AN EVALUATION OF MANDATED JOINT WORKING IN MENTAL HEALTH SERVICES IN TWO SITES IN ENGLAND

by

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Abstract

This study explores the processes of joint working in mental health services, mandated by statute or regulation, between local organisations. The interest in doing so lies in examining the apparent contradiction of using compulsion to stimulate avowedly voluntary activity.

A bespoke realist approach, aligning critical realism and aspects of realist evaluation, provided the framework for the study in two differing case study sites of mandated joint working examples– aftercare (Section 117, Mental Health Act 1983), delayed transfers of care and the use of police powers (Section 136, Mental Health Act 1983). Nested case studies enabled comparison between two groups of organisations within and across the sites. Data were collected through semi-structured interviews, observations and documentary analysis.

Differences in implementation of these examples were found between the two sites, which stemmed from the relationships between processes and the contexts in which they were set. The study shows that mandating joint working can be necessary and productive.

The study affirms the role of mandated joint working in mental health services as a means of directing joint working, and supporting its strengths, at a local level. This is a complex endeavour which needs to take account of local limitations, policy changes and professional distinctiveness.

Keywords – mandated joint working, health and social care services, mental health and emergency services.

Dedication

This study is dedicated to Maggie

Acknowledgements

I owe a very large debt of thanks to all those people who supported me in carrying out this study in the two case study sites. I am particularly grateful to the people who consented to being interviewed or observed. Many of these interesting people suggested other (equally interesting) interviewees, who, it turned out, shared their enthusiasm for and commitment to the development of mental health services. It's a shame that I cannot name any of these people as I promised them anonymity.

I should include in my thanks the equally enthusiastic and supportive representatives of research governance in the various organisations, including the University of Birmingham.

I can name my supervisors at the University of Birmingham – Professor Jerry Tew and Dr Robin Miller. Words cannot do justice to their wisdom, guidance and unbelievable patience in steering my stumbles through the stages of completing this study. All the same, words are all I have, so…thank you so much.

Contents

List of figures

CHAPTER 1

A study of mandated joint working

Introduction

This study is an evaluation of mandated joint working in mental health services at two sites in England. Joint working, and related terminology such as inter-agency working, collaborative working or integrated care, has been a persistent feature of English public policy over much of the last three decades. Governments during this period have viewed joint working as offering an appropriate response to the issues which arise from the increasingly complex and financially-constrained environment for public services. These governments have applied their policy-making to joint working through a variety of measures, including formal strategies, resource allocation accompanying such strategies (or less highly-structured planning), procedural guidance and, where deemed necessary, legislation and/or regulation. A starting point for the definition of mandated joint working for this study is provided by the application of the last two items on this inventory of measures, in other words the use of compulsion or enforcement by policy makers, to direct collaboration between public agencies in relation to users of mental health services in England.

Three discrete policy examples have been selected for study as they provide the opportunity to examine and compare a range of distinctive issues and joint working arrangements. First, Section 117 Aftercare (Mental Health Act 1983) – referred to throughout the thesis as S117 Aftercare - seeks to ensure that service users obtain appropriate programmes of aftercare following detention in hospital for treatment. Second, although it has a basis in legislation, for mental health

services delayed transfers of care (DTOC) regulations are applied to the aim that service users remain in hospital for no longer than they need to. Lastly, Section 136 use of police powers (Mental Health Act 1983) – abbreviated here to S136 - is directed to the engagement of mental health services for people who come to the attention of the police when not in their own homes and who may have mental health issues.

Why this study?

I have three sources of motivation, all generated from my experience from the 1980s until my retirement in 2012, for undertaking this study. The first is my participation in the developments of national policy in relation to mandated joint working in mental health services. The second is my engagement in academic activity and long-term interest in research. The third stems from my own professional experience

The starting point for a consideration of policy developments is my understanding that national governments have faced, and continue to face, a challenge of where to place the appropriate emphasis in driving implementation of joint working between the options of enforcement, direction-setting and the encouragement of local initiative so as consistently to provide a positive contribution to the lives of people with mental health issues. It has seemed that the influence and impact of mandated joint working, while its originating purpose may remain more or less constant, shifts over time when accompanied by changes in implementation styles and conflicts with cumulative government policies. For S117 Aftercare and DTOC, the changes can be seen in the shift for community teams from the tightly-prescribed National Service Framework for mental health services of the last

Labour government to the far looser current No Health Without Mental Health strategy. Also, the trend for local health and social care mental health services to be bound together closely through the contractual arrangements of Section 75 of the Health Act 2006 is fading with such arrangements being dissolved in many parts of England. Interestingly, the shift in the nature of relationships between mental health and emergency services, the organisations designated to implement S136, has moved (at least in the short term) in the opposite direction towards greater prescription with the introduction of the Mental Health Crisis Care Concordat. Irrespective of the directions in which they travel, government policies for mental health services seem set to retain an emphasis on inter-organisational joint working for the foreseeable future. It is equally likely that mandated joint working will have its place in the changes that are being, and will be, planned. At the time of writing, these changes include the drive to create parity of esteem for physical and mental health care and a review of the Mental Health Act. It seems important to identify as many as possible of the significant drivers of the changes in order to approach a comprehensive understanding of their programmes of implementation.

In relation to my second motivation, I had the opportunity to engage in research activity in the 1980s, which enabled me to pursue my interest in the impact of mental health legislation upon the experience of people detained in hospital and upon the practice of social workers (Williams, 1988, 1989, 1990). I was again able to resume this activity during a Public Service MBA programme at the University of Birmingham in the 1990s; as part of the programme, I completed an action research project which examined the process of integration between the Care Programme Approach and care management (Williams, 1997). As an outcome of

the literature review for the MBA project, I referred frequently to an article by Hudson (1987) which, to me, had the status of a seminal paper as it had been cited in several of the references I had read. The tone of the article appeared to be cautious, if not at times pessimistic, in relation to mandating joint working between public service organisations. A particular passage caught my eye:

> Formalisation increases as an agreement [for collaboration] is verbalised, written down, contractual and, ultimately, mandatory. Mandated interactions involve laws or regulations specifying areas of domain, information and financial obligations…Aldrich (1976) found that these tended to be more intense, unbalanced in favour of one of the organisations studied and associated with lower perceived co-operation.' (ibid, p179)

I can trace this passage as being the conscious beginning of my puzzlement with the notion of enforcing joint working.

Hudson's article is of its time in the sense that the language and profile of inter-organisational collaboration in the 1980s was more muted than currently. In this way, his general suggestion that '…an agency prefers not to become involved in inter-organisational relationships unless it is compelled to do so…' (ibid, p175) would have been met perhaps with fewer overt objections by public service organisations than it would be today. His article gives priority to pre-existing or voluntary organisational and personal features which support joint working, suggesting that these factors are more significant than being mandated by legal provisions and government policy. My review of some of the literature of joint working in public services, which is covered in the next chapter, could be seen as maintaining and updating this emphasis. For example, a number of authors (Sullivan and Skelcher 2002, Huxham and Vangen 2005, Dickenson and Glasby 2013) suggest that the propensity to engage in joint working is a 'natural' feature of organisational life. The notion that joint working has its own life cycle or

progression is also promoted by these and other sources (Williams and Sullivan 2007, Goodwin 2013). In my view, this perspective risks neglecting the influence of mandated joint working which, as I indicate above, has continued to be brought to bear in mental health services, amongst other public services, since the time of Hudson's article and, in some instances (for example, the history and implementation of S136), for considerably longer.

Lastly, my own professional experience can provide a distinct practical perspective of the significance of this study. I have a professional social work background and worked within public services for over thirty years in local authority and health care organisations initially as a practitioner and subsequently at various levels of management. The latter half of this period was spent exclusively as a senior manager in a number of local authority and NHS mental health organisations, preparing for and then engaging in the development and evolution of integrated health and social care services. During this period, the three policy concerns referred to above were the sources of continual discussion and, on occasions, dispute between the organisations with formal responsibilities for them. Also, my employment at this time included both strategic/operational management and, in my last post before retirement, professional (social work) leadership.

The joint working processes in which I participated exposed persistent and apparently-unresolvable issues for these organisations. The regular occurrence of these issues became unsurprising to me. However they remained a puzzle, as they arose irrespective of the level of commitment of participants to joint working. The notion of *enforcing* positive or productive *relationships* between managers and professionals of differing organisations seemed incongruous or ineffective. After all, how do you force influential people to like or trust one another sufficiently

to work well together? Also, two of the specific mandated provisions (Section 117 Aftercare and S136) had been in place for decades and the third (DTOC), although more recently formalised, represented a longstanding point of contention between health and social care organisations. A reasonable assumption would be that, if effective, mandated joint working, would have defined clearly and addressed these issues over the years – and if not, why was the policy of mandating joint working persisted with and alternative approaches not pursued? The purpose for me, therefore, of this study is to provide explanations for the use and impacts of mandated joint working through detailed examination of its contexts and processes in contrasting sites.

More personally, this study is a manifestation of a preoccupation that I have held consistently for as long as I can remember – that the use and balance of power is the most important influence on the course of events or lives. By power, I mean the power that can be used through the agency of individuals, of local organisations and 'the powers that be', usually of governments. From my experience, I have come to understand that this preoccupation is not mine alone.

I consider that, collectively, the motivations for this study illustrate the importance and relevance of its principal research question (see below) from the perspectives of policy, academic activity and practical implementation. My intention is for this study to provide insights for local areas, both the case study sites and beyond, and for policymakers at national level which will be helpful in improving the performance of mental health services and thereby promoting positive outcomes for service users and their families.

Definition and discussion

Mandated joint working is defined here, therefore, as the combined activity of designated public service organisations which is required through statutory and, on occasions, regulatory means. It can be found to differing degrees across many areas of public service in England including transport, health (including public health) care, housing, environmental protection, safeguarding children and vulnerable adults, and social care. Indeed, some researchers view mandated joint working to form the default style of much joint working for public services in England (Sullivan and Skelcher 2002, Hill and Hupe 2014). English mental health services provide some of the most easily-recognisable examples of mandated joint working between public agencies as assessment of need, admission to, treatment in and discharge from hospital and aftercare all can be delivered within this context. Indeed, while the huge majority of mental health services are delivered on a voluntary and consensual basis in both public and private settings such as general practice and individual therapy provision, the term 'being sectioned' to describe compulsory admission and treatment in psychiatric hospital is understood immediately (if not always correctly) when used in the public media.

However, as a public policy, mandated joint working has attracted consistent critical attention from researchers of organisational partnerships (Hudson 1987, Williams and Sullivan 2007). Hudson's conclusions are cited above. Twenty years later, in a literature review of the experience in the UK of 'collaboration' between public service organisations, Williams and Sullivan considered the approach of governments to be 'a mixture of coercion, exhortation and prescription…and statutory duties aimed at forcing organisations to work together…' (p11). They suggested that joint working had become the accepted norm for effective public

service organisations 'but…there are very real costs to this activity…loss of status…loss of control…conflict over domain…'(p21)'. The common thrust of these prospective and retrospective conclusions is their shared caution about the capacity of mandated joint working to create successful combined activity.

In contrast, other researchers consider that governments are justified in using their authority 'to address matters of public concern' (May and Jochim, 2013, p445) through joint working and that such authority need not be a negative application of power but can also be a force for productive and focussed activity (Morgan et al, 2016).

Mandated joint working and S117 Aftercare, DTOC and S136

As indicated in the opening paragraph, the Mental Health Act 1983 is the legislative vehicle for S117 Aftercare and S136. The Mental Health Act 1983 provides the main context for mandated or enforced joint activity in the field of mental health care and treatment; its key provisions are summarised briefly in the previous section. The Community Care (Delayed Discharges) Act 2003 introduced the practice of mandated joint working for DTOC; mental health services have never been included in the formal provisions of this Act and subsequent legislation, such as the Care Act 2014, but scrutiny of DTOC for mental health services in local areas is applied with rigour by national regulatory bodies.

S117 Aftercare places a joint duty upon health care commissioners and local authorities to ensure that mental health aftercare is available for people who have been detained in hospital for treatment. S136 empowers police officers to remove a person who appears to suffer from a mental disorder from a place other than

their home[1]. Once implemented, police officers then are required to take her or him to a place of safety, ideally in a hospital, where medical and social work staff members subsequently are obliged to complete a mental health needs assessment of her or his needs. While S136 is framed in the legislation and its Code of Practice as the use of police powers, the implementation of the powers places a requirement on the police to liaise with mental health services and for mental health services to respond appropriately. Moreover, as explained in Chapter 3, practical and policy considerations and pressures at national level have generated expectations that the staffs of mental health and emergency services work together more closely than in the past, with an emphasis upon simultaneous rather than sequential joint working.

The national DTOC policy is imbued with an assumption that a person who no longer needs to be in hospital is compelled to remain there because the arrangements for her or his care outside hospital are not in place. For mental health services, the responsibility for making these arrangements is laid jointly by regulation upon local NHS agencies and local authorities. DTOC performance of all NHS Trusts and local authorities is scrutinised formally from mandatory monthly returns by regulatory bodies such as Monitor for foundation trusts and NHS England.

These provisions require two discrete groups of local organisations to work together. These groups form an important part of the research design which will be explained further in the following section. For S117 Aftercare and DTOC, the key agencies are those responsible for or to health and social care services – health

[1] The definition of the 'eligible' location of the person detained has been amended by the Policing and Crime Act 2017, which came into force in April 2017.

and wellbeing boards (HWBs), clinical commissioning groups (CCGs), mental health trusts MHTs), local authorities (LAs) and advocacy providers (Advs). For S136, the agency group is described in this study as mental health and emergency services, including all the health and social care services agencies referred to above and, for emergency services, police and ambulance services. The requirement upon ambulance services stems from statutory guidance rather than legislation; however, the rigour of this guidance has intensified in recent years to the point where ambulance service engagement in the use of Section 136 powers is expected in all but exceptional circumstances.

Research questions

The objective of this study is to evaluate the policy, processes, and practice of the three examples of mandated joint working so as to contribute to knowledge, policy or practice development of the organisations in the two case study sites and to reflect upon national policy implementation. As the intended 'targets' of mandated joint working are local organisations, the key areas of interest for the study are the processes of joint working in relation to inter-organisational and inter-professional relationships. The following research questions are directed to these areas and, in combination, to evaluating them:

How is mandated joint working in mental health services conducted between health and social care services in relation to the areas of Section 117 Aftercare and delayed transfers of care, and between mental health and emergency services in relation to the area of Section 136 police powers, in two differing sites in England?

- How do the national and local contexts influence these examples of mandated

joint working at each of the sites?

- How are these examples managed, interpreted and implemented in the sites by managers and front-line staff?
- What evidence is there of positive outcomes for the mandated joint working processes between organisations?
- What differing practices are revealed in the study between mandated joint working and joint working in other circumstances or settings?
- What policy, practice and research implications are suggested by the findings of the study for the future?

The principal question is addressed to the central purpose of the study, described above (p6) – that is to say, explanations of the impacts of the mandates in the three areas referred to above upon the processes and outcomes of joint working. The subject areas of the first three subsidiary questions – respectively contexts, mechanisms and outcomes - together make up a format for coding data and as part of the evaluation process. The framework is explained briefly later in this chapter (p11) and, more fully, in Chapter 4. The fourth question concerning mandated and non-mandated joint working provides the opportunity for further comparisons within and across the case study sites in addition to those between the implementations of S117 Aftercare, DTOC and S136. The intention here is to create as full an account of inter-agency working as possible. The final question is directed towards the wider application of the learning from the study.

Research structure

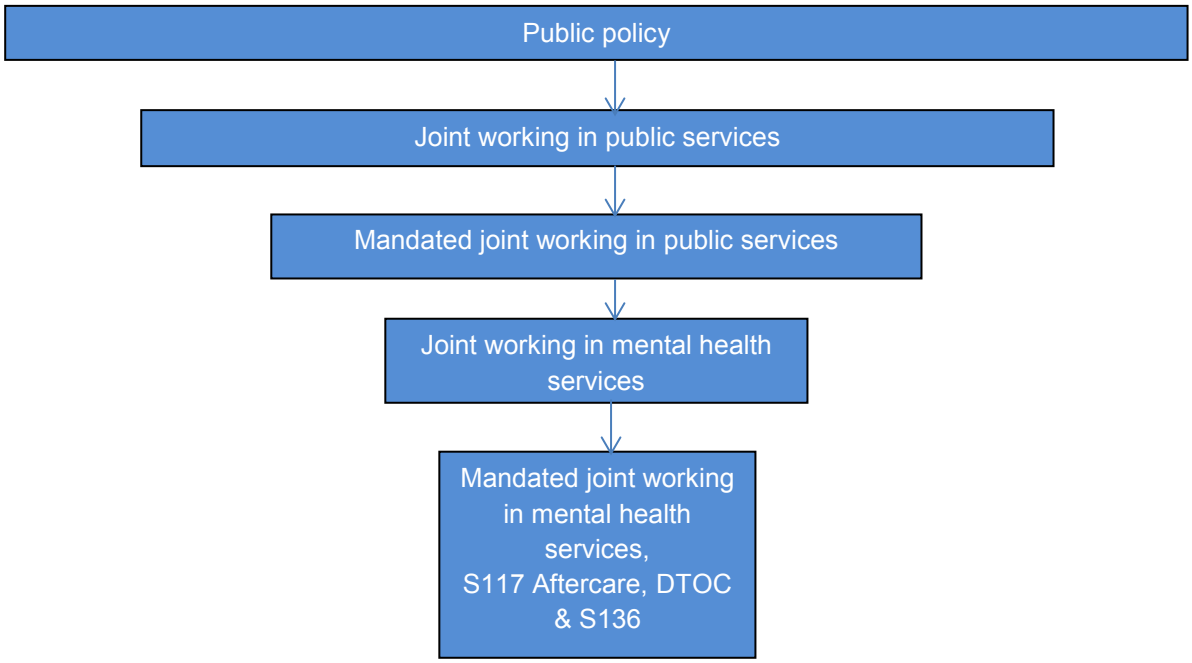
The following seven chapters cover the elements of the research structure and are summarised here.

Literature review

I have chosen to devote Chapters 2 and 3 to the literature review which I have formulated into a sequence of five progressively-narrower topic areas (see Figure 1 below). This sequence places S117 Aftercare, DTOC and S136 at the core of cumulative and linked layers of complexity.

The five topic areas have been divided between the next two chapters for the benefit of the reader and because they serve two purposes in the analysis of the

Figure 1: Literature review sequence



study's findings. The first three of these areas together form a theoretical framework in Chapter 2 and the last two an account of the national (English) context in Chapter 3.

