning and development. Examples include merged provider organisations that span health and social care services, such as care trusts and mental health Trusts. Scott et al\(^{(99)}\) point out that there has been a growing interest in the need for cultural change to accompany structural reform.

Glendenning (2002) describes some core characteristics of integrated organisations\(^{(100)}\). Integration, she suggests, is more likely when several of the following are evident: joint goals; very close-knit and highly connected networks of professionals; little concern about reciprocation, underpinned by a mutual and diffuse sense of long-term obligation high degrees of mutual trust; joint arrangements which are ‘core business’ rather than marginal; joint arrangements covering operational and strategic issues; shared or single management arrangements; joint commissioning at macro- and micro- levels.

Rosen and Ham (2008) report on the lessons that can be drawn from existing practice and research\(^{(101)}\) (based on Ramsay and Fulop\(^{(95)}\)).
These are:

- be very clear about the reasons for which integration is pursued and reflect carefully on whether integration is the best way to achieve stated goals;
- do not start by integrating organisations – which may not bring about improvements for patients. A more promising place to focus is services and clinical relationships, with the consequences for organisations and structures being considered subsequently.
- ensure the local context will support integration – requiring trust between partner organisations and teams; supportive local leaders;
- a culture of quality improvement and effective communications and IT.
- do not overlook cultural differences between potential partner organisations and work to overcome these.
- protect community services in initiatives to integrate acute services with primary and community services.
- create the right incentives – which may involve risk- and gain-sharing, and incentives for frontline staff.
- do not assume economies of scope and scale.
- there is little evidence that integration increases efficiency; start-up costs may wipe out savings and where economies do exist, it may take time to harvest them.
- be patient: establishing effectively integrated services takes time, and it may take even longer to deliver measurable changes in outcomes and patient satisfaction.

In some parts of the UK, health and social care services are provided by the same body. For example, there are a total of five Health and Social Care Trusts in Northern Ireland that provide integrated health and social care. Care trusts were introduced in England in 2002\(^{(67)}\) to provide better integrated health and social care and represented a move towards closer health and social care partnership working by bringing the agencies together as a single organisational entity. By combining both NHS responsibilities and local authority responsibilities under a single management and governance system, it was suggested that Care Trusts could increase continuity of care, simplify administration and, due to the formal status these organisations have in law, reduce some of the complexity of partnership working\(^{(102)}\). In some parts of England (but not in Wales) mental health trusts offer similar integration.
The policy of partnership in mental health services is being implemented and is reflected in the growth of ‘integrated’ multi-disciplinary community mental health teams. Data from the Service Mapping database\(^2\) show that between 2002 and 2004 the number of ‘fully integrated’ teams doubled, ‘multi agency’ teams reduced from over 300 to 30, and ‘single agency’ teams almost disappeared (from 79 to four).

Research evidence is limited, but the results of one study suggest that in a mental health context the provision of health and social care together, through teams using treatment at home methods, can produce better outcomes i.e. reduced hospitalisation\(^{103}\). Nevertheless, it is not clear exactly what the ‘combined responsibility for health and social care’ in this study actually meant, nor how far that responsibility extended into the wider social care field (which also includes employment services, leisure services and financial support services).

Services that provide care in the person’s home (the traditional mode of operation in social work) tend to have advantages over other forms of care. A systematic review of crisis intervention services\(^{85}\) that also provided home care, found that this approach reduces the number of people leaving the study, reduces family burden, and is a more satisfactory form of care for both patients and families. No data on staff satisfaction or team variables were reported in these studies and the authors suggest that more research is needed into these workforce issues.

We know that the nature of team work and its organisation has an impact on outcome in terms of voluntary and compulsory hospitalisation.\(^{104}\) Weekend working, staff burn-out and lack of patient / service user contact with other services were associated independently with a higher probability of both voluntary and compulsory admission. Nevertheless, contact with other services (possibly those outside the health sector) was also a positive prognostic factor. Fifty-four percent of these newly developed (and to some extent experimental) community mental health team services were not sustained beyond the end of the study period, (and half of the remainder were no longer in existence by the publication date).\(^{105}\) This makes sustainability an important issue for future research.

In preliminary analysis of national survey data (the main results of which have been reported elsewhere)\(^{14}\), it would appear that in teams with greater staff mix, social workers suffer from more emotional exhaustion and more days off sick. Social workers in balanced teams (where there are roughly equal numbers of nurses and social workers) have lower job satisfaction, feel less valued at work, are more emotionally exhausted and have less decision latitude compared to social workers in teams where they
are outnumbered by nurses and others – perhaps because clarity of role perception is greater in the latter context?

Alternatively, it may be that where one staff group is in short supply they are valued more highly by their colleagues. Another possibility is that where teams are more balanced in terms of health and social care professionals, the potential for a clash of cultures increases. Whatever the explanation, there could be positive and/or negative effects on the quality of care provided. Compared to social workers in CMHTs, those in newly created teams (i.e. assertive outreach, early intervention in psychosis, crisis resolution; n=62) had less decision latitude, greater job demands, lower job satisfaction, and were key-worker for a higher proportion of their caseload (77% cf 64%); social workers in assertive outreach teams (n=11) had more decision latitude and higher job satisfaction than workers in all other types of teams and were key-worker for a lower proportion of their caseload (60% cf 75%). New teams can be considered to be at greater risk of what has been called 'survivor sickness' resulting from loss of identity and concomitant feelings of detachment and bereavement (106, 107), anger and resentment (108) and anxiety and stress (109, 110) argue that role ambiguity underlies a lot of workplace-related stress and others have suggested that professional support and supervision needs to be in place to ensure professional development and identity (52, 111).

Previous research has pointed out that in partnership mental health Trusts, social workers have poor mental health, are overstressed, emotionally exhausted and feel undervalued (14).

It is important to note the limited sense in which social care services have been conceived when integration has been considered to date. The social care element is almost always exclusively confined to the social work and other services provided by the local authority social services department, rather than the totality of the services that they commission, or those services that are out-with social services (leisure, housing, education etc) or out-with the local authority altogether, in the third sector. This lack of attention to the full range of social care staff was notable in the workforce section of the Report 'Mental Health Ten Years On' (112).

In most cases, therefore, ‘integration’ in mental health services is interpreted very narrowly, in the sense the local authority social workers (and/or social care support staff) are transferred into the Trust (with a variety of budgetary arrangements). This is the basic sense in which we use the term in the present study, while attempting to reflect the variety of interpretations of ‘integration’ that we observed in the four participating
Trusts. Leutz\textsuperscript{(113)} crystallised the nature of the challenges involved in this policy area in his five laws of integration:

- You can integrate all of the services for some of the people, some of the services for all of the people, but you can’t integrate all of the services for all of the people.
- Integration costs before it pays.
- Your integration is my fragmentation.
- You can’t integrate a square peg and a round hole.
- The one who integrates calls the tune

Peck et al\textsuperscript{(111)} noted that in new partnership Trusts, staff were patrolling the perceived professional boundaries with added vigilance. Another study found that arrangements to include social workers in CMHTs were very variably implemented.\textsuperscript{(52)}.

### 2.2.2 Team culture and climate

As indicated earlier, Scott et al\textsuperscript{(99)} have pointed to the increasing attempts to make cultural changes in the organisation to accompany and support structural integration efforts.

Research into culture and climate has been mainly conducted at the organisational level. While teams are parts of organisations the lessons from organisational research may or may not be transferable to them, so a degree of caution is necessary in interpreting the organisational level findings in the present context.

The SDO commissioned review of the relationship between service organisation and outcomes\textsuperscript{(72)} concluded on the basis of the reviewed papers (research conducted mostly outside the UK) that there is no consistent or strong relationship between organisational size, ownership, leadership style, contractual arrangements for staff or economic environment (competition, performance management) and performance. In spite of this largely negative conclusion, decision makers want to move away from traditional structures based on professional ‘silos’ to more operationally and functionally-based structures; this desire is evident in UK mental health policy where there is a very clear imperative for a large range of health and social care agencies to work in ‘partnership’, a mode of coordination and decision-making that sits far more comfortably with the type of governance structure known as ‘networks’ than with the hierarchies or quasi-markets of the NHS over the past decades.\textsuperscript{(114)}
The strongest message emerging from the review is “that there is no simple or clear-cut relationship between the form of an organisation and the way that it functions. Instead, the relationship is complex and contingent.” Nevertheless, and significantly for the present study, it also concludes that there are some findings in which one can have confidence. Among these findings are for instance:

- hierarchical and bureaucratic structures (such as the health service or local authority) operate most effectively in a stable external environment (one can argue that the mental health policy environment is not stable currently for organizations or teams);
- the engagement of staff is a pre-requisite for its success (there may be poor engagement of social care staff in teams);
- professional support is essential for the implementation of change (the way social care staff are supported may be influential within the team);
- smaller organisations are easier to manage, respond more rapidly, and have happier staff (although this refers to organisational size, team size may be related to these intermediate outcomes);
- collaboration across agencies and sectors is inhibited by lack of coherence at the level of policymaking (this may be the case for national mental health policy but also for local implementation);
- cross-professional working such as clinical networks or ‘communities of practice’ may improve practice, and people able to work at professional interfaces (boundary spanners) produce more effective teams;
- multidisciplinarity and/or skill mix may contribute to the effectiveness of teams in relation to service users’ valued outcomes).

The review points out that the evidence for the impact of culture and climate on organisational performance is equivocal currently, but adds that organisational climate and culture has a contingent impact on performance. In particular, there is evidence that organisations with a dominant clan culture are happier places to work in, but organisations with a dominant rational or market culture are more productive.

Brown defines organisational culture as:

"The patterns of beliefs, values and learned ways of coping with experience that have developed during the course of an organisation’s history, and which tend to be manifested in its material arrangements and in the behaviour of its members."
Scott et al.\textsuperscript{(117)} point out:

“While it is important to acknowledge that some observers contest the nature and importance of organizational culture, this should not inhibit empirical research into an issue that has potential both as a lever for quality improvement and as an aid for understanding the management of change in health care organizations. This paper has....argued that the purpose and context of cultural assessment should determine the choice of instrument or instruments used.” (p 941)

They suggest that most significant impact of culture is on morale and staff retention. There is considerable evidence in the research literature that organisational culture and climate play central roles in the social context of an organisation\textsuperscript{(118, 119)}. A number of studies in various types of organisations link culture and climate to service quality, service outcomes, worker morale, staff turnover, the adoption of innovations, and organisational effectiveness. Team composition as a mediating factor in these relationships has not been explored fully.

A literature review in the late 1990s found more than 50 definitions of culture and more than 30 definitions of climate.\textsuperscript{(120)} The literature review helped address the confusion around the boundaries that separated the two constructs. Based on a content analysis of the 84 definitions, the review found consensus that culture captures the way things are done in an organisation, and climate captures the way people perceive their work environment. This results in a definition of culture as the norms, expectations, and way things are done in the organisation.\textsuperscript{(118)} This is the way we interpret these concepts in the present study and we expect to use a tool that captures these elements of the way things are done in the team.

More recently, another review\textsuperscript{(121)} found 70 measures of organisational culture, 48 of which had sufficient psychometric information to be assessed. The authors point out that culture and climate are often used interchangeably and that both have been linked to organisational outcomes, and some people have argued that they have become virtually indistinguishable.\textsuperscript{(122)} Despite some overlap they conclude that they address different concepts, with culture being more encompassing and global, and climate being more of an index of an organisation’s operation.

The definition of climate (which we use in the present study) is the individual employees’ perceptions of the psychological impact of their work environment on their own wellbeing. Organisational climate is created when individuals in a work unit, team, or organisation share the same perceptions of how their work environment affects them as individuals. In these terms the Karasek JCQ measure\textsuperscript{(123)} that we plan to use in the present study is a
measure of climate. There is evidence that organizational culture and climate affect staff morale, staff turnover, service quality, and service outcomes in various ways.\(^{(124-128)}\)

The present study will explore the relationships between these variables at the CMHT level.
3 Methods

3.1 The national survey of Trusts

Data were collected in a national telephone survey of mental health service managers in Mental Health Trusts in England and Wales, conducted in 2007. A sampling frame was constructed using Binleys Guide, Trust websites and/or national mental health mapping data\(^{129}\). We identified managers with responsibility for community teams. Where the named person turned out not to have that responsibility we asked for contact details of the person who did. Managers were contacted by telephone or email to arrange a convenient date and time to inform them about the study, invite their participation and arrange an interview slot. Interviews were conducted by research staff using an interview schedule designed specifically for this study. This schedule consisted of five open-ended questions. The first two considered the structure of the service within the Trust:

- number and types of teams within the Trust;
- number of staff in each staff group in each team;

and the other three related to the thinking behind team composition:

- rationale for composition of CMHTs;
- reasoning behind the inclusion of social work and social care staff in CMHTs;
- planned changes in CMHT structures and composition.

Managers were given a copy of the questions prior to interview to enhance the quality of the data provided (see Appendix 1). No limit was set for the number of reasons that could be cited by each respondent, and all reasons were treated equally and not ranked by importance, although a note was taken of the first reason given. In retrospect, it would have been preferable to then ask the respondent which if any of these they considered to be of most importance. Responses were recorded verbatim at the time of the telephone interview and analysed thematically by two research team members following the Ritchie & Spencer framework\(^{130}\) to produce coded categories for entry in SPSS\(^{131}\) and analysis alongside the quantitative data.
Descriptive frequencies, mean scores and skewness statistics were used to describe the sample in terms of staff numbers, membership and composition, and to assess the normality of distributions. Variables that were skewed significantly were square-root or log transformed as appropriate\(^{(130)}\) and their distributions rechecked. Chi-square \((\chi^2)\) and Phi effect size statistics were used to test for differences in rationale between more and lesser levels of integration. Independent samples t-tests were used to test the equality of mean staff numbers in total and for nursing, social work and social care support staff groups in Trusts citing and not citing each team composition rationale; effect sizes were calculated using the following formula\(^{(131)}\):

\[
\text{cohen's } d(d) = \frac{M_1 - M_2}{\sigma_{\text{pooled}}} \quad (\sigma_{\text{pooled}} = \frac{\sigma_1^2 + \sigma_2^2}{2})
\]

Potential interaction effects between level of integration and rationale were tested using two-way between-groups analysis of variance and partial eta-square \((\eta^2_p)\) statistics.

In accordance with convention and statistical advice results are reported for statistically significant \(p\) values in the range \(p \leq 0.05\), non-significant trends in the range \(p = 0.5 - 0.10\), and for small, medium and large effect sizes\(^{(132)}\), within these ranges.

### 3.2 Staff Survey

Using the national survey (Phase I) data we were able to identify Trusts where the social care composition of teams varied, in terms of the proportion of social workers and social care support workers (e.g. Support Time and Recovery workers) to the total number of staff employed. In some Trusts there were a number of teams that had no social care staff at all, whilst in others social care staff were the major staff group. Informed by these data, we approached our four first choice Trusts on the basis of their differing social care staffing input and rationale for team composition. Three of the four Trusts agreed to participate in the study, but one Trust that was balanced in terms of health and social care provision was unable to participate due to imminent service reorganisation. An alternative, nearest equivalent Trust that was identified and approached to take part in the study agreed to do so. Unfortunately in the event this participation was limited to the staff survey (phase II) as this Trust’s attempt to achieve Foundation status took priority over the research as one might expect, causing them to withdraw from participation in the service user interviews.
3.2.1 Locations

Trust A is located in Wales and services an ethnically diverse urban population. Health and social care services are managed and financed separately by the Trust and the Local Authority but the services work together in a partnership. The Trust reports that several areas within the geographical limits of the Trust have high mental health needs index (MINI) scores that are up to 30% higher than the rest of Wales with addiction and homeless rates being particularly high in the urban centre.

Trust B is also located in Wales and services a large geographical area within a pre-1996 county borough, incorporating urban, traditional mining and rural communities. Trust B works alongside the different local authorities within the geographical area in an integrated way. The management structures for health and social care are separate however, with management and finance coming from the Trust for health service staff and from the Local Authorities for social care staff.

Trust C was the second choice location and is located in England. It too services a large geographical area within an existing county borough, which encompasses urban centres and rural areas. The Trust is an integrated health and social care partnership.

Trust D is located in England and also services a large county borough that includes urban centres but a largely rural population. Trust D is a Foundation Trust, health care staff are financed and managed by the Trust while social care staff are financed and managed by the Local Authority.

In setting up the staff survey we worked closely with senior and then middle managers in each of the four participating locations to make arrangements for a cross-sectional data collection from all teams. The principal investigator, co-applicants and research staff visited each of the Trusts to set up this phase of the study. Based on our previous experience we know that data collection is more likely to succeed where the teams providing the data are familiar with the project and the research staff, and where the burden on them is reduced. In this case we organised sessions that followed on from planned team meetings, which were attended by research staff and where team members were asked to complete the survey, over a lunch provided by the research teams.
Table 1: Location characteristics for the staff survey

<table>
<thead>
<tr>
<th>Trust</th>
<th>Country</th>
<th>Pop(k)</th>
<th>Working age(133)</th>
<th>Over 65(133)</th>
<th>Long term limiting illness(133)</th>
<th>Economically inactive(133)</th>
<th>CMHT</th>
<th>Crisis resolution</th>
<th>Early intervention</th>
<th>Assertive Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Wales</td>
<td>500</td>
<td>61%</td>
<td>15%</td>
<td>19%</td>
<td>26%</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>Wales</td>
<td>600</td>
<td>55%</td>
<td>20%</td>
<td>18%</td>
<td>23%</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>England</td>
<td>530</td>
<td>58%</td>
<td>19%</td>
<td>18%</td>
<td>23%</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>D</td>
<td>England</td>
<td>725</td>
<td>61%</td>
<td>17%</td>
<td>20%</td>
<td>28%</td>
<td>12</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
We did this in as many teams as possible, but also allowed staff to return questionnaires independently of these sessions by providing stamped addressed envelopes where necessary. Although the senior staff encouraged teams to participate, it was always voluntary and either decided by the team leader or the whole team at team meetings. Even then, individuals could still refuse to participate or could withdraw.

This was a labour intensive method, but produced good results in that the required number of individuals responding went beyond the protocol target of 276 (see section 4.2).

3.2.2 Measures

In the original proposal we planned to use several different measures to capture aspects of organisational and team culture and climate and working patterns. Seventy different instruments and approaches for measuring organisational culture have emerged over the past five decades, most of which have emerged since the 1980s.\(^{(134)}\) Prior to data collection a new validated measure was published\(^{(135)}\) and used recently to examine how, and with what impact, workforce substitution and specialisation is influenced by workforce change policies in the context of older people’s services. The measure met most of our requirements in the one instrument; the Workforce Dynamics Questionnaire (WDQ).\(^{(136)}\) (See Appendix 2). The WDQ also enabled us to address the issue raised by one of the reviewers of the original proposal, that we needed comparative data from another client/patient group. WDQ data was already available for older people’s and intermediate care teams in England, and is now also available for older people’s teams in Wales, and mental health and older people’s teams in Scotland.\(^{(137)}\) These comparative data are being examined outside the time frame of the present study.

The WDQ consists of 68 questions, three of which - overall job satisfaction, plans to leave the employer and plans to leave the profession - stand alone, and the other 65 make up ten subscales (autonomy, integration, uncertainty, management style, role flexibility, teamwork, role perception, access to IT, training and career progression and quality of care). All are rated on a ten point scale and standardised to a score of 100. As indicated below, these dimensions are commonly agreed to be elements of integrated services and the organisational culture that arises in them, and so justified the use of this instrument.
In addition, the WDQ asks respondents how closely they work with other team members and how much role overlap they have with them. All the team members are included in the list, with scope to add others. These variables, and the WDQ subscales (especially integration and teamwork) and data about co-location and pooled budgets can be taken to be the range of ways in which we attempt to measure integration in the present study. The role overlap aspect of the WDQ was not covered in such detail by the instruments we originally intended to use.

We retained the Karasek Job Content Questionnaire (JCQ)\(^{(123)}\) (Appendix 2) identified in the original proposal for two reasons: first we already had data from the Karasek JCQ from a national survey of mental health social workers\(^{(14)}\) with which to compare data from the present study; and secondly it is a very widely used and well validated instrument.

It is a 22 item instrument, which produces three main subscales which relate to decision-latitude, psychological job demands, and social support (from peers and managers). It is rated on a five point scale and can be standardised using z scores. As indicated elsewhere, we regard this as more a measure of climate than of culture.

### 3.2.3 Data analysis

Data were entered into SPSS version 16\(^{(138)}\) and analysed using SPSS and STATA version 10\(^{(139)}\), following transfer using STAT transfer.

Data were first prepared for analysis. The distribution of continuous variables was first examined using box-plots and skewness statistics, and where significant skew was observed according to the formula skewness / s.e. skew > ±1.96, data were transformed appropriately in order to achieve a normal distribution. Missing data analysis were undertaken in order to examine the likely significance of retaining missing values in analysis and to explore whether any form of imputation would be necessary.

Descriptive statistics including frequencies, mean scores with standard deviations and chi-square \(\chi^2\) statistics were used to describe the sample in terms of team size, proportion of health and social care staff, gender etc and to examine between group differences in categorical variables. Between group differences in normally distributed continuous variables were examined using independent samples t-tests or one-way analysis of variance. Where it was not possible to normalise the distribution of dependent variables, between group comparisons were examined using non-parametric tests (Mann Whitney-U and Kruskall-Wallis).
In order to accommodate possible Type 1 error due to multiple-testing Simes procedure\(^{(140)}\) adjustments were made to all analyses; this is a modified Bonferroni adjustment that has greater power to detect significance differences, using the formula:

\[
\text{Test } p = \frac{1}{X} \times 0.05
\]

(where \(X\) = number of tests undertaken\(^{(140)}\).

The Simes adjustment produces values that are less conservative than the originals by comparing unadjusted \(p\) values that take account of the number of tests and a target \(p\) values (\(p<0.05\)).

In the analyses that follow we first describe the whole sample in terms of team type (CMHT or other), location, country, professional group, and social care composition. Next we examine the team culture and climate using WDQ and Karasek JCQ items, making similar comparisons between areas and teams, and different features of integration. Finally we examine the relationship between area, team and individual level indicators including process indicators of team culture and climate and interim outcomes of integration and teamwork, and final outcomes relating to quality of care, job satisfaction, and intention to leave the employer. This final element of analysis requires multivariate analyses that control for a multitude of potential mediating and confounding factors.

As outlined in the original protocol it was our intention to undertake multi-level modelling analysis in recognition of the fact that individual responses are nested or clustered within teams, within areas, within countries; this approach reduces the chances of identifying false positive findings (Type 1 error). Although we had a sufficient number of teams to undertake this specialist approach we did not have a sufficient number of individuals within teams to do this.

In order to take some account of team level clustering, and so reduce error relating to false positives we opted to conduct a series of regression models using the regress command in STATA that controlled for some team level factors. Prior to the construction of these models sample size requirement was determined according to the formula \(n \geq 50 + 8m\)\(^{(141)}\) (where \(m\) = the number of independent variables). Potential collinearity between variables to be included was checked using correlation coefficients, and variables that correlated at \(r=0.7\) were excluded\(^{(141)}\).
On the basis of these checks it became evident that we could not simply construct a dummy variable that identified each team as that would transgress the sample size condition and undermine the model. Therefore we constructed a typology of teams based on the proportion of social care staff in the team that could be included legitimately in analyses.

Also due to relatively small sample size compared to the number of variables, independent variables were entered in three blocks rather than in one block. Personal characteristics – professional group, age and gender were entered in Block 1; individual level team climate variables - WDQ sub-scores, Karasek JCQ sub-scales, length of time in team, close working with nurses and social workers, role overlap with social workers and nurses were added in Block 2; location/ area and team level indicators, team typology (social care composition), team size, CMHT or not, and co-location were added in Block 3.

Variables that did not make a statistically significant contribution to the variance explained in Blocks 1 and 2 were not carried forward to the final model, unless the variable was considered conceptually important.

Following the fitting of each model, residuals (random fluctuations around the regression line) were examined and plotted to ascertain model fit and check model assumptions. Outlying residuals were identified using Cook’s distance statistics, and where appropriate the adequacy of the model was checked by refitting it when outliers were removed. Regression models were also refitted using transformed dependent variables or in binary logistic regression models where it was not possible to normalise distributions. As the models included items that were measured on different types of scales, standardised beta coefficients that standardise all values to between 0 and 1, are reported.

### 3.3 Service user interviews

#### 3.3.1 Locations

The selection of the locations was informed by the previous two phases. As the study was concerned with the social care composition of community mental health teams, we purposively selected two Trusts in which the balance of social care composition differed in the operational teams. Their team composition was significantly different from one another when other variables were controlled in a regression equation (Section 3.5.4). The team sizes were similar ($t=1.26$ df 138, $p=0.21$, mean difference 1.07 (CI -0.62, 2.75) but the proportion of health staff, in particular nurses was
significantly higher in Trust A (t=15.27 df143 p=0.000, mean difference 4.9 (CI 4.3, 5.5) and social care workers (social workers and support workers) significantly higher in Trust D (t=-10.0 df73 p=0.000, mean difference = -5.2 (CI -6.2, -4.1).

The service managers from the two locations were each asked to provide us with a list of 25 randomly selected service user participants to be interviewed. This information was obtained from a dedicated proprietary computer system in location A and by an administrator in location D.

In the first instance and as previously arranged, the research staff in the university had to match the availability of the service user researchers to the convenience of the date and time provided by the service users to be interviewed, which sometimes proved difficult. They visited the teams and conducted interviews with the service users in their own homes during which they completed three standardised measures. In two of these there are open text boxes for the service users to make any comments they wish. This data collection method was working fairly well in location A, but proved increasingly problematic in Trust D. As the research progressed, it became difficult to sustain this approach in Trust D. Problems arose mainly around location and time as the contracted service user researchers were from the NE of England, the research team in South West Wales, and location D under study was in the north of England. The method and data from Phases I and II of the study dictated that these were necessary arrangements, but more problems arose when one of the service user researchers was hospitalised and timescales became tight.

Consequently, the data collection methods were changed. Initially we attempted to visit the teams as we had done in Phase II to collect the data, but governance approvals had expired, and some teams were declining to take part in this Phase. We found that dealing at a distance with several different teams in different areas within location D was exceptionally time consuming and often fruitless. Frequent phone calls, follow up reminders and e-mails merely served to aggravate team leaders and managers, and hence put the data collection at risk. A suggested plan to conduct telephone interviews proved to be even more complicated for the service managers to arrange and was subsequently abandoned. After discussion with managers on several occasions, it was decided that batches of questionnaires would be delivered by post with accompanying high-street vouchers to be distributed to the service users on completion of the questionnaires. These forms would then be returned to us in a stamped addressed envelope along with the consent forms. No personal identifiers were required for this part of the study only the study team code number on the forms.
As well as struggling to reach the target number of 50 service users for this essentially qualitative phase of the research, it became clear that not all of the service users identified and who had agreed to complete the forms, had informal carers. If we had insisted that each service user had to suggest a carer to be involved in the study, the service user sample size would have been reduced. Subsequently we thought it best to persist with the attempt to reach the target number of service user participants. In addition, many of those who did have carers refused us having access to them. As a result, we were only able to obtain one of the target number of 35 making this part of the study impossible to complete satisfactorily.

3.3.2 Measures

Carers and Users Expectations of Services (CUES) is a questionnaire that arose from the Department of Health Outcomes of Social Care for Adults (OSCA) initiative\(^\text{(142)}\) (see Appendix 6). The CUES scales\(^\text{(143)}\) were developed with service user involvement and designed to be used in community mental health services. The three aims of CUES are:

1) to directly improve clinical care planning, by allowing individuals to tell staff about their experiences and current practical problems;

2) to measure users’ satisfaction with their life and the local mental health service, acting as a baseline for future service developments; and

3) to allow comparison of the local mental health service with other areas of the UK. \(^\text{(144)}\)

It is therefore a useful measure to use that fits well with present day policy directives.

The Manchester Short Assessment of Quality of Life (MANSA)\(^\text{(145)}\) was also developed for use in community mental health services and we have a decade’s experience of its use and a large data base of results. In addition many of the questions appear in the National Psychiatric Morbidity Survey (NPMS)\(^\text{(146)}\). The questionnaire measures the different aspects of the quality of life and satisfaction of people who use mental health services. The items cover issues that they have identified themselves as being their own priorities. The MANSA covers nine life domains (accommodation, safety, leisure, living situation, social life, relationships, family, income, health and mental health) with objective and subjective questions. It has good psychometric properties\(^\text{(145, 147)}\) and it has been found to be easy to use and administer.\(^\text{(148)}\) The questionnaire is completed by the service user, with support if needed from a relative, friend or advocate. The questionnaire has previously been used to investigate whether patient’s satisfaction with their mental health care and quality of life is related to their age, gender, psychiatric diagnosis and duration of mental disorder\(^\text{(149)}\) and in an epidemiological survey of need amongst psychiatric patients\(^\text{(145)}\).
The MANSA has been used to measure the subjective quality of life in patients with a variety of mental health problems including patients with post-traumatic stress following conflicts in ex-Yugoslavia\(^{148}\) chronic fatigue syndrome\(^{150}\) and schizophrenia\(^{151}\).

The Service User Questionnaire (SUQ) used service satisfaction questions of the type commonly used in patient surveys (see Appendix 7)

### 3.3.3 Data analysis and preparation

Most of the SUQ satisfaction scales were highly skewed towards positive responses.

We square root transformed the 10 SUQ satisfaction scales, but this failed to provide a normal enough distribution to allow parametric tests. Because of the small sample size, most of the descriptive statistics using the 4 point scale for SUQ items, violated the assumptions for cross tabulated data, so we collapsed the variables into bivariate form and repeated the analyses for a 2X2 table, and computed Fisher’s Exact Test.

We used parametric tests for the MANSA D-T scales, which were normally distributed. The MANSA also contains questions within each of the domains, asking whether the service user wants their circumstance in that domain to be improved, and if they do whether their opportunities to obtain improvements have been restricted in any way. We used cross-tabulations and other descriptive statistics for all the categorical variables in the MANSA and the CUES.

Although the original WDQ subscales were skewed, in some cases transformations made them more skewed. We ran the analysis using both skewed and transformed variables and found that the original variables gave the most conservative results, so we present those in the final part of this report.

The open ended questions in the SUQ and the CUES were transcribed and coded separately by two researchers who then compared ratings and resolved disagreements or consulted the PIs in any cases they found hard to resolve. All the free-text comments were classed as ‘positive’, ‘negative’ or ‘neutral’. It was not possible to analyse these data other than descriptively, due to the small cell sizes.
4 Results

4.1 The national survey of Trusts

Of the 79 mental health provider Trusts in England and Wales at the time of data collection, 42 participated in the study (53.2%), 36 in England and six in Wales. Comparison with national mental health mapping data\(^{(129)}\) for the nearest time period indicated that our sample (n=381, 48.9%) was representative of all CMHTs (n=780), in that there were no significant differences between responding and non-responding Trusts in terms of reported integration status nor the number of: CMHTs; number of hospital beds; Approved Social Workers (ASWs) who had statutory duties under the 1983 Mental Act\(^{(152)}\); all social workers; support workers; Support Time and Recovery (STR) workers; psychiatrists; assertive outreach teams (AOTs); all AOT staff; Crisis Resolution Teams (CRTs); Early Intervention Teams (EITs); social workers in CRTs; and total staff numbers.

While most services were administered and managed at the Trust level, a small number (n=4) were managed at a locality level because they had formerly been Trusts in their own right, which resulted in different rationale for team composition in each of the eight localities. In the results that follow we refer to the 50 localities as Trusts to avoid confusion.

All team and staffing number variables were significantly positively skewed. Following square-root transformation total CMHT and social care support staffing became normally distributed, as did total social work and nurse staffing following log transformation.

Table 2 shows the average and range of team sizes, and staffing numbers in the study sample.

The average team size (based on total CMHT staff) was 17.7 (sd=5.5, range 7-33.5), slightly lower than the national mapping data average of 19.4\(^{(46)}\) but higher than the 1994 mean of 15 (sd=7.4)\(^{(12)}\).