Theoretical framework. The first topic area provides an appraisal of the nature, implementation and contexts of public policy. The impacts of national and organisational cultures upon policy implementation are explored. Public policy, I conclude, cannot be assumed to be a straightforward imposition of a government's

will. The second topic area pulls together theories of the purposes, forms and characteristics of joint working as an English public policy so as to appreciate its complexity and sensitivity to local circumstances – that is to say, in which sphere of activity (where) and in which manner (how) it takes root. The concept of layers at which joint working policy is understood and implemented is introduced. The third topic area reviews research studies of mandated joint working in a number of public service areas in England and other countries, including services for children and families, substance misuse and environmental management. These studies suggest that some examples of mandated joint working are inappropriately-focussed. However other studies conclude that mandated joint working can possess one or the other or both of coercive and cooperative elements dependent on local circumstances and can provide a useful framework for successful joint working.

National context. The fourth topic area is concerned with the differing characteristics of joint working in mental health services in England for the two groups of organisations referred to above. This section presents for each group the national policy context and the cultures and values of the staff of the professional groups involved. Attention is given to the impacts upon joint working. The final section of the chapter suggests the rationales for mandated joint working which underpin S117 aftercare, DTOC and S136.

Research framework, design and methodology

An additional literature search was undertaken to support the elements of the study's methodology. The sources for this search included doctoral research seminars at the University of Birmingham, recommendations from supervisors and citations from the reference listings, reference lists from the required training

modules of the University of Birmingham Postgraduate Research Training Programme (Research Design and Social Research Methods) and regular selection of articles from journals including Evaluation, Journal of Psychiatric and Mental Health Nursing, Nursing Inquiry and the Journal of Critical Realism. The sources used appear under a 'Methodology' heading in the Bibliography.

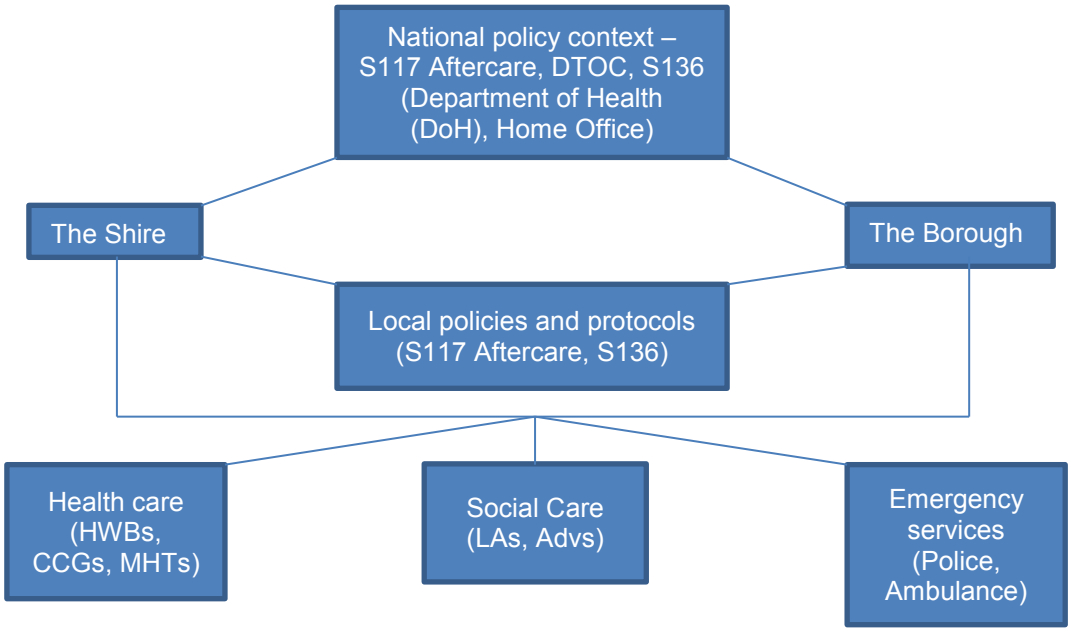
Chapter 4 covers the evaluation framework for this study, its research design and its methods of data collection and analysis.

Evaluation framework. The framework was developed iteratively from an alignment of adapted approaches – critical realism and realist evaluation - which share a concern with the underlying theories of social programmes and an approach which entails detailed examination of how social policies or programmes work in practice. Critical realism shares an interest in mechanisms (how processes work) with realist evaluation but adds the concept of reality possessing 'several different levels' (Bhaskar and Danermark, 2006, p280) which reflects the layered nature of joint working referred to above. I use the term 'layers' throughout the thesis. This approach enables me to give attention to three layers of organisational operation: policy; management or leadership; front-line teams and staff. Realist evaluation provides an additional element to the framework because of its focus upon contexts (or circumstances), mechanisms and outcomes of social programmes. For this study, outcomes are interpreted as the intended and experienced or reported impacts of mandated joint working upon organisations and frontline staff. Chapter 4 explains how the two approaches are structured and aligned. The benefit of adapting and aligning these approaches lies in making possible a more detailed evaluation by combining critical realism's depth and realist evaluation's scope.

Research design. The research design of the study takes the form of case studies of two differing sites in England, a shire county and a metropolitan borough - referred to in the study respectively as 'The Shire' and 'The Borough' – in each of which are embedded the two groups of organisations, healthcare and social care services and mental health and emergency services. This design together with the evaluation framework just described, was selected in order to maximise access to a level of detail about contexts or circumstances and processes.

Methodology. The data collection methods are qualitative and mixed and include semi-structured interviews, observation and documentary analysis. The fieldwork was conducted in two phases in order to provide a basis for local evaluation within and between sites. The first phase included documentary analysis of policies and protocols, interviews with senior managers and leaders in local agencies and observations of key management fora. The second phase included interviews with front-line managers and practitioners and observations of joint practitioner activity

Figure 2: Research domains



across the same range of agencies. Figure 2 above shows the principal domains to which research activity was directed; it includes the national policy contexts and procedural documentation reviewed in Chapter 3.

Thematic analysis provided the structure for drawing out the study's findings, based on the aligned realist approaches.

Findings

Chapters 5 and 6 comprise respectively the study's findings for The Shire and The Borough. In each chapter, findings are arranged under the headings of 'context' and 'mechanisms and outcomes' and are presented separately for the two groups of organisations. 'Context' covers local organisational configuration, history of joint working and local cultures of joint working in both sites and includes other relevant contextual influences for The Shire which emerged from the fieldwork. 'Mechanisms' and 'outcomes' are addressed at three layers of operation – formal documents for local policies and procedures, senior manager and leader perspectives and team and frontline practitioner perspectives.

Analysis

Chapter 7 is structured in accordance with the common themes that emerged from the key findings of the previous two chapters. The perspectives of policies and senior managers and leaders are combined into a single layer of operation for the purpose of analysis. The common themes are: locality cultures; professional roles; leadership; nature of joint working. Examples of non-mandated joint working which emerged from the study also are reviewed.

This approach enabled me to review and compare the relationships between the contexts and processes of joint working at each layer of operation for the two

groups of organisations within The Shire and The Borough, and to explore the influence of mandation upon those relationships.

Conclusions

Chapter 8 is structured around the research questions. An initial section identifies the key points of learning from the study about the impact of mandated joint working. This section considers in particular whether mandated joint working has a continuing role in the development of mental health services in England – which it affirms. A second section suggests fruitful areas for further research. The final section offers a brief summary of the study's contribution to knowledge.

CHAPTER 2

Literature review: Theoretical framework

Introduction

As summarised in the previous chapter, the literature review has been arranged into a sequence of five inter-related topic areas which progressively adopts a more limited focus so as to arrive at the subject area of this study. I have divided the topic areas between this chapter and the next for the benefit of the readers as the length of a combined chapter would be unwieldy. The three wider topic areas presented in this chapter are concerned principally with theories or layers of meaning while the narrower areas in the following chapter focus upon issues of mental health policy and implementation. In this way, a review of public policy, joint working and mandated joint working in public services has provided an overall theoretical context or framework for this study. In the following chapter, joint working and mandated joint working also are each covered in the two more specific topic areas which take mental health services in England as their point of focus and thereby provide an account of the national context. The content of both chapters will be drawn upon for analysis of the study's findings in Chapter 7.

The theoretical framework is underpinned by the perception that mandated joint working is an expression of public policy and that in turn public policy is an expression of governmental power. The most explicit use of this power is through legislation and formal regulation. However the impact of this use of power changes according to the circumstances in which it is applied and represents not only an aspiration to direct but also to stimulate local activity.

Literature search

There are several strands to the literature search as it includes material accrued from my professional and academic experience, sources recommended by supervisors, regular access to journals and the use of Google Scholar as well as formal literature database searches. The advantage (and disadvantage) of the literature of joint working are that it is extensive, reflecting the complexity of the issues involved. In addition, it can be confused by the use of differing terminologies. Further, the more specific literature of the examples of mandated joint working is uneven; for example, Figure 3 below shows that academic and professional attention to S117 Aftercare is very limited. As a result, my approach has been to acquire a sense of the principal issues of the subject area through initial informal access to literature sources and survey of database platforms such as Ovid and ASSIA which included accumulating material from reference lists of such sources, before adopting a more structured engagement with database searches and use of journals.

The journals which were most helpful in providing access to relevant articles included: Health and Social Care in the Community, Journal of Integrated Care, International Journal of Integrated Care and Journal of Mental Health. Websites and blogsites such as those for the King's Fund and MentalHealthCop were important providers of policy and commentary material on organisational and practice issues for health, social care, mental health and emergency services in England. Google Scholar was especially useful in identifying articles and book chapters on the cultures and values of the police and ambulance services.

A more rigorous series of database searches was undertaken during July 2016 and its results are summarised in Figure 3 below. The purpose of this later activity

was to ensure that a comprehensive coverage of the literature had been achieved. As can be seen, 8 subject areas are covered; safeguarding children was included as a comparative sphere of mandated joint working. These subject areas are not exclusive as journal articles often were cited in common across the areas. Some indications of my criteria for literature selection are given in the notes at the bottom of Figure 3 but more detailed explanation is offered here. The first three subject areas (first, second and third rows), being closely related, produced many common references. As indicated in the diagram, abstracts in these two subjects were scanned for reference to inter-organisational and inter-professional joint working in mental health services; many references were not related to mental health services in England or were related to service users or agencies other than those included in the study. For the mandated joint working in mental health services in England search (third row), the huge majority of the references related to other mandated provisions of the Mental Health Act 1983 rather than the examples of this study. For the four more specialist subject areas which follow – delayed transfers of care, S117 Aftercare, S136, and policing and mental health – results which I assessed as relevant had a direct bearing upon joint working between the two nominated groups of organisations. Lastly, for safeguarding of children, abstract-scanning was conducted according to the same criteria as the first two rows. The total of 163 relevant articles were reviewed with increased rigour by reading the introductions, conclusions and scanning of the contents with a view to excluding repetitious material to arrive at the eventual total of 119 articles which were read in depth and added to the sources obtained during the preliminary stage of the search.

The collected literature for joint working was categorised under three 'literature grid' joint working headings – definitions and purpose, governance and mental health practice. This categorisation acted as a preliminary stage which enabled the literature to be classified into the topic areas which are explored here.

Public policy

Public policy is not simply a set of instructions by governments to its citizens and institutions. Even an apparently-straightforward definition of the two words 'public policy' introduces complexity. Parsons (1995) offers such a definition: 'public' is taken to mean 'A public good or service which is available to all' (ibid, p10); 'policy' 'is an attempt to define and structure a rational basis for action or inaction' (ibid, p14). For the sake of clarity, this 'attempt' is taken here to apply to the exercise of national governments' power. It may seem surprising and unnecessarily complicated that 'inaction' is a desired outcome of policy. If the purpose of policy is the action of 'doing something' (ibid, p181), 'inaction' can be assumed to mean *not* doing something in the specific policy area at the time of consideration. This is often not the same as doing nothing. It may purely be the effect of prioritising the use of resources, doing something in one area of policy rather than another. It may also be a planned (and perhaps covert or implicit) goal of policy to create the conditions for a long term desired outcome rather than the achievement of immediate tangible change (Stoker 2002, Bemelmans-Vedec and Vedung 1998).

The conception of public policy as an expression of governmental power does not

Figure 3: Literature searches

Subject area	Databases	Search terms	Search limits	Search results	Relevant results	In-depth review
Joint working and mental health services	(OVID)PsycARTICLES Full Text, Embase, HMIC, Social Policy and Practice (ProQuest)Health Sciences, ASSIA	Mental health (MH) services, joint or partnership or interagency or interprofessional working	Abstracts, 2000-current	792	42*	20
Integrated care or services and MH services	(OVID) HMIC, Social Policy and Practice (ProQuest) Health Sciences, ASSIA	Integrated care or services and MH services	Abstracts, 2000-current	286	11**	9
Mandated joint working, MH services, England	(OVID)PsycARTICLES Full Text, Embase, HMIC, Social Policy and Practice (ProQuest) Health Sciences, Social Sciences, ASSIA	Mandated joint working or enforced integration, MH services, England	N/A	222	8	7
Delayed transfers of care, MH services	(OVID) Embase, HMIC, Social Policy and Practice (ProQuest) Health Sciences, ASSIA	Delayed discharges or delayed transfers of care, MH services	N/A	46	11	9
Section 117	(OVID) Embase, HMIC, Social Policy and Practice (ProQuest) ASSIA, Social Sciences	Mental Health Act 1983, Section 117, aftercare mental health	N/A	13	7	7
Section 136	(OVID) Embase, HMIC, Social Policy and Practice (ProQuest) Criminal Justice, ASSIA, Social Sciences	Section 136	N/A	102	49	37***
Policing and mental health	(OVID) HMIC, Social Policy and Practice (ProQuest) Criminal Justice, ASSIA	Police or policing, MH services	N/A	180	17	14
Safeguarding children and joint working	(OVID) HMIC, Social Policy and Practice (ProQuest)ASSIA	Safeguarding children or child protection, joint or partnership or inter-agency or multi-agency working, England	Abstracts, 2000-current	466	18****	16
Totals				2107	163	119

*abstract: excluding all but inter-organisational and inter-professional joint working
**results not included in search above
***inclusion criteria: prevalence, joint working
****abstract: excluding all but inter-organisational and inter-professional joint working

provide the recipe for simplicity either. Such power can be expressed in relative ways, either as enforcement or through the promotion of perceptions which lead to compliance (Pollitt et al, 1992). Further, Pollitt et al cite the view that policy-making is 'a collective puzzlement on society's behalf' (ibid, p8) when applied to complex issues as the resolution of such issues often cannot be provided by detailed procedure or defined processes. The impact of power exertion also may depend on the circumstances of the policy that is being introduced.

Morgan et al (2016) summarise differing theories of power which include the liberal concept, that governmental interference should be a last resort and only used when public interests are threatened, and theory attributed to Michel Foucault that power can be productive as well as repressive. A reflection of this latter theoretical approach in particular can be seen in the paradigm for policy implementation proposed by Hill and Hupe (2014); this is discussed further below.

It is unsurprising, therefore, that complexity of public policy is reflected in its implementation and through its contexts of national, organisational and professional cultures. The first two of these contexts are discussed in this part of the chapter as they can be applied across a broad range of public policy. The third context has more specific application in mental health services and so is referred to here but explored more fully in the next chapter in a review of joint working in mental health services.

The implementation of public policy

Theories of implementation

Hill and Hupe (ibid) take a historical perspective in reviewing the conflicting theories underpinning 'top-down' and 'bottom-up' public policy implementation over the past thirty years. In their review of the thinkers on both sides of the

debate, they cast top-down policy implementation as being rational, hierarchical, bureaucratic and vertically-driven with policy formation being clearly separated as an activity from its implementation. This theory emphasises compliance and therefore epitomises one perception of mandated policy.

By contrast, bottom-up implementation theorists place emphasis upon the agency of staff at the front-line of policy, 'street-level bureaucrats' (Meyers and Vorsanger, 2007, p153-163) who may change or divert, and thereby create, policy to accommodate or cope with pressures (such as workloads) they may face, upon the horizontal power of networks between front-line staff and upon the place of negotiation and compromise between front-line staff and policy formers to achieve 'performance rather than conformance (p57)'.

The essential common feature of these concepts is that different perceptions can be held by those at the top and bottom of organisations about either the means or the ends of policy implementation. On the one hand, both camps may agree about ends but disagree about the means or they may disagree about the ends, the objectives. For example, as will be seen in later chapters, national policy or senior managers and leaders may choose to be prescriptive about means which can lead to resentment or non-compliance at the front-line layer of implementation. Equally, for mandated joint working for mental health and emergency services, findings in this study suggest that there exist pockets of disagreement or ambivalence about the imperative for joint engagement in implementation.

Arguably, this binary theoretical approach is too simplistic as it fails to recognise other dimensions of policy implementation. Exworthy and Powell (2004) suggest that 'horizontal' (p264) dimensions of power are placed not only at the operating layer of front-line staff (local-local) but also at a higher level between government

departments (central-central). The central-central layer is outside the scope of this study. The local-local layer is discussed further below in relation to implementation processes. It seems reasonable to suggest that there is a further layer of horizontal relationship – that between senior and middle managers in a local layer (who are very much part of the study) as middle range implementers of policy whose direction of influence can be both 'up' and 'down'. O'Toole (2012) suggests that the impact of networking between such managers is of particular significance in the implementation of joint working.

Hill and Hupe argue for a third paradigm – a 'multiple governance framework (p126)' to which they give the intimidating name of 'trias gubernandi…[which]…entails the combination of creating settings, giving direction and getting things done (p129).' This construction thereby combines the spirit of each of the top-down (giving direction and getting things done), middle range and bottom-up (creating settings and getting things done) policy implementation dimensions.

The nature of implementation processes

O'Toole (2007) picks up the theme of mixed implementation styles in his definition.

> …policy implementation requires institutions to carry the burden of transforming general policy intent into an array of rules, routine and social processes that can convert policy intention into action. The process is the core of what is meant by implementation. (p142)

This 'array' of processes occupies the middle ground of implementation between policy formation and policy delivery (Schofield 2001). It is the area where a policy actually takes shape. A number of the features of this middle ground have received the attention of researchers, for example the nature of the policy under review, the congruence of its processes and the behaviour of its implementers.

The nature and type of a policy, in particular the degree to which its aims are clear and unambiguous, has a vital impact upon its design (Schofield 2001, Winter 2007, Meyers and Vorsanger 2007) which in turn influences the context in which it is enacted. Some policies may be driven primarily by moral, instrumental or political imperatives (respective definitions of which could be the pursuit of what is right, what is efficient or what is safe), some of which may remain hidden even where the policy outcomes are stated clearly (Hupe, 2014). These variations will determine the degree of formal proscription or discretion associated with the policy – the former may be more likely with an instrumental policy, the latter with a morally- or politically-driven policy (Schofield, ibid). It will be argued in the next chapter that the specific contexts of mandated joint working between them illustrate each or a mixture of each of these imperatives.

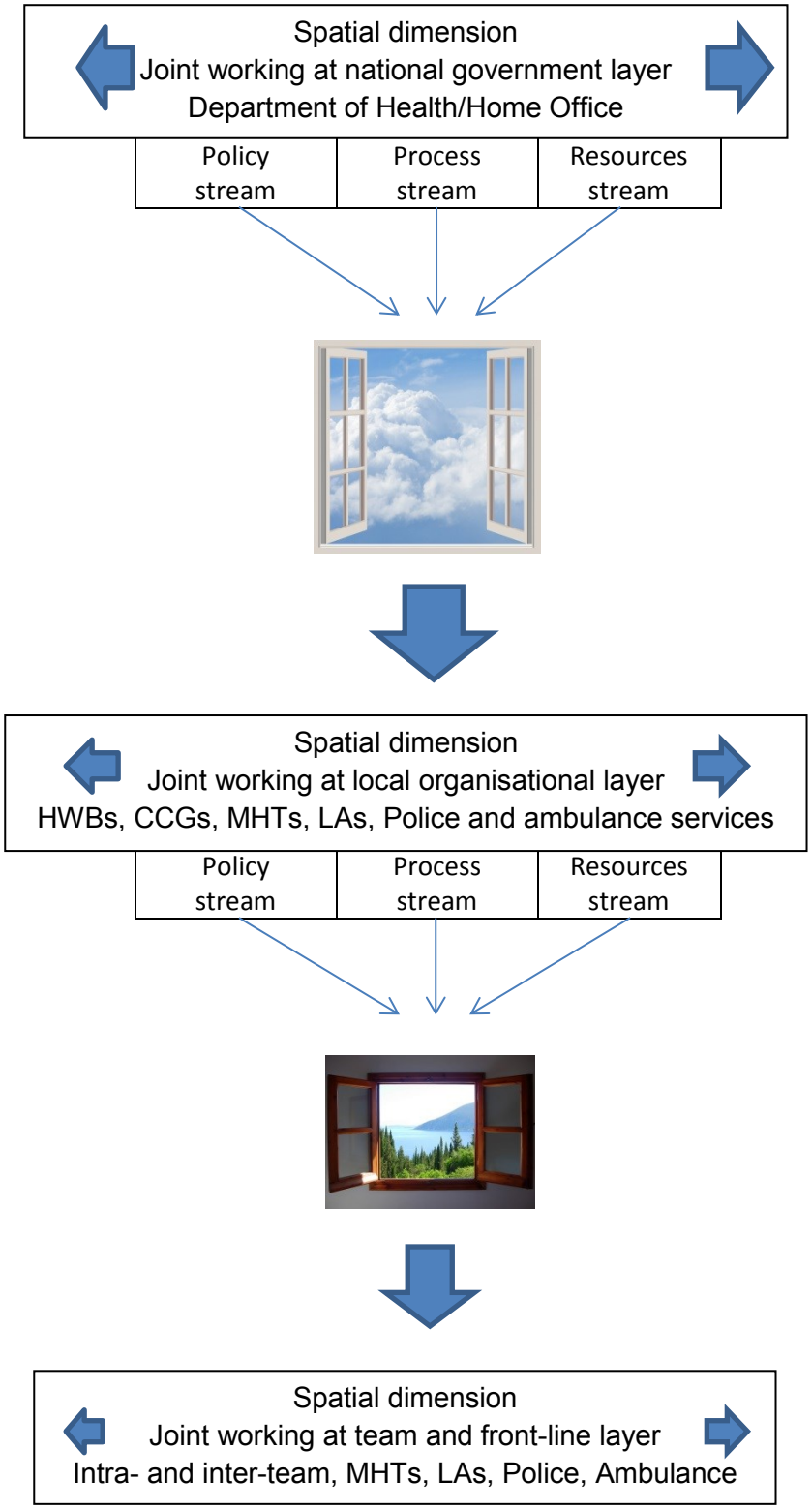
If policy formation by government is an initial stage of the policy process and policy delivery the final stage, the activities that lie between the two make up a vital bridging stage. Meyers and Vorsanger (ibid) consider that 'the organisational context of implementing agencies [needs to be] congruent' (p156) with the policy in question if it is to be delivered successfully. Exworthy and Powell (2004) take the concept of congruence a step further with an intricate image of policy 'windows' which, they argue, need to be connected and aligned for successful policy delivery and where the efforts of both government departments and local organisations need to be brought together. A 'big' policy window 'opens' (p265), to enable a policy to pass through, if three streams or 'little windows' are linked together – a *policy stream* which defines 'goals and objectives' (p266), a *process stream* which identifies mechanisms of implementation and a *resources stream* which ensures sufficient finance, staffing and other resources are available. Both big and little

windows are placed by Exworthy and Powell within three ‘spatial dimensions’ (p278) of implementation: vertically from ‘the centre’ (that is, at governmental level) to localities, horizontally between government departments and also horizontally between local organisations. This complicated image has been adapted for this study (see Figure 4 below). As suggested in an earlier paragraph above, spatial dimensions in the diagram have been placed in three layers – central government, local organisations and teams and front-line staff. Joint working at each layer is indicated by horizontal arrows. Vertical arrows represent the direction and targets of policy implementation. The attention of this study is given principally to the two local layers.

The relevance of this image is that it is applied in circumstances where ‘a plurality of forms of governance, multiple layers and inter-organisational networks’ (p264) are engaged in addressing ‘wicked issues’ – those issues which elude straightforward resolution, such as those which characterise the specific areas of this research. Tenbensel (2005) also picks up the theme of ‘collegiality’ (p271) of local organisations to emphasise the influence of networks upon policy governance.

Lastly, the delivery of much public policy, particularly social policy, depends upon the behaviour of front-line staff and managers. Schofield (2001) considers that the belief systems and important relationships of the people who operate at the formulation stage of policy will differ from those of the staff at the delivery end. Additionally, Meyers and Vorsanger (2007) provide an illustration of how the ‘visible’ actions of staff may be more easily proscribed by their managers in pursuance of a policy in contrast to ‘less easily observed factors such as the

Figure 4 – Big and little windows of policy implementation[2]



[2] Adapted freely from Exworthy and Powell, 2004, p269

strictness of inspections or harshness of penalties' (p155). In relation to prison education programmes, they cite the significance of:

> – the numerous little actions, like sleeping in class or being dressed down by correctional officers for missing class – that taken together *are* the substance of policy. (p155). [Emphasis at source]

Winter (ibid) reports the similar findings of a study into 'the discretion of street-level bureaucrats in enforcing agro-environmental regulation in Denmark' (p138) as a result of which he concluded that 'their preferences for certain instruments and for less workload have strong impacts' (ibid).

These studies therefore ascribe prominence to the subtle and often unobserved activity as well as the visible conduct of front-line staff in the delivery of public policy, such as the examples of mandated joint working which are the points of focus for this study.`

The mechanisms of implementation

Some authors use colourful analogies to illustrate the mechanisms or 'instruments' (Bemelmans-Vedec, 1998, p9) of policy implementation. Vedung (1998) suggests that there are three such 'instruments'.

> The three classes will be called regulation, economic means and information. The popular expressions used in this context are the stick, the carrot and the sermon. The government may either force us, pay us or have us pay, or persuade us. (p29-30)

Tenbensel (2005) uses the traditional suits of card games – spades, diamonds, clubs and hearts – to propose an expanded range of governance modes.

> …spades signifies hierarchical authority and scientific and legal objectivity, diamonds stands for market governance, clubs signifies governance based on the practices of providers and professionals and hearts denotes governance based on community values. (p281)

The card game image provides Tenbensel with the scope to suggest that these modes can be shuffled and dealt appropriately in accordance with the given

context with some modes acting as more powerful trump cards over others (ibid, 2008). Bemelmans-Vedec et al and Tenbenzel share the view that modes can be combined selectively according to the nature of policy goals and implementing organisations.

By contrast, although agreeing with the combination of approaches, Glasby and Dickinson (2008) propose that in addition to the stick, carrot and sermon modes of governance, 'structural change' can also be used as a means '…to change behaviour at the front line…(p52).' While they offer a criticism of an over-reliance on organisational restructuring (pp29-33), this mode offers not just regulation or a 'stick' to drive change but reflects one of the arms of Hill and Hupe's 'trias gubernandi' – that is, creating a setting or framework within which governance can be steered.

These approaches have a common factor of top-down policy implementation. Schofield (ibid), however, highlights the place of 'dynamic processes within the implementation phase (p255)' which are in tune with the bottom-up mode. These processes include 'bargaining, negotiation and compromise' and also conflict, some of which (exchange and negotiation) she cites from another study 'as being more prevalent than the use of authority or sanction' (ibid). In this way, she provides a more rounded or balanced picture of implementation by maintaining that 'negotiated agreements' (p255) are as much a product of 'the use of power' as 'coercion' (p255).

<u>The contexts of public policy</u>

The discussion in the previous subsection above has indicated that national, organisational and professional perspectives are *interactive* elements in the process of policy implementation. Therefore, although these perspectives are

presented separately here, the same dynamic inter-relationships are understood to apply to national, organisational and professional *contexts* and are indicated where possible. A principal feature of this study – the concept of layers of operation - is the distinctive impact of these perspectives upon activity or operation in each context. This concept is explored later in the chapter.

The brief review of national contexts below includes influences upon policy which are systemic (governmental structures) and cultural (traditions). The organisational contexts in which policy implementation takes place are suggested to be sometimes-neglected factors in the evaluation of a policy's success or failure (Meyers and Nielson, 2012) and also obstacles to success if not 'congruent' with the policy (Meyers and Vorsanger 2007, p156). Organisational cultures are presented here as the main components of this level of context. Professional contexts in relation to mental health services, expressed through culture and values, are reviewed in the next chapter. Schein (2010) defines all of these contexts in cultural terms, each of which influence the operation of organisations. *Macrocultures* are held to be the kind of national, regional or ethnic entities described above. *Subcultures* exist within organisations; Schein divides these into executives, engineers (system designers) and operators which have been translated for the case study sites into senior managers and leaders, policies and front-line staff. He echoes Exworthy and Powell's image of connected windows:

> For organisations to be effective, these subcultures must be in alignment with each other because each is needed for total organisational effectiveness. (p68)

He further subdivides operators into *microcultures* which for this study represent the various professional or occupational groups.

National and locality contexts and cultures

National contexts have been shown in various studies to have provided the settings for distinctive policy styles (May 1995, May and Burby 1996, May and Winter 2007, Tenbensel 2008). May's and Tenbensel's comparative studies, respectively on environmental management in New South Wales and New Zealand and health care in Canada and New Zealand, suggest that differing internal (e.g. commitment and capacity) and external (e.g. level of risk, community activism) factors (May's study) and the existence of federal or centralised government (Tenbensel's study) account for these differing styles. Valentijn et al (2013) consider that supra-national traditions also cast a significant shadow over policy areas such as health care.

> …Western health systems are dominated by the paradigm of a disease-focused view that neglects the underlying causes of health and well-being. (p4)

Sullivan and Skelcher (2002) bring the focus closer to home. They argue that despite the increasingly complex nature of public service provision in the U.K., which they call 'the congested state' (p14) because of the extent of 'interconnections' (p14) between the growing number of policy-implementing agencies, '…the traditional norms of public administration… still underlie the approach to government in the UK.' (p32). These norms include top-down, hierarchical and bureaucratic approaches to public policy. The same authors view mandated joint working as 'a familiar scenario in the UK [whereby] a superordinate body such as government legislates that work coordination between organisations should be high even though domain consensus is low (p44)'. An example of this low or weak consensus is considered to be shown in the historical and structural

division between health care and social care in most parts of the UK (Glasby 2012), being built for separate rather than integrated operation (Wistow 2012).

Further, Newman (1994) argues against an assumption that the cultural contexts of public services are closed and thereby provide protection for organisations in the public sphere from change in their environments. In this way, she reinforces the notion that the layers of context are dynamically connected. Nolte and Pitchforth (2014) provide a specific example of this connection by suggesting that the specific needs of a local population would both influence and be influenced by, and importantly therefore be a feature of, the immediate contexts within which organisations are set.

Organisational cultures and values

A number of theories of organisational cultures have been useful for this study. First, the plural term 'cultures' has been used deliberately – it is applied here to groupings of people (Pollitt et al, 1992). It can be a term of reference for an organisation as a larger grouping (Meyerson and Martin 1987, Hofstede 1991, Meek 1994) and/or to smaller groupings such as managers, administrators or professionals within an organisation (Trompenaars 1994, Newman 1996, Schein 2010). Meyerson and Martin take an inclusive approach.

> …we believe it is more informative to define organizational culture as a nexus where broader, societal 'feeder' cultures come together. What is unique, then, is the specific combination of cultures that meet within an organization's boundary. (ibid, p631)

Meyerson and Martin take a nuanced and varied view of the successful operation of cultures within organisations (ibid, p633). They use a series of images to illustrate ways of thinking about culture. A 'clearing in the jungle' (the integration paradigm) represents a high degree of consensus and reduced ambiguity; it could also be called the alignment paradigm. 'Small islands of clarity set in a sea of

ambiguity' (differentiation paradigm) exist within organisations as numerous and often conflicting subcultures. A 'jungle' (ambiguity paradigm) is the image of organisations where individuals can become pre-eminent and the organisational form is not a priority. Each form can be effective if recognised by powerful subcultures such as managers (Newman, 1996).

Second, a debate about whether culture is a definition or a property of organisations – whether it is something they are or something they have – is avoided here by accepting ideas that have driven each of these perceptions. On the one hand, the definition perception places emphasis upon the identity or recognition that culture confers to an organisation (Meyerson and Martin 1987, Hofstede 1991, Meek 1994). This identity can be conferred at the surface or outward-facing level of organisations by what Schein (ibid) calls 'artefacts' – uniforms, logos and routine activities such as annual general meetings. On the other, the property perception allows for the possibility of cultural change being open, albeit with difficulty, to influence or being shaped (Newman 1996) by the groupings within organisations (such as managers or front-line staff) through the distribution of power and authority and the development of rules for relationships (Schein 2010). Both perceptions have been relevant for this study.

Lastly, a vital aspect of organisational culture is formed by the values which an organisation adopts, expresses or practises. Differing terms are used by authors to define values but they are linked for the purposes of this study by the meanings they can ascribe to activity (Meek 1994, Newman 1996) such as a 'taken for granted' status (Pollitt et al, 1992, p4). Morgan et al (2016) provide a straightforward definition of values in relation to frontline professions but are used here with reference to organisations:

> Taken together values can be thought of as *anything positively or negatively weighted as a guide to decision and action*' [emphasis in original] (2016,p38)

Schein (ibid) makes a distinction between explicit forms through which organisational culture is expressed, such as mission statements, and underlying 'basic assumptions' which he sees as being at the core of an organisation's culture and which add detail to Morgan et al's definition.

> Culture as a set of basic assumptions defines for us what to pay attention to, what things mean, how to react emotionally to what is going on, and what action to take in various kinds of situations. (2010, p29)

Hofstede (1991) takes a slightly different stance in offering a more pragmatic view of the determinants of activity by making a distinction between shared beliefs and 'shared perceptions' - that is to say, the difference between what it is considered right to do and what, from experience, is the best thing to do.

> The conclusions…[from studies]…are at variance with the popular literature on 'corporate cultures' which insists…that shared values represent the core of a corporate culture. On the basis of the research described… *shared perceptions of daily practices* should be considered to be the core of an organisation's culture [emphasis in original] (Hofstede, 1991, p182/3).

Accordingly, the usefulness of a cultural perspective for this study is found in identifying the manner of expressed attitudes and consequent actions (in relation to joint working) of key groups within organisations. Differing definitions of what culture means seem to coalesce around such attitudes. Hofstede (ibid) calls this '...*the collective programming of the mind which distinguishes the members of one organisation from another* [emphasis in original text] (p180).' Trompenaars offers a straightforward view of the connection between attitude and action: 'Culture is the way in which a group of people solves problems (1994, p6).'

Hofstede famously proposed that a number of dimensions channelled the influence of culture upon activity. His dimensions were applied to countries but are considered here to be relevant to organisations. Of these, three have been found

to be immediately appropriate to organisations engaged in this study. *Individualism-collectivism is a reference to* 'the degree to which people… prefer to act as individuals rather than as members of a group' (Hofstede 1994, p6). *Uncertainty avoidance is shown by* 'the extent to which…[an organisation]…feels threatened by uncertain and ambiguous situations...' (Hofstede 1980, p45)' and as a result demonstrates '…preferences for clear rules and guidance.' (Hofstede 2001, p149). *Masculinity-femininity* contrasts a tendency in organisations for assertiveness and competitiveness as opposed to 'cooperation' (ibid, 2001, p281) and 'solidarity' (ibid,1994, p6).

Professional cultures and values

The main thrust of these theories in relation to organisations and organisational leaders is shared with professional groups in the sense that culture and values determine the choices of decisions and actions. The key difference between these two interests is, naturally, their scope. For frontline professionals, their cultures and values are likely to be more focussed upon 'the content of the job' (Busch and Murdock 2014, p37) than upon wider organisational issues. In addition, for mental health services, values are notable for their plurality within and between the organisations in which frontline professionals are placed (Morgan et al, ibid). Plurality in turn gives rise to a number of challenges – imbalance of the relative power of professions, for example the predominance of doctors (Woodbridge-Dodd, 2012), and the incidence of conflicts between the values of different professions (Fulford and Woodbridge, 2008), demonstrated in the findings chapters in the interactions between mental health service staff and police officers. However, equally, the main prize of effective joint working between frontline professionals for addressing the needs of service users is mutual acceptance –

‘an agnostic approach to values’ (Woodbridge-Dodd, ibid, p509) - by these staff of their differing values in the complex settings in which they operate.

> The implications of this suggest that the clinician acknowledges a value-pluralism wherein there is no truth or higher set of values but a constant effort to work within the diversity of service user’s, carer’s, manager’s and clinician’s life worlds. (Woodbridge-Dodd, 2012, p509)

*

In summary, public policy is not a straightforward use of governmental power. Its implementation can take a number of forms, often combined, whose success or failure can be influenced by the contexts in which it is applied. This complexity is matched by the nature and characteristics of joint working in public services which has been promoted by governments over three decades and continues to be so.

Joint working in public services

Joint working has been adopted as a public policy over the past three decades and more in England (Sullivan and Skelcher, 2002) This section aims to address in turn three questions in relation to joint working, the answers to which were influential for this study. First, what is it for? Second, what does it mean in the arena of public services? Third, what makes it work the way it does?

<u>What is joint working for?</u>

The complexity of joint working in public services is reflected in the variety of its purposes - not least because they have been, and remain, contested. Despite this complexity, the rationale for joint working will be reflected by necessity in the circumstances where it is mandated. The purposes have been commonly grouped together under the headings of ‘economy, efficiency and effectiveness’ (Jones et al, 2013) and these will be used in the paragraphs that follow. In addition, a

culture-based purpose, defined by Dickinson and Sullivan (2014) as 'efficacy' will be explored.