Staffing numbers did not differ significantly in less integrated Trusts (where social care staffing was determined solely by the local authority (n=11)), although a small-medium effect (d=0.34)\(^{(49)}\) on social work staffing was apparent with lower numbers being employed in less integrated Trusts.
Table 2. Average and range of team sizes and staffing numbers

<table>
<thead>
<tr>
<th>Staff</th>
<th>n</th>
<th>Mean per Trust (sd)</th>
<th>Range</th>
<th>% of total staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>1279</td>
<td>25.6 (20)</td>
<td>0-93</td>
<td>19.3</td>
</tr>
<tr>
<td>Nurses</td>
<td>2212</td>
<td>44.3 (30.4)</td>
<td>8-135</td>
<td>33.3</td>
</tr>
<tr>
<td>Social care support workers</td>
<td>655</td>
<td>13.1 (21.1)</td>
<td>0-96</td>
<td>10.0</td>
</tr>
<tr>
<td>Total staffing</td>
<td>6646</td>
<td>132.9 (sd 91.1)</td>
<td>38-400</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Data from the present study and a variety of other sources (Table 3) show that the average team consists mostly of nurses and social workers, followed by doctors, but with less input from other staff.

Firstly, in relation to the Policy Implementation Guidance (PIG) we can see that the intention was that there should be a fairly even distribution in terms of the composition of nurses and social workers in a ratio of 4:3, supported by Occupational Therapists (OTs), Psychologists, Doctors and three social care support staff.

All of the data since the publication of this guidance indicates that this kind of representation has never been achieved, and that nurses are the dominant workforce within CMHTs, compensating for shortages in other staff groups. There has been considerable growth in the numbers of CPNs in CMHTs that is matched by the number of Social Workers, but while social work shows an overall surplus compared to guidance of 16.7%, the surplus over guidance of nurses is a massive 52.5%.

Considerable deficits are observed in relation to psychologists and other staff whose role has a more social orientation such as social support workers of whom there are 53% fewer and OTs of whom there are 40% fewer than the estimated requirement. Just taking social workers and social care support staff there is an apparent undersupply of social care provision of 36.3%, and if OTs are included in this group the undersupply of people trained to deal with the social aspects of mental ill health reaches 76.3%.
Examination of CMHT composition since 2001 (when guidance was issued) shows that provision has remained relatively stable over time in most respects. The supply of support workers has increased by 155% to 2009, but between 2007 and 2009 the rate of growth in numbers of social care support workers had slowed to 18%, which would on average represent 5 staff per team. When the number of social care support workers in 2009 is added to the number of social workers the picture does appear somewhat more balanced in relation to nursing staff but an imbalance between health and social care expertise remains (Social work plus social support workers = 4,357, nurses = 4,720, other health workers = 6,032).

<table>
<thead>
<tr>
<th>Source</th>
<th>Community Psychiatric Nurse</th>
<th>Social Worker</th>
<th>Occupational Therapist</th>
<th>Psychologist</th>
<th>Doctor</th>
<th>Social Care Support Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onyett et al. 1994</td>
<td>3.3</td>
<td>1.9</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Policy Implementation Guidance 2001</td>
<td>4</td>
<td>3</td>
<td>1.5</td>
<td>1.5</td>
<td>2.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Boardman and Parsonage 2005</td>
<td>4.9</td>
<td>2.7</td>
<td>1.6</td>
<td>1.0</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>National mapping data 2007</td>
<td>6</td>
<td>3.5</td>
<td>0.9</td>
<td>1.1</td>
<td>1.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Present study 2007</td>
<td>6.1</td>
<td>3.5</td>
<td>0.9</td>
<td>0.8</td>
<td>2.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Growth since 1994</td>
<td>+84.8%</td>
<td>+84.2%</td>
<td>-10%</td>
<td>-20%</td>
<td>+110%</td>
<td>+55.6%</td>
</tr>
<tr>
<td>Surplus (+) or deficit (-) over Guidance</td>
<td>+52.5%</td>
<td>+16.7%</td>
<td>-40%</td>
<td>-46.7%</td>
<td>-16%</td>
<td>-53%</td>
</tr>
</tbody>
</table>

Table 3. Average CMHT team composition by data source (for major staff groups only)
We asked the service managers questions about team composition. The first was concerned with the factors that the manager thought influenced composition. The second concerned the specific factors leading to social care staff being included in the team, and the third was which factors are now influencing any proposed changes to team composition.

Managers provided up to five different reasons explaining team composition. Reasons were post-coded initially into 14 categories and then under five broad themes. From the original 14 the influence of commissioners on funding, vacancies due to financial constraints and citing finances as a determinant were classified under a general ‘financial resources’ heading. Benchmarking to reach a certain level of provision, usually by comparison with Trusts of a similar size and location was reported infrequently and was classed alongside similar exercises based on use of Department of Health (DH) or other guidance. Local client needs, the demands of primary care, local population characteristics and ratings based on local deprivation indices were classified with other ‘demand for services’ factors. Team roles and the need to ensure integration and multidisciplinarity were classed together, and historical reasons stood alone.

Table 4 shows the proportion of Trusts citing these five themes, and shows that history is a prominent factor.
**Table 4 Determinants of the composition of CMHTs**

<table>
<thead>
<tr>
<th>Classes of reason</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>30</td>
<td>27.0</td>
</tr>
<tr>
<td>Guidance</td>
<td>25</td>
<td>22.5</td>
</tr>
<tr>
<td>Demand factors</td>
<td>24</td>
<td>21.6</td>
</tr>
<tr>
<td>Financial resources</td>
<td>22</td>
<td>19.8</td>
</tr>
<tr>
<td>Multidisciplinarity</td>
<td>10</td>
<td>9.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>111</td>
<td>100</td>
</tr>
</tbody>
</table>

The picture becomes more mixed when looking at the reasoning behind the social care composition of CMHTs. In some instances, historical levels of funding played a part in these decisions, but again resources were not the main issue for most responding services (see Table 5). As one might expect, the policy (or strategy) of developing integrated services and the desire to maintain multidisciplinarity accounted for almost a third of the reasons driving the need for more social care staff. History and workload complexity were also important, specifically in relation to people on the enhanced Care Programme Approach (CPA) or needing the services of an ASW, as they required more social care input from the team. Other determinants of additional social care input related to the social deprivation experienced by people in some areas, or the wish to promote peoples’ social inclusion.

There were indications that for some Trusts (12.8%; n=11) these matters were entirely out of their hands, services were not integrated or co-located, budgets were not pooled and decisions were made entirely by the local authority social services department. Table 5 shows that the level of integration was associated with a medium (or approaching medium) magnitude effect on the rationale for team composition, in which social care input was determined less by history and slightly (but not significantly) more by ‘financial resources’ in lesser integrated services.
Table 5. Determinants of the social care membership of CMHTs

<table>
<thead>
<tr>
<th>Contributing reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload complexity (including ASW*)</td>
<td>15</td>
</tr>
<tr>
<td>History</td>
<td>15</td>
</tr>
<tr>
<td>Guidance</td>
<td>5</td>
</tr>
<tr>
<td>Financial</td>
<td>9</td>
</tr>
<tr>
<td>Integration requires it</td>
<td>20</td>
</tr>
<tr>
<td>Team needs (inc Multidisciplinarity)</td>
<td>8</td>
</tr>
<tr>
<td>Social services determined</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
</tr>
</tbody>
</table>

Social care determinant by level of integration

<table>
<thead>
<tr>
<th>Contributing Reason</th>
<th>Level of integration</th>
<th>n</th>
<th>%</th>
<th>$\chi^2$</th>
<th>df</th>
<th>p</th>
<th>Phi</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>More integrated</td>
<td>15</td>
<td>38.5</td>
<td>6.04</td>
<td>1</td>
<td>0.021</td>
<td>-0.35</td>
</tr>
<tr>
<td></td>
<td>Less integrated</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial resources</td>
<td>More integrated</td>
<td>5</td>
<td>12.8</td>
<td>3.22</td>
<td>1</td>
<td>0.093</td>
<td>0.25</td>
</tr>
<tr>
<td></td>
<td>Less integrated</td>
<td>4</td>
<td>36.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5 also shows that the number and balance of staff in teams were not associated, largely, with the cited reasons for the social care composition of teams.

Total staffing numbers appeared to be slightly higher in Trusts citing ‘financial resources’ as a determining factor of team composition. Despite being statistically insignificant the ‘financial resource’ effect was of medium magnitude$^{(132)}$. 
Similarly, there was a non-significant but approaching medium-sized effect on higher numbers of social care support staff when guidance was cited as a rationale for CMHT composition.

None of the rationale for social care composition was associated significantly or with any great magnitude with total, social work or social care staff numbers. A non-significant ($p=0.076$) medium magnitude ($\eta^2_p=0.067$) trend towards higher staff numbers existed in more integrated trusts not citing financial resources.

### 4.1.1 Drivers for change

Drivers for any planned changes to CMHTs were clearly policy related in most cases. Almost two-thirds of first reasons given (63.7%) and 47.1% of all reasons given related to new roles, new ways of working, various DH guidance about the creation of new teams and the resulting redeployment from CMHTs.

Redeployment of staff emerged as the main factor for more than half of the Trusts sampled, with 34% citing ‘redemption’ specifically and a further 18% referring to the ‘guidance’. New worker roles accounted for just over 10% and the same proportion reported financial issues including in one case disinvestment by commissioners. Demands from primary care were the main driver for change in five Trusts, while six had other reasons including multidisciplinarity, skill mix and in one case external consultant advice.

Table 6 shows a medium-magnitude, statistically significant association between redeployment and total staffing in which Trusts with smaller CMHTs were most likely to be considering redeployment to other teams. The association between redeployment and social work numbers was larger in magnitude, with Trusts having to consider redeployment having significantly less input to CMHTs from social workers. These results might suggest that smaller Trusts struggle to populate the emerging new teams without impacting upon existing CMHTs, and raises questions about the sustainability of these services where this is the case.

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Table 6. Staffing numbers by reason for CMHT team composition (n=50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Reason</th>
<th>n</th>
<th>Mean (sd)</th>
<th>t test (df)</th>
<th>p</th>
<th>Cohen's d</th>
<th>Mean difference</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All staff</strong></td>
<td>Not Financial</td>
<td>28</td>
<td>1.97 (0.25)*</td>
<td>-1.65 (48)</td>
<td>0.105</td>
<td>-0.51</td>
<td>-1.65</td>
<td>-0.29 to 0.03</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
<td>22</td>
<td>2.11 (0.31)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Care support staff</strong></td>
<td>Not Guidance</td>
<td>25</td>
<td>0.53 (0.60)*</td>
<td>-1.67 (48)</td>
<td>0.101</td>
<td>-0.47</td>
<td>-0.30</td>
<td>-0.66 to 0.06</td>
</tr>
<tr>
<td></td>
<td>Guidance</td>
<td>25</td>
<td>0.83 (0.67)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing numbers by reason for social care composition (n=50)</td>
<td>Nothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing numbers by change driver (n=50)</td>
<td>All staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not redeployment</td>
<td>35</td>
<td>2.08 (0.27)*</td>
<td>2.09 (48)</td>
<td>0.033</td>
<td>0.66</td>
<td>0.18</td>
<td>0.02 to 0.35</td>
</tr>
<tr>
<td></td>
<td>Redeployment</td>
<td>15</td>
<td>1.91 (0.27)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social work staff</td>
<td>35</td>
<td>5.07 (1.96)**</td>
<td>2.43 (48)</td>
<td>0.019</td>
<td>0.75</td>
<td>1.49</td>
<td>0.22 to 2.76</td>
</tr>
<tr>
<td></td>
<td>Redeployment</td>
<td>15</td>
<td>3.58 (1.02)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2 The staff survey

Three hundred and four staff members responded to the survey representing 42 teams in four locations in two countries. Four WDQs were completed by administrators in one location only, so they were omitted from further analyses.

Twenty-eight of the teams were CMHTs representing a team level response rate across the four locations of 90% (28/31), but the response in the newly created teams was lower at 61% (14/23). Of the 300 individual responses, 240 staff worked in CMHTs and 60 in the other teams. The overall staff response rate was 46%, which is reasonable for a survey of this type and similar to previous studies of the mental health workforce.\(^{(14, 153)}\)

Team coverage was similar in both countries with 18 teams from Wales and 24 from England. Data were provided from seven teams in Trust A (16.7%), 11 teams in Trust B (26.2%), 14 in Trust C (33.3%), and 10 in Trust D (23.8%).

Most teams were managed by a nurse (n=39, 92.9%) and all but one team was co-located (all health and social care staff in the same place/building). In just under half of the teams (n=20, 47.6%) health and social care budgets were pooled (though in effect this simply meant that local authority funds had been transferred to the Trust to employ social worker and support workers). The factors determining team composition included history for 50% of team, resources for 26.2%, guidance for just under half the teams (47.6%) and multi-disciplinarity, also in just over half (52.4%). All mentioned demand as a determining factor.

4.2.1 Team Composition

On average the proportion of social care staff within these teams (as reported by managers in Phase I) was 29% (sd 17.2%), but ranged from zero to 88.2%. Six teams had no social care input at all either from social workers or social care support workers, eight teams had no social workers and 16 had no social care support workers. Clearly these data were significantly skewed and required log-transformation to normalise the distribution. Significant differences in the composition, by area, country, CMHT status and degree of integration, in relation to co-location and pooled funding were observed in transformed and untransformed data and in non-parametric tests. Therefore for ease of interpretation untransformed results are presented below.
On average the proportion of social care staff within teams was higher in the English participating locations than in the Welsh locations (Means 35.3, sd 19.9 cf 22.7, sd 10.7; t=6.83, df 228.8, p=0.000). Two of the English teams had no social workers (8.3%), eight had no social care support workers (25%) but only one team had no social care input at all (neither social work or social care support). In Wales, six teams had no social workers (33.3%), seven had no social care workers (38.9%) and five had no social care input at all (27.8%).

Clearly these teams are nested within areas that were selected on the basis of their rationale for team composition and levels of integration, so it is not surprising that the proportion of social care in teams also varied by area (F=143.7, p=0.000). The respective means, standard deviations and ranges are shown in Table 7, which shows that the social care composition was significantly higher in locations A (p<0.001) and D (p<0.000) than in any other group; the proportions in locations B and C did not differ from each other. Both of the English teams with no social workers and all but one of the English teams with no social support workers were located in location C. Only location B of the Welsh teams had no social work and / or social care input to their teams.

Table 7. Social care staff as a proportion of total team size in the four locations

<table>
<thead>
<tr>
<th>Location (n)</th>
<th>Mean % (sd)</th>
<th>95% CI</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (78)</td>
<td>27.6 (8.3)</td>
<td>25.7 - 29.5</td>
<td>27.5 – 58.8</td>
</tr>
<tr>
<td>B (72)</td>
<td>17.4 (10.5)</td>
<td>14.9 - 19.9</td>
<td>0 – 34.2</td>
</tr>
<tr>
<td>C (81)</td>
<td>20.9 (8.8)</td>
<td>19.0 - 22.9</td>
<td>0 – 36.8</td>
</tr>
<tr>
<td>D (69)</td>
<td>52.2 (15.6)</td>
<td>48.5 - 56.0</td>
<td>19.7 – 88.2</td>
</tr>
</tbody>
</table>

CMHTs differ from other types of team, in that the latter are significantly smaller and team composition varied considerably, in terms of the social care component. In the CMHT sample the average proportion of social care staff was 31.5% (sd 17.6), compared to less than one-fifth in the other types of team (19.1%, sd 10.6; t= -0.70 (df 150.76), p=0.000).

Forty-three percent of the new teams have no social workers in them (n=6) and almost three-quarters (71.4%, n=10) have no social support workers.
(There is an argument about whether some of these teams need support workers or social workers – see later). Just over a quarter (28.6%, n=4) had no social care input at all.

There was less variability in the corresponding figures for CMHTs, of which only two had no social care input at all (7.1%), although just over a fifth (21.4%, n=6) had no social care support staff.

### 4.2.2 Integration

The proportion of social care staff was lower in co-located services than where staff were not co-located (28.8% (sd 17.5%) cf 33.7% (sd 0%)), t=4.73 (df 287) p=0.000, although all of the teams with no social care input were co-located.

Finally the proportion of social care staff was higher where health and social care budgets were pooled (mean 35.3 (sd 19.9) cf mean 22.7 (sd 10.7); t=-16.8 (df 228.8) p=0.000). This result is consistent with the finding in the national survey that where social services determined the staffing levels the proportion of social care staff was lower (see section 2.5). None of the teams in Wales had access to pooled budgets, whereas all the English ones did, which is due to the absence of mental health Trusts in Wales ($\chi^2 = 38.1$, df 1, p<0.001, Phi 1.00). Sixty-two percent of CMHTs had pooled budgets.

### 4.2.3 Team typology

Team typology in relation to the social care composition of teams was determined according to the distribution of the proportion of social care staff (including social work and social care staff groups) to total staffing. Figure 2 shows that six clear groups were identifiable. For some subsequent analyses these groups were collapsed further to form three groups <20%, 30-40% and >40%, but where possible the six groups identified in Table 8 were retained in order to identify factors associated with very high, high and very low social care membership.
Figure 2: Proportion of social care staff in teams

Table 8. Social care staff as a proportion of the full team (Team typology)

<table>
<thead>
<tr>
<th>Proportion</th>
<th>Number of teams (%)</th>
<th>Number of staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% or less</td>
<td>8 (19.0)</td>
<td>35 (11.6)</td>
</tr>
<tr>
<td>Up to 20%</td>
<td>9 (21.4)</td>
<td>62 (20.6)</td>
</tr>
<tr>
<td>Up to 30%</td>
<td>13 (31.0)</td>
<td>105 (35.0)</td>
</tr>
<tr>
<td>Up to 40%</td>
<td>6 (14.3)</td>
<td>41 (13.6)</td>
</tr>
<tr>
<td>Up to 60%</td>
<td>3 ( 7.1)</td>
<td>28 ( 9.3)</td>
</tr>
<tr>
<td>Over 60%</td>
<td>3 ( 7.1)</td>
<td>31 (10.3)</td>
</tr>
<tr>
<td>Total</td>
<td>42 (100)</td>
<td></td>
</tr>
</tbody>
</table>
4.2.4 Team member characteristics

Seventy percent (n=212) of the 300 respondents included in analyses were female, with an average age of 45 years (sd 8.8 years) but ranging from 23 years to 66 years. On average staff had worked in their team for 4.2 years (sd 3.9 years) but their experience in the team could range from less than a year to 20 years.

Two hundred and ninety eight respondents provided details about their professional background. Nurses formed the dominant group representing 45.3% (n=137) of the sample, which is higher than the proportion of nurses in the workforce identified in the national survey (33.3%), but only slightly over-representative of the number of nurses employed in the four selected locations (41.7%, n=269.7). Ninety-two percent of the nurses in the sample were community psychiatric nurses (CPNs).

Social workers formed 17.5% (n=53) of the sample which is very slightly lower than the proportion of the workforce identified in the national survey (19.3%), but slightly higher than the proportion of social workers employed in the four locations (15%, n=96.5). One half of the social work sample were Approved Social Workers (n=27, 50.9%) with statutory duties under the 1983 Mental Health Act\(^{152}\), relating to compulsory admissions to hospital for psychiatric treatment. These statutory duties have now been extended to other mental health professionals under the 2008 Mental Health Act.

Social care support staff formed 11.9% of the sample (n=33), again very slightly higher than the national average (10%) but very similar to the proportion of social care support workers employed in the four locations (11.5%, n=74.5).

The other respondents included 14 doctors, 27 occupational therapists, two physiotherapists, twelve psychologists and 20 other health staff. Just over one-fifth of the sample were employed in a team leader or manager role (22.7%, n=67).

Of the 300 respondents, 298 provided details of their professional background (see Table 9 below)
Table 9. Professional group of respondents (Phase II teams only)

<table>
<thead>
<tr>
<th>Professional</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>14</td>
<td>4.7</td>
</tr>
<tr>
<td>OT</td>
<td>27</td>
<td>9.1</td>
</tr>
<tr>
<td>Social worker</td>
<td>53</td>
<td>17.8</td>
</tr>
<tr>
<td>Nurse</td>
<td>137</td>
<td>46.0</td>
</tr>
<tr>
<td>Support worker</td>
<td>33</td>
<td>11.1</td>
</tr>
<tr>
<td>Psychologist</td>
<td>12</td>
<td>4.0</td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>298</td>
<td>100</td>
</tr>
</tbody>
</table>

There were no differences in the responses from different staff groups between countries, areas nor more and less integrated teams (as indicated by pooled funding and / or co-location), but differing responses were observed between CMHTs and the new teams. Nurses and social workers in the two team types responded in similar proportions but it appeared that fewer support workers responded from CMHTs (9.2% (n=22) cf 18.3% (n=11) and fewer ‘other’ staff members responded from the new teams (10% (n=6) cf 29% (n=69; $\chi^2=11.34$ (df 3) $p=0.010$). Further examination of the ‘other’ professional group difference suggested that it was a lack of response from doctors within the new teams that contributed the groups’ lower response, but as this analysis violated the expected cell count assumption this assertion should be treated with some caution ($\chi^2=11.92$ (df 5) $p=0.036$). While it is almost certain that a lower response from doctors in the new teams is due to the low numbers employed in these teams, it is not the case that social support staff are employed in lower numbers in CMHTs.

Nevertheless, on the whole the data can be considered representative of the mental health workforce within the selected locations.

4.2.5 Team Culture and Climate

Organisational and team culture was assessed using WDQ and Karasek JCQ subscales. Three of the WDQ subscales were normally distributed (autonomy, integration and uncertainty), but others had to be transformed to normalise their distributions. Intention to leave the employer was
normalised by log-transformation, while role perception, teamwork, access to information technology and quality of care required reflect square root transformations, which caused positive associations to be indicated by the negative beta coefficients in the regression analyses. It was not possible to normalise the distributions of role flexibility, management, training and career progression or intent to leave the profession. Of the Karasek JCQ subscales, only psychological job demands was not normally distributed in the original data requiring square-root transformation.

In most respects the results of transformed and untransformed data were similar in terms of statistical significance and magnitude of effect, therefore, to make the results more readily interpretable we have, for the most part, reported the untransformed means and standard deviations rather than the transformed results. Where transformation did alter the findings, this is reported in the text.

Missing data analyses indicated that most variables had less than 1% missing data, only intention to leave the profession (1.3%), intention to leave the employer (2.3%) and overall job satisfaction (10.6%) were higher; the higher level of missing data in job satisfaction is thought to be due to the location of the question within the questionnaire, which on reflection appears to be easily overlooked. Nevertheless, repeated analyses that were undertaken both with and without the missing data (as recommended by Tabachnick and Fidell\(^{141}\), p63) demonstrated that the influence of missing data was limited and only related to access to IT, in that it had a significantly different relationship with overall job satisfaction in the two forms of analysis. Access to IT subscale scores were higher when the missing data were included (t=2.3, 33.6 p=0.013), but became statistically insignificant following Simes procedure adjustments. As access to IT was not deemed a conceptually important variable and would not be included in regression analysis, the analyses that follow contain the missing data.

Table 10 describes the sample as a whole in terms of team culture and climate as measured by WDQ and Karasek JCQ items. On both scales higher ratings generally indicate a positive rating for each aspect of team climate and culture. Nevertheless, for uncertainty, psychological job demands and indicators relating to future work plans lower scores are desirable as they reflect less uncertainty and intent to leave the employer or the profession. All WDQ indicators are rated on a percentage scale, on which the minimum possible score is 10. Karasek JCQ items are rated on different scale: the minimum possible score for decision latitude is 14 and the maximum 92; scores for psychological job demands can range between 15 and 48, and those for social support between four and 32.
Table 10. Team culture and climate: Descriptive statistics

<table>
<thead>
<tr>
<th>WDQ Subscales</th>
<th>Median</th>
<th>Mean (sd)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>55.0</td>
<td>58.33 (17.04)</td>
<td>12.5-100</td>
</tr>
<tr>
<td>Role perception</td>
<td>62.2</td>
<td>61.27 (10.99)</td>
<td>17.8 – 87.8</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>78.3</td>
<td>77.87 (12.53)</td>
<td>26.7-100</td>
</tr>
<tr>
<td>Integration</td>
<td>66.6</td>
<td>66.80 (16.05)</td>
<td>20-100</td>
</tr>
<tr>
<td>Teamwork</td>
<td>77.0</td>
<td>75.02 (15.56)</td>
<td>6 -100</td>
</tr>
<tr>
<td>Management</td>
<td>90.0</td>
<td>83.35 (17.90)</td>
<td>10 -100</td>
</tr>
<tr>
<td>Access to IT</td>
<td>80.0</td>
<td>74.73 (18.57)</td>
<td>22.5 – 100</td>
</tr>
<tr>
<td>Training, career</td>
<td>62.5</td>
<td>61.81 (12.84)</td>
<td>17.5 – 88.8</td>
</tr>
<tr>
<td>Quality of care</td>
<td>90.0</td>
<td>84.65 (13.93)</td>
<td>10 -100</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>58.8</td>
<td>59.94 (12.59)</td>
<td>15 -100</td>
</tr>
<tr>
<td>Intend to leave employer</td>
<td>30.0</td>
<td>43.10 (35.51)</td>
<td>10 -100</td>
</tr>
<tr>
<td>Intend to leave Profession</td>
<td>20.0</td>
<td>37.94 (35.43)</td>
<td>10 -100</td>
</tr>
<tr>
<td>Overall job satisfaction</td>
<td>70.0</td>
<td>67.16 (19.43)</td>
<td>10 -100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Karasek Subscales</th>
<th>Median</th>
<th>Mean (sd)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological job demands</td>
<td>33.0</td>
<td>34.10 ( 5.96)</td>
<td>18-48</td>
</tr>
<tr>
<td>Decision latitude</td>
<td>62.0</td>
<td>63.52 (11.62)</td>
<td>24-88</td>
</tr>
<tr>
<td>Social Support</td>
<td>25.0</td>
<td>25.64 ( 3.43)</td>
<td>14-32</td>
</tr>
</tbody>
</table>

All WDQ items were above the mid-point, which with the exception of uncertainty (in relation to job security, team direction and clarity of role within the team) suggests positive team climate and culture. Psychological job demand scores were relatively high at 68.8% when the median rating was standardised as a percentage of the maximum possible score. High levels of social support were in evidence however, reaching 78% when standardised as a percentage. Accordingly, job satisfaction ratings were high and intention to leave ratings low, suggesting that there was an overall positive feeling about the employer and profession. Ratings were particularly high for quality of care and management, perhaps reflecting...
social desirability bias. Access to IT was generally highly rated, as were team work, role flexibility and to a lesser extent integration. WDQ scores for autonomy and Karasek JCQ decision latitude were significantly correlated (r=0.25, p=0.000) and both indicated that autonomy ratings were slightly lower (median decision latitude ratings expressed as a percentage of the maximum possible rating =67.4%).

4.2.6 Location

Table 11 shows that ratings for uncertainty, quality of care and overall job satisfaction were similar across the four locations. Given individual staff motivation for going into community mental health work and the presence of ubiquitous change in the NHS it is not surprising that these variables did not differ by location. It is interesting that the location with the most uncertainty was the Trust applying for Foundation status, and which, as a direct consequence was unable to take part in the service user interviews phase of the present study. In terms of wanting to leave the employer, staff in location C were more likely to want to leave compared to staff in location A (mean difference = 24.3, CI 9.7, 38.8); similarly location C ratings for leaving the profession were higher than locations A (mean difference =-0.30, CI -0.47, -0.13) and D (mean difference =-0.30, CI -0.48,-0.13) (all p<0.001).

The pattern of the significant results usually reveals that location C most often has higher (better) scores on most subscales and that location D most often has the lower (worse) scores (except the intention to leave variables which are reversed). In terms of integration, location C was significantly different to all the others locations, but most different from location D (mean difference = -15.1, CI -21.7, -8.4). A similar result, between locations C and D was observed for autonomy (mean difference = -8.4, CI -15.7, -1.0), teamwork (mean difference = -8.7, CI -15.4, -2.07, p=0.003), management style (mean difference = -8.5, CI -16.25, -0.67, p<0.001), training (mean difference = -7.43, CI -12.77, -2.08, p=0.002), and access to IT subscales (mean difference = -8.15, CI -16.21, -0.09, p= 0.46).

While psychological job demands and decision latitude did not differ significantly by area (despite a non-significant trend in untransformed data), social support did; ratings were lowest in location D and highest in location C (p=0.04) and the result remained significant following Simes procedures adjustment\(^{140}\). Social support was the only Karasek JCQ subscale to be significantly correlated with the proportion of social care staff in the team. (Table 12) The larger the number of social care staff the less social support there was from colleagues and supervisors (r=-0.15 p=0.012).
Table 11. WDQ subscales scores by location

<table>
<thead>
<tr>
<th>WDQ subscale</th>
<th>Location A Mean (sd)</th>
<th>Location B Mean (sd)</th>
<th>Location C Mean (sd)</th>
<th>Location D Mean (sd)</th>
<th>Statistical significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>64.5 (12.6)</td>
<td>66.6 (17.6)</td>
<td>74.9 (16.8)</td>
<td>59.8 (12.7)</td>
<td>F=13.08 (293) 0.001</td>
</tr>
<tr>
<td>Autonomy</td>
<td>52.3 (15.1)</td>
<td>55.3 (17.6)</td>
<td>57.8 (18.3)</td>
<td>49.4 (16.7)</td>
<td>F= 3.45 (295) 0.017</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>61.9 (11.3)</td>
<td>59.1 (14.9)</td>
<td>58.5 (11.5)</td>
<td>60.2 (12.6)</td>
<td>F= 1.14 (294) NS</td>
</tr>
<tr>
<td>Access to IT</td>
<td>73.6 (18.2)</td>
<td>72.5 (18.9)</td>
<td>80.1 (17.4)</td>
<td>71.9 (19.1)</td>
<td>F= 3.90 (293) 0.009</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>84.2 (12.6)</td>
<td>85.6 (13.8)</td>
<td>86.2 (13.6)</td>
<td>82.3 (15.6)</td>
<td>F= 1.20 (294) NS</td>
</tr>
<tr>
<td>Teamwork</td>
<td>73.8 (13.3)</td>
<td>77.4 (14.3)</td>
<td>78.5 (16.4)</td>
<td>69.7 (16.8)</td>
<td>$\chi^2 = 18.40 (3) 0.001$</td>
</tr>
<tr>
<td>Training</td>
<td>65.5 (9.0)</td>
<td>64.3 (11.1)</td>
<td>62.1 (11.5)</td>
<td>54.7 (16.7)</td>
<td>$\chi^2 = 23.12 (3) 0.001$</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>75.1 (12.1)</td>
<td>79.9 (11.1)</td>
<td>80.2 (12.9)</td>
<td>76.0 (13.4)</td>
<td>$\chi^2 = 10.74 (3) 0.013$</td>
</tr>
<tr>
<td>Role perception</td>
<td>59.6 (10.0)</td>
<td>61.8 (10.3)</td>
<td>63.7 (12.9)</td>
<td>59.7 (9.8)</td>
<td>$\chi^2 = 13.13 (3) 0.004$</td>
</tr>
<tr>
<td>Management style</td>
<td>84.4 (17.0)</td>
<td>80.7 (20.8)</td>
<td>87.8 (13.7)</td>
<td>79.4 (19.0)</td>
<td>$\chi^2 = 9.26 (3) 0.026$</td>
</tr>
<tr>
<td>Overall Job satisfaction</td>
<td>68.2 (15.7)</td>
<td>68.9 (15.7)</td>
<td>67.9 (20.3)</td>
<td>63.2 (25.0)</td>
<td>$\chi^2 = 1.48 (3) NS$</td>
</tr>
<tr>
<td>Intention to leave the employer</td>
<td>29.8 (27.3)</td>
<td>47.7 (36.2)</td>
<td>54.1 (38.7)</td>
<td>40.5 (34.6)</td>
<td>$\chi^2 = 15.45 (3) 0.001$</td>
</tr>
<tr>
<td>Intention to leave the profession</td>
<td>26.4 (25.4)</td>
<td>40.6 (36.7)</td>
<td>55.8 (40.0)</td>
<td>26.8 (28.3)</td>
<td>$\chi^2 = 13.40 (3) 0.001$</td>
</tr>
</tbody>
</table>

* All significant results remain significant after Simes adjustment
### Table 12. Karasek JCQ Scores

<table>
<thead>
<tr>
<th>Karasek variable</th>
<th>Test result</th>
<th>Mean (sd)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>By location</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological job demands</td>
<td>F= 2.21 (3,284)</td>
<td>A= 33.8 (5.4) B =32.8 (5.2) C =34.7 (6.6) D = 35.3 (6.4)</td>
<td>NS</td>
</tr>
<tr>
<td>Social support</td>
<td>F=2.81 (3,286)</td>
<td>A = 25.8 (3.7) B= 25.9 (3.7) C= 26.2 (3.3) D=24.6 (3.3)</td>
<td>0.040*</td>
</tr>
<tr>
<td>Decision latitude</td>
<td>F=2.73 (3,277)</td>
<td>A= 61.6 (11.9) B= 65.0 (10.5) C = 65.9 (12.7) D=61 (12.7)</td>
<td>0.044*</td>
</tr>
<tr>
<td><strong>By team type</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological job demands</td>
<td>t=-0.79 (286)</td>
<td>CMHT = 34.2 (5.9) New = 33.6 (6.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Social support</td>
<td>t=0.92 (285)</td>
<td>CMHT = 25.5 (3.6) New = 26.0 (3.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Decision latitude</td>
<td>t=1.42 (279)</td>
<td>CMHT = 63.0 (11.8) New = 64.5 (10.7)</td>
<td>NS</td>
</tr>
<tr>
<td><strong>By professional group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological job demands</td>
<td>F=2.84 (3,275)</td>
<td>Nurse 34.5 (5.7) SW 36.6 (6.5) Support W 29.3 (6.5) Other 33.5 (5.4)</td>
<td>p=0.039*</td>
</tr>
<tr>
<td>Social support</td>
<td>F=2.07 (3, 284)</td>
<td>Nurse 25.5 (3.7) SW 25.9 (3.9) Support W 25.8 (2.9) Other 25.8 (3.0)</td>
<td>NS</td>
</tr>
<tr>
<td>Decision latitude</td>
<td>F=10.67 (3,282)</td>
<td>Nurse 64.1 (11.6) SW 61.2(13.2) Support W 59.5(9.3) Other 65.7 (10.7)</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>

* no longer significant after Simes procedure applied
### Table 12. Karasek JCQ scores (continued)

<table>
<thead>
<tr>
<th>Karasek variable</th>
<th>Test result</th>
<th>&lt;10%</th>
<th>Up to 20%</th>
<th>20-29%</th>
<th>30-39%</th>
<th>40-59%</th>
<th>60% and over</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological job demands</td>
<td>F= 0.38</td>
<td>33.4 (6.1)</td>
<td>33.5 (6.0)</td>
<td>34.3 (5.7)</td>
<td>34.5 (6.8)</td>
<td>34.8 (5.7)</td>
<td>33.9 (5.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Social support</td>
<td>F= 3.39</td>
<td>25.1 (3.3)</td>
<td>26.1 (3.4)</td>
<td>26.5 (3.6)</td>
<td>24.5 (3.5)</td>
<td>24.9 (3.6)</td>
<td>24.5 (2.9)</td>
<td>p=0.005</td>
</tr>
<tr>
<td>Decision latitude</td>
<td>F=1.59</td>
<td>62.5 (11.9)</td>
<td>67.5 (10.3)</td>
<td>62.9 (11.9)</td>
<td>62.7 (10.9)</td>
<td>63.7 (10.9)</td>
<td>61.1 (12.8)</td>
<td>NS</td>
</tr>
</tbody>
</table>
4.2.7 Team culture and team composition

Table 13 shows that integration varies significantly with the proportion of social care staff in the team. The lower the proportion the higher (better) the perceived integration score is. The significant differences are between the top two (more than 40%) and the bottom two (less than 20%). This result tends to confirm the previously reported findings from a national survey of mental health social workers. The patterns for management style, teamwork and training and career development are not dissimilar, where on the whole having 30% or less of social care staff seems to produce the higher scores on the WDQ variable. Interestingly, overall job satisfaction is also significantly higher where there are fewer social care staff. There are no variables where the results are in the reverse order, so there is no evidence that more social care staff improves culture and climate, but there is evidence that the more social care staff there are, the more certain aspects of culture and climate are adversely affected, and integration is one of these. As we shall see later, integration scores do not differ by professional group, from which we conclude that having more social care staff affects all professional groups equally and is not confined to any one in particular.

There were no significant differences between the psychological demand and decision latitude Karasek JCQ subscales in relation to the proportion of social care staff in the teams. There were low but significant inverse correlations between the decision latitude subscale and the proportion of social care staff in the team (r=-0.126, p=0.034) and the proportions of support workers (r=-0.133, p=0.024) but not the proportion of social workers (after Simes adjustment). There was a significant difference in social support depending on the proportion of social care staff (F=3.39 (5,284) p=0.005). The proportion below the mean percentage (20-29%) differed from the group just above the mean (30-40%) (mean difference =-2.03 (-3.95, -0.10) p=0.03), with higher ratings being reported where the social care proportion was higher.

Overall, the proportion of social care workers in the team was unrelated to higher scores on the psychological job demand scale, however, both the number of social workers (r=0.144, p=0.015) and the proportion of ASWs in the team were related to the psychological demand scale (r=0.131, p=0.026).
Table 13. WDQ subscales by proportion of social care staff in the team

<table>
<thead>
<tr>
<th>WDQ subscale</th>
<th>Less than 10%</th>
<th>Up to 20%</th>
<th>Up to 30%</th>
<th>Up to 40%</th>
<th>Up to 60%</th>
<th>Over 60%</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>71.2 (16.9)</td>
<td>68.1 (15.7)</td>
<td>69.3 (15.5)</td>
<td>64.8 (17.3)</td>
<td>58.6 (13.5)</td>
<td>59.6 (13.8)</td>
<td>F=3.94 (291) 0.002*</td>
</tr>
<tr>
<td>Autonomy</td>
<td>57.0 (19.2)</td>
<td>56.6 (17.6)</td>
<td>53.9 (16.40)</td>
<td>54.4 (14.2)</td>
<td>49.7 (17.7)</td>
<td>47.1 (16.8)</td>
<td>F= 1.86 (293) NS</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>58.4 (14.5)</td>
<td>60.6 (13.4)</td>
<td>60.4 (11.7)</td>
<td>57.4 (12.5)</td>
<td>64.5 (13.1)</td>
<td>58.1 (10.7)</td>
<td>F= 1.31 (292) NS</td>
</tr>
<tr>
<td>Access to IT</td>
<td>77.4 (18.1)</td>
<td>72.7 (21.1)</td>
<td>76.5 (17.9)</td>
<td>75.2 (15.8)</td>
<td>74.6 (16.5)</td>
<td>64.0 (20.5)</td>
<td>F= 0.39 (292) NS</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>84.0 (12.0)</td>
<td>85.1 (16,4)</td>
<td>85.6 (12.2)</td>
<td>83.4 (12.4)</td>
<td>82.8 (18.2)</td>
<td>84.2 (14.8)</td>
<td>F= 1.00 (291) NS</td>
</tr>
<tr>
<td>Teamwork</td>
<td>77.8 (14.1)</td>
<td>80.4 (117)</td>
<td>77.2 (12.4)</td>
<td>78.5 (14.3)</td>
<td>77.3 (2.4)</td>
<td>75.1 (12.3)</td>
<td>χ² = 15.0 (5) 0.010*</td>
</tr>
<tr>
<td>Training</td>
<td>60.8 (9.9)</td>
<td>63.5 (12.3)</td>
<td>65.2 (9.9)</td>
<td>60.0 (13.4)</td>
<td>56.9 (17.8)</td>
<td>54.7 (15.9)</td>
<td>χ = 18.22 (5) 0.003 *</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>77.7 (12.4)</td>
<td>80.4 (11.7)</td>
<td>77.2 (12.4)</td>
<td>78.5 (14.3)</td>
<td>77.3 (12.4)</td>
<td>77.9 (12.5)</td>
<td>χ² = 5.1 (5) NS</td>
</tr>
<tr>
<td>Role perception</td>
<td>64.8 (9.9)</td>
<td>60.9 (12.2)</td>
<td>61.3 (10.7)</td>
<td>62.3 (11.0)</td>
<td>59.9 (12.0)</td>
<td>57.8 (8.3)</td>
<td>χ² = 9.3 (5) NS</td>
</tr>
<tr>
<td>Management style</td>
<td>81.1 (19.8)</td>
<td>83.6 (19.3)</td>
<td>86.8 (15.8)</td>
<td>80.2 (17.6)</td>
<td>82.5 (17.5)</td>
<td>78.4 (19.2)</td>
<td>χ² = 11.9 (5) 0.036</td>
</tr>
<tr>
<td>Overall Job</td>
<td>66.6 (18.10)</td>
<td>70.4 (16.8)</td>
<td>68.7 (17.6)</td>
<td>67.5 (20.1)</td>
<td>66.8 (24.6)</td>
<td>63.2 (25.1)</td>
<td>χ² = 15.75 (5) 0.008*</td>
</tr>
<tr>
<td>satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intention to leave the employer</td>
<td>59.4 (35.9)</td>
<td>41.2 (36.3)</td>
<td>40.0 (34.6)</td>
<td>46.1 (36.5)</td>
<td>39.6 (34.7)</td>
<td>37.3 (32.9)</td>
<td>χ² = 9.01 (5) NS</td>
</tr>
<tr>
<td>Intention to leave the profession</td>
<td>59.7 (39.0)</td>
<td>33.8 (33.7)</td>
<td>39.2 (36.3)</td>
<td>38.3 (34.1)</td>
<td>26.0 (26.2)</td>
<td>25.4 (29.1)</td>
<td>χ² = 5.38 (5) NS</td>
</tr>
</tbody>
</table>

* remain significant when Simes adjustment applied
4.2.8 Team culture by team type

Table 14 shows that the new teams ratings are significantly higher than those for CMHTs for integration and teamwork, role perception, access to IT and autonomy, all of which are understandable. CMHTs have a greater degree of uncertainty, which is possibly a consequence of service reconfiguration and the loss of staff to the new teams. The new team staff are however, much more likely to report that they intend to leave the employer and the profession, which could be interpreted as a worrying sign. The difference in intention to leave between the two teams could be due to the nature of the work in the new teams, or the type of employment contract of the workers. Other possible explanations are that the new team staff are the more ambitious and younger and are planning their career moves, or the CMHT staff are more comfortable in the work they are doing and less ambitious. Length of time in the team differs between the team types, but that is an artefact of the recent creation of the new teams. Age (46.4 (sd 8.9) cf 44.6 (sd 8.8)) and gender are not significantly different in the two team types (New teams 75% female, CMHT 62%).

None of the Karasek JCQ sub-scales differed by type of team (CMHT or other).

4.2.9 Team culture and professional groups

Once again, as Table 15 shows, professional groups did not differ on a number of the subscales. This may be in part a consequence of the fact that they are members of the same teams, and subject to many of the same experiences. So, as with the location data, uncertainty is consistent across the groups, as is overall job satisfaction. On this occasion, however, ratings on the quality of care subscale were significantly different because support workers had rated it more highly than social workers (mean difference = -1.42 CI -2.6, -0.21, p=0.012). Support workers also reported higher scores in relation to access to IT than social workers (mean difference = -1.57 CI -2.93, -0.22, p=0.042) and ‘other’ workers (mean difference = -1.67, CI -2.94, -0.39, p=0.004).

Integration, which differed by location did not differ by professional group, nor did teamwork, training, role flexibility, management style, or the intention to leave the profession.

Support workers had, as one might have expected, significantly lower autonomy scores (38.3 sd 16.5, CI 12.5-82.5) compared to nurses (55.9 sd 15.7 CI 17.5-100), social workers (55.6 sd 17.8, CI 22.5-87.5), and others (55.7 sd 16.1, CI 2.5 -92.3). As a result, the composition of the team, in
Table 14. WDQ subscales by team type

<table>
<thead>
<tr>
<th>WDQ subscale</th>
<th>Functional teams Mean (sd)</th>
<th>CMHTs Mean (sd)</th>
<th>Statistical significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>81.1 (18.8)</td>
<td>63.2 (17.9)</td>
<td>t = 6.95 (74) p&lt;0.001</td>
</tr>
<tr>
<td>Autonomy</td>
<td>62.8 (18.9)</td>
<td>51.6 (15.8)</td>
<td>t = 4.24 (81) p&lt;0.001</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>54.5 (11.1)</td>
<td>61.3 (12.6)</td>
<td>t = -3.79 (296) p&lt;0.001</td>
</tr>
<tr>
<td>Access to IT</td>
<td>82.1 (17.0)</td>
<td>72.9 (18.5)</td>
<td>t = -3.86 (295) p&lt;0.001</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>86.7 (12.6)</td>
<td>84.1 (14.2)</td>
<td>t = -1.3 (296) NS</td>
</tr>
<tr>
<td>Teamwork</td>
<td>81.3 (14.2)</td>
<td>73.4 (15.5)</td>
<td>MWU= 4688, z=-4.10, p&lt;0.001</td>
</tr>
<tr>
<td>Training</td>
<td>63.7 (11.0)</td>
<td>61.3 (13.2)</td>
<td>MWU= 6519, z=-1.04, NS</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>80.3 (11.5)</td>
<td>77.2 (12.7)</td>
<td>MWU= 6176, z=-1.66, NS</td>
</tr>
<tr>
<td>Role perception</td>
<td>66.8 (10.8)</td>
<td>59.8 (10.6)</td>
<td>MWU= 4388, z=-4.70, p&lt;0.001</td>
</tr>
<tr>
<td>Management style</td>
<td>86.8 (15.4)</td>
<td>82.5 (18.4)</td>
<td>MWU= 6171, z=-1.50 NS</td>
</tr>
<tr>
<td>Overall Job satisfaction</td>
<td>68.2 (20.1)</td>
<td>66.9 (19.1)</td>
<td>MWU= 5217, z=-.81 NS</td>
</tr>
<tr>
<td>Intention to leave the employer</td>
<td>81.2 (25.7)</td>
<td>33.5 (30.9)</td>
<td>MWU=1949, z=-8.8) p&lt;0.001</td>
</tr>
<tr>
<td>Intention to leave the profession</td>
<td>87.8 (21.0)</td>
<td>25.3 (25.9)</td>
<td>MWU= 934, z=-11.1) p&lt;0.001</td>
</tr>
</tbody>
</table>

* All significant results remain significant after Simes adjustment
Table 15. WDQ subscales by professional group

<table>
<thead>
<tr>
<th>WDQ subscale</th>
<th>Nurse</th>
<th>Social worker</th>
<th>Support worker</th>
<th>‘Other’ group</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>64.1 (10.4)</td>
<td>66.9 (15.9)</td>
<td>64.3 (15.2)</td>
<td>67.7 (14.6)</td>
<td>$F=0.25$ (293) NS</td>
</tr>
<tr>
<td>Autonomy</td>
<td>55.9 (15.7)</td>
<td>55.6 (17.7)</td>
<td>40.5 (18.3)</td>
<td>52.6 (12.1)</td>
<td>$F=5.30$ (295) 0.001*</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>59.4 (13.8)</td>
<td>58.5 (11.8)</td>
<td>60.4 (12.5)</td>
<td>61.5 (11.1)</td>
<td>$F=0.77$ (294) NS</td>
</tr>
<tr>
<td>Access to IT</td>
<td>75.9 (18.3)</td>
<td>72.9 (17.8)</td>
<td>85.0 (18.9)</td>
<td>71.6 (18.7)</td>
<td>$F=4.58$ (293) 0.004*</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>85.7 (13.2)</td>
<td>81.2 (14.8)</td>
<td>90.5 (13.9)</td>
<td>83.6 (14.0)</td>
<td>$F= 3.83$ (294) 0.01*</td>
</tr>
<tr>
<td>Teamwork</td>
<td>76.2 (15.6)</td>
<td>71.4 (17.1)</td>
<td>80.2 (15.2)</td>
<td>74.2 (14.3)</td>
<td>$\chi^2 = 7.0$ (3) NS</td>
</tr>
<tr>
<td>Training</td>
<td>61.6 (13.2)</td>
<td>63.4 (12.2)</td>
<td>59.4 (16.1)</td>
<td>61.7 (11.8)</td>
<td>$\chi^2 = 1.4$ (3) NS</td>
</tr>
<tr>
<td>Role flexibility</td>
<td>77.5 (13.0)</td>
<td>78.1 (13.7)</td>
<td>81.3 (11.0)</td>
<td>77.5 (11.4)</td>
<td>$\chi^2 = 1.95$ (3) NS</td>
</tr>
<tr>
<td>Role perception</td>
<td>64.1 (10.4)</td>
<td>56.3 (10.2)</td>
<td>65.0 (11.8)</td>
<td>59.0 (10.8)</td>
<td>$\chi^2 = 30.6$ (3) 0.001*</td>
</tr>
<tr>
<td>Management style</td>
<td>84.5 (16.9)</td>
<td>81.9 (20.0)</td>
<td>86.5 (20.9)</td>
<td>81.7 (17.4)</td>
<td>$\chi^2 = 6.18$ (3) NS</td>
</tr>
<tr>
<td>Overall Job satisfaction</td>
<td>66.4 (20.0)</td>
<td>64.2 (19.9)</td>
<td>66.5 (23.9)</td>
<td>70.3 (17.1)</td>
<td>$\chi^2 = 2.35$ (3) NS</td>
</tr>
<tr>
<td>Intention to leave the employer</td>
<td>44.0 (36.7)</td>
<td>52.4 (34.1)</td>
<td>43.5 (38.2)</td>
<td>36.2 (32.8)</td>
<td>$\chi^2 = 8.3$ (3) 0.04</td>
</tr>
<tr>
<td>Intention to leave the profession</td>
<td>38.9 (35.6)</td>
<td>43.2 (38.7)</td>
<td>46.5 (37.7)</td>
<td>31.4 (31.9)</td>
<td>$\chi^2 = 5.5$ (3) NS</td>
</tr>
</tbody>
</table>

* remain significant after Simes adjustment
terms of the proportion of social care staff was inversely correlated with autonomy. \( r=-0.185 \ p<0.001 \)

Nurses and support workers were the most confident about their role in the team and social workers and others less so. The proportion of social care staff in the team was inversely related to role perception \( r=-0.154, \ p=0.008 \). The proportion of social care workers in the team was also inversely related to integration \( r=-0.227, \ p<0.001 \), training and career development \( r=-0.240, \ p<0.001 \), and teamwork \( r=-0.206, \ p<0.001 \), but social care input was unrelated to uncertainty, access to IT, role flexibility, management style and overall job satisfaction.

The psychological job demand subscale had to be transformed to render it normal. The results of untransformed and transformed data indicated that psychological job demands differed significantly between the professional groups \( F=10.67 \ (2, \ 282) \ p<0.001 \) and \( F=11.05 \ (3, \ 282) \ p<0.001 \) respectively. Post hoc analyses showed that support workers’ scores were significantly lower than social workers \( \text{mean difference} = -0.63 \ (-0.92, \ -0.33) \ p<0.001 \), nurses \( \text{mean difference} = -0.46, \ (-0.72, \ -0.19) \ p<0.001 \), and ‘other’ staff \( \text{mean difference} = -0.37 \ (-0.65, \ -0.21) \ p=0.024 \) but the latter difference became non-significant when Simes adjustments were applied.

Decision latitude also differed between the groups \( F=2.83, \ (3, \ 275) \ p=0.039 \) with support workers, as might be expected scoring lower than the other groups; nevertheless this difference became insignificant when the Simes procedure was applied.

Professional group differences were also observed in staff outcome variables relating to future work plans. Tests of original and transformed data identified significant differences in intention to leave the employer (original \( F=3.99, \ (3, \ 287) \ p=0.18 \) and transformed \( F=3.75, \ (3, \ 287) \ p=<0.01 \).

It was not possible to normalise the intention to leave the profession variable and the significant result of the ANOVA \( F=4.88 \ (3, \ 290) =0.003 \) was confirmed by nonparametric testing \( \chi^2 = 13.83, \ df \ 3 \ p=0.003 \). As one might expect, support workers were more likely to leave (probably to undertake other forms of professional training or higher paid jobs), scoring significantly higher than the score in the ‘other’ category. Social worker and nurse median scores were 20, while support workers scored 50 and ‘others’ 10.
The higher the proportion of social care staff in the team, the lower the intention to leave the profession, a result in the same direction as the last one but stronger ($r=-0.208$, $p<0.001$). Taken together the two suggest that those who are intending to leave are more likely to want to do so where the proportion of social care staff is lower.

4.2.10 Team culture and demography

There were no age or gender differences in overall job satisfaction and intention to leave. The only team culture subscales to show an age difference were role perception and psychological job demands. Workers who were under 25 years old had lower role perception scores compared to older workers (in both the original and transformed variables $F=4.86$ (4, 291) $p=0.001$; and $F=4.28$, (4, 291) $p=0.002$); similarly staff aged under 25 had lower psychological job demands than staff aged between 25 and 45 ($F=3.53$, df 4,279, $p=0.008$).

4.2.11 Integration and inter-professional working

Individuals rated how closely they work with other professional groups within and outside the mental health team using a scale that ranges from zero indicating that they did not work with that profession at all, to five indicating a very close working relationship with that staff group. They also provided ratings of the extent of role overlap between their own role and that of the same professional groups, using the same scale. Most variables were significantly skewed and could not be normalised using the appropriate transformation techniques, so these are analysed using non-parametric tests.

In the analyses that follow we focus on inter-professional working between different professional groups located within community mental health teams, to indicate the extent of integration in a practical sense within the mental health context. We also examine the working relationships between key staff groups within these teams and general practitioners operating outside the system in primary care, other nurses some of whom will be outside the mental health system and other health care professionals operating in the wider context. We do this in order to examine the extent of structural level integration, as defined in Section 3.2.

All team members reported some form of working relationship with a psychiatrist or some type of social worker, although five did not work with ASWs, and a different five did not work with non-ASW social workers. Overall, the vast majority reported having some form of working relationship with the key professional groups involved in mental health care.
with only three people not working with any nurses, four not working with CPNs, two not working with psychologists, six not working with GPs, nine not working with psychologists and 13 not working with OTs. Nevertheless, a reasonable proportion did not work with nurses who were not CPNs (18.5%, n=48), a finding that we will investigate further, later. As you might expect the proportion not working with staff groups outside of these core professions was considerably higher ranging from around 50% for dieticians and physiotherapists to 80% for geriatricians and 85% for podiatrists and speech and language therapists.

This is reflected clearly in Graph A presented in Figure 3. These radial graphs indicate the extent to which each staff group works closely with the other professions (in the black area) and the extent to which their own role overlaps with other professions (in the grey area). The larger the area covered the closer the working relationship or the extent of role overlap.

Graph A illustrates that overall, staff within community mental health teams work most closely and have more role overlap with fellow teams than with fellow health professionals operating outside the mental health field. Working relationships with general practitioners and to a lesser extent nurses (who may also operate in primary care settings) were closer than for other allied specialisms. Given the lack of integration with the profession that are largely unrelated to the mental health field, further analyses focus upon the core staff groups, including GPs and other nurses. Graph B is presented to facilitate comparisons with other presented later in this section.

Both graphs in Figure 3 show that Approved Social Workers, non-approved social workers, CPNs and support workers work very closely together. Inter-professional working relationships with occupational therapists, psychologists and psychiatrists are slightly less close, but nevertheless the findings suggest that on a practical level community mental health services (at least in the locations being studied) are reasonably well integrated. Working relationships with other nurses and general practitioners are less well established averaging 2.3 and 2.8 respectively, but still suggest some integration at a structural level, particularly with the services that are most involved in mental health care.

Figure 3 also demonstrates considerable overlap between roles within community mental health teams. Approved social worker, CPN, other social worker and support worker roles overlap considerably, while there is slightly less overlap with OT, psychologist and psychiatrist roles.
Figure 3: Inter-professional working and role overlap in the whole sample

Graph A

Graph B
Graph A illustrates that overall, staff within community mental health teams work most closely and have more role overlap with fellow teams than with fellow health professionals operating outside the mental health field. Working relationships with general practitioners and to a lesser extent nurses (who may also operate in primary care settings) were closer than for other allied specialisms. Given the lack of integration with the profession that are largely unrelated to the mental health field, further analyses focus upon the core staff groups, including GPs and other nurses. Graph B is presented to facilitate comparisons with other presented later in this section.

Both graphs in Figure 3 show that Approved Social Workers, non-approved social workers, CPNs and support workers work very closely together. Inter-professional working relationships with occupational therapists, psychologists and psychiatrists are slightly less close, but nevertheless the findings suggest that on a practical level community mental health services (at least in the locations being studied) are reasonably well integrated. Working relationships with other nurses and general practitioners are less well established averaging 2.3 and 2.8 respectively, but still suggest some integration at a structural level, particularly with the services that are most involved in mental health care.

Figure 3 also demonstrates considerable overlap between roles within community mental health teams. Approved social worker, CPN, other social worker and support worker roles overlap considerably, while there is slightly less overlap with OT, psychologist and psychiatrist roles.

Nevertheless, Table 16 indicates that with the exception of staff groups that are or might be located outside of the mental health context (GPs and other nurses) the proportion of staff reporting that their own role did not overlap at all with the ASW role was higher, (albeit slightly) than the proportion reporting no overlap with psychiatrists’ roles who also held statutory powers and psychologists; the proportion reporting no role overlap with non-ASW social workers (and CPNs) was considerably lower than for ASWs suggesting that it is likely to be that statutory function that mediates role overlap with ASWs. This raises questions about the nature of the social work role in mental health teams now, since that function has been opened up to other professionals within the team.
### Table 16. Proportion of sample with no overlapping role

<table>
<thead>
<tr>
<th>Role</th>
<th>No overlap (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>30 (11.9%)</td>
</tr>
<tr>
<td>GP</td>
<td>98 (38.1%)</td>
</tr>
<tr>
<td>CPN</td>
<td>15 (5.7%)</td>
</tr>
<tr>
<td>Other nurse</td>
<td>85 (35.0%)</td>
</tr>
<tr>
<td>OT</td>
<td>23 (9.0%)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>27 (10.3%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>12 (4.7%)</td>
</tr>
<tr>
<td>ASW</td>
<td>37 (14.4%)</td>
</tr>
<tr>
<td>Support Worker</td>
<td>22 (9.0%)</td>
</tr>
</tbody>
</table>

#### 4.2.12 Location comparisons

Location comparisons also indicate that in the main most professional groups involved in the delivery of mental health care, work closely together. Each location had staff who did not work with non-CPN nurses and there was a non-significant trend to this being more likely in locations A (n=18, 25.4%) and D (n=14, 24.1%) than in B (n=9, 15%) and C (n=7, 10%); $\chi^2=7.27$ (df 3) $p=0.064$, Cramer’s $V =0.17$. All four people not working with a CPN were based in location B and the three not working with nurses were in C; eight of the nine not working with support workers were also based in location B (with one in location A). Six of the 13 who had no working relationship with OTs were based in location C with another six in location D and one in B. Finally three of the five not working with ASWs were in location B and two in D, as were four of the five having no working relationship with non-ASW social workers. These location differences were statistically significant ($p<0.05$) but are not being treated as important due to the small numbers and a failure to meet the expected cell count assumption of the analysis.

Radial graphs for the four locations included in Phase II (Figure 4) suggest that inter-professional working relationships and role overlap operate differently in different locations. While ASWs usually work most closely with CPNs, other social workers and support workers, in the same way as outlined for the sample as a whole, the extent of that close working varies notably. Statistically significant location differences were observed for all staff groups.
In location C there are extremely close working relationships between most staff groups, particularly CPNs and other social workers, but also with OTs, psychologists and psychiatrists, suggesting that teams are well integrated at a practical level. Trusts B and D seem to be integrated to a similar extent at a practical level in that their area coverage are very similar, with less close working relationship with support workers in location B being offset by closer working relationships with psychiatrists. Location A is clearly the least integrated of the teams, at a practical and structural level.

In locations A and B, staff work significantly less closely with support workers than locations C and D. This support function might be provided by OTs and other nurses in location B where staff worked significantly more closely with OTs compared to other locations, but it is not clear who provides this supporting role for service users in location A. These findings raise questions about the nature of these roles and the comparative availability of these staff in different locations (see Chapter 5 – Final discussion).

In contrast, Trust C and to a lesser extent Trust B appear to have closer working relationships with GPs and other nurses suggesting better structural level integration compared to locations A and D; significance tests based on ANOVA indicate that there are indeed closer working relationships with other nurses in locations B and C compared to location A, and with GPs in location C compared to A, but not D.

Role overlap is clearly greater in location C than in all of the other locations. Location C differed significantly from most others in relation to overlap with nurses that are not CPNs, ASWs and psychiatrists, and support workers (compared to B only) even when Simes adjustments were applied, indicating closer working in location C in all instances.

---

1 F=7.02 (3, 286) p=0.000; A cf B p=0.003, A cf C p=0.019, B cf D p=0.004, C cf D p=0.022
2 χ²=21.81 (df 3) p=0.000
3 χ²=10.84 (df 3) p=0.013
4 F=7.65 (df 3, 278) p=0.000; C cf A p=0.000, cf D p=0.015
5 F=6.07 (df 3, 278) p=0.001; A cf 3 p=0.000
6 χ²=19.31 (df 3) p=0.000;
7 F=8.75 (df 3, 253) p=0.000; cf A and D p=0.000, cf B p=0.000
8, 9 F=2.84 (df 3, 241) p=0.039; cf B only p=0.045
Figure 4. Inter-professional working and role overlap by location
4.2.13 Professional group comparisons

Given the subject of this research and the preponderance of nursing, support and social work staff within mental health teams, we have selected these professional groups for inclusion in further analyses.

Comparison of the four diagrams presented in Figure 5 suggest that ASWs work more closely with more staff groups than non-ASW social workers, CPNs and social support workers. Although the area of the ASW graphs are slightly larger than the other staff groups, their shape are similar for both sets of social worker and CPNs; nevertheless ASWs appear to work slightly more closely with GPs than the other staff groups, which might have something to do with their statutory functions under the mental health acts. The main differences between the four graphs is in the way that support workers interact with health staff, working less closely, as one might expect, with psychiatrists, GPs and other nurses (although they are not dissimilar to non ASW social workers in that regard).

The area of the role overlap graph for ASWs is larger than for the other three groups, all of which were very similar, suggesting that the ASW role overlaps more with others, than the other key staff groups within mental health teams. The shape of the graphs vary for each staff group, demonstrating different patterns of role overlap, mirroring to a large extent the shape of the close working relationship graph for CPNs, but less so for the other professions. ASW and CPN roles overlap more with psychologists than either non-ASW social workers or support workers, and in these data at least, ASWs roles overlap less with support workers than either CPNs or other social workers. Again, the assumption is that the distinguishing factor is the statutory function. Understandably, ASWs report significant role overlap with other social workers and CPNs, but interestingly, ASW ratings were in excess of one whole scale point higher (+1.1 and +1.16 respectively) than their counterparts, suggesting that the ASWs recognise that their role is not limited to their statutory duties whereas others do not. Although ASW ratings of agreement with feeling threatened by the amount that others' roles overlap with their own were significantly higher than those for nurses when all other staff groups were excluded from analysis (F=2.63, (df 4, 193) p=0.036, this finding was not upheld in non-parametric analysis nor analyses using appropriately transformed data.
Figure 5. Inter-professional working and role overlap by professional group
Although these results indicate apparent differences in the close working relationships with CPNs and other nurses in actual fact the number of non-CPN nurses is very small (n=11, 8% of all nurses). On this basis all nurses are grouped together in the analyses that follow, in order to optimise the number of cases to variables included in the regression models. Similarly, ASWs and other social workers have been combined in one group (for the same reason) on the basis that their patterns of close working and role overlap are similar. The results that follow are almost identical to those of models that did separate the distinct groups.