Economy. The potential to reduce costs has continued to be claimed for joint working. Cropper (1996) considers there to be 'a distinctive logic' of collaboration in that it can address the 'central concern' of 'the relative costs incurred in transactions' (p86) which are likely to occur on a frequent basis between organisations when separated and can therefore be reduced if combined. Parker and Gordon (1998) see the potential 'of reducing overhead costs' where services are jointly provided. Jelphs and Dickinson (2008) cite a number of studies which found cost savings were made by 'interagency teams' (p27) working with older people but go on to suggest that incentives for such savings may diminish if they do not accrue directly to the teams – for example where hospital stays are reduced through the effective working of community-based teams. Other studies (Ramsay and Fulop 2008, Nolte and Pitchforth 2014) express reservations about the evidence for cost reduction. Monitor (2015), however, persists with the argument that efficiency savings from integrated working in the NHS have 'the potential to make financial savings (p8)'.

Efficiency. Numerous sources refer to the potential of joint working to improve the use of resources (staffing, information and budgets) (Glasby and Lester 2004a, Dickinson and Glasby 2010, Department of Health 2013a, Nolte and Pitchforth 2014) by reducing duplication (Parker and Gordon 1998), by sharing these resources (Huxham and Vangen 2005), by system efficiency through improved communication (Petch et al 2013) and increasing productivity (Jupp 2015), particularly in the context of 'a challenging financial environment' (Public Health England 2013, p4) and 'rising demand for services' (Cameron et al, 2014, p226).

Both of the 2014 sources cited here, however, conclude that the evidence for efficiency continues to be slender.

Efficiency and effectiveness (the achievement of desired outcomes) can be expressed as conjoined purposes of joint working (Shaw et al 2011, Taylor 2015) and are claimed theoretically to offset the trend towards fragmentation of services (Sullivan et al 2012, Goodwin 2013) and to promote flexibility and responsiveness to the changing and complex needs of service users (Scragg 2006, Barker Report 2014). It is striking that over the past 20 years these claims have been made persistently with only variable or weak supporting evidence (Ramsay and Fulop 2008, Shaw et al 2011, Nolte and Pitchforth 2014).

Effectiveness. As mentioned above, effectiveness is defined as the achievement of outcomes. A range of outcomes are claimed to be the goals of joint working. Since the 1980s until recently, these outcomes were framed primarily as organisational objectives (Hudson 1987) such as benefits to each partner agency (Huxham 1996, Sullivan and Skelcher 2002). Particular emphasis during the 2000s was given to the apparent capacity of joint working to address what have become known as 'wicked issues' (Peak and Dickinson 2008, Rummery 2009, Sullivan et al 2012) which have been defined as 'policy problems which fall between the responsibilities of agencies but which pose significant challenges for them (Rummery 2009, p1799)'. More recently the key purpose has shifted towards meeting the needs of service users (Ballatt and Campling 2011) and qualitative objectives such as the improvement of 'health and wellbeing outcomes of people and places' (Wistow and Dickinson 2012, p680), the experience of care of service users (Frontier Economics 2012) and improved access to care (Broadbridge 2014, National Voices/NHS England 2014). This has become refined further to be

framed as ‘whole person care’ (Broadbridge 2014, p6) or person-centred care (Monitor 2015). The important theoretical impact of these recent trends is that these outcomes are seen to be achieved through a relationship *between* professionals and/or agencies *and* service users rather than a service provided by professionals *to* service users. A more ambitious objective is for joint working to be led or defined by service users (Department of Health 2013a, National Voices/NHS England 2014).

At face value, these outcomes seem to have undergone significant evolution. However this progress may not be matched by the conditions in which they are to be exercised.

> One of the ironies of the health and social care arena over the past quarter of a century has been that just as the concept of the ‘whole patient’ was being (re)-discovered…the professions of health and social care have become ever more specialised and narrowly focused. (Jelphs and Dickinson, 2008, p18)

Efficacy. Economy, efficiency and effectiveness share the status of being *explicit* outcomes, albeit in different forms and for different beneficiaries, of joint working. Nevertheless, it has been suggested that joint working can also be viewed as an *implicit* outcome in itself for the managers and professional staff engaged in it. Cropper (1996) proposes that the collaborative activities of agencies can be valued ‘…for what they are…rather than for what, instrumentally, they can do (p90)’. In this way, attitudes in addition to ‘rational motives’ (Dickinson and Sullivan 2014, p165) can be a significant motivation for joint working – a perspective that complex issues can be addressed only by agencies working together (Huxham and Vangen 2005) or, more simply, that experience is the best guide to practice.

Dickinson and Sullivan (2014) use the term ‘efficacy’ to describe a cultural purpose of joint working. Joint working produces artefacts such as organisational language, a corporate identity, routine practices as well as emotions ‘[which] are of

interest in collaboration, less for what they are than for what they do (ibid, p169).' And 'what they do' is to perform one of the key functions of organisational culture mentioned above – to give meaning to everyday activities.

> For actors the 'rightness' and 'goodness' of collaboration may be a matter of faith rather than evidence – it is the 'right' way to work. Collaboration may be perceived as a means of finding work fulfilment. The very challenges…require them [managers and professionals] to make use of skills such as judgement that cannot be read off a performance chart but instead need to be honed through experience.' (Dickinson and Sullivan, ibid, p174)

Dickinson and Sullivan (ibid) go on to attribute the continuing appeal of joint working to its efficacy or cultural influence which can support local actors to persist with it in the face of enduring difficulties and pressures to act otherwise.

What does 'joint working' mean in public services?

'Integration' often is used in the literature as a generic reference for joint working but I use it here with a specific meaning. Therefore I have chosen the phrase 'joint working' in this study as the umbrella term for combined activity between organisations and/or between their individual representatives as this activity can differ in degree, type and layer of operation.

The degrees of joint working. A number of authors make multiple distinctions of joint working by *degree*. Leutz (2005) draws a distinction between '…three levels of integration: the 'full integration of…the UK ideal, as well as two 'lesser' levels called coordination and linkage' (p6). He argues that these levels will be generated largely by the needs of service users with integration addressing the highest level of needs. Williams and Sullivan (2007) cite a four point continuum of ever-increasing joint activity beginning with cooperation and moving through coordination and collaboration to an ultimate or highest point of coadjunation; the last term is defined as the '…complete relinquishment of autonomy of at least one

partnering entity in an effort to strengthen a surviving organisation'(p28). Petch (2012) cites a survey conducted by the NHS Confederation and the Association of Directors of Adult Social Services which identifies a five point scale which places 'relative autonomy' as the lowest point and, in ascending order, includes 'coordination', 'joint appointments', 'enhanced partnership' and 'structural integration' (p4). While there are similarities between these constructions of joint working forms, there are different points of emphasis. For the purposes of this study, I have applied three terms to the specific areas of mandated joint working in the research sites, drawing selectively from each of the models cited or presented here – cooperation, coordination and integration.

Cooperation is defined as 'shared information and mutual support' between organisations and frontline staff (Williams and Sullivan, ibid, p29). Coordination is characterised by 'a reasonable level of formal commitment to joint working, with coordination around some areas of strategy and/or commissioning, depending on circumstances' (Petch, ibid, p4). Both of these forms assume a functional and structural separation between organisations. Leutz's version of integration (ibid, p6) is adapted for this study to describe the circumstances where staffing and financial resources are pooled within a single organisation, teams provide unified systems of care and care recording information is held in common between staff disciplines. In this adaptation, therefore, integration takes place between 'service sectors' - NHS commissioners, NHS Trusts and local authorities - and 'professions' – for example, nurses, social workers and doctors (Petch, ibid, p5).

The types of joint working. The nature of joint working activity is also expressed in differences by type as systemic, normative, organisational, administrative and

clinical integration (Shaw et al 2011, Lilo 2016). Lilo cites brief explanations of each type.

- ‘Systemic, where policies, rules and regulatory frameworks are aligned
- Normative, where shared values and cultures are nurtured across professional boundaries
- Organisational, where structures and governance are coordinated
- Administrative, where functions such as finance and information technology are aligned
- Clinical, where patient care is integrated in a single process with information and services coordinated (Bamford 2015, Shaw et al 2011).’

Valentijn et al (2012, p8) adapts this approach for primary health care by arranging the types into macro (system), meso (organisational, professional) and micro (clinical) layers. Professional integration has a more limited scope than the normative dimension described above as it is confined to professional roles. He uses the terms ‘normative integration’ (given wider application of ‘shared values, culture and goals…’ (p8) across all layers) and ‘functional integration’ (broadened slightly from the administrative form above, to include functions such as human resource management) to indicate how the types can be linked between layers.

Shaw et al suggest that these types are not hierarchical in nature, do not need all to be present ‘in every project’ (p9) and will vary in importance depending upon local circumstances. Valentijn et al present the types in a hierarchical manner and argue that for service delivery to be ‘continuous, comprehensive and coordinated’ (p9), activity at a number of layers needs simultaneously to take place.

The value of this analysis of joint working *by type* is that it adds substance to the *by degree* constructions. For example, Lilo’s clinical and normative types can be applied to cooperation where organisations remain separate, can be supplemented by the organisational type for coordination and all five of the types

Figure 5: Potential alignment of joint working dimensions

Difference by degree	Cooperation	Coordination	Integration
Difference by type	Clinical Normative	Clinical Normative Organisational	Clinical Normative Organisational Administrative Systemic

Difference by type adapted from Lilo (2016)

can be applied to Leutz's version of integration. Figure 5 above provides an illustration of the potential alignment of these dimensions. This alignment has been helpful in identifying the joint working activity in each case study site.

Layers of joint working. I have made reference in the previous paragraph to Valentijn et al's concept of joint working taking place at a range of layers of operation. This concept can be represented as a theme in the literature. I use it here to define a further dimension of joint working which incorporates the use of the term 'levels' in the sources quoted below. A number of sources argue that for joint working (or integration as it is termed in some texts) to be sustained, effort needs to be made at structural, organisational and individual layers of activity (Glasby 2004, Rutter et al 2004, Heenen and Birrell 2007, Glasby, Dickinson and Miller (2011). Each presentation is addressed to different settings of joint working: Glasby and Rutter et al to hospital discharge and care management respectively; Heenan and Birrell to Northern Ireland's health and social care services; Glasby, Dickinson and Miller to equivalent services in England. However, a central theme linking all four sources is evident.

> …any policy designed to achieve true partnership working will need to operate at all three levels of activity at the same time if it is to be successful.' Glasby, Dickinson and Miller (ibid, p5)

Heenan and Birrell (2007) consider that this ‘true partnership working’ is rooted in a ‘culture of integration…[which]…must permeate all levels of service planning and provision.(p63)’ .

The structural layer is interpreted in the literature as comprising national policy for England and Northern Ireland. In particular, the historical division between the national structures for health and social care in England is viewed as inherently unhelpful (Glasby 2003). In Northern Ireland, the absence of this division is seen as positive but insufficient on its own (Gray and Birrell, 2016).

The organisational layer is self-explanatory and embraces the range of NHS and local authority organisations and their capacity to implement normative, organisational, administrative and clinical types of joint working. For this study, this layer was represented by the senior managers and leaders of the key healthcare, social care and emergency services agencies and includes local policies and procedures derived from national policy. However, the importance of individual people, who occupy key positions within organisations from where they can exert influence, also is given prominence in the sources referred to above as a further element necessary for robust joint working between health and social care organisations. These individuals include staff members who have particular skills, often at middle management level, within organisations. Sullivan and Skelcher (2002) see collaborative capacity to be based on both individual and organisational factors and give especial focus to the former in an inventory of the requirements for ‘reticulists’ (p101)

> … key individuals who bring particular skills and play particular roles in collaborative effort (p50)’, which includes ‘communication, networking, conflict resolution, risk-taking, problem-solving (p101).

Similarly, Williams (2011) ascribes additional roles to exceptional individuals whom he calls 'boundary scanners' – 'entrepreneur, interpreter/communicator and organiser' (p27) – who are responsible respectively for 'making things happen', 'managing relationships' and 'housekeeping' (pp27-30).

The individual layer refers principally in this study to first-line managers and frontline staff of community teams and agencies and of advocacy agencies.

As will be explained in Chapter 4 (Methodology), this concept of layered operation influenced the structure for much of the fieldwork (documentary analysis, semi-structured interviews and focus groups) for this study.

Although these themes have been drawn from the joint working literature of health and social care services, they have been applied also to the other joint working group of mental health and emergency services addressed by this study.

What makes joint working work the way it does?

In addition to offering definitions of joint working, the literature also proposes concepts of its key characteristics which influence its implementation. Four broad characteristics are of relevance to this study. Joint working is a *natural feature* of social policy and organisational life. It has a '*life cycle*' (Sullivan and Skelcher 2002, Huxham and Vangen 2007) or *life progression*. It is replete with persistent and ever-changing *tensions*. *Leadership* needs to be imbued with distinctive traits if it is to be exerted successfully in joint working settings.

A natural feature. Sullivan and Skelcher describe 'informal networks' as the 'life-blood' or 'substructure' (ibid, p136) of joint working. It seems reasonable to suggest that these enduring features are natural mechanisms (even if such a concept appears a contradiction in terms). Dickinson and Glasby (2013) cite a bodily analogy of joint commissioning to suggest that both collaboration and

competition are the outcomes of the combined activity of the conscience, the brain, the eyes and the ears comprehensively to identify and prioritise the issues that need addressing. Further, Huxham and Vangen (2005) include other human characteristics of trust, communication and language, commitment and determination and power among the key themes they considered from their research into 'collaboration practice' to be the cause of 'grief, 'pain' and 'reward '(p12). Lastly, the complexity of joint working, in contrast to single responses to social issues, reflects the complexity of Western public policy in general (Sullivan and Skelcher, ibid) and of mental health issues in particular (Glasby and Lester 2004a). The key point here is joint working (and, for that matter, competitiveness) will take place naturally or automatically around and within modern social policy, depending upon the specific organisational structures that surround it.

Life cycle/progression. A concept that emerges in various forms in the literature is that joint working has a life cycle or life progression and is therefore an ever-evolving process rather than a static end result (Williams and Sullivan 2007, Goodwin 2013). The distinction between life cycle and life span is that the former assumes a return to its starting point, or a point that is similar, and the latter assumes continued development. From its inception in a particular service area or project through its establishment and period of effective operation to its termination (where it has one), joint working is understood to require differing supporting activities and governance (Sullivan and Skelcher 2002, Huxham and Vangen 2005) which '…reflect those questions of power, trust and motive that are central to any form of collaboration (Sullivan and Skelcher ibid, p1).' The balance between the issues raised by these 'questions' will alter during the life of the joint

working arrangements; Sullivan and Skelcher 2002 therefore argue that all of the traditional governance modes associated with theories of hierarchy, networks and markets are likely to be required at different times and in varying combinations. This cyclical or progressive characteristic of joint working has particular application to mental health services and will be discussed further in the next chapter.

Tensions. The complexity inherent in joint working is illustrated in the literature by frequent reference to the characteristics of 'paradox, ambiguity and tension' (Williams, 2011). Sullivan and Skelcher (ibid) pay especial attention to the persistent nature of these characteristics.

> …dilemmas… need to be managed rather than to be resolved in favour of one element rather than another. *This is because the dilemmas are inherent in any form of collaboration that concerns matters of public policy* [author's emphasis] (p218).

An example of an unresolvable issue – 'capacity-releasing vs control exertion (p220)' - is defined as:

> The ability of collaboration to reach parts that have eluded other forms in the past against the drive for control and direction which may include wider representation that excludes some interests.' (p220)

Rodriguez et al (2007) see another 'paradox' of 'interorganisational collaboration' around the issue of control in the conflict between 'autonomy and dependence' (p151). Lymbery (2014) provides an illustration of this conflict when he cites the 'state-mediated' nature of social work as being 'a key difference between the professional status of social work and other occupations such as medicine or the law (p796).' For the former, formal and at times closely-defined accountability to external forces such as legislation and local communities through their elected representatives (local councils) is an enduring cultural feature. For the medical profession, clinical judgement or decisions have maintained a continuing if varying autonomous status which is accountable primarily to professional bodies.

Leadership. The place of leadership in joint working is discussed in the literature as an important contextual influence and clearly has a bearing upon modes of governance. The definition of leadership as being '*those activities that might enable effective organising, especially within partnerships* [emphasis in original]' (Peak and Dickinson, 2008, p23) is accepted here. Effective leadership has been accorded a significant factor in the success of joint working that ranges from being one of the solutions to challenges (Glasby and Lester 2004a) to 'one of the top 5 priorities' cited in a survey (Petch 2012) to being pivotal (Hutchison 2015).

> It could be argued that the success or failure of a local change [Scottish health and social care integration arrangements] may not rest with the indicated structures, either national or local, but the ability of the key local leaders to exhibit assured traits throughout implementation. (Hutchison, 2015, p137)

The 'traits' of effective leaders in joint working activity have been summarised in a number of sources. These summaries have some common (if loose) threads. A successful leader in joint working arrangements is helped by being able to demonstrate a 'requisite variety' (Peak and Dickinson, ibid, p97) of skills when needed, to adopt the appropriate leadership style for the circumstances at hand and to possess conducive personal qualities 'to deal with the 'discomfort, ambiguity and uncertainty' inherent in leadership for collaboration (Sullivan et al, 2012, p45). The skills include empowerment of staff (Huxham and Vangen 2005, Lonsdale et al 2015), creativity (Peak and Dickinson 2008), providing direction (Ballatt and Campling 2011) and clear vision (Larsen et al, 2013). Helpful styles, again when required, include leading in 'the spirit of collaboration' (Huxham and Vangen, ibid p213) by employing the skills just mentioned and (perhaps counter-intuitively) 'collaborative thuggery' (ibid p213) which refers to political skills such as gaining influence over the priorities of the joint working arrangements. The personal qualities include leading by example (Lonsdale et al, ibid) and ability to

network or build interpersonal relationships within and across organisational boundaries (Peak and Dickinson, ibid).

Important though the leadership traits of individuals may be, the distinctive element of leadership for joint working for this study is in its application to networks of organisations and key players within them (6 et al, 2006). Networks have been framed usefully into four 'basic ways of organising' (Peak and Dickinson ibid, p 19): isolate; hierarchy; individualism; enclave. Further, these types are used to identify organisational circumstances of relevance to this study according to the strength or weakness of regulation and integration. Silvia (2011) argues that the activities of leaders in networks differ from those who operate in more traditional bureaucratic settings. The former 'spend significantly more time on people-oriented behaviors (sic)' and the latter give priority to 'scheduling, assigning and coordinating work' (p67). Agranoff and McGuire (2001) drill further down into such 'behaviors (sic)' and categorise the activities into four types: 'activation, framing, mobilization and synthesizing' (cited by McGuire and Silvia, 2009, p39). These activity types, which respectively include identification of resources, facilitating agreement on roles, developing the support and motivation of participants and maintaining the network, are suited to particular stages of the life cycle or life span of the network. McGuire and Silvia (ibid) conclude that a leader who spends most of her or his time in mobilization and synthesising rather than framing – a focus on outcomes rather than tasks - is likely to be engaged in an effective operating network.