4.3 Multivariate Analysis

4.3.1 Integration

Integration scores were normally distributed and so did not require transformation. In order to determine what factors were associated with higher integration (better) scores a series of regression analyses were undertaken in which conceptually or theoretically important factors were controlled for.

The initial model controlled for the age, gender and professional group of each respondent, none of which were significantly associated independently with integration ratings (F 5, 285=0.08, p =0.996) and the model was unable to explain any of the variance in integration itself.

Professional group was retained in the next model in which WDQ ratings for autonomy, role perception and flexibility, teamwork, management, training and career opportunities, and uncertainty were included alongside Karasek JCQ items for decision latitude, social support and psychological job demands, and four separate items relating to how closely team members worked with nurses and social workers, and how much other team roles overlapped with nursing and social work. This interim model explained 23.5% of the variance in integration (17.4% when adjusted; F 17, 216 = 3.89, p=0.000), with autonomy and management being associated significantly with better integration ratings, and job demands and uncertainty emerging as trends. When area and team level indicators of team size, team typology (six-item), CMHT status and co-location were added the amount of variance explained increased to 37.7%. 
Table 17. Regression models: WDQ integration

<table>
<thead>
<tr>
<th>Variance explained</th>
<th>Explanatory variables</th>
<th>$\beta$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2 = 0.338$</td>
<td>Not being in a CMHT</td>
<td>-0.38</td>
<td>0.000</td>
</tr>
<tr>
<td>$AR^2 = 0.296$</td>
<td>Better management</td>
<td>0.29</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Not being a nurse, social worker or support worker</td>
<td>0.11</td>
<td>0.043</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>-0.10</td>
<td>0.071</td>
</tr>
</tbody>
</table>

Possible interaction effects between team typology and independent variables

<table>
<thead>
<tr>
<th>Team typology 1: Social care component &lt;20%</th>
<th>Explanatory variables</th>
<th>$\beta$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2 = 0.285$</td>
<td>Not being in a CMHT</td>
<td>-0.31</td>
<td>0.011</td>
</tr>
<tr>
<td>$AR^2 = 0.196$</td>
<td>Better management</td>
<td>0.29</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td>Support worker cf nurses</td>
<td>-0.22</td>
<td>0.059</td>
</tr>
<tr>
<td></td>
<td>Co-location &amp; Location D dropped</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team typology 2: Social care component 20 - 40%</th>
<th>Explanatory variables</th>
<th>$\beta$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2 = 0.459$</td>
<td>Not being in a CMHT</td>
<td>-0.59</td>
<td>0.000</td>
</tr>
<tr>
<td>$AR^2 = 0.408$</td>
<td>Better management</td>
<td>0.38</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Not being a nurse, social worker or support worker</td>
<td>0.24</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Support worker cf nurse</td>
<td>-0.13</td>
<td>0.099</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team typology 3: Social care component &gt;40%</th>
<th>Explanatory variables</th>
<th>$\beta$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2 = 0.409$</td>
<td>More autonomy</td>
<td>0.46</td>
<td>0.008</td>
</tr>
<tr>
<td>$AR^2 = 0.291$</td>
<td>Not being a nurse, social worker or support worker</td>
<td>0.37</td>
<td>0.019</td>
</tr>
<tr>
<td></td>
<td>Support worker cf nurse</td>
<td>0.32</td>
<td>0.046</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>-0.33</td>
<td>0.054</td>
</tr>
<tr>
<td></td>
<td>Better management</td>
<td>0.24</td>
<td>0.073</td>
</tr>
<tr>
<td></td>
<td>Social Worker cf nurse</td>
<td>0.24</td>
<td>0.095</td>
</tr>
<tr>
<td></td>
<td>CMHT and locations C &amp; D dropped</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Normal distribution and no outlying residuals.
Final model includes: autonomy, management, job demands, professional group area, team typology, co-location, team size and CMHT status.

(29.2% adjusted, $F_{28, 205} = 4.44$, $p=0.000$). At this point most individual level variables became insignificant and membership of a new team and not a CMHT emerged as a significant explanatory factor. Area and team typology were not associated with integration.
In order to meet the sample size requirement a final model (outlined in Table 17) that controlled only for team culture and climate factors that were associated significantly (or with a trend p<0.10) with integration in the second model, plus area and team level indicators was fitted. This confirmed that new teams are significantly more integrated (or perceived to be by staff) than CMHTs, and that integration is better where management is strong. Higher ratings by staff other than nurses, social workers and support workers (i.e. doctors, psychologists and others) might be interpreted as meaning that these staff, who tend to work part-time and are present in small numbers) are less aware of the true level of integration operating within the team, or perceive it to be better because staff members have to work closely with them because they are in short supply. Also a non-significant trend towards fewer job demands where integration is better, suggests that close working can reduce pressures on individuals and staff groups.

Due to interaction effects between team typologies separate models were fitted for each of the three types that included only the significant factors (or non-significant trends) identified in the whole sample model, obviously minus the confounding team typology variable (in order to reduce error due to inadequate sample size).

Although the model is less robust for team typologies 1 and 3 than for team type 2 (and so should be treated with some caution), the factors associated with integration did appear to be similar in all three team types. It’s of interest that while there is a non-significant trend towards lower ratings of integration among support workers where the social care component is very low and to a lesser extent where team composition is more mixed, their ratings for integration are significantly higher where the social care component is high. It appears that fewer job demands might be related (non-significant trend) to better integration only in the teams with a higher social care component, where having more autonomy also emerges as a factor related to better integration; the team function and the two locations with less social care input were dropped from these analysis, suggesting that if valid these results are only generalisable to non-CMHTs in teams with a high social care component.

4.3.2 Teamwork

Initial models of team-working suggested that it was not associated with personal characteristics, nor close working with other professionals or overlapping roles with other professionals. These models did suggest that teamwork was associated with team culture and climate variables relating to autonomy, role perception and flexibility, management, job demands and social support, but team-working was not associated with integration, uncertainty, training or decision latitude.
A final model including autonomy, role perception, role flexibility, management style, psychological job demands, social support (co-worker and supervisor support combined), team typology (social care composition), team size, co-location, CMHT status and area was then fitted.

This model, presented in Table 18, explained around 70% of the variance in the sample as a whole. It suggested that the only integration related variables making a statistically significant contribution to the explanation of higher teamwork scores was not being co-located, hardly a positive finding! Team culture and climate variables had a stronger and more positive influence, with better team-working being related to greater role perception and flexibility, better management and social support. In addition where team-working is good, job demands appear to be lower.

There appeared to be significant interaction effects between the team typology variable and team-working, so regression models were fitted for each of the three team types but again including only the variables that had emerged as significant in the whole sample.

The imbalanced models need to be treated with some caution because they are still underpowered but they do appear to have face validity, in that the results are understandable.

The models were somewhat similar in each of the three groups, with up to six variables explaining between two-thirds and three-quarters of the variance in team-working. Having a clear understanding of each others’ roles, greater flexibility within roles and management style were important in the three groups.

Co-location did not enter either of the imbalanced models due to most or all teams being co-located in those groups, but being co-located was associated with lower teamwork scores where team composition was more balanced.

There was a negative association between high job demands and good teamwork where social care composition is imbalanced (whether high or low) but not where it is balanced.

Social support is not associated with teamwork where the social care composition dominates, but it is in other team types.
Finally having more autonomy was associated with better team working in an imbalanced team but not where the balance between health and social care was more equal.

**Table 18 Regression models: WDQ Teamwork**

<table>
<thead>
<tr>
<th>Variance explained</th>
<th>Explanatory variables</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>( R^2 = 0.710 )</td>
<td>Greater role perception</td>
<td>0.33</td>
<td>0.000</td>
</tr>
<tr>
<td>( AR^2 = 0.685 )</td>
<td>Better management</td>
<td>0.31</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Greater role flexibility</td>
<td>0.20</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Greater social support</td>
<td>0.22</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Not co-located</td>
<td>-0.11</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>-0.11</td>
<td>0.004</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Significant interaction effects between team typology and independent variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team typology 1: Social care component &lt;20%</td>
<td>Greater role perception</td>
<td>0.32</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Better management</td>
<td>0.30</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Greater role flexibility</td>
<td>0.24</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Greater social support</td>
<td>0.17</td>
<td>0.024</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>-0.17</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>Co-location dropped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( R^2 = 0.690 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( AR^2 = 0.671 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team typology 2: Social care component 20 - 40%</td>
<td>Greater role perception</td>
<td>0.38</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Better management</td>
<td>0.32</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Greater role flexibility</td>
<td>0.20</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Greater social support</td>
<td>0.26</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Not co-location</td>
<td>-0.19</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>0.00</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Co-location dropped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( R^2 = 0.725 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( AR^2 = 0.712 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team typology 3: Social care component &gt;40%</td>
<td>Better management</td>
<td>0.34</td>
<td>0.006</td>
</tr>
<tr>
<td></td>
<td>Greater role perception</td>
<td>0.33</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>Greater role flexibility</td>
<td>0.27</td>
<td>0.012</td>
</tr>
<tr>
<td></td>
<td>Fewer job demands</td>
<td>-0.23</td>
<td>0.012</td>
</tr>
<tr>
<td></td>
<td>Greater social support</td>
<td>0.17</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Co-location dropped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>( R^2 = 0.675 )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( AR^2 = 0.636 )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No outlying residuals
4.3.3 Perceived Quality of Care

The perceived Quality of Care variable was significantly skewed and required a reflect square root transformation to normalise its distribution. The model produced very similar results to that using untransformed data but more significant factors were identified in the transformed data that did not transgress the assumption of normality so in this instance the transformed data are presented; please note that negative beta coefficients due to the reflect procedure\(^1\) indicate positive associations in the regression models. Initial models of quality of care suggested that social workers rated quality of care lower than nurses and that team climate and culture variables relating to autonomy, management and job demands were related to quality of care. Perceived quality of care was not associated with integration scores, working closely with nurses and social workers, training and career opportunities or other team culture and climate indicators.

A final model that included only significant and conceptually important variables was constructed using team culture and climate variables for autonomy, team-working, management, job demands, role overlap with nurses and social workers, area, team typology, team size, co-location and CMHT status.

Table 19 shows that in the sample as a whole and in all team typology groups, quality of care was associated significantly with better teamwork and management. Perceived quality of care (QOC) also appeared to be better where there was a high proportion of social care staff in the team. One explanation would be that social workers and social care workers rate quality of care higher than other staff, but the initial regressions showed that this was not the case and that social workers actually rate quality of care slightly lower than other staff; social care support workers did not differ from other staff in their ratings.

Due to interaction effects between team typologies, models that included only the significant effects in the overall sample were fitted for each of the three team typologies as before. Although again underpowered (for typologies 1 and 3) the results suggested that the non-significant trend towards better quality of care where other roles overlap more with social work was found to be limited to teams where there is a relative balance between health and social care composition, perhaps suggesting skill-sharing that contributes to downward substitution to support worker roles or role transference to other staff. In contrast to the integration model in which more autonomy was associated with more integration in social care dominated teams, there was a non-significant trend towards better quality of care where role autonomy was lower. This could have resulted from the

\(^1\) calculated as SQRT (K – original variable) where K equals the largest possible value plus 1

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Project 08/1619/114
fact that support workers have less autonomy than other workers, but their presence in the team contributed to a better perception of the quality of care (univariate analyses suggested that support workers rate QOC more highly but this effect did not emerge in early regression models).

Table 19. Regression models: WDQ Perceived Quality of Care

<table>
<thead>
<tr>
<th>Variance explained</th>
<th>Explanatory variables</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>R² = 0.526</td>
<td>Better teamwork</td>
<td>-0.56</td>
<td>0.000</td>
</tr>
<tr>
<td>AR² = 0.484</td>
<td>&gt;60% social care in team</td>
<td>-0.23</td>
<td>0.011</td>
</tr>
<tr>
<td></td>
<td>Better management</td>
<td>-0.19</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>Larger team size</td>
<td>-0.15</td>
<td>0.080</td>
</tr>
<tr>
<td></td>
<td>40-60% social care in team</td>
<td>-0.14</td>
<td>0.090</td>
</tr>
<tr>
<td></td>
<td>Less autonomy</td>
<td>0.11</td>
<td>0.057</td>
</tr>
<tr>
<td></td>
<td>More overlap with social work role</td>
<td>-0.11</td>
<td>0.076</td>
</tr>
</tbody>
</table>

Significant interaction effects between team typology and independent variables

<table>
<thead>
<tr>
<th>Team typology 1: Social care component &lt;20%</th>
<th>Better teamwork</th>
<th>Better management</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>R² = 0.534</td>
<td></td>
<td></td>
<td>-0.42</td>
<td>0.000</td>
</tr>
<tr>
<td>AR² = 0.504</td>
<td></td>
<td></td>
<td>-0.41</td>
<td>0.000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team typology 2: Social care component 20 - 40%</th>
<th>Better teamwork</th>
<th>Better management</th>
<th>Less autonomy</th>
<th>More overlap with social work role</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>R² = 0.511</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.55</td>
<td>0.000</td>
</tr>
<tr>
<td>AR² = 0.492</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.21</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.13</td>
<td>0.045</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.11</td>
<td>0.085</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team typology 1: Social care component &gt;40%</th>
<th>Better teamwork</th>
<th>Larger team size</th>
<th>Less autonomy</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>R² = 0.580</td>
<td></td>
<td></td>
<td></td>
<td>-0.91</td>
<td>0.000</td>
</tr>
<tr>
<td>AR² = 0.531</td>
<td></td>
<td></td>
<td></td>
<td>-0.34</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.20</td>
<td>0.070</td>
</tr>
</tbody>
</table>

All models reflect square-root transformed hence negative symbol for positive result
4.3.4 Perceived job satisfaction

Perceived job satisfaction was significantly skewed but not normalisable by any form of transformation. Consequently this model is somewhat flawed because it does not meet the assumption of normality. Nevertheless, we can have some confidence in the findings because a binary logistic regression model that sought to explain above average job satisfaction produced very similar results, with the exception of uncertainty and training, which were not significantly associated with the binary variable.

Initial models of job satisfaction indicated that no personal characteristic variables explained job satisfaction, and only training and career opportunities and job demands of the team culture and climate variables were associated with it. Close working with nurses was also associated significantly with job satisfaction. Non-significant trends towards higher satisfaction where management was good and where there was more overlap with nursing roles were also observed, in these early models.

A final model was fitted that included significant and conceptually important variables, namely integration, management, training and career opportunities, job demands, close working with nurses, overlap with nursing roles, professional group, area, team typology, co-location, decision latitude, uncertainty and role flexibility.

This model (presented in Table 20) indicated that higher job satisfaction was associated significantly with team culture and climate and to a limited extent integration. Specifically higher job satisfaction was associated with fewer psychological job demands, working closely with nurses, better management, having more decision latitude, a bit of uncertainty, less overlap with the nursing role, better training and career development opportunities and being co-located; no other integration related variables were associated with it. There was a trend towards lower scores in one location.

Separate models for each team typology were fitted following the same principles of significance and conceptual importance as outlined previously. Splitting the models in this way failed to produce a robust model for teams with a high social care component, which were all located in one area. The models were rather dissimilar in the other two typologies being associated with fewer job demands in both but that’s where the commonality ends.
### Table 20. Regression models: WDQ Perceived job satisfaction

<table>
<thead>
<tr>
<th>Variance explained</th>
<th>Explanatory variables</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2 = 0.513$</td>
<td>Fewer job demands</td>
<td>-0.35</td>
<td>0.000</td>
</tr>
<tr>
<td>$AR^2 = 0.461$</td>
<td>Working closely with nurses</td>
<td>0.28</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Better management</td>
<td>0.21</td>
<td>0.001</td>
</tr>
<tr>
<td></td>
<td>More decision latitude</td>
<td>0.18</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>More uncertainty</td>
<td>0.15</td>
<td>0.006</td>
</tr>
<tr>
<td></td>
<td>Less overlap with nurse role</td>
<td>-0.16</td>
<td>0.010</td>
</tr>
<tr>
<td></td>
<td>Better training &amp; career opps</td>
<td>0.12</td>
<td>0.044</td>
</tr>
<tr>
<td></td>
<td>Being co-located</td>
<td>0.14</td>
<td>0.050</td>
</tr>
<tr>
<td></td>
<td>Location B cf Location A</td>
<td>-0.15</td>
<td>0.068</td>
</tr>
</tbody>
</table>

#### Significant interaction effects between team typology and independent variables

| Team typology 1: Social care component <20% | Fewer job demands | -0.48 | 0.000  |
|                                             | Better training & career opps                  | 0.36  | 0.000  |
|                                             | Greater role flexibility                       | 0.25  | 0.022  |
|                                              | Less overlap with nurse role                   | -0.24 | 0.055  |
|                                              | More uncertainty                               | 0.20  | 0.058  |
|                                              | Location B & collocation dropped               |       |        |

| Team typology 2: Social care component 20 - 40% | Fewer job demands | 0.35  | 0.000  |
|                                                | Working closely with nurses                     | 0.31  | 0.001  |
|                                                | Better management                               | 0.26  | 0.005  |
|                                                | Being co-located                                | 0.18  | 0.024  |
|                                                | Greater decision latitude                       | 0.17  | 0.065  |
|                                                | Location B cf Location A                        | -0.14 | 0.094  |

| Team typology 3: Social care component >40%     | Failed to fit a model                           |       |        |

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Inadequate sample size and the dropping of some variables due to a lack of variance in the model for team type 1 suggests that these results should be treated with some caution and perhaps are only relevant to teams that are not co-located. Nevertheless, it did appear that where the social care component is very low, job satisfaction is also associated with better training, greater role flexibility, less overlap with the nursing role (perhaps indicating that specific skills are used more appropriately in teams of this type) with a trend towards uncertainty.

Where team composition is more balanced (or at least the social care contribution is in less short supply) job satisfaction is associated with working closely with nurses, better management and being co-located, with a trend towards higher satisfaction where more decision latitude is present.

**4.3.5 Intention to leave**

The intention to leave the employer variable was also significantly skewed and required log transformation. The results were identical to those for non-transformed data so for ease of interpretation the latter are presented here. Unlike previous models this was fitted in four blocks rather than three in order to observe the effect of job satisfaction, which can dominate models of this type.

Initial models suggested that intention to leave the employer within twelve months was not associated with demography but was associated professional groups and four of the eight process indicators of team culture and climate variables - role perception, training and career opportunities, uncertainty, and integration. These factors continued to contribute to the explanation of future work plans when overall job satisfaction was controlled for, but the influence of uncertainty and integration became insignificant when area and team related indicators were controlled for.

A final model was fitted that included role perception, uncertainty, professional group, job satisfaction, location, team typology, team size, co-location and CMHT status. This model presented in Table 21 indicated that the integration related findings of these early models were confounded with location and team related variables and became insignificant when these factors were controlled for. It also suggested that two team culture variables had a positive effect on intention to leave the employer. Staff were less likely to intend leaving where there were better training and career opportunities, higher job satisfaction and conversely where role perception was poor, perhaps indicating that where this was the case staff do not have the confidence to move on. Intent to leave was also less where staff were located in CMHTs and larger teams. Social workers were more likely than nurses to want to leave their employer, even when other
mitigating circumstances are controlled for. This finding is concerning given the already small numbers of social workers in mental health teams, and the potential lack of capacity to deliver on the New Horizons policy that already exists, especially given a non-significant trend in univariate analysis towards social workers being more likely than ‘other’ staff to intend to leave the profession within a year.

Table 21. Regression models: Intention to leave the employer

<table>
<thead>
<tr>
<th>Variance explained</th>
<th>Explanatory variables</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>R² = 0.422</td>
<td>Less likely if in CMHT</td>
<td>-0.51</td>
<td>0.000</td>
</tr>
<tr>
<td>AR² = 0.376</td>
<td>Less likely - larger team size</td>
<td>-0.23</td>
<td>0.019</td>
</tr>
<tr>
<td></td>
<td>Less likely – better training</td>
<td>-0.17</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>Less likely – higher job satisfaction</td>
<td>-0.17</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>Less likely – poor role perception</td>
<td>0.16</td>
<td>0.007</td>
</tr>
<tr>
<td></td>
<td>Social Worker more likely than nurses</td>
<td>0.13</td>
<td>0.021</td>
</tr>
<tr>
<td></td>
<td>Less likely in Location C</td>
<td>-0.18</td>
<td>0.089</td>
</tr>
</tbody>
</table>

Significant interaction effects between team typology and independent variables

| Team typology 1: Social care component <20% | Less likely if in CMHT | -0.64 | 0.000 |
|                                             | Social Worker more likely than nurses                       | 0.20  | 0.027 |
|                                             | Support workers more likely than nurses                     | 0.16  | 0.056 |
| R² = 0.551 AR² = 0.498                      |                                                            |      |      |

| Team typology 2: Social care component 20 - 40% | Less likely if in CMHT | -0.39 | 0.000 |
|                                                | Less likely – higher job satisfaction                       | -0.17 | 0.047 |
|                                                | Less likely – poor role perception                          | 0.18  | 0.049 |
|                                                | Support workers less likely than nurses                     | -0.14 | 0.088 |
| R² = 0.363 AR² = 0.314                        |                                                            |      |      |

| Team typology 3: Social care component >40%   | Less likely – higher job satisfaction                       | -0.39 | 0.009 |
|                                                | Less likely – more uncertainty                              | -0.32 | 0.028 |
|                                                | Less likely – better training                               | -0.28 | 0.063 |
|                                                | Less likely – poor role perception                          | 0.27  | 0.072 |
The models for different team typologies were quite different, with the exception of the effect of CMHT in typologies 1 and 2, and job satisfaction and poor role perception in typologies 2 and 3. Again error associated with inadequate sample sizes in the less balanced team models should be considered when interpreting these findings. Nevertheless, there is a clear face validity to a model that indicates that social care staff are more likely to have plans to leave teams in which they form the minority group by far. The findings for the social care dominated teams may be less easily interpreted, but suggest that having access to better training and being subject to more uncertainty are related to plans to leave.\textsuperscript{(14)}

Role perception and job satisfaction are associated with job intentions in team types two and three only. The training effect is limited to teams with a high proportion of social care staff.

4.4 Service user interviews

Locations were selected on the basis that one had just below the Phase II average proportion of social care workers in the teams (Location A), and the other (Location D) had almost double the average. Data were supplied by seven teams, three in D and four in A. Forty-five service users responded (n=26 from A and n=19 from D), and 68.1\% were female. 96\% were white. The three teams from location D came from a large rural county in northern Britain, where the teams were based in centres of population. The four location A teams were all part of one large service covering a major city plus its rural surroundings. This means that the comparison of A and D services is also an urban-rural comparison.

4.4.1 Service User Questionnaire (SUQ)

The length of contact with the team was different, but not significantly so. Over a third of A’s service users and a quarter of D’s had been in contact for more than ten years, but only eleven percent of D’s service users had been in contact for between 6 and 10 years compared to almost a quarter of the service users in location A.
Table 22. Contact details (SUQ)

<table>
<thead>
<tr>
<th>Variable</th>
<th>A</th>
<th>D</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion in contact over 10 years</td>
<td>9 (34.6)</td>
<td>5 (27.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Proportion seen in the last week</td>
<td>17 (68.0)</td>
<td>11 (61.1)</td>
<td>NS</td>
</tr>
<tr>
<td>Proportion seen more than 4 months ago</td>
<td>5 (20%)</td>
<td>0 (0.0)</td>
<td>($\chi^2 = 20.6$, df1, p&lt;0.001)</td>
</tr>
</tbody>
</table>

There were a number of other differences between the teams. As expected, because they had been purposively selected to differ in composition, care coordinators were more likely to be nurses in A (n=19, 76%) than in D (n=11, 61.1%).

Satisfaction with services was also different, with the majority of service users in A being very satisfied with the way the staff worked as a team (n=17, 68%) and the majority in D being either mostly satisfied or dissatisfied ($\chi^2 = 24.5$, df1, p<0.001). This finding is the opposite of what we expected to find based on previous work reporting the advantages of integrated working. The same is the case in respect of needs being met. One has, however, to bear in mind the small sample size and the possibility of selection bias.

Table 23. Satisfaction with care received – SUQ

<table>
<thead>
<tr>
<th>Variable</th>
<th>A</th>
<th>D</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received excellent care</td>
<td>13 (50%)</td>
<td>7 (38.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Very satisfied with the way the staff work as a team</td>
<td>17 (68.0)</td>
<td>6 (33.3)</td>
<td>($\chi^2 = 24.5$, df1, p&lt;0.001)</td>
</tr>
<tr>
<td>Yes enough say in care and treatment</td>
<td>19 (73.1)</td>
<td>11 (61.1)</td>
<td>NS</td>
</tr>
<tr>
<td>Almost all needs are met</td>
<td>16 (61.5)</td>
<td>6 (33.3)</td>
<td>($\chi^2 = 14.6$ df1, p&lt;0.001)</td>
</tr>
</tbody>
</table>
4.4.2 MANSA – Manchester Short Assessment of Quality of Life

Wanting change and restricted opportunities

The MANSA covers ten life domains (accommodation, safety, leisure, living situation, social life, relationships, family, income, health and mental health).

Within each of the MANSA life domains, the respondent is asked whether they want circumstances in that domain to be improved, and then if they want improvement, they are asked if they feel that their opportunities to produce improvement are restricted in any way.

Understandably, the area requiring most attention, in their view, was their health, with only eight people appearing to be content with their current health status. All twenty-four of the people wanting improved health felt that their chances of attaining improvement were restricted in some way.

Quite a large proportion of people had no leisure activities at all (45.5%, n=20). Unsurprisingly, almost three-quarters of the respondents wanted to improve their leisure activity. A similar proportion wanted to improve their financial situation.

As in other samples of people with long term mental health problems, most people were not in any form of full or part time work, only two reported themselves as working currently (4.4%), one in location A and one in D. Improvements in the work domain were only wanted by just under half of the sample (n=21, 46.6%), and opportunities for work were restricted for almost three-quarters of those who wanted to improve their lives in this respect (n=16, 72.7%).

Three-fifths of the sample did not want improvements to their personal safety but half wanted improved accommodation (n=25, 55.6%) and almost two-thirds wanted an improved social life (n=29, 64.4%). These findings are consistent with the CUES data and free text data described later in the report.

Many people (46.6%, n=21) lived alone, but most people (86.7%, n=39) had daily or weekly contact with family and friends; only two people reported no family contact at all and most (80%, n=36) had at least one close friend.
We compared these MANSA results for locations A and D and mostly found no significant differences, summarised in Table 24.

**Table 24. MANSA: Proportion wanting change and restricted opportunities by locations A (n=26) and D (n=19)**

<table>
<thead>
<tr>
<th>Wanting improvements in</th>
<th>A n (%)</th>
<th>D n (%)</th>
<th>χ² (df) p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>22 (88.0)</td>
<td>19 (100.0)</td>
<td>NS</td>
</tr>
<tr>
<td>Leisure</td>
<td>18 (75.0)</td>
<td>13 (68.4)</td>
<td>NS</td>
</tr>
<tr>
<td>Finances</td>
<td>16 (69.6)</td>
<td>16 (84.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Family</td>
<td>17 (68.0)</td>
<td>12 (63.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Social life</td>
<td>17 (65.4)</td>
<td>12 (63.2)</td>
<td>NS</td>
</tr>
<tr>
<td>Work</td>
<td>8 (36.4)</td>
<td>14 (73.7)</td>
<td>χ²= 27.66, (1) p&lt;0.001</td>
</tr>
<tr>
<td>Safety</td>
<td>10 (40.0)</td>
<td>7 (38.9)</td>
<td>NS</td>
</tr>
<tr>
<td>Accommodation</td>
<td>15 (57.7)</td>
<td>10 (52.6)</td>
<td>NS</td>
</tr>
<tr>
<td>Living situation</td>
<td>9 (36.0)</td>
<td>8 (42.1)</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Experiencing restricted opportunities in**

| Health                  | 13 (52.0) | 11 (57.9) | NS |
| Leisure                 | 14 (56.0) | 14 (73.3) | χ²= 5.59 (1) p=0.02 |
| Finances                | 11 (47.8) | 8 (42.1) | NS |
| Family                  | 11 (44.0) | 12 (63.2) | χ²= 6.51 (1) p=0.01 |
| Social life             | 15 (57.7) | 11 (7.9) | NS |
| Work                    | 11 (55.0) | 11 (57.9) | NS |
| Safety                  | 7 (28.0)  | 5 (27.8) | NS |
| Accommodation           | 10 (38.5) | 7 (38.9) | NS |
| Living situation        | 9 (36.0)  | 8 (42.1) | NS |

- When Simes’ adjustment for multiple testing is made this becomes non-significant
- Any discrepancies in % caused by missing data

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A distinct pattern emerges in Table 2, which suggests that there was more unmet need in location A in certain areas and more unmet need in D in others.

Significantly more people in D wanted improvements in their work situation (all bar one were unemployed), and more found restrictions to improved leisure and family life. These may be related to the geography of D.

Although not significant, it appeared that D respondents (in comparison with A) wanted more health improvements, to improve their finances. Location A respondents more often wanted improved accommodation. Some of the reasons for these differences emerge in the free text responses later.

**MANSA Subjective well-being**

Subjective ratings on the MANSA are made in each of the life domains, on the Delighted – Terrible (D–T) seven-point scales. All of these were normally distributed.

Figure 6 compares the domain satisfaction scores on the D–T scale with the data from the National Psychiatric Morbidity Survey (NPMS)\(^{(146)}\). The data from location A mirrors almost exactly the NPMS data, but in each instance is almost one rating scale point less. In previous work a difference of this magnitude has usually been significantly different. (This is confirmed by computing a Reliable Change Index over time, where a difference of 1.3 points on the scale would be needed to be sure that the result was not simply produced as a result of measurement error)\(^{(154)}\). There is a debate about the issue of the reliability of individual subjective judgements, which some argue are not subject to unreliability of measurement, in the way that scales applied by a rater (such as the HONoS [Health of the Nation Outcome Scores]) are. The issue is perhaps whether their subjective rating is made in a way that accurately reflects their true feelings at the time, a topic well beyond this research. Another possibility is that they intended to make one rating but mistakenly made another. Again we have no way of knowing if this was the case.

For almost all domains location D scores are lower than A, but only significantly so for relationships with the family where the location A mean is 5.4 (sd 1.2) and location D mean is 4.2 (sd 1.7) \((t=2.31 \text{ df } 28 \text{ p}=0.03, \text{ mean difference } = 1.15 (CI \text{ 2.1, 0.21}).\) Trends were evident for mental health and leisure activity. The mean D–T score for those not working was low at 3.8, whereas the D–T scale score for both people who were working was 7 out of 7 (delighted).
Figure 6. QOL comparison between 3 CMHTs (D and A from this study)

(1= terrible, 7= delighted)

Team composition and MANSA results

There were no significant associations between the subjective well being ratings in any domain, and the proportion of social care staff in the team.

4.4.3 CUES data

CUES data are in three parts. A – where the respondents rate their circumstances as being as good as a normative statement of how things should be in a life domain or an aspect of service delivery. B – where they then rate whether they are satisfied with this state of affairs, and C – where they are asked to say in what way they would like things to change (a free text response).

In tables 25 to 29 we have compared our results with those of the original Lelliot\(^{(143)}\) UK data and the Blenkiron\(^{(142)}\) data from one team in the north of England.
Table 2. Service users’ satisfaction in key areas of their life

<table>
<thead>
<tr>
<th></th>
<th>Part A responses (% who rated their experiences ‘as good as’ the normative statement)</th>
<th>Part B (% who replied ‘yes’ to satisfaction questions below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lelliot et al 2001 % (n =449)</td>
<td>Blenkiron et al 2003 % (n= 86 )</td>
</tr>
<tr>
<td>Where you live</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the place you live in?</td>
<td>75</td>
<td>77</td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have enough money to meet your basic needs?</td>
<td>65</td>
<td>72</td>
</tr>
<tr>
<td>Finances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the level of help you get with your finances?</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>How you spend your day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the way you spend your day?</td>
<td>72</td>
<td>64</td>
</tr>
<tr>
<td>Family and friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your relationships with the people closest to you?</td>
<td>57</td>
<td>69</td>
</tr>
<tr>
<td>Social Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your social life?</td>
<td>54</td>
<td>62</td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the way people treat you?</td>
<td>52</td>
<td>72</td>
</tr>
</tbody>
</table>

$^1 \chi^2 = 4.07$, df1, p=0.04  $^2 \chi^2 = 4.52$, df1, p=0.03 but when Simes adjustment is applied these are no longer significant
Table 26. Service users’ experience of and satisfaction with services

<table>
<thead>
<tr>
<th></th>
<th>Part A responses (% who rated their experiences ‘as good as’ the normative statement)</th>
<th>Part B (% who replied ‘yes’ to satisfaction questions below) Local UK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lelliot et al 2001 % (n = 449)</td>
<td>Blenkiron et al 2003 % (n=86)</td>
</tr>
<tr>
<td>Information and advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the information and advice you get?</td>
<td>58</td>
<td>76</td>
</tr>
<tr>
<td>Access to mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your ability to get help when you need it?</td>
<td>52</td>
<td>73</td>
</tr>
<tr>
<td>Choice of mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the range of choice you have?</td>
<td>52</td>
<td>73</td>
</tr>
<tr>
<td>Relationships with mental health workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your relationships with mental health workers?</td>
<td>64</td>
<td>85</td>
</tr>
<tr>
<td>Consultation and control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the level of consultation and control you have?</td>
<td>65</td>
<td>84</td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the help you get in dealing with difficult situations?</td>
<td>63</td>
<td>72</td>
</tr>
</tbody>
</table>

Table 26. Service users’ experience of and satisfaction with services (continued)

<table>
<thead>
<tr>
<th>Your drug treatment</th>
<th>51</th>
<th>71</th>
<th>72</th>
<th>58</th>
<th>73</th>
<th>64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you satisfied with your current medication?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to physical health services</th>
<th>77</th>
<th>83</th>
<th>80</th>
<th>74</th>
<th>80</th>
<th>80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you satisfied with your access (General practitioner, hospital, dentist, opticians, chiropodist)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationships with physical health workers</th>
<th>74</th>
<th>88</th>
<th>86(^{13})</th>
<th>70</th>
<th>86</th>
<th>82</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you satisfied with the way your physical problems are dealt with?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{1-13}\) significantly different between Lelliott and present study. Test results given in Table 25.

NB none of the differences between Blenkiron’s data and the present study were significant.
Table 2. Test results for Table 26

<table>
<thead>
<tr>
<th>Result number</th>
<th>$\chi^2$ All 1 degree of freedom</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10.31 p=0.001</td>
</tr>
<tr>
<td>2</td>
<td>11.48 p=0.001</td>
</tr>
<tr>
<td>3</td>
<td>7.66 p=0.005</td>
</tr>
<tr>
<td>4</td>
<td>14.96 p=0.001</td>
</tr>
<tr>
<td>5</td>
<td>23.36 p=0.001</td>
</tr>
<tr>
<td>6</td>
<td>4.81 p=0.03</td>
</tr>
<tr>
<td>7</td>
<td>5.58 p=0.02</td>
</tr>
<tr>
<td>8</td>
<td>18.21 p=0.001</td>
</tr>
<tr>
<td>9</td>
<td>9.44 p=0.003</td>
</tr>
<tr>
<td>10</td>
<td>14.11 p =0.001</td>
</tr>
<tr>
<td>11</td>
<td>18.55 p =0.001</td>
</tr>
<tr>
<td>12</td>
<td>8.45 p =0.004</td>
</tr>
<tr>
<td>13</td>
<td>3.78 p =0.05</td>
</tr>
</tbody>
</table>

All remain significant after application of Simes procedure
Table 28. Service users’ satisfaction with key areas of their life

<table>
<thead>
<tr>
<th></th>
<th>Part A responses (% who rated their experiences 'as good as' the normative statement)</th>
<th>Part B (% who replied 'yes' to satisfaction questions below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A % (n)</td>
<td>D % (n)</td>
</tr>
<tr>
<td>Where you live</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the place you live in?</td>
<td>92 (23)</td>
<td>79 (15)</td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have enough money to meet your basic needs?</td>
<td>75 (18)</td>
<td>63 (12)</td>
</tr>
<tr>
<td>Finances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the level of help you get with your finances?</td>
<td>83 (20)</td>
<td>77 (13)</td>
</tr>
<tr>
<td>How you spend your day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the way you spend your day?</td>
<td>72 (18)</td>
<td>53 (10)</td>
</tr>
<tr>
<td>Family and friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your relationships with the people closest to you?</td>
<td>63 (15)</td>
<td>53 (10)</td>
</tr>
<tr>
<td>Social Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your social life?</td>
<td>57 (13)</td>
<td>68 (13)</td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the way people treat you?</td>
<td>63 (15)</td>
<td>72 (13)</td>
</tr>
</tbody>
</table>

\(^1\chi^2 = 6.91, df1, p=0.008\) \(^2\chi^2 = 4.55, df1, p=0.03\) \(^3\chi^2 = 12.64, df1, p<0.001\) \(^4\chi^2 = 6.2, df1, p=0.01\)

*Not significant when Simes adjustment applied

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Project 08/1619/114
Table 29. Service users’ satisfaction with mental health services

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Part A responses (% who rated their experiences ‘as good as’ the normative statement)</th>
<th>Part B (% who replied ‘yes’ to satisfaction questions below)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A % (n=26)</td>
<td>D % (n=19)</td>
</tr>
<tr>
<td>Information and advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the information and advice you get?</td>
<td>82 (18)</td>
<td>78 (14)</td>
</tr>
<tr>
<td>Access to mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your ability to get help when you need it?</td>
<td>83 (20)</td>
<td>58(^1) (11)</td>
</tr>
<tr>
<td>Choices of mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the range of choice you have?</td>
<td>74 (17)</td>
<td>84 (16)</td>
</tr>
<tr>
<td>Relationships with mental health workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your relationships with mental health workers?</td>
<td>76 (19)</td>
<td>83 (15)</td>
</tr>
<tr>
<td>Consultation and control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the level of consultation and control you have?</td>
<td>88 (21)</td>
<td>95 (18)</td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with the help you get in dealing with difficult situations?</td>
<td>86 (19)</td>
<td>87 (13)</td>
</tr>
<tr>
<td>Your drug treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your current medication?</td>
<td>78 (18)</td>
<td>63 (12)</td>
</tr>
<tr>
<td>Access to physical health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you satisfied with your access (general practitioner, hospital, dentist, opticians, chiropodist)?</td>
<td>84 (21)</td>
<td>74 (14)</td>
</tr>
</tbody>
</table>
Table 29. Service users’ satisfaction with mental health services (continued)

<table>
<thead>
<tr>
<th>Relationships with physical health workers</th>
<th>88 (21)</th>
<th>84 (16)</th>
<th>88 (22)</th>
<th>74 (14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you satisfied with the way your physical problems are dealt with?</td>
<td>88 (21)</td>
<td>84 (16)</td>
<td>88 (22)</td>
<td>74 (14)</td>
</tr>
</tbody>
</table>

\(^1 \chi^2 = 13.85, \text{ df} = 1, p < 0.001\)  \(^2 \chi^2 = 7.74, \text{ df} = 1, p = 0.005\)

When Simes adjustment is applied these remain significant.
In our data, people’s experience is less good in terms of how they spend their day, and their social life, in the former being below the figure in the original UK data. Later we will compare the two locations to see if they differ on any of these items.

**Team composition and CUES results**

We compared the team composition with the CUES variables. Basically, these results are not at all robust, due to multiple testing, and all the significant results violated the assumptions (due to a larger number of cells with a count less than five than expected). There were no significant results that stood up to the assumptions or Simes testing. A larger sample is required to examine the relationship in a robust way.

**CUES differences between locations A and D**

When we compared A and D on the same CUES items, significant differences emerged in relation to satisfaction with financial help (higher in D); how they spent the day (better in A); satisfaction with social life (better in A); and stigma (better in D). The family and friends result was no longer significant after Simes adjustment was applied.

It may be worth observing that stigma and discrimination have been the subject of much policy, research and campaigning since both the previous CUES papers were published so it is perhaps not surprising to see significantly higher levels of satisfaction in our 2010 results. What may be surprising are the lower ratings in location A, which are not significantly different from Lelliot’s from ten years earlier. Free text responses suggested that this dissatisfaction stemmed from public rather than service sources, and the reverse was the case in location D.

The only significant differences in service provision concerned access to services which favoured location A, which might be associated with the rurality of D. The result might also be related to difficulties accessing out of hours services. There were a number of complaints about this in the free text responses.

**Free text responses on the CUES**

The third part of the CUES asks the respondents what thing they would like to change in each of the CUES domains and provides an empty box for them to write free text.
The 45 respondents made 297 free text entries (42% of a possible total number of free text opportunities of 704 for the whole sample). The average number of responses was 6.5 out of a possible 16 (sd 6.8). Only four individuals chose to make no responses at all, one in location D and three in location A (Table 30).

Table 30. CUES Section C: Free text responses, proportion responding

<table>
<thead>
<tr>
<th>CUES</th>
<th>Respondents answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=45</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>19 (42%)</td>
</tr>
<tr>
<td>Money</td>
<td>24 (47%)</td>
</tr>
<tr>
<td>Help with money</td>
<td>15 (33%)</td>
</tr>
<tr>
<td>Spend the day</td>
<td>26 (58%)</td>
</tr>
<tr>
<td>Family &amp; friends</td>
<td>20 (44%)</td>
</tr>
<tr>
<td>Social life</td>
<td>21 (46%)</td>
</tr>
<tr>
<td>Advice</td>
<td>17 (38%)</td>
</tr>
<tr>
<td>Access to mental health services</td>
<td>21 (46%)</td>
</tr>
<tr>
<td>Choice</td>
<td>13 (29%)</td>
</tr>
<tr>
<td>Relationships with mental health workers</td>
<td>19 (42%)</td>
</tr>
<tr>
<td>Consultation and control</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Advocacy</td>
<td>16 (36%)</td>
</tr>
<tr>
<td>Stigma</td>
<td>20 (44%)</td>
</tr>
<tr>
<td>Medication</td>
<td>28 (62%)</td>
</tr>
<tr>
<td>Access to physical health services</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Relationships with physical health workers</td>
<td>13 (29%)</td>
</tr>
<tr>
<td>Total</td>
<td>297 (42%)</td>
</tr>
</tbody>
</table>

There is a consistent relationship between the free-text responses and the structured element of the CUES (Parts A and B). Clearly not all respondents completed all items, but those who were moved to do so were almost exclusively negative about the teams in location D, and either positive or balanced between positive and negative remarks about the teams in location A. One of the A teams in particular came in for considerably more positive remarks than any other team.
Table 31 shows the ratio of negative to positive comments for locations A and D. Overall there is a ratio of 6.8 to 1 negative to positive comments in D, and a slightly better than 1:1 ratio of positive to negative comments in A.

**Table 31. Positive and negative free text responses: CUES section C**

<table>
<thead>
<tr>
<th>CUES item</th>
<th>Location A (n=26)</th>
<th>Location D (n=19)</th>
<th>Fisher’s Exact Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative</td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>Home</td>
<td>9</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Money</td>
<td>10</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Help with finances</td>
<td>7</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Day activity</td>
<td>11</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Family Friends</td>
<td>7</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Social life</td>
<td>6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Stigma</td>
<td>7</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Information advice</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Access</td>
<td>3</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Choice</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Relationship with mental health</td>
<td>6</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation &amp; control</td>
<td>0</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Advocacy</td>
<td>4</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Medication</td>
<td>7</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Access physical health workers</td>
<td>8</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Relationship with physical</td>
<td>4</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>health workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>96</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>117</td>
</tr>
<tr>
<td>OR 0.12 (0.07, 0.23) (χ² = 58.28 df 1 p&lt;=0.001)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The significant areas, all in favour of location A are money, social life, access (as indicated the rural features of D probably account for this) and consultation and control, which seems to be particularly popular in A. Stigma, access, medication and access to physical health workers were all exclusively negative in D. There were trends toward an advantage for A in help with finances, day time activity, and medication. The overall difference in negative and positive remarks was significant.

4.4.4 The relationship between the WDQ data and the service user data

One of the main purposes of the present study was to see how the culture and climate of different teams impacts upon the staff and service users. The Phase II results examined the differences between the four locations, and the teams in them, in terms of the WDQ and Karasek JCQ subscales and found that while team composition was not related to team features of teamwork and integration, it was related to staff rated outcomes of quality of care, job satisfaction and intention to leave the employer. In this section, we look at the teams who delivered services to the 45 service users who completed the MANSA, CUES and SUQ, to explore whether services users are affected in a similar way. There were 95 WDQ responses from these teams. Table 32 shows the professional group of the respondents.

<table>
<thead>
<tr>
<th>Professional</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>OT</td>
<td>8</td>
<td>8.4</td>
</tr>
<tr>
<td>Social worker</td>
<td>19</td>
<td>20.0</td>
</tr>
<tr>
<td>Nurse</td>
<td>35</td>
<td>36.8</td>
</tr>
<tr>
<td>Support worker</td>
<td>7</td>
<td>7.4</td>
</tr>
<tr>
<td>Psychologist</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>15.8</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td></td>
</tr>
</tbody>
</table>
There were 58 responses from Location A and 37 from D. Table 33 shows location comparisons in relation to team size and composition. The support worker data were skewed and so were transformed. There was no significant difference in team size (A mean 21.2 (sd 4.3) D mean 22.3 (sd5.5). There were significantly more nurses in the teams in location A (10.2 sd2.2) than in D (5.7 sd 0.8) and significantly more social care support workers in D than A. Teams in location A had only 1 or 2 support workers, whereas the teams in D have between 4.5 and 10.2 per team.

Table 33. Comparison of team composition in locations A and D

<table>
<thead>
<tr>
<th>Staff</th>
<th>A (n=58)</th>
<th>D (n=37)</th>
<th>t test, df, p</th>
<th>mean difference (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers</td>
<td>4.31 (0.8)</td>
<td>4.94 (1.9)</td>
<td>-1.9, df 94.5, p=0.06</td>
<td>Mean difference -0.63 (1.3, 0.03)</td>
</tr>
<tr>
<td>Support workers</td>
<td>1.2 (0.4)</td>
<td>8.1 (2.5)</td>
<td>-27.3 df 64.5 p=0.000</td>
<td>Mean difference -0.82 (-0.9, -0.8)*</td>
</tr>
<tr>
<td>All social care staff</td>
<td>5.5 (0.9)</td>
<td>13.0 (4.4)</td>
<td>-10.28 df 37.8 p=0.000</td>
<td>Mean difference -7.7 (-7.7, -6.0)</td>
</tr>
</tbody>
</table>

* log transformed

As the number of interviews was small and might be unrepresentative we assessed whether the teams where the interviews were conducted differed in their culture and climate from teams in the sample where interviews were not conducted. We compared the WDQ and Karasek JCQ sub scores for the teams where interviews took place with teams where interviews had not taken place. Psychological job demands differed and were more demanding in the service user interview (Phase III) locations (t=-3.37, df86, p=0.001. Mean difference = -0.32 (-0.51, -0.13). All the other Karasek JCQ and WDQ subscales were not significantly different in the interview locations and non-interview locations. This gives us some confidence that the interview findings, although largely descriptive have not been conducted in teams in the sample with atypical culture or climate.
Because of the large number of variables in the WDQ, MANSA, CUES and SUQ, we need to take a theoretically informed approach about which items to use in the analysis. As the purpose of the study is to see to what extent culture and climate impact on workers, and thence upon the service users and the quality of care, we isolated those variables that lent themselves to addressing these questions.

We selected the WDQ teamwork subscale, the integration subscale, the quality of care subscale, training and staff development sub-scale and overall job satisfaction. We selected the variables on the CUES that related to worker characteristics and team characteristics: access to mental health services, choice, relations with mental health workers and satisfaction with care coordinator, social worker, CPN and support worker. Chronologically, the WDQ data were gathered before the user data. Although the original WDQ subscales were skewed, in some cases transformations made them more skewed. We ran the analysis using both skewed and transformed variables and found that the original variables gave the most conservative results, so we present those in Table 34.

The first and perhaps most interesting result to report is that the ‘integration’ subscale was unrelated to all the service user variables, suggesting that it is something that has little impact on service user perceptions.

The pattern of the remaining results is interesting because it shows which aspects of team culture and climate are related to user experience in the present study. Training opportunities and quality of care (which themselves are significantly correlated) are both associated with similar factors to do with how service users perceive the competence and listening abilities of the workers, and met needs. Teamwork was associated with the service users’ feelings about the choice of service available, and overall job satisfaction of the workers was also associated with choice, both in relation to the normative statement comparison and satisfaction with choice.

Even though the WDQ data were collected before the CUES and MANSA data the direction of the relationship cannot be assumed. Service user satisfaction with the service choices that they have been afforded could well be reflected in worker job satisfaction, and vice-versa, workers may have greater job satisfaction where the range of services they provide is greater. Nevertheless, the results in Table 34 are readily interpretable and intuitively make sense. This form of analysis will need to be repeated on a much larger sample in order to explore these potential relationships robustly.
Table 34. Associations between WDQ subscales and service user variables

<table>
<thead>
<tr>
<th>WDQ subscale</th>
<th>CUES item</th>
<th>Correlation, p (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>None</td>
<td>n/a</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Available choice (CUES A)</td>
<td>-0.037, p=0.02 (38)</td>
</tr>
<tr>
<td>Quality of care</td>
<td>CPN competent and knowledgeable</td>
<td>0.66, p=0.002 (20)*</td>
</tr>
<tr>
<td></td>
<td>Social worker listened and understood</td>
<td>0.58, p=0.04 (13)</td>
</tr>
<tr>
<td></td>
<td>Quality of care</td>
<td>0.45, p=0.02 (26)</td>
</tr>
<tr>
<td></td>
<td>Needs met</td>
<td>0.34, p=0.03 (41)</td>
</tr>
<tr>
<td>Training</td>
<td>Social worker listened and understood</td>
<td>0.70, p=0.03 (13)</td>
</tr>
<tr>
<td></td>
<td>Social worker competent and knowledgeable</td>
<td>0.65, p=0.03 (11)</td>
</tr>
<tr>
<td></td>
<td>Support worker listened and understood</td>
<td>0.51, p=0.02 (20)</td>
</tr>
<tr>
<td></td>
<td>Support worker competent and knowledgeable</td>
<td>0.47, p=0.03 (20)</td>
</tr>
<tr>
<td></td>
<td>Available choice (CUES A)</td>
<td>-0.54, p=0.001 (35)*</td>
</tr>
<tr>
<td>Overall job satisfaction</td>
<td>Choice (satisfaction) (CUES B)</td>
<td>-0.36, p=0.02 (37)</td>
</tr>
<tr>
<td></td>
<td>Choice (satisfaction) (CUES B)</td>
<td>-0.36, p=0.02 (37)</td>
</tr>
</tbody>
</table>

1 In location A only
* remain significant after Simes adjustment

The quality of care subscale was related to the service users’ rating of the quality of care provided by the team in location A, but not in D. To some extent this is inconsistent with the results of the multivariate analysis which showed that quality of care was related to the proportion of social care workers in the team, so one might have expected this to emerge in location A and not in D. The small sample size in D may have been responsible.

Because management structure and style emerged as an important contributor in the multivariate analysis, we examined the association with the service users’ experiences. Management style did not differ significantly between A and D teams. It was unrelated to quality of life scores on the
Mansa and the CUES. It was however related to the Karasek Job Content Questionnaire, as one might expect. Better management (higher WDQ scores) were weakly (but significantly even after Simes was applied) related to lower psychological job demand ($r=-0.162, p=0.04$), greater decision latitude ($r=0.344, p<0.001$) and more social support in the team ($r=0.519 p=<0.001$).

4.4.5 CUES free text response

Each of the domains of the CUES has a section C, which permits the user to add free text. The wording of the questions is slightly different for each domain, but they are generally asking what changes people would like or for them to give examples of the sorts of situations they encounter e.g. in the advocacy section, the question is “What situations do you most want help with?” Where there are no observable differences in response between A and D this is confirmed in the text, otherwise the statements are presented separately to illustrate the difference in response.

In the text that follows we provide examples of the types of comments made by service users, first in relation to aspects of their lives that they would like to change and later in relation to services. These are grouped into themes. As most of the themes were self-evident and related to the specific questions that they had just been asked we saw no need to process them using proprietary software.

Remarks relating to the home suggest that the remoteness of some of the communities in D does contribute to the service users’ problems:

“I would like my very supportive friend to live nearer.”

“No shop in village restricts any life so no purpose to pop to the shop or get out to do something.”

“People are not very friendly, very standoffish. Isolated - no shops, few buses, beautiful but remote.”

On the other hand, many people clearly valued their home and its location as the following quotes suggest:

“I feel comfortable where I live”

“I would not like to change anything”

“No changes needed”

There were some remarks that indicated the need for small practical changes that might lead to improved quality of life:
“Wish we had a smaller garden. Or even nicer would be to have someone to do it.”

“It would be nice to have a clothes line outside, to dry clothes.”

“To have the money to decorate it as it’s still the same as when the last occupied it.”

In a few instances in A there were indications that some more substantial social needs might be going unaddressed:

“Perhaps have somebody I could call in an emergency.”

“I worry about the rent as financially restrained. Also would like the house to be redecorated throughout but nervous of asking the landlord. A bit ashamed of asking people in for coffee as it looks so tired.”

“I would like it to be quieter. All I hear are trains screeching people coming out of the bars, waiting for taxis, neighbours banging loud music. Skateboarders. I have no heating, so would like heating.”

Changes to finances and help with finances

In both A and D the impact of the economic downturn was evident with a lot of people reporting debts, bankruptcies and home re-possessions. The MANSA subjective well-being score was the same in both areas, and the picture painted by the free text does not suggest that there was any difference between the areas in terms of the nature of financial problems people faced.

In relation to help with finances, there were no indications in D that help was being provided directly by the CMHT. Some people clearly had difficulty in paying for the basics, and paying for transport was an issue for those in remote parts of D.

Any help that was mentioned was from external agencies, as the following quotes illustrate:

“Have been above my limit. Bought too much so I have debts but CAB helped to sort it out for me. My partner (then) advised me to go to CAB.”

“Get food in, paying the bills e.g. getting a new toaster etc. Feel cold in the winter, I (Name) her son helps her with the cooking, because she’s forgetful and would burn the meal. Quality Care comes in to watch her take her tablets so she doesn’t forget to take them.”
On the other hand, in A there were several indications that the workers were engaged directly in assistance with financial issues, including help with filling in forms such as benefit claims.

“CPN helps me with finances with the help of my brother.”

“Would like to have my CPN and social worker back in communication with me. Their visits were a great help and pleasure to me.”

Nevertheless, there were some clear indications that some individuals required further assistance in relation to their finances, and not all their problems are attributable to the recession.

“Am in arrears with the gas, elec and water, also have to keep £50 towards the rent.”

“Just getting by. Shopping with the girls is more restricted now.”

“Husband bankrupt 2 yrs ago. That was upheaval, not very pleasant. His circumstances have impacted on us. After 42 yrs of marriage lost house etc.”

“Debt incurred over years of chronic ill health and bringing up a family.”

“More money going out than coming in.”

One person suggested that their financial situation would be improved if they were able to claim a “grand-parenting benefit”. Others were clearly struggling and would benefit from further advice and guidance but appeared not to be receiving it:

“Trying to work out after basics to budget for little extras as for myself and girls. Want to make ends meet, would like to have some left over to get things for the girls.”

“Have found the CAB very helpful so is my CPN who also advises me but I often can’t stretch my money out. Find it stressful. Have to ask my sister to help me out, she lives in NE England but very supportive.”

Changes to daytime activity (including work)

Low levels of satisfaction with leisure activities and work were observed on the MANSA and the structured part of the CUES. The free text responses confirm that this is one of the most neglected areas in both of the locations (23 of the 41 respondents made critical remarks in this section).
The issues are not simply the lack of available opportunities, although this was mentioned in D:

"Limited places you can go in (area X) for people with mental health problems. There could be some drop ins or day centres. Last day centre died down nothing re-opened."

More often, the individual attributed the problem to their own lack of confidence or motivation, two areas where specific forms of help (such as motivational interviewing) are available:

"I would like to have confidence to go about the opportunities on offer. Sometimes I know I can’t do it other times I know I can do it but I still do not do it. That annoys me."

"Like to be more motivated. Find it hard to do it and can put myself off doing things."

"Would like to get out more. If I do go out I feel I get more done when I get back home."

"Would like the confidence to be involved and go to day centre or something."

In accordance with the MANSA and CUES results the free text responses indicated a strong desire to be helped back into employment by training, getting a career or simply a job. Of course, whether these plans are realistic or not cannot be determined, but we know that employment has positive benefits for the health and well-being benefits for people with serious mental health problems. (155)

"I want full time employment NOT stacking shelves."

"Would like to be well enough to manage a career."

"Went to search - various activities becoming more limited. Classes being cut back."

"I'd like the opportunity to be able to do courses but money to pay for these is not available."

In location A people complained of inactivity and of needing help to become engaged in doing something social or leisure activity related. In some cases the illness was having an adverse impact on their ability to participate in activities:

"To get out of my bedroom more often."

"If it is a bad (MH) day I get bored."
“Depends how I am. Would like to do something in the day which will make a difference.”

“Just like to get out and about. Have free bus pass and cannot get out to use it.”

The task of accompanying people to help them to overcome this kind of difficulty, and other practical tasks such as those related to the home (see section above), usually fall to support workers, but none were mentioned in the free text (under home or daytime activity) in any of the free text responses in A. This may be because between the seven teams in location A there were only 4.5 support staff. This role was obviously being performed for some people by their CPN:

“I don’t leave my house. If I have to leave my CPN takes me.”

A couple of respondents expressed feelings of loneliness, and again the professional staff were the preferred helpers for these people:

“Would like CPN back visiting me. Would like to have CPN and social worker back.”

“Meet people instead of being lonely.”

One person who was motivated to go out, was at the same time not motivated to take care of their own well-being.

“I attend 2 classes a week and volunteer 1 a week but not motivated to do general housework also do not cook meals.”

Throughout the responses in this section, there is a general air of passivity, sometimes attributed to the illness or illness-related factors like lack of motivation. On the MANSA 93% wanted to improve their health. There is also a sense that many people expect the services to resolve these matters, while others appear not to have been offered assistance in relation to social participation. This is the domain in which the lowest CUES and MANSA subjective well being (SWB) scores were recorded. Low SWB scores were also recorded in terms of living alone.

Some of these responses point to the differences between role and task. So in a team with lots of social care support workers, nurses may not accompany people on visits or deal with money-related issues. But where there are fewer (or no) support workers, social care needs may still be met but by other members of the team (e.g. nurses).
Changes to social life

On the MANSA 61% wanted to improve their social lives and 56% felt that their opportunities to do so were restricted. Statements under this heading are similar to those for daytime activity. People want to do more, but find various factors restrict their opportunities or they lack the ability, sometimes attributed to the illness:

"Would like to be a bit more outgoing if my condition improved."

Self-confidence appeared to be a factor for some people:

"Would like to be more confident mixing with people - especially people who I know which I will avoid so as not to talk to them. Always OK in a structured situation. Can meet new people on holiday but get tongue tied."

As we have observed in similar samples before financial resource problems restrict people’s ability to participate:

"Restricted by limitations of income. Basics covered but doesn't extend to any more Would like more money to do more things that I enjoy."

"Not enough money for transport cannot access countryside and concerts etc that I'd like."

"Don't have one again no available money."

"Would like to be able to get out when I want - don't always have money for a drink."

"Have to watch money for petrol to go out fishing if invited. All money goes on collecting fetching girls."

Some of the statements indicated that there might be a role for support workers to help people to pick up previous interests, or to accompany someone to social or other events (these are the kind of tasks that STR workers take on):

"Would like to get back into my amateur dramatics again. It was such a big part of who I am. I got so many positives out of it."

"Go to church but am only one under 40 but would like to go some where with others of my age."

It was quite common in our STR study(24) to find workers accompanying people who found going out was difficult for them for some reason. In location A however, CPNs were undertaking this type of work:
"I never leave my home unless accompanied by CPN. Don’t like going out on my own."

Some people appear to have had something of a dependent relationship with their workers:

"More contact with the fabulous mental health team. Wish I had more time with them."

For others physical and mental health problems limited their activities:

"...physical ailments affecting mental state and at present time I cannot improve it."

"I prefer not to socialise as very nervous and self conscious. Also cannot use public transport on my own. I have a very good friend and I meet her every week for a chat."

Contact with Services

Table 35 indicates that most service users in both locations are aware of who their care coordinator is and feel able to contact them when necessary, in the knowledge that they are likely to listen and be helpful.

It is striking that having a social worker as a care coordinator is unusual even in D where it does happen, even though the social care composition of teams is dominant.

Although none of the area comparisons produced significant differences it is also striking that so few people have actually had contact with a social worker, again even in D. Having contact with a support worker is much more common. The CUES question about the competence and understanding of the worker asks about ‘the last time you saw a social worker’ (or CPN etc) so the ‘n’ for responses to those questions can be greater than the number of people who saw a worker in the last year, as they may have seen them more than a year ago. The relatively low proportion rating their CPN in the highest category of competence in location A, is offset by the higher proportion rating them as mostly competent (n=12, 75%).
Table 35. Care coordination

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes I have been told who my care coordinator is</td>
<td>22 (84.6)</td>
<td>17 (94.4)</td>
</tr>
<tr>
<td>My care coordinator is a CPN</td>
<td>19 (76.0)</td>
<td>11 (61.1)</td>
</tr>
<tr>
<td>My care coordinator is a social worker</td>
<td>0 (00)</td>
<td>3 (16.7)</td>
</tr>
<tr>
<td>I can always contact my coordinator about a problem</td>
<td>14 (79.2)</td>
<td>14 (77.8)</td>
</tr>
<tr>
<td>My care coordinator was helpful on the last occasion</td>
<td>22 (91.2)</td>
<td>13 (72.2)</td>
</tr>
<tr>
<td>My care coordinator listened and understood me</td>
<td>14 (79.2)</td>
<td>16 (88.9)</td>
</tr>
<tr>
<td>My care coordinator is highly competent and knowledgeable</td>
<td>20 (83.3)</td>
<td>17 (94.4)</td>
</tr>
<tr>
<td>My CPN was helpful on the last occasion</td>
<td>14 (87.5)</td>
<td>5 (100.0)</td>
</tr>
<tr>
<td>My CPN listened and understood me</td>
<td>13 (81.3)</td>
<td>5 (100.0)</td>
</tr>
<tr>
<td>My CPN is highly competent and knowledgeable</td>
<td>3 (18.0)</td>
<td>4 (80.0)</td>
</tr>
<tr>
<td>I have seen a social worker in the last 12 months</td>
<td>4 (16.7)</td>
<td>5 (31.3)</td>
</tr>
<tr>
<td>Social worker was helpful on the last occasion</td>
<td>3 (50.0)</td>
<td>5 (100.0)</td>
</tr>
<tr>
<td>My social worker listened and understood me</td>
<td>5 (100.0)</td>
<td>5 (100.0)</td>
</tr>
<tr>
<td>My social worker is highly competent and knowledgeable</td>
<td>4 (80.0)</td>
<td>5 (100.0)</td>
</tr>
<tr>
<td>I have seen a support worker in the last 12 months</td>
<td>10 (40.0)</td>
<td>11 (61.1)</td>
</tr>
<tr>
<td>Support worker was helpful on the last occasion</td>
<td>7 (70.0)</td>
<td>10 (90.9)</td>
</tr>
</tbody>
</table>

1 mostly n=12 (75%),

4.4.6 Comments on services received (from the CUES)

Access

In location D the most common complaints were about accessing services out of hours:

“Major element missing is out of hours access. There is no one to get hold off when I am high as a kite. Crisis team will not respond as I am not on their books.”