Briefly, the supporting arguments for joint working as a response to complex social issues are varied, and vary in their forcefulness, but have persisted over recent decades. The degrees, types and layers of joint working are varied also and have

shown a capacity for adaptability to national and local circumstances. Joint working has distinct characteristics which are inseparable from organisational life in public services and which require commensurate skills of their leaders. Joint working could be represented by the image of an amoeba because of its ability to alter shape and evolve in response to external influences and pressures.

When joint working is mandated in public services, a particular external influence and set of pressures are introduced.

Mandated joint working in public services

It seems clear that the term 'mandated' continues to attract the limited and pejorative meaning of 'enforced' in relation to joint working in various service settings in England. It may be that this perception stems from a national predisposition for the framing of, and resistance to, public policy in general as enforcement. Hill and Hupe (2014) appear to confirm the existence of this national characteristic.

> …a continued awareness of the debate [about differing types of approaches to policy implementation]...remains important. This is particularly so because of the continued tendency of everyday statements about implementation – from politicians, the media and so on – to be formulated in uncompromising top-down terms. (p60)

Services for children and families, including the contentious area of safeguarding children, have provided the sites for distinctive mandated joint working over the past three decades in England and elsewhere. This distinctiveness appears to lie, for safeguarding children in England, in a combination of a top-down implementation style, a preference for bureaucratic working processes and a high level of prescription of the activities of front-line managers and professional staff. Standard processes which, for example, define what and how information should be shared between the professional staff of various agencies are overseen by

Local Safeguarding Children Boards which were introduced by the Children Act 2004 following the inquiry into the death of Victoria Climbie in 2000. A number of authors offer critiques of this style of mandated joint working in England for safeguarding children services (Horwath 2009, Horwath 2010, Munro and France 2011, White et al 2015) and elsewhere for social care services for children and families (McKeown 2012, Roets et al 2016) which form a common thread – that prescriptive and 'functional' (Roets et al, p306) processes cannot reflect the complexity of the social care tasks of working with children and families. Horwath gives a simple example:

> It is all too easy to state how practitioners should share information without considering the process that they need to go through before reaching a decision to share information. (2009, p130)

White et al make a broader point that:

> …'rational' decision-making relies on our capacities as human beings to make sense of the world using our *emotions*.[author's emphasis] (2015, p14)

In summary, it is the extent of the mandate, or the level of enforcement – the reliance on detailed processes and the degree of prescriptiveness of front-line activity – that is seen as counter-productive because it does not account sufficiently for or value 'responsive' (Roets et al, p306) professional judgement.

A single, small-scale study into the introduction of Drug Treatment and Testing Orders (DTTOs) in England under the Crime and Disorder Act 1998 indicates further drawbacks to this prescriptive approach (Barton and Quinn 2001). A DTTO was a community sentence available to criminal courts designed to address a perceived link between drug misuse and offending by, as the name of the order implies, imposing a compulsory treatment programme and a schedule of frequent physical drug tests. The authors suggest that DTTOs placed a higher priority on criminal justice (the prevention of drugs offences) than treatment (the reduction of

drug use) and thereby distorted the joint working of probation officers and drug workers which was mandated by this policy. Barton and Quinn considered that in addition this style of mandate was inappropriate as it imposed an interagency (integration) model of joint working when a looser multi-agency (co-ordination) model 'may have been the preferred organisational option' (p59). For example, drug workers viewed confidentiality of personal information as being one of the conditions for effective engagement with their clients and a distinctive feature of their role. This had enabled them previously to make judgements, for example, about disclosure of drug-taking activity. This autonomy was removed by the contractual arrangements which underpinned the implementation of DTTOs.

In neither of these service areas, however, do authors claim that mandated joint working per se is mistaken. Indeed in both cases, governmental commitment gains approval. It is the emphasis of the policies in the circumstances of each area that raises concern.

May (1995) argues that all government policy carries a mandate by definition but uses different types of mandate to achieve the desired goals. Bemelmans-Vedec and Vedung (ibid) are clear that whatever means are used for the implementation of policy, 'they are the tools through which governmental authorities wield their power (p272).' This power needs to be adapted so as take account not only of the contexts in which it is exercised but also of its likely impacts. In this way, research into the policy for the management of natural disasters such as flooding in Australia and New Zealand (May 1995) and wildfires in America (Brummel et al 2010) shows that, even in these emergency situations, the need for variation according to local commitment to the policy aims needs to be acknowledged. May (ibid) concludes that both 'coercive' and 'cooperative' implementation styles can

be successful, the former where low local commitment exists, the latter where local commitment is high. The pre-existence of positive working relationships between managers and front-line staff is recognised as another variable which has influence upon implementation style (May 1995, Dunlop and Holosko 2004); the cooperative style is more likely to succeed in those circumstances where these relationships exist.

Brummel et al (ibid) found in their case studies for wildfire planning that there was a potential for '…policy-mandated collaboration [to] set the organisational context for learning [which they argue is the outcome of successful joint working] by convening key stakeholders (p695)'. This picks up the theory attributed to Foucault earlier in the chapter that the use of power can be productive as well as repressive.

The enforcement element of mandated joint working is likely therefore to be mitigated by factors such as the nature of the service area and the commitment of, and working relationships between, local actors. A number of authors argue that the governance of mandated joint working needs to embrace and balance a range of approaches, beyond an exclusive reliance upon the 'stick' of enforcement, so as to engage with key players at strategic, operational and front-line layers of operation (Hudson 1987, Perry 1993, Freeman and Peck 2006, Henwood 2006, Rodriguez et al 2007, Glasby and Dickinson 2008, Peck and Dickinson 2008, Valentijn et al 2013, Cameron et al 2014). This appears to support Hill and Hupe's previously-mentioned concept of a 'multi-governance framework' for policy implementation.

Conclusions

The first paragraph of this chapter introduced the notion that public policy expresses the power of government and that mandated joint working as a public policy is an example of that expression. However, apart from occasions of emergency or disaster management, public policy constitutes usually more than a set of instructions issued by governments. It seems that it may be an English habit to understand the meaning of the public policy of mandated joint working as enforcement. The variable nature of governmental power seems to be reflected in the range of theories, processes and mechanisms of policy implementation and in the consideration of the cultural contexts in which implementation are applied.

A number of concepts have been drawn from the discussions of public policy which have been useful in developing the study's methodology and thereby providing structure for findings and analysis. As indicated above, the use of governmental power as enforcement is usually only part of the story which needs to be accompanied by other approaches. The theories implicit in 'top-down', 'bottom-up' and 'multi-governance framework' perceptions of policy implementation have provided me with ways of thinking and discerning how policy takes or has taken shape in the two case study sites. Perhaps the most valuable insight for me has been that local policy implementation is primarily a matter of the way in which organisations *tend* to make decisions and to act in given circumstances. Policy imperatives and their mechanisms are complex – Exworthy and Powell's 'windows' analogy is an illustration of this complexity, can vary and be mixed not only across the sites but within them. The concept of layers of operation is introduced as 'a principal feature of this study' (see above) in the discussion about the contexts of public policy and is implicit in the implementation

theories just referred to. It is picked up again in the discussion about joint working in public services and in the methodology, findings and analysis chapters of the thesis. Lastly, the discussion about cultural influences upon policy-implementing organisations reinforces the notion about their tendencies in reaction to external and internal pressures. In relation to primarily external influences, Meyerson and Martin's emphasis upon the power of ambiguity and Hofstede's concept of 'uncertainty avoidance' have been useful guides for analysis. Similarly for internal influences, Hofstede's other cultural dimensions of masculinity-femininity and individualism-collectivism have yielded insights from consideration of the findings.

Joint working in public services has been asserted here as a persistent and longstanding feature of public social policy. Interrogation of the purposes, meanings and characteristics of joint working provide valuable and additional constructs which have generated some of the findings and their analysis. It has been possible to draw out the intended purpose of, for example, the S117 policies and provide reflections on the mechanisms used at each site by making links with notions of economy, efficiency, effectiveness and indeed efficacy. The meanings by degree and type have been helpful to surface differences, which can be subtle, in the nature of joint working *within* as well as between each site. As mentioned above, a discussion of layers of operation adds the contribution of exceptional individuals or people with boundary-spanning responsibilities to the resolution of issues that arise at each layer – there are a number of such individuals identified in the findings. The suggestion that joint working possesses characteristics of its own has provided especially-useful guidance for findings and analysis – in particular the concepts of a life cycle or progression, each of which are

represented in the sites, the existence and management of tensions and the conduct of leadership within network settings.

A brief discussion of mandated joint working in public services illustrates, in relation to safeguarding of children and drug testing and treatment orders, a somewhat polarised and negative view that it represents enforcement and highly prescribed activity. A more balanced perspective is offered from international studies. Enforcement is suggested from these studies to vary in its nature and extent according to local circumstances. Most significantly, enforcement is presented as being not only desirable but also necessary in certain circumstances either where local resistance is substantial or to provide a sense of direction to overcome local obstacles. This discussion enabled me to develop a sense of the impact of mandated joint working in the case study sites, including a perception that its impact may be negligible.

CHAPTER 3

Literature review:

National context for joint working in mental health services in England

Introduction

In presenting the remaining two topic areas of the literature review, this chapter aims to identify key features of the national mental health context for both joint working and mandated joint working and is divided accordingly into two sections. The discussion in the first section reviews in turn these contextual features in relation to the two groups of organisations identified in Chapter 1 as primary participants in inter-organisational relationships: health and social care services for Section 117 Aftercare and DTOC (health and wellbeing boards (HWBs), clinical commissioning groups (CCGs), mental health trusts (MHTs), local authorities (LAs) and advocacy providers); mental health and emergency services for S136 (all the health and social care services agencies referred to above and, for emergency services, police and ambulance services). A common presentational format has been adopted for each group. A review is provided of governmental mental health policy-making for joint working, followed by an account of the cultures and values of key professional groups. The second section presents a review of the development and rationale of these three examples of mandated joint working. Alongside the theoretical framework developed in the previous chapter, these national contextual features provide reference points for the analysis of the study's findings in chapter 7.

Joint working in mental health services

Joint working between healthcare and social care services

Policy context.

The history of this context is drawn from policy development over the past three decades and its influential elements can be arranged in three layers. National mental health strategies constitute a structural layer. Standard systems and processes can be placed at an organisational layer. The drive to establish a common value base for mental health professionals can be seen as operating at an individual or frontline layer of operation.

Since 1999, governmental mental health *strategic activity* has been embodied principally in two documents – a National Service Framework (NSF), introduced by the last Labour government (DoH,1999c), and a No Health Without Mental Health (NHWMH) strategy developed by the last Coalition government (DoH, 2011). A common thread that links the two documents is the expectation of close joint working between local health and social care organisations. In addition to the scope of the two strategies - the NSF was applied to mental health services for people of working age and NHWMH to people of all ages, there are significant differences in focus and implementation styles between them.

The NSF set seven standards for specific mental health service development including mental health promotion, primary care, services for 'severe mental illness', carers' services and suicide. NHWMH introduced six 'shared objectives to improve outcomes' such as 'more people will have good mental health' and 'fewer people will suffer stigma and discrimination' (ibid, p6). The implementation mechanisms and styles of the two strategies also differed markedly. NSF

implementation can be characterised as a mixture of enforcement and incentive (in Vedung's terms, the 'stick' and the 'carrot' or in Tenbensel's images, 'spades' and 'diamonds')[3], conforming to a top-down mode of governance. The NSF was accompanied by prescriptive and directive processes in the form of detailed Policy Implementation Guides (which came to be known as 'PIGs') for individual services such as community teams, adult inpatient care and specialist community teams (DoH 2002a, 2002b and 2003), additional national resources including finance and workforce planning. and a rigorous regulatory regime. As a result, the majority of local areas introduced integrated community teams during the early 2000s, including the two case study sites. By contrast, implementation of NHWMH can be viewed as a 'sermon' or primarily in the 'hearts' mode with a nod to 'clubs' with a strong emphasis upon bottom-up implementation. The NHWMH strategy was accompanied by an 'Implementation Framework' co-authored by a range of agencies (Centre for Mental Health et al, 2012), issued in the style of 'Best Practice Guidance'. The strategic aims were not accompanied by new resources for local organisations. Responsibility for its implementation was devolved to the newly-created local health and wellbeing boards and a range of statutory and community agencies.

The development of *systems and processes* has had several strands. The Care Programme Approach (CPA) introduced a framework for inter-agency working arrangements for front-line staff in England (DoH 1990); the CPA is still in place, its scope and prescriptiveness having been reviewed and revised on a number of subsequent occasions (DoH 1996, DoH 1999a, DoH 1999b, DoH 2008, DoH

[3] See Chapter 2, p25

2015). The CPA process (assessment, care planning, review and care coordination) has been linked explicitly with Section 117 in their respective purposes – '…the principles of the CPA and after-care are the same…' (DOH, 1999b, p21) and through the entitlements they each confer on service users. The 1999 guidance, for example, describes assessment, care planning and review as being a 'right' for service users (ibid, p5). In more recent years, the CPA has been refined and focused upon '…those people in contact with secondary mental health services who have complex needs' (DOH, 2015, p363, Para 34.6) adding that 'This would include most people who are entitled to after-care under section 117 of the Act…' (ibid, p363, para 34.8). The most recent guidance also specifies which needs are '…likely to involve consideration…' (ibid, p365, para 34.19) including, for example, '…continuing mental healthcare…daytime activities or employment…social, cultural or spiritual needs…contingency plans…'(ibid, pp365-6, para 34.19) and which agencies or professionals should be involved (ibid, p364, para 34.12). As the 2015 guidance was included as a chapter in the Mental Health Act 1983 Code of Practice (MHCoP), it has become mandated effectively as health and social care professionals are obliged to 'consider' the Code (ibid, p6) with the expectation that non-compliance will be exceptional.

Community care reforms in the 1990s led to the creation of care management, an equivalent process for adult social care to the CPA. The 'full integration' of the two separately-implemented processes was proposed subsequently as a formal indicator of 'effective partnerships' (Hancock, Villeneau and Hill, 1997, p19) with 'the [service] response being driven by the assessed need' (DoH 1995 cited by Parker and Gordon 1998). In addition, the creation of community mental health teams (CMHTs) incorporating health and social care staff within a single

management arrangement, a common workbase, single referral process and agreed protocol for information sharing formed the basis for other indicators (Hancock, Villeneau and Hill, 1997). These publications, among others, shaped the principal template for CMHTs following the introduction of the Health Act 1999 which made possible the pooling of budgets and the transfer of staff and finance between health care and social care agencies. The overall vision for joint working was for systems and staff activity to be *blended* in the pursuit of service integration – a vision which was universally driven by the NSF (ibid) and NHS Plan (DoH 2000a), if not uniformly adopted, in the 2000s throughout England.

During the past five years, this joint working vision has been eroded somewhat. Some local authorities have withdrawn from joint organisational agreements with NHS Trusts and have returned to separate management and/or organisational arrangements. Some 40% of local authorities in England have done so apparently due to 'financial pressures' (Lilo 2016, p19) arising from budget reductions. The progressive introduction of exclusive health and social care processes also has provided potential barriers to the blended image of joint working. For health care, the introduction of care clustering as a feature of the policy of Payment by Results (DoH 2013b) has determined eligibility for healthcare resources in such a manner that harmonisation with social care resourcing cannot be taken for granted (Lilo, ibid). Indeed in each case study site, the impact of care clustering has differed. Briefly, the effect of the clustering approach is to summarise the mental health needs, characteristics and circumstances of service users within discrete 'clusters' which act as the 'currencies' (DoH 2013b, p4) that form the basis for 'contracting arrangements between commissioners and providers'. In relation to social care, a number of measures have been introduced progressively during the past 15 years

which have introduced the potential for disruption to integrated processes including the Fair Access to Care Services (FACS) eligibility criteria for social care (Cestari et al, 2006), personalisation in adult social care (Lymbery 2014) and the Care Act 2014 (Lilo, ibid). A recent 'strategic statement' for mental health social work (Allen et al, 2016), endorsed by the Department of Health, announces an intention to mitigate the blended form of joint working.

> We need to ensure we do not waste the skills and knowledge of professionally trained and committed staff within blurred or disempowered roles. (p9)

This 'statement' makes clear that joint working as a concept is not at fault but reflects a preference for the 'salad' over the 'soup' model (Jones et al 2013, p48) whereby the professional 'ingredients' of joint working remain distinct rather than being blended.

The drive to create *a common value base* for integration as the ideal model of joint working in mental health services, a 'middle ground' (Bogg, 2008), has been fuelled by the concept of recovery. Governmental mental health strategy since the beginning of the 2000s (DoH 2001, DoH 2009, DoH 2011) has promoted this concept, and continues to do so, as a progression from a purely medical perception of mental illness towards a social model of mental health in recognition of the move from institutional care to community-based support over the past thirty years.

> Unlike the 'medical model' of diagnosis based on symptoms, then treatment and cure, recovery is a more dynamic concept with three core components – hope, agency and opportunity. (Evans and Huxley, 2012, p147)

'Hope' has a central place in the concept, taking its literal meaning of wanting or expecting something positive to happen and thereby being 'essential to sustaining motivation and supporting expectations of an individually fulfilled life' (Evans and

Huxley, ibid). 'Agency' refers to the ability of people with mental illness to steer or take control their experience of mental health care. 'Opportunity' refers to 'social inclusion' (Evans and Huxley, ibid) – the ability to have equal participation in what their communities have to offer, including education, employment and leisure activities.

This strategic resolve has been supported explicitly by practical measures. The Ten Essential Shared Capabilities: Learning Pack for mental health practice (NHSU, 2005) is a detailed, DoH-sponsored training manual 'to support staff at all levels to develop their capabilities to work in a spirit of hope and optimism, often in challenging circumstances' (ibid, 1st page). These shared capabilities include explicitly value-laden aims such as 'respect', 'ethical practice', 'social inequality', 'the preferred lifestyle and aspirations of service users' and 'making a difference' alongside more practical objectives – 'personal development', 'promoting safety and positive risk taking' and 'working in partnership' (ibid, p2-3).

The manual makes explicit reference to differing cultures and values in relation to this last objective with its guidance that 'any tensions created by conflict of interest or aspiration that may arise between partners in care' (ibid, p2) should be addressed. While the guidance gives prominence to partnership not only between staffs but also between service users, carers and staffs, it also acknowledges the fragility of inter-professional relationships implicit in joint working between the staff of differing professions or agencies. Sullivan and Williams (2012) suggest that this tension lies in '…the development of a systemic approach to promote common standards while also respecting diversity of professional practice' (p701).

Professional cultures and values

Peck and Norman (1999) suggest that the move away from the institutional model of mental health care in the late 1980s and early 1990s has presented challenges to the cultures of each of the professional groups that make up the membership of a CMHT – doctors, nurses, occupational therapists, psychologists and social workers. They make a distinction, however, between the culture of social work and 'the more paternalistic culture of health professionals' (p237). Moreover, the cultural difference between doctors in particular and social work, '…in which the condition of the individual is perceived respectively as a function of their physiology or their environment (Sullivan and Skelcher, 2002, p211)', has engendered growing reservations about the integrated model of joint working.

This difference has been compounded by additional cultural aspects. The pre-eminence of doctors, in particular their assumption of professional leadership (Scragg 2006), has long been a source of potential tension for the staffs of CMHTs, especially (but by no means exclusively) social workers (Colombo et al 2003, Glasby and Lester 2004a). Despite the more collegiate nature of medicine over recent years (Evans and Huxley, 2012), the personal skills of doctors remain important in offsetting their continuing dominant position (Bailey and Liyanage, 2012). Further, a key and persistent cultural issue for social work is that social work as a profession has eluded easy definition leading to the loss of identity and confidence perceived by many social workers in their role within CMHTs.

Peck and Norman (ibid) suggest that this difficulty of defining social work may lie in its distinctiveness arising from the values of the profession rather than the possession of exclusive skills.

> The unique contribution of social work lies not in the skills themselves, but in the way they are applied, that is in the approach that social workers take to their work. (p6)

Bogg (2008) suggests that this distinctiveness also is rooted in wider cultural differences:

> It is difficult to define clearly the boundaries between the two areas [health and social care] , but the fact remains that they operate between different perspectives and cultures, and have differing agendas in terms of the delivery of services. (p143)

Tew (2012) asserts that 'the social and the biological' perspectives of social and health care are 'two sides of the same coin rather than contradictory modes of expression…' (p124) and goes on to propose that social theories of mental distress such as crisis theory, power relationships, systems theory and social capital and psychodynamic, attachment and cognitive theories provide social workers with distinctive opportunities to exercise their role.

However, the ambiguity surrounding the roles of social workers continues. Lilo (2016) considers that the dynamics of integrated joint working have shifted over the past decade, necessitating removal of this lack of clarity by reference to underpinning values:

> …mental health social work can be defined by the values ['…promoting human rights, empowerment and the citizen voice…' citing Social Care Strategic Network 2013] to which it aspires and from which base it works, not to manage or process service users through ever narrowing service gates but to work alongside them in effecting change. (p20)

and to key skills: 'advanced relationship-based skills'; 'tackling stigma, discrimination and exclusion'; 'legal and statutory knowledge'; 'working holistically' (ibid, p22).

Further, a number of sources point to enduring organisational and professional tensions which sustain these differences. Differing approaches to eligibility for services between the NHS and local authorities were noted at an early stage

(Hancock and Villeneau, 1997) for their potential to disrupt integration and, as shown above, this is a continuing tension. Tew (ibid) notes the tendency in the practice of social workers for the protective functions of safeguarding and focus upon risk to take priority over the proactive activity he proposes. Differences in strategic decision-making between the NHS and local authorities at a local level reflect their differing accountabilities – respectively to a non-executive board and to elected members (Griffith and Glasby, 2015). On an intra-organisational level, professional leadership and management remain distinct for health care staff but separation of the two can be a source of confusion and tension for social care staff within CMHTs (Scragg 2006).

Joint working between mental health and emergency services

Joint working between mental health and emergency services has followed a different course to that discussed in the previous section. In contrast to the apparent re-evaluation of integrated care within mental health services, the trajectory for policy development over the past decade in England and elsewhere is towards closer joint working from a position of functional separation. During the same period, research activity has suggested that police engagement in mental health issues involves complex decision-making processes and that these processes and the cultures for police, ambulance and mental health services have a distinctive influence upon the nature of joint working between them.

Policy context.

Unlike joint working between health and social care services, until recently little governmental attention has been paid to strategic engagement with joint working between mental health and emergency services, in particular police services.

However pressures upon the organisations involved and frontline services (especially the police) has gathered pace steadily over the past three decades, leading to marked recent policy changes. In particular, the most significant strategic activity – the introduction of a Mental Health Crisis Care Concordat (HM Government, 2014) for England – has been stimulated by the accumulation of these pressures which are described in the following paragraphs.

The formal engagement of the police with mental health services dates back to the nineteenth century; the police powers granted by legislation at that time to address the needs of people with mental health issues in certain circumstances have remained and developed. However, since the 1990s, two factors have increased and changed the nature of, this engagement, and, as importantly, the public perception of that engagement. First, the closure of the majority of large mental health hospitals housed in nineteenth century asylum buildings has increased the visibility of mental health issues and their potential for social disruption or concern (Fry et al 2002, Morabito 2007, McLean and Marshall 2010, BBC Radio 4, 2013, De Tribolet-Hardy et al, 2015, Normore et al 2015). Second, the perceived shortcomings of the (largely) community mental health services which partially replaced these institutions have impelled the police into increased contact with people with mental health problems (Fry et al 2002, Adebowale Report 2013, Menkes and Bendelow 2015, HASC 2015, Cummins and Edmondson 2015). These shortcomings have been linked also to reduction of public service expenditure by governments (McLean and Marshall 2010, Bendelow 2014). Further, the degree of this contact has been accorded the status of being '…part of the core business of policing' (Adebowale Report, 2013, p6) in the independent report into deaths in police custody of people with mental health issues in London.

The dimensions of this 'part of core business' were given further definition in the Home Affairs Select Committee report (HASC 2015):

> One in four people will suffer from mental illness at some point, and their illness brings with it a vulnerability that makes it likely they will come into contact with the police. (p7)

While this claim of likelihood may be over-stated – the report provides no evidence for it – the perception that is behind it gives an indication of the priority now given to policing and mental health, especially in the arena of care in crisis situations.

A particular feature of the increased contact by police with mental health issues - the use of police cells for detaining people with mental health issues – has become prioritised by governments over the past decade. The use of police cells following Section 136 detention in particular began to be addressed through the first national research project in 2004-6 (Docking et al 2008, Docking 2009). This found that, in 2005/6, 11517 people were detained in police cells and only 5900 in hospitals. Over the following years, studies and government data indicate that a shift in this pattern of use has taken place. An influential joint review (HMIC et al 2013) suggested on the basis of data from 9 sites in England and Wales that in 2011/12 a police place of safety could have been used on 9000 occasions and a hospital place of safety on 16035 occasions. In 2013/14 more accurate national statistics for England (DoH/Home office, 2014, p77) showed that the respective uses were 6028 and 17008 occasions and in 2014/15 on 3996 and 15407 occasions (HSCIC, 2015, p19). The aspiration of the most recent version of the MHCoP is that a '…police station should not be used as a place of safety except in exceptional circumstances….' (DoH, 2015, p146). It is becoming closer to reality.

In addition, evidence has accumulated over the past decade that the increased use of healthcare facilities as places of safety often has not led to improved

outcomes for service users. The Care Quality Commission (CQC) found that, in 2012/13, 'only 17% of uses of hospital-based places of safety resulted in further detention.' (CQC, 2014, p61) Other studies have shown that a high proportion of S136 detentions resulted in neither informal or compulsory hospital admission, (Borschmann et al 2010, Keown 2013) although this varied widely between different areas of the country or even locality (Borschmann's study took place in South London). These findings, which are supported by the Docking review mentioned above, suggest that the operation of S136 too often can involve inappropriate, inefficient and ineffective use not only of facilities but also of the time and expertise of the professionals involved. Further, qualitative research studies of the perceptions and experience of police officers of S136 pointed to an unhelpful gap or separation between the services operated by the police and mental health professionals (McLean and Marshall 2010, Riley et al 2011, Menkes and Bendelow 2014) as an explanation for the outcomes identified above.

National policy during the period of the last coalition government reflected these concerns with striking vigour and framed them as failures or critical gaps in mental health crisis care. Specifically, a different joint response was now required. In 2013, the Department of Health funded nine pilot 'street triage' projects (Reveruzzi and Pilling, 2016) for a year to test the viability of two crisis care models of police and mental health joint working – an integrated model of a joint team of police officers and health professionals (sometimes including paramedics) or a coordinated model of mental health nurses either based in police control rooms or exclusively available to police – as alternatives to the separate or parallel operation of the two services in relation to crisis care in general and S136 in particular. These pilot projects of joint working have continued beyond the initial

period of funding. They have been adopted or are being pursued also in areas, including the two case study sites for this study, which were not part of the original cohort of pilot schemes.

Further, national concern with the variability of mental health crisis care was accentuated by the tragic circumstances of deaths of people with mental health issues in police custody (the Adebowale Report, ibid). In response to this report and the cumulative evidence mentioned above, the coalition government introduced a Mental Health Crisis Care Concordat in 2014 (HM Government, 2014) for England in collaboration with NHS, police and local authority agencies and professional bodies, which mandated the production by relevant local agencies of 'Mental Health Crisis Declarations' and subsequent action plans (p7) for improved partnership working. A standard format for the action plans was structured so as to reflect a wide range of intended outcomes: 'Access to support before crisis point; Urgent and emergency access to crisis care; Quality of treatment and care when in crisis; Recovery and staying well / preventing future crises' (ibid, p5). The middle two of these outcomes are related directly, if not exclusively, to the S136 concerns presented above. Declarations and action plans were duly submitted across all areas of England within the given timescale (April 2015).

The mandated nature of declarations and action plans has not been carried over, however, into the implementation processes. Subsequent implementation of the action plans has been subject to evaluation by third sector agencies (Gibson et al, 2016) rather than national regulation. Nevertheless, the local continuing impact of the Concordat, as well as the triage schemes, has been significant and is attested to in the findings chapters of the thesis.

Professional cultures and values

Police services

A key element of the culture of policing is the degree of discretion accorded to police officers 'where the most power is afforded to the lowest ranks of the organisation (Westmarland 2012, p158).' A number of sources indicate that this discretion is a function of the complexity of the police role. Morabito (2007) proposes that police officers are compelled to address 'horizons of context' (p1582) which include a scenic horizon (what is happening at the time of the incident as well as pragmatic considerations such as workload), a temporal horizon (what, from their experience, is likely to ensue for the individual following the decision) and a manipulative horizon (the behaviour of the individual and the severity of the crime, if any). The wish to avoid criminalising the behaviour of the individual may be a pressure also (Lamb et al 2002, McLean and Marshall 2010). Further, Cockcroft (2014) argues that the police have multiple roles 'within increasingly complex organisational environments. (p12).' Cummins and Edmondson (2016) claim that 'tackling crime does not constitute the majority of police work (p41)' and that the engagement of the police in mental health issues is entirely consistent with their more time-consuming wider role of 'community safety (p41).'

Jones and Mason (2002) suggest that the police engagement with mental health issues is characterised by various considerations which have to be balanced or juggled with.

> …the decisions the police have to make will often involve a degree of judgement based on a balance of satisfying public safety, protection of civil rights and procedural difficulties in gaining admission to hospital for the person. (Jones and Mason 2002, p74)

The MentalHealthCop blogsite, set up in 2011 by a police inspector in England to provide comment on policy proposals and advice to police colleagues, gives a

specific example of the decisions which may be available to a police officer who has been called to a (hypothetical) incident on a bridge over a public highway where a person appears to be intoxicated and is expressing suicidal intentions:

> 1. Do nothing in law – provide help, signposting or any number of other things that may help, but don't invoke the law to detain him.
> 2. Detain the man under the Mental Health Act, because he was threatening to jump so he must be or may well be mentally disordered, right?
> 3. Detain the man for an 'on or over' offence? – it is an offence (s22A of the Road Traffic Act 1988) to put yourself on or over a road, causing a danger to road users; it is an offence (s34 of the Offences Against the Person Act 1861) to endanger railway users.
> 4. Detain the man for a 'public order' offence – this could include drunk and incapable, drunk and disorderly or drunk in a public place; equally it could include disorderly, threatening or violent behaviour under the Public Order Act 1986 depending on which of those were appropriate, if any.
> (MentalHealthCop, 20.9.14)

It seems reasonable to suggest that this discretion, and the complex decision-making that goes with it, will have an impact on the extent and nature of joint working.

The cultural feature of police services in England that is most recognised by citizens is '…its authoritarian appearance and communication style..' (De Tribolet-Hardy et al, 2015 p297). Herrington and Pope (2014) suggest that this perception is shared by police officers themselves:

> …police have tended to see their role as one of enforcer, and their organisational philosophy as one of public control, with the social care aspect of engaging with PWMI [people with mental illness] deemed the responsibility of other agencies… (p503)

The expression of the authority most associated with the police is the use of physical force (Westmarland 2012) in the pursuance of public order. This orientation may be seen as a key difference between police and mental health services, even though physical restraint of violent or aggressive people is a mandatory element of training for the staff of mental health in-patient services. The difference is found, however, in technique and purpose. For example, '…[the]

police technique is to use pain control' (Adebowale Report ibid, p51) and to hold a person in a prone (face-down) position to control behaviour. For NHS staff, the prone position is embargoed (MentalHealthCop, 16.4.16) and restraint techniques are aimed 'to isolate and restrain with the aim of engaging the patient (Adebowale Report ibid, p51).' However, it seems clear from the regular appearance of this issue in MentalHealthCop posts (25.4.14, 29.4.14, 16.6.14, 11.5.15, 14.4.16,) that mental health staff continue to rely on police assistance in addressing or preventing difficult behaviour within in-patient services, to the dismay of police officers. This suggests that the cultural legitimacy of the police's use of force perceived by mental health staff both supports their continued involvement with mental health issues *and* surrounds it with tensions.

Ambulance services

The ambulance services of England have undergone significant changes since a national review in 2005 (DoH 2005); a major structural reorganisation following the review resulted in the formation of twelve ambulance trusts from the previous thirty-three. However, the key change envisioned by the review was cultural:

> …development of a new culture of treating a greater number of patients in the community and performance of an enhanced clinical role by the ambulance personnel (often referred in the ambulance jargon as the "see and treat" as against the "scoop and run" model) (Wankhade and Brinkman, 2014, p5).

The national review built upon previous attempts to '…modernise and professionalise ambulance service education [through paramedic degrees]… (ibid, p6).' The impact of this cultural change appears to have been accepted and pursued by ambulance trusts, although its implementation may be uneven. A case study of an ambulance trust, from an account of which the two quotations above have been drawn, found there to be strong commitment of senior executives to the change but a mixed response from frontline staff. On the one hand, the staff

expressed ‘uncertainty and confusion regarding structures and roles’ (ibid, p18) but on the other hand, there was growing evidence of a positive attitude towards the change.

The relevance for this study of this continuing cultural change is its impact, both potential and actual, upon this form of joint working. The paramedic staff of ambulance services, as the new models of joint working are adopted more widely, become a third *professional* partner recognised as such by the police and mental health services – as opposed to being seen merely as the provider of ‘scoop and run’ transport.

Combined cultural impacts

The cultures of the ambulance and police services show common features through their shared and frequent engagement ‘within the boundaries of emergency, public facing, potentially dangerous work’ (Charman 2013). Also, the wearing of recognisable clothing (uniforms), for example, is a clear shared cultural ‘artefact’ (Schein 2010). There are two aspects of this shared culture which have a particular bearing upon joint working with mental health services.

First, both ambulance and police services have similarly structured management systems, sometimes cast as ‘command-and-control’ (Wankhade 2012 p381, McCarthy and Neill 2014, p246) with the common model of a central control room function directing the activities of frontline staff. This can be the cause of tensions. The model provides an apparent contrast to the professional autonomy of the front-line staff of mental health services. In a nuanced argument about the police services in Australia (but which has resonance for their equivalents in England), Carpenter et al (2016) consider that the ‘top-down hierarchical nature of policing…[causes]…the fundamental tension between collaborative intention and

action (p21)' which overshadows joint working - even if it cannot prevent successful pragmatic collaborative activity through the exercise of discretion by individual frontline police officers.

Second, a further cause of tension between frontline staff is the focus of police and ambulance services upon 'a desire for action' (Charman 2014, p162) which can have its roots in a culture of heroism among police officers in the performance of duties (Westmarland 2012) or, less dramatically, upon pragmatic completion of the specific task which faces them (McCarthy and Neill ibid, Carpenter et al ibid). This 'get-the-task-done' approach can provide a contrast to the 'let's-think-about-what's-the-right-thing-to-do' approach of mental health staff members who are enjoined to act, for example, according to principles of least restrictive practice (Mental Health Act Code of Practice, DoH 2015) and who therefore may be more inclined to caution and discussion. Research has illustrated how this tension can also cause a mismatch in the emotional approaches of frontline staff to the task. For example, some studies have noted the compassion expressed by police officers for vulnerable people (Riley et al 2011) in the face of professional objectivity of mental health staff in the practice of 'of defining and treating mental illness…(Menkes and Bendelow 2014, p80)'.

*

Joint working in mental health services has been subject to consistent pressure from government for closer alignment in recent years between both health and social care services and mental health and emergency services. The nature and direction of this alignment in each case has differed in accordance with the professional cultures and values of the frontline staff engaged in them. A key

continuing challenge is to maintain closer joint working where it is mandated in the face of the tensions that can result from doing so.

Mandated joint working in mental health services

This final topic area of the literature review narrows the focus onto the examples of mandated joint working which are the points of interest for this study. Section 117 Aftercare, delayed transfers of care and Section 136 use of police powers are explored in their contexts with a view to establishing why mandated joint working has been deemed necessary. It is argued that the rationale differs in its emphasis in each case and that the requirements for joint working can also differ in their nature and impact on organisations and frontline staff.

Section 117 (S117) Aftercare

The Mental Health Act 1983: Code of Practice summarises the core provisions of S117 Aftercare:

> [Paragraph 33.1] Section 117 of the Act requires clinical commissioning groups and local authorities, in co-operation with voluntary agencies, to provide or arrange for the provision of after-care to particular patients detained in hospital who then cease to be detained.'
>
> [Paragraph 33.6] 'The duty to provide after-care services continues as long as the patient is in need of such services.
>
> (DoH 2015, p357)

These provisions are therefore threefold: the provision of aftercare in specified conditions (detention in hospital for *treatment*); the joint duty required of health and social care agencies; the currency of the duty determined by the need of the individual concerned rather than a set period of time.