“Weekend availability is JUST NOT THERE. Last time I tried to ring after 5 on a Friday told to contact NHS direct! Try explaining mania.”
“Out of hour’s service. Getting attention 24/7 weekends/bank holidays.”

In some cases, people found that access was difficult during office hours:

“Have difficulties getting through to services in day. Sometimes no answer and can get cut off. When you get put through to admin dept.”

“Well its too expensive for my mum to ring on her mobile and they make her wait ages, sometimes she says please will you ring back and they never do. She needs some grab handles on the bath because she’s not got any, its so hard for to get in and out of the bath. Me her son has to be there for everytime she has a bath. Social worker is good at ringing back though.”

By contrast, services in location A were seen to be readily available:

“They have been there when needed or required.”

“I have a CPN to talk to weekly.”

“I have a very good relationship with my psychiatrist and feel able to ring them anytime.

“Can ring Dave anytime 24/7.”

There were one or two indications that services were not providing what the service users wanted:

“Our mental team are so busy and under pressure. Would be lovely to have CPN and have visit as I used to have before they stopped due to excessive lack of time.”

“One pointed me in direction of things but no follow up to see if you have done it. Sign posted to what is useful but no follow up.”

Choice

A small number of people in D gave examples of how their choices had been restricted and how they had not received what they wanted:

“In the past requested lady psychiatrist but refused. Had to fit in with what they provided. Not comfortable with men - do not even sit next to them on bus.”

“Have mentioned about counselling and therapies and have hit a brick wall with trust, would like to go and talk things through with someone to put things in perspective.”

“Psychiatrist asks same questions every time only about medicine.”
“Very much geared to activities and relaxation but there is no psychotherapy or counselling. Not made clear how I could get there.”

Respondents from A made both positive and negative comments about the choices that they had:

“"The fact that you have no choice really false. Choices that they are choosing for you.”

“"Don’t know anything about many of the above (i.e. choice of mental health services)"

“"Would love to see more of the mental health team if possible. Increase number of staff so as to increase time spent with patients especially me.”

“"I am very pleased with the choice of mental health services I have.”

“"I been ill for a while and this health service is the best so far.”

“"No concerns, very satisfied.”

Relationships with mental health workers

Given the significance of relationships in mental health work (24) it is unsurprising that the service users had a lot to say in this section. In D, their concerns focused on three things, confidentiality, continuity and repetition.

“"Don't want to keep meeting different psychiatrists each time. Want to avoid repetition.”

“"Have had to repeat my medical history so many times. It is probably poor record keeping or not passing them on. Have been asked about medication and can see my records on the shelf and have said it is in these records why don't you look there?”

“"Felt confidentiality was not there. Told I had no capacity but I was sectioned.”

“"Passing on of info not as good as it could be. Psyc talked to me and then realised I was not the person whose notes he was looking at. What does this mean about confidentiality?”

In some cases, it was the worker’s style that provoked a negative comment:

“"As far as the psychiatrists concerned - he stretches back in chair and yawns and then I think to myself I might as well go home. Not first the first time that noticed it - a good friend of mine gets exactly the same behaviour!”
"Threatened to lose support worker if I did not do what social work told me to do."

"In recent past social workers always late! Used to think it was part of their training."

Similar complaints were voiced in A regarding continuity and repetition:

"They seem to change my keyworker every nine months and I been with the service for 20 years. They need to read my files more and ask less questions as there’s nothing worse than going over your mental condition every 9 months."

"Does my head in how am I supposed to forget the past and keyworkers don’t have or read up enough information on me."

Some people felt that the worker listened to them while others felt not:

"They don’t give you enough time to explain yourself and give you answers."

"My CPN listened to me."

On the whole, relationships were reported to be good, but some people felt they required more contact, and some sounded as if they were dependent on the team:

"I have a very pleasant relationship with the CPNs."

"I would not change anything about my nurse. She is very supportive of all my needs."

"In the past appointments have been missed by CPNs and then I’ve ended up in hospital without their knowledge. All due to missed appointments on 2 occasions."

"Only see CPN and sometime a psychiatrist (6 monthly) otherwise do not see anyone."

"Would like to have more visits to doctor at health centre. Have my CPN back visiting me. Worrying that one day the health team will be taken away from me."

"Do not feel happy about what the present worker is going to say to the next one when she leaves. Worker failed to come to appointments - missed 4 and never rang. The reaction was that things cropped up I just had to do. But she never rang me. Makes me feel I count for nothing."
Consultation and control

Respondents were asked if they were ‘satisfied with the level of consultation and control you have?’ in relation to the care that they were receiving. All the comments made by D service users were negative:

"In past totally not satisfied. I felt as though I needed permission to do everything."

"Don't know that they always listen not sure they always take me seriously."

"Would like to find out other options to normal procedure - therapy, counselling etc."

"When they halved my medication - they should have spoken directly to me and not just left a message with my husband. Then I might have questioned them about their instruction."

By contrast, the comments made by location A respondents tended to be positive:

"My CPN listens to me and my family and that is important."

"I am pleased with my mental health workers."

"Just to see them more often. Realise that I am dependent on health team. But literally my life and well being is linked with the good work of the health team."

"I feel more at ease with my new CPN than any one else it so helpful knowing some one there to listen to you."

"I always feel listened to."

Advocacy

In D there were signs that some people used the advocacy services for practical help, such as filling in forms, or phoning on someone’s behalf. One said that is was not relevant to them as:

"I can speak up for myself."

In A, it appeared that an advocacy service was not widely used (if available?) and people mentioned several others who could act on their behalf when required, such as siblings, partners and CPNs.
Stigma and discrimination

In D most comments referred to stigma and discrimination within the services themselves, only one person mentioned the general public.

In contrast, all the comments made by respondents in A concerned negative responses from people outside the services. The services themselves were not criticized:

"Sometime I have trouble in streets on local or local shops."

"I only go places where the people know me for sometime."

"Stigma with MH although majority of people are fine."

"Wish there was more understanding of mental health issues generally. Feel a bit at odds with the community."

Medication

Location D respondents made negative comments about side effects such as weight gain, drowsiness, feeling sedated and tiredness. They also had anxieties about the long-term effects:

"Worry about long term effects of lithium have mentioned it to doctors - they say you are having a regular blood test - so that's enough - but it does not reassure me about long term effects. Physical consequences (troubles) worry me."

Location A respondents also mentioned side effects, but more seemed to be happy with their current regime:

"My GP/Psychiatrists sorts out my medication."

"Satisfied. Years ago had injections."

"My doctor keep a close eye on my medication."

"Prozac was wrong medication for me first place. Definitely wrong for me. But sorted out now."

"My medication is always discussed with me when I see Dr every 6-8 weeks. No complaints."

Access to physical health care

Both A and D respondents complained about being unable to access the GP, chiropody services, dentists and opticians.
Relationships with physical health care staff

Very few respondents in location D made comments. One was happy with the GP and another complained that they:

"Would like GPs to understand more about mental health issues."

Similar remarks were made by location A respondents. There was again some evidence of dependency on popular staff in the responses from A:

"More contact as they seem to settle my nervous. Every health worker I know has been helpful and understanding in supporting teams they are champions"

Care coordinators

Both sets of respondents made comments about their care coordinators, nurses, social workers and support workers. They were almost universally positive and reported that their workers were: helpful, positive, supportive, understanding, listened to them, were empathic, and were there when they were needed. Some of the (few) negative remarks may have been due to illness:

"From my choice due to previous experience I keep them at a distance so they are not controlling me."

What they liked about the service and what they would change

These questions were followed by the opportunity to say whether there was anything that they liked about the service and how, if at all, they would change it.

There were further positive comments on the teams in D, but there were also some indications of dissatisfaction:

"No not really."

"It has been a complete utter farce. We have not been able to make appointments because of work they've changed them (wrong dates given). It has been like ships that pass in night."

Some further dissatisfaction emerged in response to the question about what, if anything they would change about the service:
“To make people feel more real - so they don’t make you feel uncomfortable. They have done all the training so they think they know it all. Make you feel you need them more than you really do.”

They took the opportunity to complain again about the out of hours service:

“Out of hours provision non existent unless you are referred to crisis team. If you are not ill enough you do not get this. Mon-Fri 9-5 10 out of 10 often is ? 0 out of 10.”

“Focus time is a volunteer service. It is good at 2am in morning but you are conscious that it is NOT the CMHT.”

“Change after hours care. If you have a problem after 5pm or at weekends no help available.”

They also repeated the continuity and access issues and added that there needed to be improved communication between the team and the service users:

“When I go to see psychiatrist - it is never same one - no continuity. Had to go to K to see him last time which is a v.long journey for me. Why couldn’t the doctor come nearer?”

“Improve communication between team and patient.”

“Continuity of care and communication broken down.”

The respondents in A repeated many of the positive points that they liked about the service that had emerged in their previous free-text answers:

“The way they listen and understand my problems was very helpful.”

“All aspects.”

“How quickly I can have an opportunity to see the psychiatrist when I need to.”

“The way the team operate is like a well oiled machine and they show compassion. They are very considerate and unbiased and non judgmental. They listen to you.”

“To me they are my family. Every one of them has that something about them which makes them to be a pleasure to be with.”

“Better than where I came from. Did voluntary work for a while but was moved as job wasn’t permanent which was very unsettling.”

“I am very familiar with all the staff at the CMHT they all call me by my first name and make me feel very accepted for who I am.”
"That they are always there for me, and they always make me feel relaxed."

When asked what they would change, the common theme that emerged was increased face-to-face contact with the team workers. The other common remark was that there was nothing to change.

Among the things to note are the low levels of leisure activities and work in both locations, according to the CUES, MANSA objective indicators, and the free text responses. We need to explain the SWB ratings in these domains, because respondents in A score more highly than the respondents in D. While there may be a multitude of factors at work here, from a clinical perspective to have people with no leisure activity and no work, content with the situation does not seem to be acceptable, especially as the free text responses suggest a number of people would like to do more. It could be that the extent of disabling aspects of their illnesses genuinely rules out greater participation and social inclusion. It might also be that this indicates that the service is not addressing these needs or that the lack of motivation to improve is not being addressed adequately.

In D, the lower ratings could either be interpreted as reflecting their aspirations to improve their circumstances, or as a failure to help them to achieve goals in these areas. In the free text responses in the financial, leisure and work domains there are more complaints about inactivity in D, and more positive comments in A, but balanced by negative ones as well. It could be argued that neither service is doing particularly well in these social domains. From the medication results it looks like there may be some cause for some concern in D (although disputes over the correct form and dose of medication are not uncommon). A seems to have worked out an effective system for communication and control given the absence of negative comments about this aspect. The structured part of the CUES suggested both locations are doing well in this respect. This would be consistent with the growing emphasis on negotiation and partnership with service users in the care process.
5 Final Discussion

5.1 Limitations of the study

In some instances these are serious and mean that we have to be tentative in drawing conclusions. The major failing is the sample size for the service user interviews, a phase which was added at the request of the original protocol reviewers. A much larger and well-powered study has now been funded by SDO and this will permit firm conclusions to be drawn about the service user experience. Our results are indicative at best.

Although our data collection methods used in the national survey, with hindsight, could have been improved, the response rate for Phase I was quite good for a national survey, but only reached 50%. This is similar to previous national surveys we have conducted[14]. Many of the respondents referred us to the Mental Health Service Mapping data[129] (see footnote p19) for their team data, while others were able to provide more up to date figures. We compared our data to that of the Mapping data[129] and found that on all the workforce variables our respondents’ data were not different from non-respondents, which gives some confidence in the generalisability of our results from the national survey of Trusts.

In retrospect, it would have been better, rather than recording the first reason for team composition, to allow all reasons to be exhausted and then ask the respondent to indicate, which in their view, was the major influence in their Trust. Also, although it was usually clear what the respondent meant by ‘financial’ or ‘resource’ issues, resources might be scarce or abundant. For CMHTs it was usually scarcity, but for new teams it could refer to the additional resources that allowed them to populate the new teams, or to the fact that even with the new resources they were still unable to populate the teams in the way that they wanted to. In the event this probably made little difference to the results, as either way resources remained an important consideration for many Trusts.

The selection of locations for the staff survey phase of the study proved problematic in that one of our initially selected locations withdrew due to internal reorganisation. This was substituted with another similar Trust without any difficulty, but subsequently this Trust also withdrew due to constraints imposed on the staff who were preparing for a Foundation Trust status application. This was unfortunate, as this Trust C was significantly
and consistently different from Trust D. In the event we substituted A for C on a number of grounds, including similar team size but significantly different composition and rationale. Having the two Trusts with the larger teams (a situation that was anticipated in the original proposal) meant that we stood a better chance of an adequate response to the staff survey, and that proved to be the case. The response exceeded the target by over 10%. Using the larger Trusts with larger teams resulted in enough teams to undertake multi-level modelling (MLM), but the number of responses per team did not result in a sufficient number for MLM.

In order to assess the impact of climate and culture on outcome we again selected A and D because of the differences revealed in the staff survey. The service user interviews, however, proved much more challenging in terms of data collection than we anticipated. Although we agreed lists of people to be assessed using the standardised instruments (removing people who were too unwell to participate), we were beholden to the team leaders and team members to operate the arrangements for selection of and contact with people who agreed to participate. As indicated in the body of the report, in some cases we have confidence that this went according to plan but in some teams we were unsure whether the approach had been applied faithfully. Representativeness at this stage is perhaps less important than in the earlier phases, and we did compare the locations and teams from which Phase III respondents came, with the other locations and found only one significant difference in terms of psychological job demands, which was higher in the interview sites. This suggests that the interview locations were broadly representative.

As the end of the project approached we had only 41 out of a target of 50 interviews and it was proving very difficult to gain the full cooperation of some team leaders in one of the Trusts. We persisted in our attempts to gather the final nine interviews, and one area manager tried to help with the process. Putting efforts into the gathering of the final user data resulted in us abandoning our attempts to gather similar data on the CUES from carers. As indicated in the body of the report we felt that pursuit of carers with the same teams who were finding it difficult to recruit service users would have resulted in more difficulties for them and more delay. In addition, as we have pointed out, far fewer of the users recruited had carers, and many that did refused us access, so reluctantly we abandoned this effort to concentrate on achieving the service user target specified in the protocol. The total number of service users included reached 45. This part of the study raises issues about the gate-keeping functions of service managers and team leaders, which we will consider elsewhere. Anecdotally, team workers are under considerable work pressures, which means that time for research (even their own) is not a priority, but also the increased amount of regulation and associated paperwork has perhaps taken the space that research might have occupied in the past.)
5.2 The national survey of Trusts

**Aim:** The composition of mental health teams appears to be determined by factors other than the need to integrate health and social care professionals. Mental Health Mapping Data\(^2\) shows that there is enormous variability in team composition, with some teams operating with no social care staff at all. We need to understand the factors that determine this situation. This will provide us with an insight into current workforce planning and provide evidence about the key determinants of team structure and inputs. This will be of general value to health and social care workforce planners.

It is possible that, given the sample size our results might be subject to response bias but our comparison of responding and non-responding Trusts suggests this is not the case.

In addition to the limitation mentioned above (regarding the relative weight of each of reasons), further prompting should have taken place when the respondent mentioned financial and resource reasons, so that a shortage of resource could be distinguished from additional resources being made available. On the whole, further information made it clear that the respondents were referring to a shortage of resource when discussing CMHTs; new teams had additional resources but in some instances these were still insufficient to develop the teams as they would have liked to. We should also have asked what role the respondent played in team construction; had they been personally responsible for team construction, or did they inherited management of the teams from someone else. We could then have created a variable representing the extent or length of their involvement.

The quantitative findings point to some disturbing though understandable findings that team size and composition (in terms of their social care component) is determined more by financial resource than by demand or any other factor. The trend towards social care staffing being greater in more integrated Trusts suggests that local authorities might be less inclined than NHS Trusts to invest in mental health social work or, perhaps, pay for social care provision in health settings; of course this finding could reflect absolute lower levels of resource within the local authority environment or a preference for spending on other priority services, such as child protection or other adult services. It might also reflect the fact that integration and pooling of budgets give larger Trusts the capacity to invest in a wider range of staff and for the senior managers with responsibility for the social care staffing may be able to exert more influence to ensure an adequate
presence of social care staff in the teams. The figures show that support staff have grown consistently in recent years, which in economic terms, looks like downward substitution, i.e., replacing more expensive staff with cheaper staff.

The absence of long-term planning endorses the need to implement the HRH Action Framework issued by the WHO and the Global Health Workforce Alliance (11) and reinforces previous criticism of NHS workforce planning (20). Despite the introduction of reams of policy guidance and an increasing emphasis on promoting social inclusion and recovery (156, 157), resource levels appear to be the only major influence on multidisciplinary team composition and shortages remain in key staff groups. Policy directives are cited as major reasons for planned changes to teams.

The findings are relevant internationally given that staff shortages are evident worldwide and service quality is dependent largely on the staff delivering those services. Inadequate numbers of trained workers has been identified as one of the major obstacles to the improvement of community mental health services in low and middle-income countries (158). The findings appear to support previous evidence based on international comparisons that mental health workforce composition is determined more by supply factors than by demand factors (13). The transfer of hospital-based nurses into community settings following deinstitutionalisation has created a mental health workforce that is dominated by nursing in the UK (13), Jamaica (159) and Canada (160), among others.

Perhaps it is naive to assume that workforce planning and its outcome in terms of team composition is a rational process. Pragmatism will always be a necessary feature of service development as managers working with limited resources often struggle to achieve acceptable (or guidance) staffing levels let alone balancing skill-mix. Nevertheless, it seems inconceivable that service, financial and workforce planning are not considered alongside each other, especially given the impact of financial resources on team size and composition.

Decisions about how best to organise services so that they meet the health and social needs of mental health service users need to consider how integrated care can be optimised. Building on the WHO HRH framework further international research could inform understanding of how long-term workforce planning can be effected within resource constraints, and whether a more consistent approach to mental health workforce planning is feasible. The alternative is that supply, resource and historical factors (161, 162) continue to dictate the shape of services and the membership of community mental health teams, rather than demand and need.
Is it likely that community teams as presently constituted are going to be in a position to deliver the government’s vision of future mental health policy? Things do not look very promising. It is not necessarily the case that teams need a perfect balance between health and social care workers but having a stronger social care component is more likely to facilitate the implementation of policies which emphasise public mental health objectives (see Section 3.2 for more detail).

Recovery is now a core component of UK Department of Health Policy New Horizons\(^{(1)}\), and the coalition government’s White paper, Liberating the NHS\(^{(163)}\), with its clear focus on service user experience and shared decision making – ‘no decision about me without me’ (Department of Health, 2010). In addition, the profession of medicine is changing. It is becoming more collaborative, with a greater emphasis on shared decision making, self-care and patient choice, and greater recognition of the contribution of service users as experts in their own conditions.\(^{(164)}\)

### 5.2.1 Workforce planning is less than systematic

The Phase I findings support Buchan\(^{(12)}\) and other critics of workforce planning in the NHS\(^{(18, 20)}\) and in mental health services in particular. It may be wishful thinking to expect workforce planning to be a rational process, but as Buchan has suggested one could at least expect some form of coordination and alignment between resources and supply factors. That this was not the case, is shown by the way in which, while multidisciplinarity was supported, the composition of new community teams was dominated by the supply of nurses, in some cases redeployed from CMHTs and in other cases hired using new resources provided for the new teams. Where resources are more readily available, in the Trusts with pooled budgets there was a higher proportion of social care staff (significantly so and with a medium to large effect size), whereas, where the local authority social services department still controlled the budget and supply of social workers, the social care component was lower. There could be a number of explanations for this finding, and it needs to be treated with caution, as it depends on univariate analysis and not multivariate analysis, which would control for other influences. Larger Trusts, which acquire pooled budgets and additional resources for new teams could be regarded as ‘resource rich’ and able to meet their objectives for multi-disciplinarity in their community teams. They would be able, by using the new monies for new teams to populate them with whichever staff they deemed necessary. The local authorities who controlled the social care staff budget might be in difficult financial times and unable to find the required level of resources. More sinisterly, and we have nothing but anecdotal evidence to support this from our previous work, there remain some local authorities who are reluctant to spend what they see as social care resources on community mental health.
services, especially in the face of competing demands from services for children and older people.

Given the prominence of guidance in the mental health field we were surprised to find how much historical reasons dominated the picture, paradoxically for the new teams as well (although this finding partly may have arisen because a handful of the informants gave a single global rationale applied to all types of teams rather than distinguishing CMHTS from new teams). Some of the new teams may now have existed for long enough in some locations for history to be a real determinant. There was a difference between the answers for overall rationale, drivers of change, and social care composition, which adds to the face validity of these data. The reverse consideration, that many said that guidance determined CMHT composition is due to the fact that NICE guidance, the NSF and the NHS Plan could all be cited as guidance as to the composition of CMHTs. Only one Trust referred to external guidance, and there had been a number of published papers on the mental health workforce that could be construed as ‘guidance’, e.g. Boardman and Parsonage.\(^\text{(15)}\)

5.2.2 The social care composition of community mental health teams is extremely variable, ranging from nil to 88%

When one looks at the composition of the CMHTs and the new teams, especially over time, it is evident that, as Buchan\(^\text{(12)}\) suggests the supply of nurses is dominating the picture. The research we conducted took place at a time when the DH in England and the ADSS in Wales were preoccupied with introducing mechanisms to increase the supply of social workers. It is somewhat ironic, that the Chief Nursing Officer’s report in 2006\(^\text{(18)}\) is urging nurses to adopt values, perspectives and roles that have long been the basis for social work (and not just in the mental health field). Shifting the policy towards prevention and a wider perspective on outcomes, as New Horizons\(^\text{(1)}\) does in England is likely to require a skill set that is much more akin to that of a community worker than that of a therapist, although of course the latter will still be centrally significant for many workers and service users, as part of a whole person, personalised approach. We note, however, the results of a recent study of IAPT (improved access to psychological therapies) that showed a lack of impact on social outcomes.\(^\text{(165)}\)

There is some limited evidence that social workers take a different view of service delivery and may have different skills to other team members that add value to the service, which is, after all, the rationale for all multidisciplinary approaches. For example, it has been shown\(^\text{(54)}\) that social workers (and to some extent psychologists) in mental health teams take a different view about the use of compulsory treatment to other health professionals (i.e. psychiatrists and nurses); they also differ in their views
of compulsory community supervision\(^{(55)}\) suggesting that team composition might influence the type of care received.

There is also evidence that different professional groups differ in their assessment decisions. In examining the relationship between assessments and eligibility decisions made by health and social care staff in multidisciplinary community mental health teams in England, one study\(^{(56)}\) found that judgements about social care needs and levels of severity or complexity according to the CPA (Care Programme Approach) were distinct from one another. Judgements of assessed need and case complexity differed by professional group; social workers’ judgements about the need for social care were significantly related to an independent measure of complex needs; nurses were less able to distinguish between the critical and substantial social care needs of the Fair Access to Care Services (FACS) criteria.

### 5.3 The staff survey

**Aims:** Does variability in team composition make any difference to the way that these teams operate? The evidence produced may show that the social care component needs to be at a certain level in order for team climate to be positively affected, or it may show that having too many social care members interferes in an unhelpful way. In either event, this is useful information for those who plan the teams, and for those who manage them.

We need to attempt to make sense of a complex set of results and identify the main messages. It is perhaps best to concentrate on the multivariate analyses to begin with as they control for the influence of other variables, and focus on the major variables, such as integration, teamwork, job satisfaction and intention to leave the profession.

Before doing that we should note that there is extreme variability in the social care composition of teams, and while some Trusts indicated in the National Survey that some of the rationale was related to meeting needs in deprived areas, or promoting social inclusion, there was no clearly discernable association of higher social care staffing with well known centres of deprivation. The failure to observe any rationale for staffing multidisciplinary teams in older people’s services has been reported recently.\(^{(135)}\) The finding that the social care composition was lower where budgets were not pooled repeats the finding in the national survey that where local authorities have sole responsibility for funding, social care staffing is lower.

Higher integration scores were not explained by other integration related variables such as co-location, closeness of working relationships with other
team members. Instead it was related to not being in a CMHT, not being a nurse, social worker or support worker, and with better management. Better management emerged as an important predictor in four of the models, and we discuss the significance of this later.

The new teams have a lower proportion of social care staff than CMHTs, which means that the integration score may actually reflect greater uni-disciplinarity rather than integration as defined in section 3.2.1. Autonomy dropped out of the final model perhaps because of a close relationship between it and management style.

A similar interpretation might be placed on the fact that support workers’ integration ratings were higher where the social care component was higher. It is important to note that less than one-third of the variance of the integration variable was accounted for by the variables we entered into the model. Either we need to consider alternative variables in an effort to increase the proportion accounted for, or accept that the measure of integration we used has some inherent unpredictability about it. There is a sense in which the composition of the integration subscale, means that it is more akin to a secure professional identity within the team, this would be consistent with the univariate finding that professional group was not associated with integration. The multivariate analysis suggested that the ‘other’ category of staff (the doctors, OTs and psychologists) do have superior professional identity scores.

Professional group was also not associated with teamwork scores. Confidence in one’s role and flexibility in roles emerged as important determinants of higher teamwork scores - which is understandable. Greater social support may be a function of better management, and both may contribute to the feeling of fewer job demands.

Integration was not related to perceptions about the Quality of Care provided but teamwork and better management were. A higher proportion of social care staff in the team was also associated with higher QOC scores, which might have been due to the support worker scores for QOC being higher as indicated by univariate analysis, rather than the social workers’ perceived QOC scores, which were lower; nevertheless, initial regression models confirmed that social worker scores were lower and also indicated that support workers’ scores were no different to the nurse reference group when other factors were controlled for. This suggests that while culture clashes may be taking place between different models of care, such as medical and social, in fact this is a creative tension, and individual contributions are actually valued, creating a ‘whole’ that participants see as leading to a better quality of care (arguably the original purpose of
multidisciplinarity). Better teamwork and management also make a contribution to the perceive QOC. In one recent study\textsuperscript{135} the teams with higher quality of care ratings also had higher service costs.

For job satisfaction the main observations to make are that the model itself was somewhat flawed but supported by a similar, more robust logistic regression model. Both models had face validity in that job satisfaction was explained by fewer job demands, better management, closer working relationships, less role overlap, more decision latitude and better training opportunities. Co-location was also related to job satisfaction and that better management also explained job satisfaction. The intention to leave analysis was more robust but explained less than 40\% of the variance. Better training, being in a CMHT, having higher job satisfaction meant that staff were less likely to leave. Social workers were more likely to want to leave than other staff groups, as were support workers when social care staff were in the minority. This might account for the new teams being more likely to lose staff than CMHTs. The support workers have lower decision latitude and less autonomy (the latter is also the case in another recent report\textsuperscript{135}) and are quite likely to want to leave to better themselves (professionally or financially).\textsuperscript{24} (Both social workers and social care staff were more likely to leave community and intermediate care services for older people.\textsuperscript{135})

Finally, univariate analyses relating to inter-professional working relationships and role overlap indicated that there were close working relationship and some role overlap between ASW, other social worker, CPN and support worker roles. Inter-professional working varied according to location, being strongest in location C which is an integrated health and social care Trust, and weakest in location A. ASWs appear to work most closely and have most role overlap with a wider range of other staff groups. These variables only entered the job satisfaction regression model, where closer working and less role overlap with nurses appeared to have a positive effect; close working with nurses was associated with job satisfaction in more balanced teams.

5.3.1 Specific professional contributions or new ways of working?

The variability in team composition seen in the national survey was confirmed in the staff survey (because the locations were selected to be variable in their approach to the composition of team). New teams have an even smaller social care contribution than CMHTs. There is an argument to suggest that the new teams do not require the particular approach of social work or social support to be part of the team. This is at odds with the situation elsewhere in the world, for instance in relation to Assertive
Outreach teams, which in the USA are made up of far more social workers than nurses\(^{(13)}\). A National Audit Office report\(^{(69)}\) bemoaned the fact that only half of CRHTTs had even a part-time Approved Social Worker.

There is of course, a long standing dilemma here, which is how best to prepare the workforce for this kind of work. While the idea of core competencies for community mental health practice underpins the New Ways of Working in England\(^{(21)}\) there are problems with the competency approach adopted by the DH\(^{(21, 67, 166)}\), which has focused on the development of competencies and capabilities applicable to all mental health professionals. These plans have paid scant attention to the criticisms of the competency and capability models, which have no association with patient outcomes\(^{(167, 168)}\) but rather mechanistically fracture work performance into ‘task’ completion as opposed to the development of ‘learning’ that can be applied to new contexts.\(^{(169, 170)}\) A significant body of research suggests that the competency and capability model is in fact characteristic only of ‘novice’ practice, given that ‘expert practice’ is characterised not by the acquisition of de-contextualised competencies but by experience that blends formal with tacit knowledge.\(^{(171-173)}\) These UK developments seem to share a common failing of capability frameworks, which are rarely used to assess real performance in practice.\(^{(174)}\) Finally, there are considerable problems in competency based workforce planning including the lack of data about the competencies of the existing workforce and a lack of clarity about how to derive commissioning strategies from competencies.\(^{(175)}\)

The concept of a generic community mental health worker raises its head every few years, but to date has not been explicitly mandated.\(^{(176)}\) We take this as a sign that organisational barriers and fundamental values, training and orientation to the work are sufficiently different for multi-disciplinarity to remain the cornerstone of community mental health care. This fact seems to have been recognised in respect of the Approved Mental Health Professional (AMHP), whose curriculum and training in England and Wales remains under the control of local authority partnerships.

### 5.3.2 Higher social care composition is related to perceived quality of care but not to WDQ integration

As the results of the staff survey suggest, however, the picture is more complicated than that. In univariate analysis, integration scores are higher where the social care component is lower. This is a similar finding to one in our previous work.\(^{(14)}\) In the multivariate analysis, however, the proportion of social care staff made no contribution to the variance of integration. Perceived Quality of Care is affected in the opposite way. In the multivariate analysis, quality of care is associated with higher proportions of social care staff in the team.
5.3.3 High social care composition is associated with a lower intention to leave the employer

A high social care component is associated with a lower intention to leave, again suggesting that staff are more content when a balanced service is working well. Conversely, those who are looking to leave the profession are working in teams with a lower social care component. This runs counter to the argument that when one staff group is in a minority, they feel more valued by their colleagues. As social workers are the most likely to want to leave this suggests that where they are in a distinct minority in the team they are more likely to want to leave. Workers in new teams are more likely to want to leave, not because they are younger, but perhaps due to the nature of the work or the nature of their contracts; alternatively they may be a more ambitious group, as demonstrated by their initiative in terms of their original move to a new team. Since the new teams have fewer social workers, it may be nurses and social support workers within those teams who want to leave.

Some of the Karasek JCQ results rather go against this picture. First of all psychological job demands are higher the more social workers and the more ASWs there are in the team. This seems to suggest that social workers and ASWs bring with them more complex cases (this is a finding from previous research)\(^{(177)}\) than is the norm in the team. In turn, the skills that the ASWs bring may be a welcome addition in this context. Another result suggests that support from colleagues and supervisors, is significantly lower where there is a larger proportion of social care staff. This may simply be an artefact of the less time available for support from senior staff, or the division of professional from team supervision, which, when both forms are operating, take up more time than combined supervision.