While the Code of Practice guidance clarifies what S117 *does*, it provides no indication of its underlying purpose and why it was included in the proposals that led up to the Mental Health Act 1983 (the 1983 Act). A number of sources argue that the joint duty element of S117 represents a *moral imperative*. Gostin (1976),

who provided the main inspiration behind the 1983 Act as a whole, expressed the principle which S117 Aftercare enacts:

> 'If the state has the right to exercise compulsory powers, it has the duty to ascertain that no less restrictive means are available by which to achieve the same purpose ['treatment…provided without confinement'] (ibid, p14)

Brown (2009) considers, with a reference to Gostin, that S117 Aftercare addresses 'the ethical point' that '…if you deprive someone of their liberty, you should have a duty to provide a good quality service (ibid, p3).' Priaulx (2002) argues that this principle not only carries an obligation to provide good services but also represents '…acceptance of social duties' and '…entitlement to services' (citing Eastman and Fennell respectively,p319). She also refers to the unique nature of these provisions: '…s.117 is the one provision of the 1983 Act that actually reflects 'positive rights in terms of entitlement to services' ' (ibid, p319).

S117 is therefore distinctive. It is a product of its time in at least two senses. It is a feature of what Gostin et al considered to be the fundamental driver of the 1983 Act '…to restore to the psychiatric patient, involuntarily detained in mental hospital, some of the rights expected and enjoyed by those of us not so detained. (1983, pi)' As importantly, S117 came into force a decade before, and could therefore not reflect, the introduction of the community care reforms in 1993. These reforms changed radically the funding arrangements for social care; a change which remains one of the key challenges to the joint delivery of aftercare.

In general terms, the statutory requirements of clinical commissioning groups and local authorities jointly to provide aftercare services are straightforward. Further, a Health Service/Local Authority circular, exclusively focused upon S117, includes as a 'point for action' the establishment of joint local S117 policies determining financial and other arrangements (Department of Health, 2000b, p4). Therefore,

local health and social care organisation have no choice but to work together in these circumstances. However, the precise working arrangements have not been prescribed and remain permissive (DoH 2015). This absence of detail is deliberate and is designed to enable 'maximum flexibility' (Mackintosh, 2000, p167) for local organisations to arrange themselves to meet the complex needs of people viewed as 'exceptionally vulnerable'(Lord Steyn cited by Priaulx, ibid, p318).

Delayed transfers of care (DTOC)

The phrase 'delayed transfers of care' is a pejorative reference to the circumstances of people who remain in hospital but are judged no longer to need in-patient treatment. The concept has a long history, at least as long as the National Health Service has been in existence (Glasby, 2003), and has been described in various ways – including 'bed-blocking' and 'delayed discharge'. Glasby has summarised the roots of this concern:

> For economic, administrative and humanitarian reasons…delayed discharges from acute hospital beds are generally perceived to be problematic by policy-makers, practitioners and patients alike. (2003, p13)

Although Glasby was referring to acute hospital care in general, mental health services have faced, and continue to face, the same issues, albeit with distinct characteristics. Acute hospital care remains the most expensive form of care within mental health services as a whole (Curtis, 2010). Further, the Health and Social Care Information Centre found that 'more than half of the 23,600 patients on mental health wards had been in hospital for 117 days or more on 31 March 2014…' (HSCIC, 2014). The same report highlights the implication of this finding for '…hospitals' capacity to accept new admissions.' In addition, the number of in-patient beds between 1998 and 2014 has reduced by over 45% (Royal College of Psychiatrists, 2015). In acknowledgement of the practice of the old psychiatric

hospitals of isolating people with mental health problems in remotely-placed institutions, the DOH has defined the purpose of acute hospital care as being '…to provide a high standard of *humane* treatment…' and that 'in-patient services must be conceived as steeping-stones to *inclusion*, not departure points for exclusion.' [my emphasis] (DOH, 2002b).

Glasby viewed joint working as being a fundamental means of addressing DTOC issues:

> Although the health and social care divide is a longstanding issue, hospital discharge has acquired even greater prominence following the community care reforms of the early 1990s. From 1993 onwards, hospitals and SSDs [local authority social services departments] were going to have to work much more closely together in order to ensure effective and timely hospital discharges, yet would have to do so in a climate characterised by the imperative to curtail increasing public expenditure on residential and nursing care. (2003, p23)

At the time of writing, the formal definition of, and criteria for, DTOC is provided by NHS England, the national healthcare commissioner for England (2014, p6):

> A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:
> a. A clinical decision has been made that patient is ready for transfer AND
> b. A multi-disciplinary team decision has been made that the patient is ready for transfer AND
> c. The patient is safe to discharge/transfer.
> A multi-disciplinary team in this context includes nursing and other health and social
> care professionals, caring for that patient in an acute setting.

The key assumption supporting joint working in this definition is that readiness for transfer is not solely assessed by medical staff and therefore is not merely a feature of physical health. The concept of 'whole person care' (New Statesman, 2014) has come to be used to encompass not only the medical needs of as person but also the risks of remaining in hospital. Users of mental health services share many of the same risks as those who use acute hospital care: boredom,

loss of skills and disempowerment (Sainsbury Centre for Mental Health 1998, Glasby and Lester 2004b, Swinkels and Mitchell 2008).

In the Community Care (Delayed Discharges) Act 2003 (DOH 2003), the last Labour government introduced the incentive, the 'carrot', of financial reimbursement at a standard daily rate from local authorities to NHS Trusts in circumstances where the transfer of care for individual in-patients was delayed according to the NHS England criteria mentioned above. The measure was introduced initially for general hospitals with the intention of extending it to mental health services. This intention was not acted upon and the Care Act 2014 'placed [the recovery of any reimbursement] on a discretionary rather than mandatory footing (DoH 2014a, p291).'

Nevertheless, joint working between health professions as well as between health and social care agencies continues to be viewed as the key means of resolving the issue (New Statesman 2014, DOH 2014a and 2014b) in the face of evidence of its apparent ineffectiveness. A number of sources point to the failure over most of the last 20 years to achieve sufficiently effective or efficient coordination between professional and other staff, both within the in-patient setting and between hospital and community settings and a lack of mutual awareness or appreciation by them of their respective challenges (Sainsbury Centre for Mental Health 1998, Waring et al 2013, Healthwatch England 2015). NHS England compiles monthly public DTOC statistics which specifies the performance of individual NHS Trusts and local authorities. In addition, Monitor, the regulatory body for foundation NHS Trusts, includes DTOC as a key performance measure. In this way, the performance of, and between, NHS Trusts and local authorities in

relation to DTOC remains under close scrutiny and consequently is experienced as mandatory by the organisations involved.

The issue of 'delayed transfers of care' is included in the scope of the study as a specific area of mandated joint working as the mandate for joint working *in mental health services* does not derive directly from legislation, but from urgent expectation and scrutiny by regulatory bodies. This urgency in turn stems from the *imperatives to make efficient and effective use of limited health and social care resources*, to develop whole-person care and, increasingly, from the impact upon individual patients of poor standards of care, identified for example by the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (House of Commons 2013).

Section 136 (S136) use of police powers

The Mental Health Act 1983: Code of Practice (DoH, 2015) presents the core provisions of S136 use of police powers[4]:

> [Paragraph 7.16] 'The police…have an emergency power under the Act in relation to people whom they find in a place *to which the public have access* who appear to be suffering from mental disorder and to be in immediate need of care and control. Any police officer can remove such a person to a place of safety…Removal may take place if the police officer believes it is necessary in the interests of that person, or for the protection of others.'
> [Paragraph 7.18] 'People removed to a place of safety can be detained there *for a maximum of 72 hours* so that they can be examined by a doctor and interviewed by an AMHP [Approved Mental Health Professional], in order that any necessary arrangements can be made for their treatment or care.'
> (DoH 2015, p89)

The key mandated elements of S136, like S117 Aftercare, are also threefold: a power of arrest or detention by police officers in the absence of a criminal offence in specific circumstances; the discretion for police officers to take the person

[4] The Policing and Crime Act 2017, as mentioned in previous footnotes, has amended the provisions in italics and has introduced a new requirement upon the police to consult health care professionals before using the power of detention. These changes, while significant for joint working between mental health and emergency services, do not alter the content of the remainder of this section of the chapter.

detained to a place of safety; the provision of assessment by mental health professional staff. In the form in which they are laid out in the legislation, these obligations upon both mental health and emergency services could be, and have been, construed as having separate application. However, the Code of Practice makes clear that the key obligations upon both the organisations involved and the tasks of frontline staff should be carried out in partnership.

Most of the organisational obligations are expressed with the term 'should' in the Code of Practice, including the development of 'local partnership agreements' (ibid, p144), the sharing of information and the performance of tasks 'bearing in mind the different purposes for which health and social services and the police service exist' (ibid, p145). However, I suggest that a less permissive exception is made in relation to local policies:

> It is also important to ensure that a jointly agreed local policy is in place governing *all* [my emphasis] aspects of the use of section 135 and section 136. (ibid, p144)

The importance of direct joint working and interaction between the frontline staffs of these services is also a feature of the Code of Practice with a view to preventing S136 detention, including the consideration of 'alternative options' and 'seeking advice' (ibid, p142). Notwithstanding the recent policy changes, I consider that the provisions of the Code of Practice cast S136 as an example of mandated joint working in the same in the same way as it does for S117 Aftercare (see p58).

S136 powers have had a statutory basis for at least three hundred years initially though vagrancy legislation whereby people considered to be 'lunatics' could be confined in secure settings such as workhouses or, later, asylums on the authority of a justice of the peace (Walker and McCabe 1973, Fahy and Bermingham 1987, Shah and Markwick 1989). Most of the current S136 provisions were introduced

by the 1885 Act to Amend the Law relating to Lunatics and then incorporated into the Lunacy Act 1890. The only substantial alteration of those provisions made by the Mental Health Act 1959 (which were transferred verbatim into the Mental Health Act 1983) was to confine the power of detention to a police officer (Walker and McCabe, 1973). Previously, this power had been shared with local authority officials. Until very recently, S136 powers received only minor revisions in the amendments to the Mental Health Act 1983 in 2007.

Government data on the use of the Mental Health Act confirm that the use of S136 detention in hospitals has increased dramatically during the time that the 1983 Act has been in force. Keown (2013) cited Department of Health (DoH) statistics for the period 1984 to 2010 which showed a 'more than sixfold [increase] from 5.2 to 33.4 per 100.000 adult population; (1959 in 1984/5; 14,111 in 2010/2011)' (p90), with the most marked rise from 2005/06 to 2010/2011 - under 6000 to over 14000. Government data show a continuing, albeit fluctuating, increase: 19073 in 2009/10, 23769 in 2011/12 and 19,403 in 2014/15 (DoH/Home office, 2014 p77 for 2009/10 and 2011/12 data and HSCIC, 2015, p19 for 2014/15 data).

Lamb et al (2002) argue that, in the USA, the power of the police 'to intervene in the lives of persons with mental illness' (p1) derives from 'two common-law principles' (p1): public safety and the protection of vulnerable people. However, Walker and McCabe (1973) argue that, despite the wording of S136 ('…the interests of that person or for the protection of others'), the justification for this power in England has been based historically on the need to preserve public order.

> …almost any behaviour of a markedly abnormal kind in a public place can be made the basis of some sort of charge, if only 'conduct likely to lead to a breach of the peace.' Consequently, Section 136 must be regarded as only one of the procedures open to the police for dealing with threats to public order. (ibid, p258)

Jones and Mason (2002), while acknowledging that the police have 'multi-factorial aspects to their role (p78)', point to the roots of S136 police powers lying in addressing public nuisance, public order and the protection of the public or, as Mclean and Marshall (2010) argue, '…a primary role of public safety (p68).'

It seems reasonable to suggest that the key purpose of S136 use of police powers is to form a connection between the preservation of public order and safety – an objective which has remained in place since the 19th century – and the care of vulnerable people. Therefore, it can be viewed as being informed primarily by both *political* and *moral* imperatives. The combination of these strikingly different objectives may account for joint working being mandated by legislation and accompanying guidance for the differing mental health and emergency service organisations and their frontline staff.

Conclusions

Joint working between health and social care organisations in mental health services has been subject to a number of forces that have produced inconsistent, conflicting or contradictory influences. National strategies have held the line for close joint working between the key players but have done so in markedly different climates. The requirement from the NSF for a rigorous national approach has given way to the broader and more permissive tenor of NHWMH. This change is mirrored in local areas by a variation in the nature of joint working, as evidenced by the withdrawal from formal integration of a significant proportion of local mental health services. In addition, the previous emphasis upon the integration of health and social care systems - the CPA and care management – has been compromised potentially by the introduction of requirements, such as care

clustering and social care eligibility and provision, that apply primarily to one or other of the organisations involved. Despite the drive to promote a common professional approach through the concept of recovery, the tensions both between and within health and social care professional groups persist in relation to the dominant position of doctors and the continuing ambiguity experienced by social workers.

A different trajectory has been followed in the development of joint working between mental health and emergency services. A strategic perspective has been introduced at a very late stage, taking into account its centuries-old history. However, its foundations can be easily traced from the momentum created by the changes over the past thirty years that have generated an alteration of the national attitude towards people with mental health issues and which have had dramatic consequences upon the front-line operation of emergency services and their interaction with mental health services. In particular, the influence of the Concordat has been significant and has led to the development of new and more proximate models of joint working such as triage schemes. These innovations are impressive in view of the continuing challenges posed by the professional cultures and values of the groups of organisations and staff implementing the legal duties of joint working underpinned by S136.

These shifts in the national contexts for joint working for both groups of organisations can be discerned in the case study sites and provide useful points of reference in drawing out findings and analysis from the data collected.

Lastly, the implementation regimes of Section 117 Aftercare, DTOC and S136 demonstrate how they can be infused with differing imperatives and how the impact of mandation can vary therefore in its nature and, particularly, in the degree

of prescription applied to organisations and frontline professional staff. These suggestions usefully foreground the theoretical conceptions of policy implementation presented in the previous chapter. Also, these features resonate in particular with the findings in Chapters 5 and 6 as, together with the broader national aspects of joint working in mental health services, they represent distinct layers of experience.

CHAPTER 4

Methodology:

Realist approach, nested case studies, mixed methods

Introduction

This chapter aims to show how the methodology of this study responds to the issues explored in the previous two chapters. As a policy, the implementation processes of mandated joint working are varied, complex and heavily influenced by the organisational contexts in which they are set and the imperatives of the governments that put them in place. Joint working itself is multi-dimensional, is expected to achieve a number of objectives and has distinctive characteristics such as endemic tensions or conflicts and leadership requirements. For mental health joint working, the key organisational players for Section 117 Aftercare and delayed transfers of care differ from those for Section 136 use of police powers in their histories, cultures, expectations and local positioning. The threads that connect these topic areas are the importance of context and the means by which the policy imperatives are made to work (or not). The study's methodology aims to support an approach and provide a framework which can accommodate the complexity of the issues involved.

Cameron et al (2012) considered in their review of research into joint and integrated working between health and social care that there were two areas which the reviewed studies either failed to cover adequately or missed.

> Details about working practices and arrangements are often limited and/or authors fail to discuss the factors that promote and hinder joint working. (p16)

I read Cameron et al's paper at an early stage of my literature review and concluded that their identification of two gaps in the knowledge of joint working provided starting points for the development of this study's methodology. To take the second 'gap' first, I have interpreted 'the factors that promote and hinder working' as mechanisms for joint working. The initial section of this chapter explains how the *realist approach* of the study enacts this interpretation by drawing from different conceptions of realist research practice. As for the first 'gap', the following section explains how *a case study research design* offers the opportunity for access to 'details about working practice and arrangements'. A further section covers the mixed qualitative methods of *data collection* and provides an account of the scope of research activity. The penultimate section presents the approaches to, and format for, *data analysis*. *Research governance* issues and implications, in particular ethical concerns, are discussed in the final section.

A bespoke realist approach

Realism

In social research texts (Breakwell et al 2006, Bryman 2008, Robson 2011), realism is referred to as one of a range of potential research approaches which includes positivism (also known as the scientific method) and constructivism. In these texts, the realist philosophy is described as drawing from the theories of reality implicit in both of the alternative approaches. It accepts the scientific assumption of objective reality, which for this study can be represented by public policy, which it conceives is connected dynamically with subjective domains of attitudes and perceptions – that is to say, the agency of people in organisations

who implement policy, the primary research focus usually associated with constructivism.

A core concept of realism is that it is concerned with 'explanations of how mechanisms produce events' (Robson 2011, p31). Mechanisms are accepted therefore as the principal dynamic connectors between the 'things' that happen and the experiences of making those 'things' happen (Bhaskar 1978). In this way, realism is suited to addressing 'how' questions which are concerned with the processes or the means of achieving policy objectives, such as the principal research question for the study:

> *How is mandated joint working in mental health services conducted between health and social care services in relation to the areas of Section 117 Aftercare and delayed transfers of care, and between mental health and emergency services in relation to the area of Section 136 police powers, in two differing sites in England?*

A further key aspect of realism is the perception that reality is complex, operating on different layers. Proponents of the different strands of realism agree with this principle even if they perceive differences in the nature of these layers (Pawson and Tilley 1997, Bhaskar and Danemark 2006); these differences will be explored further below. Despite this variation, realist research as a whole seeks to encompass this complexity. For this study this means including for examination as many as possible of the relevant 'factors that promote and hinder joint working'.

Two strands of realist inquiry have been adapted and aligned for this study – critical realism and realist evaluation. This practice has been supported by Robson:

> I favour what might be termed 'realism-lite', pragmatically selecting ideas and terminology from different realist approaches which appear likely to be useful for the real world researcher. (ibid, p38)

Critical realism (CR)

CR has been described as a way of thinking. Dickinson (2006) views CR as 'not a methodology, but a philosophical endeavour…[which]…informs the kinds of questions put to reality and the manner in which this is done (p380)'. CR originated in the late 1970s in the theories of Bhaskar (ibid, 1978). He proposed an alternative to what he regarded as the insufficiency of the scientific approach where '…men are regarded as passive recipients of given facts and recorders of their given conjunctions (ibid, p16)' with a more nuanced theory of 'the tendency of things' (ibid, p10) or 'generative mechanisms' (ibid,p15). Bhaskar set out a number of domains – mechanisms, events and experiences – the relationships between which, he suggested, made up the 'domain of [the] real (1978, p13)'.

He went on to develop the concept of '…*a necessarily laminated system*, that is, a system that refers essentially to several different levels of reality [emphasis in original source] (Bhaskar and Danemark, 2006, p280)'. He proposed that each 'level' (which in this study is referred to as a layer) required a different way of thinking as it reflected a discrete reality. All of these layers needed to be captured in research activity in order to get as near as possible to identifying the nuances - the 'least restrictive perspective' (Bhaskar and Danemark, ibid, p294) - that he considered more nearly to reflect the operation of social issues.