5.3.4 Management style is an important predictor

Management style emerged as a significant factor in four of the regression models, team integration, teamwork, quality of care, and job satisfaction. The fact that it did not enter into the intention to leave model could be viewed positively, as an indication that whatever variables did contribute to the intention to leave, management style was not one of them. The fact that management style contributed to the regression models and was related to greater social support, lower psychological job demands and greater decision latitude are also positive findings. Greater decision latitude implies greater autonomy. A number of previous studies have referred to the way in which management in community teams is low key and unlike the styles adopted in more structured environments. This produces relative autonomy when it comes to professional decision making.\(^{(178)}\) Teams operate from multiple bases and locations, and perhaps come together once a week (or less often) for a team meeting, and even less often for formal
supervision. Team members spend a large amount of their time in service users’ homes and communities. In such a context management is:

“...not about the rational task of resource distribution or task planning, but is about developing subjectivities which are self–governing and self tasking in the team and in the field.” (179) (p68)

In the absence of formal support and guidance from their senior colleagues (staff) have effectively become self-regulating so that professionalism itself has become a disciplinary mechanism.” (180) (p79)

This lack of managerial direction and the encouragement of generic working (and shared competencies), makes some team members more insistent on separate professional identities, and, according to some researchers (181) boundaries are actively encouraged by the experience of multi-disciplinary working. This strikes at the heart of the issues in the present study. Has the New Ways of Working agenda (74), inadvertently contributed to a renewed sense of professional identification, and to greater levels of stress within teams (182) by role blurring? Brown et al (182) argue (2002):

"The idea of health and social care staff working together with clearly defined roles is often frowned upon as poor and retrogressive practice, out of step with the government’s modernisation agenda, but increasingly blurred roles in already stressful and demanding clinical teams can be counterproductive, with practitioners becoming entrenched in their own perception of particular roles, and less flexible in their work.” (p38)

Others have come to a rather different conclusion (183) suggesting that local managers and team members tend to work together to promote professionalism. It has been suggested that since the strategic culture of management is about performance rather than the process by which performance is achieved, this allows local managers to support practitioners in their exercise of professional judgement. We found evidence that better management scores were related to greater decision latitude.

Recently the argument against the temptation to modernise mental health care by the creation of a generic mental health practitioners has been reiterated. (175) The case is made for the unique role of the mental health social worker, in challenging the emerging ‘bureau-medicalisation’ of mental health services resulting from the New Labour government’s policy agenda. Others (182) have suggested that well defined boundaries and clearly defined roles can be ‘supportive and enabling’. Over ten years ago, the argument was made for role clarity and the recognition and management of boundaries, rather than merging them. (184) It was suggested that the challenge is for CMHT operational policies to resolve the tensions at the service delivery level, by establishing: the teams aims, priorities, target
client group and boundaries; team membership and the roles and responsibilities of professional groups; eligibility criteria for access to services; agreed client pathways to and from care; unified models of case management and care coordination; standardised documentation; compatible information technology systems; shared standards for the exchange of information and the protection of client confidentiality; agreement over the role of team leader; and agreed management and accountability arrangements. On reflection then, another limitation of the present study may be that we did not collect more detailed information on these operational policies, which might have given a different perspective on the extent of integration at the coal face.

5.4 Service user interviews

**Aims:** Does the composition or characteristics of the teams, relate in any way to outcomes for service users? As one referee of the original proposal pointed out, without an understanding of whether the structure and the processes make a difference to outcomes, the exercise would be far less worthwhile and fail to address a key issue. We therefore need to interview service users, using standardised instruments to see if the differences in structure and process can be identified at the outcome stage. Service user researchers conducted the interviews in two of the locations.

As this Phase was not in the original proposal, the resources that could be devoted to it were less than ideal resulting in any quantitative analysis being underpowered. The results cannot be considered as robust, but rather as indicative findings. A larger better powered study is required.

As we did not have any clinical details about the service users, we cannot be certain that their diagnoses, length of illness or severity were the same in both locations. The fact that they match the age profile and gender profile and were all on the current caseload of a CMHT professional, means that they are broadly comparable in these terms. Also the profile of their MANSA and CUES scores are similar to results from elsewhere\(^{(142, 143)}\) and they were not significantly different in terms of their length of contact with the team.

Results in location D for satisfaction with their own mental health could be a reflection of greater clinical severity, or persons at an earlier stage of care and treatment than in A. The results for not working and for leisure indicate that service users may have needs in these areas that are not being met, or could reflect the fact that more people are being encouraged to want to improve these matters, than in A. The proportion wanting to improve their
work situation was significantly greater according to that MANSA item (Table 22).

The MANSA results are broadly consistent with the CUES results in that the satisfaction levels with mental health and leisure and not working are all low, and friends, safety and living accommodation are higher, approaching NPMS levels.

On the CUES, there are significantly better results for the present sample, compared to the national data, on all items except satisfaction with access, medication, access to physical health services and relationships with physical health workers. All these results are similar to those of Blenkiron’s\(^{(142)}\) responses against the normative statement. As indicated earlier a great deal of attention has been focused on user choice, improved access and greater involvement in care over recent years, and these results suggest that this effort is having some impact.

It was unfortunate that none of the City teams in location D responded to the WDQ survey, because this means that the A:D comparison is in effect an urban/rural comparison as well as a team culture/climate comparison. As a consequence some of the findings result more directly from the accessibility issues in rural areas rather than the way that services are delivered and organised. Having said that, the difficulty of access to services out of hours, which was a frequent complaint in D, could have been due to the way that this service was delivered. Also, D teams, despite the rural location, saw their service users more often, and everyone had been seen within the last four months. The aspects of the rural services that may have influenced the differences between A and D include the restriction on contacts with family members. The differences in the stigma experiences of the A and D users might also be because stigma may be less prevalent in closer, smaller communities. Certainly, the examples given of the stigma experiences in D came from contacts with the workers, whereas, on the whole, in A, stigma experiences seemed to relate more to the general public. A’s user experience of stigma and their dissatisfaction with it is at the same level as that in Lelliot’s study\(^{(143)}\) of ten years ago.

In both locations, relationships with the workers were, nevertheless, reported to be very positive, a common finding in research of this kind.\(^{(185, 186)}\) Higher ratings on the WDQ teamwork subscale did not differ by team, but were related to the service user ratings of available choice. Available choice and satisfaction with choice were both related to the overall job satisfaction of the workers. The integration subscale of the WDQ, which asks about access to peer support and formal management support from members of their own profession, and professional isolation, was unrelated.
to all the user experience data, suggesting that it is unobservable to the services users compared to other aspects of team culture and climate. Given the nature of the integration items this is not surprising, although one might argue that professional isolation might restrict professional development through the broadening of horizons, which might then have a negative impact on the user experience.

The only finding that reflected negatively on these locations when compared to the national figure, although not significantly so, was satisfaction with current medication. In clinical terms, this may be an issue that requires further investigation.

The small sample size along with multiple testing, require that these findings be treated with extreme caution. In addition, as there was more than one respondent per team in many cases, service user data, like staffing data are also nested within teams and locations, but the numbers are insufficient to be able to control for this, or to aggregate responses to the team level.

Nevertheless, the results suggest that the relationship between team culture and climate and service user satisfaction, ought to be demonstrable in a larger sample. Given the difficulties we have experienced in obtaining service user level data, such a study would have to have engaged with services at the pre-funding development stage, in order to achieve the complete support of the agencies involved, at all levels. Even then, there is a threat to successful completion posed by front-line workers who may be less enthused by or committed to the research, have inadequate time available to participate in the study and who may also be protective of their service users, and so act as a gatekeeper to their participation. There may be a case for seeking funding from the Research for Patient Benefit programme for a much larger and better powered study, (but these funds are not open to researchers in Wales). We note that the DH has funded such a study in England, under the SDO programme (187) which has ambitious targets, which if met, would give the study more power than the present study has achieved, but as we have indicated several times, gathering these data presents considerable challenges.

5.4.1 A more integrated service was less popular with service users

The theme of integration continues in the service user interviews, where the more integrated service according to the results of the national and staff surveys is less popular with the service users, who made significantly more negative remarks about it. It is important to recognise the potential here for sampling bias to be operating; Users from the two chosen locations had significantly different stigma ratings on both sections of the CUES.
(normative and satisfaction ratings). Interestingly, the bulk of the negative comments in the integrated service concerned aspects of the service or its workers. While this did happen in the less integrated service as well, the majority of these remarks concerned stigma experienced at the hands of the general public. Previous research has shown that while team members believe that they work towards the reduction of stigma for their service users, this represents a rather passive view of the service users. In reality, it was found that service users actively challenged discrimination themselves when they experienced it.\(^{182}\)

5.4.2 Quality of life outcomes were not different, but there were relationships between CUES variables and WDQ subscales (but not the integration subscale)

The outcome in terms of quality of life, as assessed by the MANSA did not differ, except in respect of relationships with family and family contacts. This may be to do with the rural nature of the more integrated service. Basically, integration appears to have nothing to do with the quality of life of the service user, nor does it bear any relation to the other outcome measures of service satisfaction and CUES. Other factors, such as teamwork, training and quality of care do relate to the CUES in meaningful ways. They suggest that well trained workers who can develop a good relationship with the service user are highly valued, and that users can recognise people who listen to and understand them, and who are knowledgeable and competent. This finding is in accordance with our earlier findings in relation to support time and recovery workers\(^{24}\) and with the views of others\(^{186}\) who argue that a high quality and stable relationship is the key to effective care, and not the professional background or individual skills of the worker.

"Anyone who has cared for someone with schizophrenia in the real world knows that what works best is a stable relationship with an understanding, patient and skilled person who stays with the patient, and their illness, over time, through thick and thin. Just how to achieve this in a culture hell bent on atomisation requires careful thought"

(p97).
5.5 How these results fit with previous research

In this study we have confined ourselves to integration in the mental health context; however, the results can usefully be located in a wider context. Minford\(^{(188)}\) conducted an international review of the health and social care boundaries in services for older people and mental health services. His conclusions are broadly in line with the general thrust of the present study. For instance:

"A broad strategy for integrated care should ensure that: care is person-centre and family-centred, with multidisciplinary needs assessment; accessible and adapted housing is available; there are transparent and flexible funding streams; care is provided by properly trained staff; people are assertively followed up and monitored with a focus on outcomes." (p3)

Anticipating the debate between integration and personalisation Minford\(^{(188)}\) argues that:

"With increasingly complex service delivery mechanisms, good outcomes are associated with making services revolve around people, not the other way round. Holistic care is likely to be both more efficient and more effective, consuming fewer total resources for a given output as well as yielding a better outcome for given inputs.” (p5)

He concludes that much of the international evidence suggests that multidisciplinary teams are worthwhile, in part because multidisciplinary assessment helps to identify all the client’s needs at the outset and therefore avoids time-consuming and costly problems arising either from undetected and unexpected complexity at a later stage or interagency referral processes. He acknowledges that multidisciplinary teams are hard to run given the different professional cultures. Finally, he suggests that the era of 'vertical' care delivery systems may be waning. Organisations which deliver care 'in one place' with vertical 'chains of command', e.g. hospitals and social services departments, have led to large health and welfare gains, but these hierarchical organisations may have reached a natural limit in delivering better care. He argues that horizontal forms of care delivery are better at providing integrated care. Examples of such models include: one-stop advice centres in Germany, 'Community Options' programs in the USA, coordinated care agencies, home and community care programmes in Australia and multidisciplinary mental health care in New Zealand. Recognising the challenges in implementing ‘horizontal’ care he lists the hurdles to be overcome:

"...the steep learning curve associated with fund pooling; the challenges of multidisciplinary team working; the difficulty of accurately targeting
home health care on those who would otherwise be institutionalised and the shortage of unpaid carers and respite facilities.” (p6)

"Ultimately, without a single funding source for chronic care, it will be hard to deliver truly integrated care. Countries with systems of social insurance and the Scandinavian countries with comprehensive public health and social care systems get closest (but not very close) to unitary funding. However, even in these countries there are still significant operational boundaries between agencies at local level.” (p4)

5.5.1 Organisational integration

There is little systematic or conclusive evidence available about the benefits of service integration. Almost twenty years ago, a review of organisational integration in respect of older people (189) identified ‘surprisingly few’ empirical studies. It concluded that instead of empirically based reports, the literature is “largely comprised of polemics, which essentially restate long-standing positions on the preferred handling of integration.” About ten years ago, national demonstration projects for people with serious mental health problems in the USA (190) produced evidence for service system change and improvement but little consistent evidence for improved client-level outcomes. About the same time Provan (191) found that integrated services were not as productive as single provider organizations; in contrast to the generally held wisdom that "more integration is better," he found that high integration among provider agencies does not result in more favorable outcomes, but that service integration is most effective when coordinated through a single core provider.

Also ten years ago a literature review of integration within health care involving the organisational merger of acute and community services in the UK (192) found that combined trusts were no more likely to provide integrated acute and community services than separate trusts. They were no more likely to provide formally or informally integrated services or better quality patient care in terms of arrangements for discharge and continuity of care. Separate acute and community trusts experienced greater problems than combined trusts in planning and developing continuity of care across the interface between health care and social services. These findings are consistent with work in the Netherlands (193), which suggested that while the common assumption that the feasibility of integrated care provision is caused by characteristics of the legislation, the financing system and other aspects of the institutional context, these characteristics are not decisive. In contrast, the conclusion of this work was that the commitment of the actors involved, their support and the way developments are managed, make the difference to outcome.
5.5.2 Team level integration

The evidence for service integration at this level is also conflicting, producing different perceptions between staff and user groups. Two studies used a naturalistic successive measures design in which community mental health staff completed a questionnaire on three occasions during the integration process. In the first study, the integration of acute inpatient and continuing care services resulted in changes to service process and outcome, which were judged by staff to be beneficial, especially with respect to continuity of patient care. The second study showed that there was a negative impact on mental health service users, during the process of integration of two service teams, and that while this was reversed after integration, the previous levels of individual performance were not achieved within a further nine months.

5.5.3 Multidisciplinary integration

Integrated care pathways (ICPs) are structured multidisciplinary care plans that detail essential steps in the care of patients with a specific clinical problem. Designed to encourage the translation of national guidelines into local protocols and subsequently into clinical practice, they are often used where people have overlapping health and social care needs. Jones has described their use in the mental health field where he found that there were some conceptual and implementation problems, particularly in pre-formulating the work of different disciplines into a care pathway sequence. Nevertheless, a study of integrated case and care management for older people in Italy found results similar to the early PSSRU community care experiments in the UK, suggesting that integrated care may be a cost-effective approach to the reduction of hospital admissions and functional decline in community residents. A similar conclusion was reached in a review of stroke care. Others have described the potential for ICP in the NHS and with reference to clinical governance. In one of the few empirical studies of ICP (for people with Parkinson’s disease) ‘disturbingly few’ community care assessments were being carried out and low levels of provision existed in some key community support services, despite high levels of need. The authors attribute these problems to weaknesses in joint working and inter-professional communication. They recommended instead, the resourcing and supporting of individual service users / carers in the management of their own care pathways.

This brings us neatly to the present preoccupation with personalization, and the hopes of the Darzi review and New Horizons that care may be improved through this means. One could argue that, given the failure of integration both conceptually and empirically to demonstrate a convincing
relationship with patient outcome, it is perhaps time to abandon it to rhetorical status and concentrate instead on what works for the individual users, family members and team workers. Whatever the future holds for the idea of integration, researchers, policymakers and practitioners need to provide a clear idea of exactly what it is that is being integrated. Also, we should not allow the term ‘health and social care’ to be used without greater specificity about what exactly is meant by the ‘social care’ element in any specific context.

Organisational culture is said to include the following items that are shared\(^{(204)}\) (in this case within the team): beliefs, values, attitudes, norms of behaviour, routines, traditions, ceremonies, rewards, meanings, narratives and sense-making. One can see that where workers come from essentially different cultures that a clash of cultures is more likely to occur. The evidence suggests that there are significant points of divergence in the ideology and work of the professions of nursing and social work, for instance.\(^{(184)}\) The results of our multivariate analysis, however, suggest that this mix may be a creative rather than a comfortable one, resulting in a higher perceived quality of care. This finding is consistent with a positive view of the outcome of inter-professional working\(^{(205)}\), which is in contrast to the often reported barriers to working caused by different professional backgrounds.\(^{(206, 207)}\)

Whether the creative mix translates into outcomes for the service users cannot be answered definitively by the present study, but the indications are that it probably does, and the qualitative data provides a little support for this proposition. If multidisciplinary community teams were impaired by this meeting of cultures then one might have expected them to have a much shorter shelf life, and the literature we reviewed earlier confirms that in mental health and other services there are advantages to multidisciplinary team-working. Disappointingly, from the social care perspective is the fact that while the social care contribution has been maintained in CMHTs, CMHTs themselves are now less well resourced and the new teams are well resourced but less multidisciplinary. To engage with and implement government policy aspirations will require the organisation of community mental health services to be revisited as it appears not to be fit for that particular purpose.

More than 95% of CMHTS in England now describe themselves as fully integrated\(^{(64)}\) by which they mean, integrated in the limited sense of social workers being employed by the mental health Trust in some form, or are working in joint and often co-located teams. In one sense, therefore, there is no longer any variance in the concept of integration when used in this loose way; its meaning and usefulness could be said to be diminished as a consequence.
Lower social care composition leads to a better integration score, which is counterintuitive. Close working relationships between CPNs, ASWs and other social workers (and all nurses and all social workers) is unrelated to the integration score. What if the integration subscale is really a measure of secure professional group identity? (This may be the case given the nature of the three items that make up the integration subscale). Then the lower social care leading to a higher integration score makes more sense.

If location D is characterised as more integrated than location A then this could be interpreted as location A staff having a more secure professional group identity (more of them are nurses). The same result applies to support workers whose integration scores are higher when they are in teams with larger social care composition. In these teams the social care staff have a more secure professional group identity.

Better integration scores are associated with the new teams, but again this is counterintuitive as they are dominated by nurses. If the WDQ integration subscale is really an indicator of a secure professional group identity, then again it makes intuitive sense that the new teams should have higher scores.

Better integration scores are associated with not being a nurse, social worker or support worker, in other words being a member of one of the clearly identifiable professions of psychiatrist, psychologist or occupational therapist.

Job satisfaction is related to having less overlap with the role of nurses. This is not a diatribe against nurses, whose presence in the teams is essential, (albeit driven more by supply factors than need), but it does suggest that weakening the professional group identity of any of the team members may be counterproductive, and that New Ways of Working may be contributing to a loss of identity especially for the two groups making up the bulk of the CMHT workforce, nurses and social workers.

If location D can be characterised as integrated, with a high level of support workers, and more close working than location A (see the radar charts for A and D (more close working with support workers and psychologists), then this is not as popular with the service users, as in the service provided by the less integrated location A. Thus a secure professional identity, combined with a good relationship with the service user produces a more positive response from the service users in location A. Integration may be invisible.
to the service user, who thinks more in terms of key relationships with different workers.

Finally, the results of research into the outcomes of the new teams suggest that they are positive and better than the traditional CMHT outcomes. These teams have even fewer social care staff in them, so one might conclude that these outcomes have been produced by staff with a secure professional identity, and without, on the whole, much social care input; therefore a social care component is not necessary to achieve improved outcomes. Alternatively, where there are few actual social care staff, someone, in most cases nurses, must be undertaking social care tasks with service users (such as we observed in free text responses to the staff survey in location A) that would otherwise be undertaken by social care staff. So, one might conclude, again, that the social care composition of the team is immaterial to the delivery of what the service user needs, so long as someone is skilled in assessing and providing appropriate help for social problems and can produce equivalent outcomes. We have seen in previous work\(^{56}\) however, that social workers make more accurate assessment of complex social needs, than nurses.

In addition, there is an emerging sense that the outcomes that the new teams improve on may not always be related to the social outcomes valued by service users\(^{56, 165}\) but are more often clinical in nature (admission rates\(^{47, 82}\) community tenure rates, symptom levels etc.\(^{48}\)). Whether this means that social care needs are not being assessed and addressed appropriately (something hinted at in the service users free text responses) cannot be determined by the present study. New Ways of Working could be said to be attempting to address this issue by bringing everyone to the same level of competence in these areas, including assessment\(^{208}\), however the approach continues to rely on examples of good practice rather than a firm evidence base, and as indicated earlier may be based on a flawed approach. More research is needed to see if the models advocated really do produce an improved quality of work experience for workers and improved quality of care and quality of life for service users.
6 Conclusions and recommendations

- The national survey of mental health service managers confirmed previous research and opinion, that there is a need to improve workforce planning by developing links between supply and demand factors and financial resources.

- The national survey of mental health service managers confirmed that the social care component of community teams is extremely variable and determined more by supply and historical factors than need. Therefore, the social care component of community mental health teams needs to be reconsidered especially in the light of the recent changes in the policy agenda. Most recent policy guidance is the driving factor for planned changes to teams, and none of this guidance refers to compositional factors.

- The multivariate analysis suggested that a strong social care component in teams seems to be related to reported better quality of care. Multi-disciplinary inter-professional care which has been seen as a barrier to integration may be a more creative force than previously supposed and should be the subject of further research.

- The multivariate analysis suggested that integration scores contributed very little to the models of job satisfaction and intention to leave. There was no relationship between this measure of integration and service user experience, but this part of the study was underpowered to discover such a relationship.

- The concept of integration needs specific explication in every context in which it is used, and its value as a useful concept in health and social care delivery may need to be reappraised.

- The survey of teams showed that social workers were in short supply in some teams, and entirely absent from some. As they were also shown to be the most likely to want to leave urgent attention needs to be paid to the supply of social workers for work in adult mental health services.

- The survey of workers used two particular measures and there is scope for further research to use other measures to assess the nature of the culture and climate difference between teams, and their causes.

- The interviews with service users used standardized measures of quality of life and user experience. There was no relationship between the culture...
and climate measure and the quality of life measure (but this part of the study was underpowered). In future research new user determined outcome measures could usefully be added to attempt to capture the effects of team differences and different working practices and operational policies on larger samples of service users.

- The knowledge base in relation to culture and climate is a growing one, as is the development of methods to capture the user experience, and these can be usefully linked in future research. The knowledge base in relation to social work and social support workers is also growing, but there are widely acknowledged research capacity problems (both in the availability of dedicated research funding and in a research skilled workforce) that mean that the pace of development is not rapid. Further investment in social work and social care research ought to be a priority given the changing policy agenda in mental health in both England and Wales.

- More research is needed to see if the models advocated really do produce an improved quality of work experience for workers and improved quality of care and quality of life for service users.
References


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Appendix 1

INFORMATION SHEET FOR PARTICIPANTS IN THE SURVEY

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Culture and Climate in Community Teams
SDO/114 - Integration of social care staff within community mental health teams

1.0 We would like to invite you to participate in this evaluation project (see specifically section 3 below and the 5 attached questions.). You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. (Contact Peter Huxley at P.J.Huxley@Swansea.ac.uk or 01792 602548).

2.0 Based at the University of Wales, Swansea, the Centre for Social Carework Research (CSCR) undertakes a wide variety of research projects concerning social work and social care. We have been given a grant by the Department of Health in England (from the National Coordinating Centre for Service Development and Organisation Research; SDO/114) to undertake a study of the culture and climate in community teams and the relationship with outcomes for service users. Previous research, almost all in the United States of America, has shown that the type of team culture and climate can have an effect on the outcomes of service for service users. The present study is the first of its kind in the UK and will assess whether the same relationship between culture and climate (measured using standard instruments) and outcomes (measured using standard instruments and service data) exists in community teams here, or not.

3.0 The first part of the study for which we are seeking your participation is a national survey of mental health services providers. We are interested in how community mental health team (including assertive outreach and crisis team) membership has been determined, and what factors affected the staffing decisions. This will require one brief interview with the senior service manager with the overall responsibility for current CMHT provision. We are aware that this person will not always have been party to the original staffing decisions which may have been made...
some time ago. However, we are also interested in current staffing levels and future plans, as you can see from the list of questions below.

4.0 We will not use your name, or the name of your Trust in any reports of this work and it will not be made known who took part. However, we might use some of the things you say to illustrate and support the findings of the evaluation. It is possible, but very unlikely, that someone who knows you very well might be able to identify you from such comments, but we will make every effort to minimise this possibility.

5.0 All information is held anonymously, using ID codes, and kept in secure systems. Hard copy records will be shredded at the end of the project and anonymous computer files held securely with password protection for 7 years and then destroyed.

6.0 It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will have no effect on you and we will not inform your managers or other staff members that you have withdrawn.
CONSENT FORM FOR PARTICIPANTS IN THE SURVEY

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: CULTURE AND CLIMATE IN COMMUNITY TEAMS (SDO/114)

- Thank you for considering to take part in this research. The person organizing the research must explain the project to you before you agree to take part.

- If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I understand that if I decide at any other time during the research that I no longer wish to participate in this project, I can notify the researchers involved and be withdrawn from it immediately.

- I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Participant’s Statement:

I ______________________________________________________________________

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed ___________________________ Date ___________________________

Investigator’s Statement:

I ______________________________________________________________________

confirm that I have carefully explained the nature, demands and any foreseeable risks of the proposed research to the participant.

Signed ___________________________ Date ___________________________
QUESTION LIST

Id

Q1 How many community teams are currently provided by your organisation? (please specify whether CMHT, Assertive outreach, crisis resolution, early intervention or other)

Q2 What is the current staffing level of these teams, by discipline?

Q3 What factors determined the present staffing levels?

Q4 Have you any plans to change the current staffing levels, and if ‘yes’ what factors are being taken into consideration?

Q5 How do you determine the need for and level of social care staffing in these teams? (please specify whether social workers, social support workers or others)
Appendix 2

Mental Health Workforce Study

_Funded by NIHR-SDO_

Workforce Dynamics Questionnaire and Karasek Job Content Questionnaire

We are very grateful to Dr Susan Nancarrow, of the School of Health and Related Research, University of Sheffield, who devised the Workforce Dynamic Questionnaire (WDQ)*, and who has allowed us to adapt it for our study, which surveys Mental Health as well as Older People’s teams, and in Scotland and Wales as well as in England.

**INSTRUCTIONS FOR COMPLETION OF THESE QUESTIONNAIRES**

- Please use black or blue ink to complete the form
- Please note that **only one** answer can be selected

All information provided will be strictly confidential. Results will be reported anonymously and care will be
taken to ensure that there is no chance of identifying any individual views.

*Please answer every question.*
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Workforce Dynamics Questionnaire

To be completed by each team member

This survey examines a range of issues around your experiences of working in your current job, including your job satisfaction, team working, and role overlap with other practitioners.

Please answer every question.

<table>
<thead>
<tr>
<th>Please sign the consent form before completing these questionnaires</th>
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<tbody>
<tr>
<td>I. Have you signed your consent form?</td>
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<tr>
<td>II. To which team do you belong?</td>
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<td></td>
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<tr>
<td>III. What is your professional group or discipline?</td>
</tr>
<tr>
<td>1. Dietician</td>
</tr>
<tr>
<td>2. General practitioner</td>
</tr>
<tr>
<td>3. Geriatrician</td>
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<tr>
<td>4. Psychiatrist</td>
</tr>
<tr>
<td>5. Other doctor</td>
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<tr>
<td>6. Community Psychiatric Nurse</td>
</tr>
<tr>
<td>7. Other nurse</td>
</tr>
<tr>
<td>8. Occupational therapist</td>
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<td>9. Physiotherapist</td>
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<tr>
<td>10. Podiatrist</td>
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<tr>
<td>11. Psychologist</td>
</tr>
<tr>
<td>12. Secretary / admin</td>
</tr>
<tr>
<td>13. Social worker</td>
</tr>
<tr>
<td>14. Approved Social Worker (Eng/Wales)</td>
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<tr>
<td>15. Mental Health Officer (Scotland)</td>
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<tr>
<td>16. Speech and language therapist</td>
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<tr>
<td>17. Support worker (mainly social care)</td>
</tr>
<tr>
<td>18. Support worker (mainly nursing/ persona/ recovery care)</td>
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<tr>
<td>19. Support worker (other/ generic)</td>
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<td>20. Other</td>
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IV. What is your current grade or designation? i.e.

for NHS staff - Agenda for change (AfC) grading;
for Social Work – grade = ‘up to 3’/ 4/ 5/ ‘6 or above’

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<thead>
<tr>
<th>Please tick</th>
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<tr>
<td>AfC .......... SW ...........</td>
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V. Are you in a team leader/management role?

VI. What is the time commitment of your work in this team

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<th>Please tick</th>
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<tr>
<td>1. Full time</td>
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<td>2. Part time</td>
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<td>3. Other (Please State) ..................</td>
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</table>

VII. Gender

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<th>Please tick</th>
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<tbody>
<tr>
<td>1. Male</td>
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<tr>
<td>2. Female</td>
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</tbody>
</table>

VIII. What is your year of birth?

1 9 ... ...
IX. Are you a volunteer? 

Please tick

1. Yes If Yes, please skip to question XI
2. No

X. a) How many hours are you contracted to work each week in this team?
   b) Who pays your salary for your work in this team?

   a) .............. Hours per week
   b) ....................................

XI. a) How long have you worked in this team?
   b) How long have you worked in this general kind of care provision (but not necessarily in this particular type of team)?

   ............ Years ........... Months
   ............ Years ........... Months

Role overlap

This question relates to the amount of role overlap you have with other practitioners in your team (including practitioners who are not a regular part of your team).

How closely do you work with the practitioners listed below?

By 'how closely' we mean the extent of liaison/discussion in dealing with a case/client.

You should score this between 0 and 5, to specify 'how closely'.

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<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
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Note: If you work with a team member whose 'skills/training' is not listed below, please write their 'profession' in an 'Other' box and complete columns B & C for that person, as for the listed practitioners.

How much does your role overlap with other practitioners in your team?

By 'role overlap' we mean the extent to which you undertake the same tasks as part of patient/client care (e.g. ordering equipment, interacting with clients/patients, organising referral).

You should score this between 0 and 5, to specify 'how much role overlap'.
<table>
<thead>
<tr>
<th>Role</th>
<th>Do not work</th>
<th>I work very closely with</th>
<th>No overlap at all</th>
<th>A great deal of role overlap</th>
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<td>Dietician</td>
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<td>Geriatrician</td>
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<td>General practitioner</td>
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<td>Psychiatrist</td>
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<td>Other doctor</td>
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<td>CPN</td>
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<td>Other Nurse</td>
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<td>Occupational therapist</td>
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<td>Psychologist</td>
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<td>Social worker</td>
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<td>Approved Social Worker</td>
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<td>Mental Health Officer (Scotland)</td>
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<tr>
<td>Speech and language therapist</td>
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<tr>
<td>Secretary / admin</td>
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<tr>
<td>Support worker *</td>
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<tr>
<td>Other 1 specify</td>
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<tr>
<td>Other 2 specify</td>
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*support worker includes social care worker, personal care, therapy assistant, recovery worker, generic worker, etc
Overall, how satisfied are you with your current job? *Please tick*

**On a scale of 1 (strongly disagree) to 10 (strongly agree) please mark which is closest to how you feel.**
(n/a = not applicable)

### Autonomy and role perception

- Most of my work involves following instructions given by other people
- I am responsible for delegating work to my colleagues
- I am responsible for deciding what care the client / patient needs
- I make important decisions that influence the direction of my team
- I am often placed in a position of having to do things that are against my professional judgement
- I am proud of my profession / discipline

- My profession is well understood by the people I work with
- My profession is well understood by the general public
- My role is valued as highly as that of the other members of my team
- If I could, I would change my profession

### Role overlap

- I am confident in my own role in my current job
- I sometimes feel threatened by the amount that others’ roles overlap with mine
- I have learnt a lot about the roles of other staff by working in this team
- I undertake joint patient visits with other members of my team
- I have learnt a lot of new skills working in my current job
- I am at risk of losing skills by working in my current job
My job requires that I am flexible in my role

**Uncertainty**

- I am unclear about the future direction of my team
- I am clear of my role within the team
- I have a clear idea of how my team will look one year from now.
- I feel secure in my current job

**Workload**

- The workload in my current job is too high
- I am satisfied with the hours I am required to work (eg shift work etc)
- I would like to have more flexibility in my hours
- I am not paid enough to reflect the level of experience and responsibility my job requires

**Innovation**

- Much of my work is governed by care protocols or clinical pathways
- I have to be innovative to work in my current job
- My current job enables me to be innovative in my role

*On a scale of 1 (strongly disagree) to 10 (strongly agree) please mark which is closest to how you feel.*

*(n/a = not applicable)*

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Agree</th>
<th>Strongly</th>
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<tbody>
<tr>
<td>Disagree</td>
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</table>

**Integration with peers and colleagues**

- I have access to peer support from members of my own profession
- I have formal management support from a member of my own profession
- I am professionally isolated
- My team members have a clear understanding of my role
- Team members make appropriate referrals to me

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My contribution is listened to in team meetings

My team works well together

### Team working

- My team has shared goals
- My team often disagrees on the treatment of a client/patient
- Team members can negotiate differences to reach a common understanding
- There is not much conflict within my team
- I get on well with my team members
- My team has a clear and common focus
- I am a valued member of my team
- I feel confident to voice my opinion in my team

### Management structures and styles

- I have a clearly defined line manager
- I am satisfied with the management of my team
- I can voice my concerns to my manager
- My manager is accessible
- My manager understands my role

### Access to technology and equipment

- I have access to the type of equipment I need to do my job (eg equipment, aides)
- I can access appropriate equipment when I need it
- I have access to administrative support when I need it
- I have access to a computer at work
On a scale of 1 (strongly disagree) to 10 (strongly agree) please mark which is closest to how you feel.
(n/a = not applicable)

<table>
<thead>
<tr>
<th>Training and career progression opportunities</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have clear career opportunities in my current job</td>
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<tr>
<td>I have access to training if I need it</td>
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</tr>
<tr>
<td>I am satisfied with the career development opportunities offered by my current job</td>
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<tr>
<td>I am more satisfied working in my current job than in other places I have worked</td>
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</tr>
<tr>
<td>If I want to progress professionally, I will have to leave my current job</td>
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<tr>
<td>I cannot see a clear direction for my future in my current job</td>
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<tr>
<td>I can take time off work for training if I need to</td>
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<tr>
<td>I have the opportunity to specialise in my current job</td>
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<tr>
<td>I am planning to leave my current employer in the next twelve months</td>
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<tr>
<td>I am planning to change my profession in the next twelve months</td>
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</table>

<table>
<thead>
<tr>
<th>Feeling prepared and trained for the role</th>
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</thead>
<tbody>
<tr>
<td>I have the skills necessary to do my job</td>
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<td></td>
</tr>
<tr>
<td>If I am uncertain about an aspect of client/patient care, I can always access someone who can help me</td>
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<td></td>
</tr>
<tr>
<td>The quality of the care provided where I work is good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My service benefits the clients/patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My team has clear systems for resolving disputes or workplace problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank you very much for completing the Work Force Development Questionnaire, now please complete the Karasek questionnaire on page 7

**KARASEK JOB CONTENT QUESTIONNAIRE**

Instructions: Please tick **ONE** response to each statement

**KARASEK JOB CONTENT QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Skill Discretion</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My job requires that I learn new things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My job involves a lot of repetitive work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My job requires me to be creative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My job requires a high level of skill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get to do a variety of things in my job</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have an opportunity to develop my own special abilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision Authority</th>
<th></th>
</tr>
</thead>
</table>

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Project 08/1619/114
<table>
<thead>
<tr>
<th>My job allows me to make a lot of decisions on my own</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my job, I have very little freedom to decide how I do my work</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>I get a lot of say about what happens in my job</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

**Psychological Job Demands**

<table>
<thead>
<tr>
<th>My job requires working very fast</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My job requires working very hard</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>I am not asked to do an excessive amount of work</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>I have enough time to get the job done</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>I am free from the conflicting demands that others make</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

**Supervisor Social Support**

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<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My supervisor/ immediate superior/ teamleader is concerned about the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>welfare of those under her/him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My supervisor/ immediate superior/ teamleader listens to what I am saying</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My supervisor/ immediate superior/ teamleader is helpful in getting the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>job done</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My supervisor/ immediate superior/ teamleader is successful in getting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>people to work together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-worker Support</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>People I work with are competent at doing their job</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People I work take a personal interest in me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People I work with are friendly in getting the job done</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you very much for completing these questionnaires
If you have any comments about your work or this survey please give them below:

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
 ........................................................................................................................................

The address for return of completed surveys is:
Centre for Social Work and Social Care Research
School of Human Sciences
Swansea University
Singleton Park
Swansea
SA2 8PP
Appendix 3

INFORMATION SHEET FOR PARTICIPANTS - TEAM MEMBERS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Culture and Climate in Community Teams

We would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information; a research team member will answer your questions on the day of participation, or you can contact one of the research team at these numbers:

Professor Peter Huxley 01792 602548
Dr Sherrill Evans 01792 602605
Chris Baker 01792 602624
Sally Philpin 01792 602632
Jo White 01792 602631

Based at Swansea University in Wales, the Centre for Social Work and Social Care Research undertakes a wide variety of research projects concerning social work and social care. We have been given a grant by the Department of Health in England (from the NIHR Service Delivery and Organisation Programme) to undertake a study of the culture and climate in community teams and the relationship with outcomes for service users. About 40 teams will be taking part in the study. Previous research, almost all in the United States of America, has shown that the type of team culture and climate can have an effect on the outcomes of service for service users. The present study is the first of its kind in the UK and will assess whether the same relationship between culture and climate (measure using standard instruments) and outcomes (measured using standard instruments and service data) exists in community teams here, or not.

Participating teams will have been identified on the basis of a national survey, and senior executives of your organisation will have consented to the organisation’s
participation by the time you receive this invitation. In selected sites (ones which differ in terms of social care composition) teams will be randomly selected from team lists provided by service managers. Participation is entirely voluntary and all information is held anonymously, and teams are identified by ID only.

A number of service user and carer participants will be randomly selected from the caseloads of teams which vary in their proportion of social care workers, and they will be interviewed about their experience of the help that they have received and complete a standard questionnaire about their needs.

If you are willing, we would like you to:

- Either at one half day team meeting or specially convened meeting, complete standard instruments on team culture climate and organisation. This should take less than one hour.

- At the same time, indicate which people on your current caseload, who are not in hospital, or detained under the provisions of mental health legislation, could be included in a list of potential interview subjects, from which a random sample would be invited by letter to participate in interviews with user researchers about the care they have received.

We will not use your name in any reports of this work and it will not be made known who took part. However, we might use some of the things you write in response to the questions, to illustrate and support the findings of the evaluation. It is possible, but very unlikely, that someone who knows you very well might be able to identify you from such comments, but we will make every effort to minimise this possibility.

All information is held anonymously, using ID codes, and kept in secure systems. Hard copy records will be shredded at the end of the project and anonymous computer files held securely with password protection for 7 years and then destroyed.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will have no effect on you and we will not inform your managers or other staff members that you have withdrawn.
CONSENT FORM FOR PARTICIPANTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet (Version 2 December 2007) and/or listened to an explanation about the research.

Title of Study: CULTURE AND CLIMATE IN COMMUNITY TEAMS

- Thank you for considering to take part in this research. The person organizing the research must explain the project to you before you agree to take part.

- If you have any questions arising from the Information Sheet (Version 2 December 2007) or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- I understand that if I decide at any other time during the research that I no longer wish to participate in this project, I can notify the researchers involved and be withdrawn from it immediately.

- I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.

Participant’s Statement:

I ____________________________

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed ____________________________ Date ____________________________

Investigator’s Statement:

I ____________________________

confirm that I have carefully explained the nature, demands and any foreseeable risks of the proposed research to the participant.

Signed ____________________________ Date ____________________________
INFORMATION SHEET FOR SERVICE USERS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Culture and Climate in Community Teams

We would like to invite you to participate in this evaluation project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (Contact Professor Peter Huxley at P.J.Huxley@Swansea.ac.uk or 01792 602548).

Based at the University of Wales, Swansea, the Centre for Social Carework Research undertakes a wide variety of research projects concerning social work and social care. We have been given a grant by the Department of Health in England (from the National Coordinating Centre for Service Development and Organisation Research) to undertake a study of community team membership and the effects it may have on people who use the services.

Participation is entirely voluntary and all information is held anonymously, and you will be identified by a number only.

If you are willing, we would like to interview you on one occasion to ask you to complete two brief questionnaires on your quality of life and your needs.

We will not use your name in any reports of this work and it will not be made known who took part. However, we might use some of the things you say to illustrate and support the findings of the evaluation. It is possible, but very unlikely, that someone who knows you very well might be able to identify you from such comments, but we will make every effort to minimise this possibility.

All information is held anonymously, using ID codes, and kept in secure systems. Hard copy records will be shredded at the end of the project and anonymous computer files held securely with password protection for 7 years and then destroyed.
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.
CONSENT FORM FOR SERVICE USERS

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

**Title of Study:** CULTURE AND CLIMATE IN COMMUNITY TEAMS

- Thank you for considering to take part in this research. The person organizing the research must explain the project to you before you agree to take part.

- If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

- *I understand that if I decide at any other time during the research that I no longer wish to participate in this project, I can notify the researchers involved and be withdrawn from it immediately.*

- *I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.*

**Participant’s Statement:**

I

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed  Date

**Investigator’s Statement:**

I

confirm that I have carefully explained the nature, demands and any foreseeable risks of the proposed research to the participant.

Signed  Date

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Appendix 5

MANSA Quality of Life Assessment – V2u

The MANSA asks a number of questions about your quality of life. The style and content of these questions have been developed and agreed by service users. The form takes only a short time to complete (about 10 minutes), the questions are quite easy and there are no right or wrong answers. The information that you provide is confidential.

What you do.

1. Please read all of the questions.

2. Most questions apply to everybody and should be completed by everyone. Some questions have instructions that tell you whether or not the question applies to you, for example there are some different questions for people who are working compared to those who are not working.

3. For most questions you just need to tick one box to answer the question. For some questions you may be able to tick more than one box, for example to show that you live with a parent and other family. Most questions have instructions that tell you whether you need to tick one box only or whether you can tick as many boxes as apply to you. Please follow these instructions carefully.

4. Some of the questions ask how you feel about certain aspects of your life and look like the examples below. Each number on the scale describes how you feel, ranging from 1 for terrible to 7 for delighted. Here are some examples of how this scale should be used.
If you think that a part of your life e.g. health is as bad as it could be you should tick box 1 like this:

<table>
<thead>
<tr>
<th>Terrible</th>
<th>Mostly dissatisfied</th>
<th>Mostly satisfied</th>
<th>Delighted</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Displeased    Mixed    Pleased

If you think that your health couldn’t be any better you should tick box 7 like this:

<table>
<thead>
<tr>
<th>Terrible</th>
<th>Mostly dissatisfied</th>
<th>Mostly satisfied</th>
<th>Delighted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Displeased    Mixed    Pleased

5. If you make a mistake or change you mind about an answer, please make sure that it is clear which response you want us to take notice of.
**MANSA QUALITY OF LIFE ASSESSMENT**

**Date of completion**

**I.D. NUMBER**

**DEMOGRAPHIC DETAILS**

**DATE OF BIRTH (dd/mm/19yy)**

- [ ]
- [ ]
- [ ]

**GENDER**

- Male
- Female

**ETHNIC GROUP**

- White
- Pakistani
- Black Caribbean
- Bangladeshi
- Black African
- Chinese
- Black Other
- Other
- Indian

**LIFE IN GENERAL**

1. **HOW DO YOU FEEL ABOUT YOUR LIFE AS A WHOLE, TODAY? (Please tick one box only)**

   - Terrible
   - Mostly dissatisfied
   - Mostly satisfied
   - Delighted
   - Displeased
   - Mixed
   - Pleased

**HEALTH**

2. **HOW DO YOU FEEL ABOUT YOUR HEALTH? (Please tick one box only)**

   - Delighted
   - Terrible
   - Mostly dissatisfied
   - Mostly satisfied
   - Displeased
   - Mixed
   - Pleased
3. **How do you feel about your present mental health? (Please tick one box only)**

   Delighted   Terrible   Mostly dissatisfied   Mostly satisfied
   [ ]   [ ]   [ ]   [ ]
   Displeased   Mixed   Pleased

4. **In the past year, have there been times when you wanted to improve your health? (Please tick one box only)**

   Yes   No

5. **In the past year, have the chances for you to improve your health been restricted in any way? (Please tick one box only)**

   Yes   No

---

**Work and Education**

6. **How many months have you worked (part-time or full-time) in the past 2 years?**

   Months

7. **What is your current employment status? (Please tick one box only)**

   - In paid work
   - Looking after the home
   - In sheltered work
   - Unemployed and actively seeking employment
   - In training / education
   - Retired
   - Not working due to long-term illness or disability
   - Other
   - Other

8. **If working:**
9. **If working:**

   **On average, how many hours a week do you work?**

   [ ] [ ] Hours

10a. **If working:**

   **How do you feel about your job?** (Please tick one box only)

   [ ] Terrible  [ ] Mostly dissatisfied  [ ] Mostly satisfied  [ ] Delighted

   [ ] Displeased  [ ] Mixed  [ ] Pleased

10b. **If not working:**

   **How do you feel about not working?** (Please tick one box only)

   [ ] Terrible  [ ] Mostly dissatisfied  [ ] Mostly satisfied  [ ] Delighted

   [ ] Displeased  [ ] Mixed  [ ] Pleased

11. **In the past year, have there been times when you wanted to improve your work situation?**

    (Please tick one box only)

    [ ] Yes  [ ] No

12. **In the past year, have the chances for you to improve your work situation been restricted in any way?**

    (Please tick one box only)

    [ ] Yes  [ ] No
## Finance

### 13. How frequently (if at all) do you find it difficult to meet the cost of household bills? (Please tick one box)

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 14. How do you feel about your financial situation? (Please tick one box only)

<table>
<thead>
<tr>
<th>Terrible</th>
<th>Mostly dissatisfied</th>
<th>Mostly satisfied</th>
<th>Delighted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displeased</td>
<td>Mixed</td>
<td>Pleased</td>
<td></td>
</tr>
</tbody>
</table>

### 15. In the past year, have there been times when you wanted to improve your financial situation? (Please tick one box only)

Yes ☐  No ☐

### 16. In the past year, have the chances for you to improve your financial situation been restricted in any way? (Please tick one box only)

Yes ☐  No ☐

## Leisure

### 17. How many leisure activities do you do on a weekly basis (if any)? (Please tick one box only)

1 ☐  2 ☐  3 ☐  4 ☐  5 ☐  6 ☐  7 ☐  8 ☐
None
One
Two or three
Four or more

18. **HOW DO YOU FEEL ABOUT YOUR LEISURE ACTIVITIES? (Please tick one box only)**

- Terrible
- Mostly dissatisfied
- Mostly satisfied
- Delighted

- Displeased
- Mixed
- Pleased

19. **IN THE PAST YEAR, HAVE THERE BEEN TIMES WHEN YOU WANTED TO IMPROVE YOUR LEISURE? (Please tick one box only)**

- Yes
- No

20. **IN THE PAST YEAR, HAVE THE CHANCES FOR YOU TO IMPROVE YOUR LEISURE BEEN RESTRICTED IN ANY WAY? (Please tick one box only)**

- Yes
- No
**SOCIAL**

21. **DO YOU HAVE ANYONE WHO YOU WOULD CALL A 'CLOSE FRIEND'?**

   Yes [ ] No [ ]

22. **IN THE PAST WEEK HAVE YOU HAD CONTACT WITH A FRIEND (EITHER FACE TO FACE OR BY TELEPHONE)?**

   Yes [ ] No [ ]

23. **HOW DO YOU FEEL ABOUT THE NUMBER OF FRIENDS YOU HAVE? (Please tick one box only)**

   Terrible [ ] Mostly dissatisfied [ ] Mostly satisfied [ ] Delighted [ ]

   Displeased [ ] Mixed [ ] Pleased [ ]

24. **HOW DO YOU FEEL ABOUT THE RELATIONSHIPS YOU HAVE WITH YOUR FRIENDS? (Please tick one box only)**

   Terrible [ ] Mostly dissatisfied [ ] Mostly satisfied [ ] Delighted [ ]

   Displeased [ ] Mixed [ ] Pleased [ ]

25. **IN THE PAST YEAR, HAVE THERE BEEN TIMES WHEN YOU WANTED TO IMPROVE YOUR SOCIAL LIFE? (Please tick one box only)**

   Yes [ ] No [ ]

26. **IN THE PAST YEAR, HAVE THE CHANCES FOR YOU TO IMPROVE YOUR SOCIAL LIFE BEEN RESTRICTED IN ANY WAY? (Please tick one box only)**

   Yes [ ] No [ ]

**SAFETY**

27. **IN THE PAST YEAR, HAVE YOU BEEN A VICTIM OF VIOLENCE?**

   Yes [ ] No [ ]
28. **HOW DO YOU FEEL ABOUT YOUR PERSONAL SAFETY?** (Please tick one box only)

- Delighted
- Terrible
- Mostly dissatisfied
- Mostly satisfied
- Displeased
- Mixed
- Pleased

29. **IN THE PAST YEAR, HAVE THERE BEEN TIMES WHEN YOU WANTED TO IMPROVE YOUR PERSONAL SAFETY?**
   (Please tick one box only)

   - Yes
   - No

30. **IN THE PAST YEAR, HAVE THE ChANCES FOR YOU TO IMPROVE YOUR PERSONAL SAFETY BEEN RESTRICTED IN ANY WAY?**
    (Please tick one box only)

    - Yes
    - No
31. In which type of accommodation do you currently live? (Please tick one box only)
   - House or flat (owned)
   - House or flat (rented)
   - Boarding out (inc B&B)
   - Mobile Home
   - Hostel/ Supported or Group Home
   - Sheltered housing
   - Residential home
   - Nursing home
   - Hospital ward
   - Homeless

32. How do you feel about your accommodation? (Please tick one box only)
   - Terrible
   - Mostly dissatisfied
   - Mostly satisfied
   - Delighted
   - Displeased
   - Mixed
   - Pleased

33. In the past year, have you wanted to improve your accommodation? (Please tick one box only)
   - Yes
   - No

34. In the past year, have the chances for you to improve your accommodation been restricted in any way? (Please tick one box only)
   - Yes
   - No

35. Who do you live with (if anybody) in your current home? (Please tick all boxes that apply)
   - Live alone
   - Children over 18
   - Spouse / partner
   - Other family
   - Parent(s)
   - Non-family
   - Children under 18

36a. If living with other people:
   How do you feel about the people that you live with? (Please tick one box only)
   - Terrible
   - Mostly dissatisfied
   - Mostly satisfied
   - Delighted
   - Displeased
   - Mixed
   - Pleased
36b. If living alone:

How do you feel about living alone? (Please tick one box only)

- Terrible
- Mostly dissatisfied
- Mostly satisfied
- Delighted
- Displeased
- Mixed
- Pleased

37. In the past year, have you wanted to change your living arrangements? (Please tick one box only)

- Yes
- No

38. In the past year, have the chances for you to improve your living arrangements been restricted in any way? (Please tick one box only)

- Yes
- No

Family

39. How often do you have contact with a relative (not including those who live with you) either face to face or by telephone? (Please tick one box only)

- Not at all
- Daily
- At least weekly
- At least monthly
- At least 3 monthly
- At least yearly
- Less than yearly

40. How do you feel about your relationship with your family? (Please tick one box only)

- Terrible
- Mostly dissatisfied
- Mostly satisfied
- Delighted
- Displeased
- Mixed
- Pleased

41. In the past year, have you wanted to improve your family life? (Please tick one box only)

- Yes
- No

42. In the past year, have the chances for you to improve your family life been restricted in any way? (Please tick one box only)

- Yes
- No
LIFE OVERALL

43. HOW DO YOU FEEL ABOUT YOUR LIFE AS A WHOLE? (Please tick one box only)

- Delighted
- Terrible
- Mostly dissatisfied
- Mostly satisfied
- Displeased
- Mixed
- Pleased

Thank you for completing the Mansa
Appendix 6

CUES Service User Questionnaire

Carers’ and Users’ Expectations of Services

Contents

1 Where you live
2 Money
3 Help with finances
4 How you spend your day
5 Family and friends
6 Social life
7 Information and advice
8 Access to mental health services
9 Choice of mental health services
10 Relationships with mental health workers
11 Consultation and control
12 Advocacy
13 Stigma and discrimination
14 Your medication/drug treatment
15 Access to physical health services
16 Relationships with physical health workers

Other issues
Introduction

CUES has a number of different uses. Such as:

- To help plan your support or care;
- For you to keep track of what's happening in your life;
- Surveys.

If someone has given you this copy of CUES, they should explain what the information will be used for.

If you would like to use it for yourself but want more information, please contact rethink at the address on the back cover.

There are a few things you should bear in mind while completing CUES:

- CUES is about what is happening in your life. It is not about anybody else.
- CUES is not a test. There are no right or wrong answers.
- Each question asks how things are at the moment.
- If you read through the questions first, it will help you to work out the best place for everything you want to say.
- There is a space at the end of the questionnaire for you to mention anything that hasn't already come up.
1 Where you live

The place you live in should meet your individual needs. You shouldn’t have to worry about having to move out, and it shouldn’t be too out-of-the-way. You should be able to come and go when you want, be alone when you want, and not be harassed by the people you live with, by staff or by neighbours.

How does the place you live in compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the place you live in?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about where you live?
2 Money

You should have enough money to pay bills, stay out of debt and not miss meals. You should not have to feel isolated or cut off from society because of lack of money.

How does your money situation compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Do you have enough money to meet your basic needs?

Yes
Unsure
No
(please tick one box only)

What are your most serious money problems?
3 Help with finances

Many people find they need help with claiming benefits, filling in forms, and working out how to manage their money. You should get as much help as you need to do these things.

How does the help you get compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the level of help you get with your finances?

Yes
Unsure
No
(please tick one box only)

What aspects of your finances would you most like help with?
4 How you spend your day

You should have the opportunity of spending your day in some form of regular and meaningful activity. This could be working, studying, training, going to a day centre or to a day hospital.

How does the way you spend your day compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the way you spend your day?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about how you spend your day?
5 Family and friends

Mental illness can affect a person's relationships with the people he or she cares most about. You should be able to maintain good relationships with the people closest to you.

How do your relationships compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your relationships with the people closest to you?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about your relationships?
6 Social life

You should have the opportunity to mix with people and form new friendships and relationships. To make this possible, you should have enough money, access to transport if you need it, and the use of a phone.

How does your social life compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your social life?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about your social life?
7 Information and advice

You should be given as much information as you want or need about the services and treatments available to you, about the Mental Health Act and how it works, and about the mental health system generally. Some people find it helpful to have someone like them (such as another service user or a member of the same community) to explain things to them. The information you are given should be clear and easy to understand, and should be available as and when you need it.

How does the information and advice you get compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the information and advice you get?

Yes
Unsure
No
(please tick one box only)

What areas would you like more information on or advice about?
Access to mental health services

You should be able to get help from your local mental health services when you need it, throughout the week, at any time of the day or night.

How does your ability to get help from the mental health services compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your ability to get help when you need it?

Yes
Unsure
No
(please tick one box only)

What kind of difficulties do you have getting these services when you need them?
9 Choice of mental health services

A range of services should be available to you, and you should be able to choose those which best meet your needs, including complementary/alternative therapies, counselling and psychotherapy. You should have a choice about the mental health workers you meet with regularly (for example being able to choose their sex or ethnic background), and be able to change workers if you don’t get on.

How does the range of choice you have compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the range of choice you have?

Yes
Unsure
No
(please tick one box only)

What are your main concerns about the choice of mental health services available to you?
10 Relationships with mental health workers

Doctors, nurses, social workers and other mental health workers should show you respect, be honest with you and discuss things with you in a way you can understand. They should be trustworthy and do what they say they will. They should offer regular appointments, not miss appointments and not keep you waiting. They should keep information about you confidential or ask your permission before passing it on to others. If they pass on information, it should be accurate and save you from having to repeat yourself to new mental health workers.

How does your situation compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your relationships with mental health workers?

Yes
Unsure
No
(please tick one box only)

What situation would you most like to change?
11 Consultation and control

Mental health workers should not pressurise you to do anything you don’t want to, or take decisions on your behalf without getting your permission first. Even if you have been ‘sectioned’, people should listen to you and take your opinions seriously.

How does your situation compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the level of consultation and control you have?

Yes
Unsure
No
(please tick one box only)

What would you most like to change?
12 Advocacy

You should be able to put your views across to people in authority. This can be difficult for several reasons, such as the effects of medication, if English is not your first language, or if the situation is frightening or intimidating. If you want, you should have someone (an advocate) to help or support you, or speak for you. You should feel this person really understands what you want and genuinely represents your views when he/she speaks on your behalf.

How do your circumstances compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the help you get in dealing with difficult situations?

Yes
Unsure
No
(please tick one box only)

What situations do you most want help with?
13 Stigma and discrimination

You should feel safe and other people should not harass, exploit, victimise or be violent towards you. You should not experience stigma or discrimination at home, at work, from mental health workers, police or any other section of the community. People should not discriminate against you because of your race, culture, religion, sex, sexual orientation, physical or mental disability or for any other reason.

How do people treat you compared with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the way other people treat you?

Yes
Unsure
No
(please tick one box only)

What situation would you most like to change?
Your medication/drug treatment

Medication should only be given to relieve symptoms of mental ill-health and to reduce your distress. All medication can have unwanted effects, but these should not cause more disruption to your life than improvement.

How does your medication compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your current medication?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about your medication/drug treatment?
15 Access to physical health services

You should be able to get the treatment and care you need for your physical health when you need it, whether you are in hospital or living at home. You should be able to be registered with a GP and have regular check-ups from a dentist. You should have access to other types of care, such as opticians, chiropodists, physiotherapists and so on.

How does your physical health care compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with your access to these services?

Yes
Unsure
No
(please tick one box only)

What type of health care do you have problems getting?
16 Relationships with physical health workers

The people who give you physical health care should listen to you, show you respect and take your condition seriously.

How does your situation compare with this description?

As good as this
Worse than this
Very much worse than this
(please tick one box only)

Are you satisfied with the way your physical health problems are dealt with?

Yes
Unsure
No
(please tick one box only)

What would you most like to change about your relationships with physical health workers?
Other issues

There may be other issues which are important to you, in addition to those the questionnaire has already asked about. Please use the space below to write down anything that’s important to you, that you’d like help with or that you’d like to change.
The CUES questionnaire was developed jointly by:

Royal College of Psychiatrists
Royal College of Nursing Research Institute
Rethink
Department of Social Work, University of East Anglia

CUES has been developed over two years to reflect the important issues for service users. It can be used in two distinct ways:

- Individual care planning and evaluation over time (Owned and used by service users)
- Service planning, monitoring and evaluation (owned and used by mental health and social care staff)

Contact address for further copies of CUES:
FRONT DOOR
0845 456 0455

The development of CUES (Carers’ and Users’ Expectations of Services) was funded by the Department of Health as part of the OSCA (Outcome of Social Care for Adults) initiative.
Appendix 7

Culture and Climate in Community Mental Health Teams

Service User Questionnaire

What is this survey about?
This survey is about the mental health services you receive from your community team.

Completing the questionnaire
For each question please tick clearly inside one box using a black or blue pen.

Sometimes you will find the box you have ticked has an instruction to go to another question. By following the instruction carefully you will miss out the questions that do not apply to you.

Don’t worry if you make a mistake; simply cross out the mistake and put a tick in the correct box.

Questions or help?
If you have any queries about the questionnaire, please call the Centre for Social Work and Social Care Research on 01792 602651

Your participation in this survey is entirely voluntary and your decision to take part or not to take part does not affect the service you receive.

If you choose to take part, your answers will be treated in strict confidence.
This questionnaire is anonymous, please do not write your name or address anywhere on it.

### YOUR CARE AND TREATMENT

1. **How long have you been in contact with your mental health team?**
   - One year or less
   - One to five years
   - Six to ten years
   - More than ten years
   - Don’t know/ Can’t remember

2. **When was the last time you saw someone from your mental health team?**
   - In the last week
   - More than one week but less than one month ago
   - One to three months ago
   - Four to six months ago
   - More than six months ago

3. **How would you rate the care you have received from your mental health team in the last 12 months?**
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor
   - Very poor

4. **How satisfied are you with the way staff in the service seem to work together as a team?**
   - Very Satisfied
   - Mostly Satisfied
   - Indifferent or mildly
5. Do you have enough say in decisions about your care and treatment?
   Yes, definitely
   Yes, to some extent
   No

6. To what extent does your service meet your needs?
   Almost all are met
   Most are met
   Only a few are met
   None are met

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**YOUR CARE CO-ORDINATOR**

A Care Co-ordinator (or key worker) is someone from your mental health team who keeps in regular contact with you. For example this person could be a Community Psychiatric Nurse (CPN), a Psychiatrist or a Social Worker.

7. Have you been told who your care co-ordinator is?
   Yes
   No
   Not sure/ Don’t Know
   Please go to question 8
   Please go to question 9
   Please go to question 9

8. Is your care co-ordinator a ……
   CPN
   Social Worker
   Other (Please State)
   Please miss out questions 14 to 18
   Please miss out questions ? to ?
Not sure/ Don’t Know

9. Can you contact your care co-ordinator if you have a problem?
Yes, always
Yes, sometimes
No

The LAST time you saw your care co-ordinator….

10. Was the care co-ordinator helpful to you?
Yes, definitely
Yes, to some extent
Not much
Not helpful

11. In what way was the care co-ordinator helpful?
Please State

12. How satisfied are you that the care co-ordinator listened to you and understood your problem?
Satisfied
Mostly Satisfied
Mostly Dissatisfied
Dissatisfied

13. How satisfied are you that the care co-ordinator was competent and knowledgeable?
Satisfied
Mostly Satisfied
Mostly Dissatisfied
Dissatisfied
HEALTH AND SOCIAL CARE PROFESSIONALS

14. Have you seen a CPN (Community Psychiatric Nurse) in the last 12 months?

Yes

No

Please go to question 15

Please go to question 19

The LAST time you saw a CPN....

15. Was the CPN helpful to you?

Yes, definitely

Yes, to some extent

Not much

Not helpful

Please go to question 16

Please go to question 16

Please go to question 17

Please go to question 17

16. In what way was the CPN helpful?

Please State

17. How satisfied are you that the CPN listened to you and understood your problem?

Satisfied

Mostly Satisfied

Mostly Dissatisfied

Dissatisfied

18. How satisfied are you that the CPN was competent and knowledgeable?

Satisfied

Mostly Satisfied

Mostly Dissatisfied

Dissatisfied
19. Have you seen a Social Worker in the last 12 months?
Yes ______ Please go to question 20
No ______ Please go to question 24

The LAST time you saw a Social Worker....

20. Was the Social Worker helpful to you?
Yes, definitely ______ Please go to question 21
Yes, to some extent ______ Please go to question 21
Not much ______ Please go to question 22
Not helpful ______ Please go to question 22

21. In what way was the social worker helpful?
Please State

22. How satisfied are you that the Social Worker listened to you and understood your problem?
Satisfied ______
Mostly Satisfied ______
Mostly Dissatisfied ______
Dissatisfied ______

23. How satisfied are you that the Social Worker was competent and knowledgeable?
Satisfied ______
Mostly Satisfied ______
Mostly Dissatisfied ______
Dissatisfied ______
24. Have you seen a support worker (Sometimes called a STR worker or STAR worker) in the last 12 months?

Yes  [ ] Please go to question 25
No  [ ] Please go to question 29

The LAST time you saw the support worker …. 

25. Was the support worker helpful to you?

Yes, definitely  [ ] Please go to question 26
Yes, to some extent  [ ] Please go to question 26
Not much  [ ] Please go to question 27
Not helpful  [ ] Please go to question 27

26. In what way was the support worker person helpful?

Please State

27. How satisfied are you that the support worker listened to you and understood your problem?

Satisfied  [ ]
Mostly Satisfied  [ ]
Mostly Dissatisfied  [ ]
Dissatisfied  [ ]

28. How satisfied are you that the support worker was competent and knowledgeable?

Satisfied  [ ]
Mostly Satisfied  [ ]
Mostly Dissatisfied  [ ]
Dissatisfied  [ ]
## OTHER COMMENTS

If there is anything else you would like to tell us about your experience of your mental team in the last 12 months, please do so here.

29. Is there anything that you particularly like about your service?

30. If you could change anything about your service what would that be?

31. Any other comments?
ABOUT YOU

32. Are you male or female?
   Male [ ]
   Female [ ]

33. What was your year of birth?
   (please write in eg 1934) [ ] [ ] [ ]

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you have answered all the questions that apply to you.

Please return this questionnaire using the stamped addressed envelope.
You can either post it or hand the sealed envelope to the person who gave it to you.
Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.