A number of authors illustrate the application of Bhaskar's ideas to research practice (Bhaskar and Danermark 2006, Stickley 2006, Price 2015) in relation to a wide range of issues including disability, service user engagement in mental health service development and male violence towards women. As an example, Stickley examined the common practice of service user involvement in the development of mental health services in England and concluded that not only did

the nature of the practice need to be examined but also its place in the context of 'the power discourse of psychiatry' and, more profoundly, of the '…structures that exist that perpetuate its domination (p576)'.

Helpful working practices emerge from CR research. Both Stickley and Price caution against accepting superficial findings – what Stickley calls '…*shallow realism*…examining what is, without examining what is behind what is [emphasis in original] (ibid, p573)'. Further, initial findings are recommended to be used as starting points of a progressive, ever-deepening sequence of inquiry (Bhaskar and Danermark 2006, Elder-Vass 2015).

Realist evaluation (RE)

RE is a theory-based approach which was developed by Pawson and Tilley in the late 1990s (ibid, 1997). It provides a framework for exposing and testing the theories that underpin social policies or 'programmes' (ibid, 2004, p3).

The central theoretical concern of RE is expressed in what has become its 'strap-line' - 'what works in what circumstances and for whom' (ibid, 1997, p85). This concern stems from an insight about the operation of social policies.

> Programmes are products of the foresight of policy-makers. Their fate though ultimately depends on the imagination of practitioners and participants. Rarely do these visions fully coincide. Interventions never work indefinitely, in the same way and all circumstances, or for all people. (ibid, 2004, p3)

RE's core 'targets' for inquiry (or evaluation) are threefold: context, mechanisms and outcomes. Mechanisms are the driving force for social policies and are seen in the theories and actions of the people responsible for carrying out the policies. They can have 'enabling' or 'disabling' functions (Kazi 2003, p812). The inter-action of these mechanisms with the circumstances or contexts, such as organisational and cultural features, in which they are set, in turn determines both the content and nature of the policy outcomes. Pawson and Tilley place emphasis

upon the direct relationships between these three elements and call these relationships ‘configurations’ (ibid, 1997, p77). That is to say, each mechanism (internal factor) should be tied, in their view, to a specific contextual influence (external factor) and with a specific outcome. For example, Harris et al (2013) used this structure in their evaluation of inter-professional teamwork for stroke care and suggested that 14 such configurations could be identified for patients, carers and the staff of the teams.

There are common aspects of RE and CR. Pawson acknowledges his debt to Bhaskar by nominating the concept of generative mechanisms to be one of the ‘seven pillars of wisdom’ (Pawson 2013, p5) which supported the initial development of RE. He also considers, like Bhaskar, that the scientific method is limited by its ‘successionist’ view (ibid, 1997, p32) – that cause, an external factor, is followed by effect - and favours a ‘generative’ theory of causation’ (Pawson and Tilley, 1997, p32), whereby both external *and* internal factors are involved. The proponents of both RE and CR claim to be able, better than the scientific experimental method, to make understandable the complexities and ambiguities of social policy implementation. Pawson cites as an illustration Popper’s analogy about sinking building piles into sludge (2013, p9) – the work stops when the firmness of the pile is ‘good enough’ for the task, rather than finding the perfect immovable foundation. The corollary for this analogy is that the piles may only be good enough on a temporary basis – this seems particularly relevant for the dimensions of joint working which are subject to shift over time and in response to tensions. These common aspects have facilitated the development of my research approach from both of these conceptions of realist research

Not all common features of the two approaches were as compatible. As mentioned above, Pawson accepted the concept of layers for RE. However, his application of the concept was more specific than Bhaskar's. Rather than the latter's view that layers represented different realities, Pawson proposed that the contexts of programmes could be layered – he called these layers 'the four I's' (Pawson 2013, p37) – individuals (stakeholders), interpersonal relationships (between stakeholders), institutional settings (local factors) and infrastructure (national factors) – which could each become elements of context, mechanism and outcome 'configurations'.

CR and RE adapted and aligned

Becker's image of the world as an organism, as 'interconnected processes' (ibid,1998, p41) has been helpful in developing the alignment of CR and RE. Briefly, this image reflects Bhaskar and Danemark's concept of 'laminations' in its acceptance that causality is complex because it is made up of interconnected factors and lends itself to a focus upon activities (or processes) and their impacts (or outcomes), and the contexts in which the activities take place. Essentially my approach for this study has been to use Bhaskar's concept of laminations or layers in preference to Pawson's in combination with RE's core elements – contexts, mechanisms and outcomes.

My interpretation of these elements and their interconnections departs from Pawson's more specific construction. I have not followed the RE practice of constructing individual and tightly-focused context-mechanism-outcome configurations. This study has taken the *relationships* between processes (mechanisms), their intended and reported outcomes and demographic, geographical and organisational contexts, as reported by the study participants, as

the points of comparison between the groups of organisations within each site and across the sites. This is the principal contribution of RE to my approach for the study. In this way, the objective is to identify broad themes for the three elements. An advantage of this less specific approach is that it avoids the practical difficulties experienced by some evaluation studies of distinguishing between contexts, mechanisms and outcomes (Dickinson 2006, Hewitt et al 2014). Hewitt et al found that the relationships between mechanisms - for example, 'Efficient, open and equitable communication' and 'Support and Value' – were such that the first mechanism was 'both a context and an outcome of [the second]' (ibid, p504).

I have also developed for this study a particular interpretation of outcomes as intended and reported or experienced impacts of processes upon organisations and frontline staff from the range of potential consequences of mandated joint working. While outcomes affecting service users should be the main focus of such a policy mechanism, and were intended to be included in the study, changes in the behaviour of senior managers and leaders and frontline staff also represent a vital outcome as an intermediate link in the policy implementation chain. Without such an intermediate outcome being achieved the final outcome, i.e. improved health and wellbeing of service users, will not be realised. To this end, I planned and carried out a wide focus for fieldwork activity so as to encompass the perspectives of policies, leaders and senior managers and frontline staff. Indeed, data was collected from 55 participants in 48 interviews (see Figure 10 below, p103).

My decision to select this interpretation of outcomes has been influenced also by a number of challenges of reflecting accurately the impacts upon service users as participants in the study. Broadly, the overall challenge was to gain access to

sufficient data, and give sufficient priority, in relation to the perspectives of service users within the resources and timescale of the study. My initial plan was to do so in relation to the impact upon their circumstances of mandated joint working - in other words, their perceptions of personal outcomes – following the completion of the fieldwork referred to in the previous paragraph. (This fieldwork had initially a primary focus upon the context and mechanisms elements of RE.)

I pursued the aim of direct engagement with service users as participants in the study with local research governance authorities and was advised that approval was likely to require a level of scrutiny which would, in turn, result in considerable delay to fieldwork activity. As an alternative, I considered the possibility of Mental Health Act Advocates acting as representatives of the perspective of service users but rejected this option as an inaccurate portrayal of the advocacy function. A further alternative was to use statistical data as evidence of outcomes across all three examples of mandated joint working. However, these data were uneven. S136 offered the most complete current 'set' for both sites, although there were variable data for the previous years. National DTOC Sitrep returns were readily available but lacked detail of individual examples. S117 Aftercare outcome data availability was considerably different between the two sites (see p108 also for reference to this issue). There was also a more pragmatic basis for my decision; fieldwork revealed that the context and mechanism elements were of a degree of complexity that doing justice to the perspective of service users within the timescale of the study would be at risk. Data collection, in addition, was sufficiently extensive to allow for analysis to include my selected interpretation of outcomes. Indeed, I have been able to provide examples (in Chapters 5 and 6) of

constructive intermediate outcomes of mandated joint working from frontline services in both sites.

I also make no attempt to activate the RE-adopted concept of 'middle range theory' (Pawson and Tilley 1997, p123). Pawson and Tilley attribute this concept to Merton who considered that there was a limited, and small, number of theories that underpinned social policies and that:

> …propositions [findings from individual studies] do not have to be developed *de novo* on the basis of local wisdom in each investigation. Rather they are likely to have a common thread running through them…[italics in original source] (Pawson and Tilley 1997, p123-4)

This study does not attempt to propose middle range theories for the operation of mandated joint working for the simple reason that there seems to be no need to do so. The purpose of the study is not to propose a distinct model for joint working, whether mandated or otherwise, but to provide a detailed account of how it works in two sites. There are already middle range theories in abundance – the notion of a sliding scale of joint activity (cooperation, coordination and integration) for example and of different layers where such an activity takes place. The emphasis here is on how local theories or ideas take effect (or otherwise).

Robson observes that 'realists are a fractious bunch with long-running feuds both between and within the various branches of realism (ibid, p38). It is clear that this academic combat continues (Porter and Halloran 2012, Pawson 2013, Porter 2015, Pawson 2016). However, Dickinson views the framework of CR potentially to offer a structure whereby the elements of RE could be augmented or deepened by the more philosophical CR approach which takes into consideration 'multiple kinds of knowledge' (ibid, p381) which emerge from differing layers of experience. De Souza (2013) usefully provides an illustration of how mechanisms can be

layered within elements of context. I have drawn from both Dickinson and De Souza in developing an alignment of the two approaches.

In this study, mechanisms and outcomes are layered within the overall contexts of each case study site. These contexts may have several aspects but they are considered as a whole in their respective impacts upon how mandated joint working operates or is operated. This alignment of CR and RE provides a structure for arranging findings which is presented diagrammatically in Figure 6 below. The format emerged from initial findings which suggested that mechanisms and outcomes could be distinguished at structural (policy and procedures), organisational (senior managers and leaders) and practitioner (professional and team staff) layers for each site.

Figure 6: CR/RE alignment

Contexts	Mechanism and outcome layers
• Organisational placement • Joint working history • Local cultures of joint working • Constraints and opportunities	1. Policies, procedures and regulation for mandated joint working 2. Approaches to and practice of joint working at senior manager/leader level 3. Approaches to and practice of joint working at team and frontline staff level

Research design: case studies

As has been confirmed above, the choice of case study research design was prompted by the reported lack of research into the *detail* of joint working arrangements. As explained below, the focus upon detail is perhaps the defining characteristic of case studies and has the added advantage of being reflected also both within RE and CR. The purpose of this part of the chapter is to explain the rationale and suitability of this choice for this study and by defining the nature and properties of case studies.

The suitability of case studies for this study

There are a number of benefits of case studies for the realist approach adopted for this study. First, the capacity to be wide-ranging in the scope and depth of data collection activity allows the researcher to identify the links between a number of contributory influences upon the subject under review – in other words, to establish 'the tendencies of things'. Gerring (ibid) considers that, for this reason, case studies are suited particularly to the examination of complex mechanisms. The case study design has the scope to be both evaluative (Thomas 2011a), exploratory or 'revelatory' (Bryman, 2004, p51) – finding out things not previously known.

An allied advantage of the design for this study is what Thomas terms its 'holism' (ibid, 2011b, p47), a perspective that seeks, as far as possible, to see the case as a whole. Therefore, not only does this perspective enable relationships to be identified between contexts and mechanisms but also to encompass the progressive trail of inquiry from easily-discernible activity such as documentary evidence to the more subtle experiences of managers and leaders and of the practice of frontline staff.

Case studies are suited also for theory building. Yin (2012) expresses a preference for starting case study research with a theoretical proposition. However, other authors suggest the evaluative and exploratory attributes of the design enable the building and testing of theories (Bryman 2004, Flyvbjerg 2006). Further, Bryman suggests that *comparative* case study research design in particular enhances capacity for theory-building (ibid, p55). Lastly, Gerring (ibid) considers that case study research is able to identify complex causal mechanisms of policies because of the depth of its enquiry.

The nature of case studies

To take the issue of the research deficit first, my selection of a case study research design is a decision to come down on one side of the debate about the purpose of research in general. Gerring (2007) stated this simply.

> All we can safely conclude is that researchers invariably face a choice between knowing more about less, or less about more. (p49)

A case study is placed firmly in the 'more about less' category; it has been defined as 'an in-depth exploration…of a particular project, policy, institution, program or system…(Simons, 2009, p21). The 'case' needs to be easily identifiable in the sense that it is 'a bounded entity' (Yin, 2012, p6) which provides the opportunity to focus in detail upon a particular 'subject' (for this study, mandated joint working in mental health services in the case study sites) and to provide a way of exploring or explaining it – the 'object', which for this study is the response of organisations and individuals within them (Thomas, 2011a). Within these stipulations, the emphasis therefore is upon a search for data limited only by the resources of, and available, to the researcher (Gillman, 2000).

Case studies can explore a single case or multiple cases (Thomas, 2011b). I selected two mental health service sites in England as suitable case studies as a result of significant differences in their organisational configurations and processes. (A detailed presentation of these differences is provided in Chapters 5 and 6.) The number of selected sites was influenced by considerations of scope and depth. I chose more than one site to enable comparison between them. I considered that the comparisons made available by this choice could yield compelling data (Yin, 2003) of relevance beyond them which also could uncover useful theoretical influences upon the conduct of mandated joint working (Thomas, 2011a).

However, the feasibility of maintaining the focus of comparison across more than two sites appeared to be at risk as a result of the complexity of the 'subject' and consequently the study's structure. Its scope extended across the three examples of mandated joint working that I was interested in and its depth encompassed layers of operation in each location.

Moreover, while helpful in identifying key relationships between organisations, the sub-division of the 'subject' within each site into the two groups of joint working relationships added a further element of complexity. This kind of research design is referred to in the literature as 'nested' or 'embedded' case studies (Thomas 2011b, Yin 2003). In this way, the overall design structure for the study, represented in Figure 7 below, makes it possible to draw comparisons both within and across the sites and thereby to capture the complexities and nuances of mandated joint working.

Figure 7 – Design structure for the case studies

Health and social care services		Mental health and emergency services	
The Shire	**The Borough**	**The Shire**	**The Borough**
Local policy guidance and procedures – S117 and DTOC	Local policy guidance and procedures – S117 and DTOC	Local policy guidance and procedures – S136	Local policy guidance and procedures – S136
Leaders/Senior management	Leaders/Senior management	Leaders/Senior management	Leaders/Senior management
Front-line practice	Front-line practice	Front-line practice	Front-line practice

The properties of case studies

Case studies are usually characterised by the use of multiple methods or perspectives (Gillman 2000, Gerring 2007) so as to gain access to a necessary level of detail. Gillman in particular argues that evidence of the details of the case will be gathered from several sources; he includes documents, interviews and observations. These methods have been included in this study.

The more striking feature of case studies is the kind of knowledge that they produce and the use that it can be put to. A criticism of the case study as a design is that it prevents the results being generalised and applied to other settings because it takes place in only one or two examples (Gillman, 2000). This criticism, however, is refuted by Flyvbjerg (2006) who points to a number of groundbreaking scientific discoveries (for example by Galileo, Newton and Alexander Fleming) which were made on the basis of a single case. Additionally, there are several individual cases which have been considered substantial enough to bring about national changes in legislation and policy for different settings of joint working – for example the Report of the Inquiry into the Care and Treatment of Christopher Clunis (DoH, 1994) for mental health services or The Victoria Climbie Inquiry: Report of an Inquiry by Lord Laming (Laming 2003) for the child protection arena (Gillman 2000). Flyvbjerg argues that the power of the knowledge produced in these circumstances is the 'force of example' (ibid, p228) rather than generalizable findings. Thomas suggests that the term 'phronesis' captures the nature of this knowledge; he defines phronesis as being 'practical knowledge…based on personal experience' (ibid, 2011b, p214) which produces a 'discernment' (ibid, 2011c, p24). Both of these authors argue that case studies provide useful knowledge that is convincing because it makes sense, rather than offering scientific 'proof', to those responsible for implementing policy in other localities, not just in the tragic or extraordinary circumstances examined in the inquiries mentioned above, but also in day-to-day situations. The capacity to strike a resonance beyond the case study sites is an aspiration for this study.

The selection of the case study sites

The Shire was the first site chosen. I opted for The Shire because of ease of enabling access through, initially, a small number of previous professional colleagues (four people) at the senior manager layer of operation who agreed to be participants themselves and one other who enabled contact with other participants. This facility stemmed from my previous tenure of a senior management post in The Shire's mental health service. I had ceased to be employed in this post some seven years before the start of the research for the study, having moved to a post at a similar level of seniority in another mental health service. I held this subsequent post for over five years before retirement.

Thomas supports this choice as one of a number of 'potential routes for selection of the subject [which provides] ample opportunity for informed, in-depth analysis…' (2011a, p514); he calls this route 'a local knowledge case' (ibid). A summary of the Shire's organisational features would include its predominantly rural nature, a two-tier local government structure, shared organisational boundaries between agencies and continued adherence to a contractual model of integrated mental health services defined by Section 75 of the Health Act 2006.

My knowledge of The Shire was helpful in identifying my eventual choice of a second site which provided 'an apparently contrasting situation which might nonetheless be conceptually similar.' (Bechofer and Paterson, 2000, p9), and therefore offered the potential for useful comparisons with each of The Shire's characteristics mentioned above. After an initial unsuccessful approach to a mental health service with such differences, my research proposal was accepted by The Borough's key agencies: the borough council, the mental health trust and the police.

The Borough's features accorded with another of Thomas' 'routes for selection' as 'a key case of a phenomenon' (ibid, p514) – an urban locality, unitary local government arrangements, limited agency coterminosity and the dissolution of Section 75 agreements. Indeed, the latter offered an opportunity for specific comparison between The Shire and The Borough of their respective joint working approaches to Section 117 Aftercare and DTOC in relation to staff deployment and funding. Also, it emerged during initial discussions that further comparative strength in relation to S136 policy and practice could be provided by the development of a street triage service in The Borough; in The Shire, a different triage model was under consideration. In this way, the degree of organisational and demographic/geographic difference between the two sites supported comparative evaluation of their perspectives of joint working in mental health services in general and of the examples of mandated joint working in particular. This became a key advantage of the choices of sites.

My previous experience of employment in The Shire, which was not replicated in The Borough, requires some exploration of the extent to which I can be described as an 'insider' in the former and an 'outsider' in the latter and of the implications of these positions. Mercer (2007, p3 citing Merton 1972) cites anthropological definitions of the two concepts.

> 'Insiders are the members of specified groups and collectivities, or occupants of specified social statuses. Outsiders are the nonmembers'

My employment history and pre-existing relationships with some of the small number of ex-colleagues referred to above could place me in or near the 'insider' camp in The Shire. The research advantages of insider status have been identified as including 'legitimacy…'and 'more rapid…acceptance' leading to

‘access, entry and a common ground from which to begin the research’ (Corbin Dwyer and Buckle, 2009, p58) – all of which I can recognise from my experience of collecting data in The Shire.

I consider however that I can also claim the position of being a partial outsider in The Shire, due to my relative ‘distance’ (Tew et al, 2006) from it. A number of factors served to create this separation. First, my engagement with The Shire’s agencies was framed clearly within my role as a researcher rather than colleague through the research governance process and written information provided to all participants prior to the fieldwork. Second, the time lapse between my employment in The Shire and the start of the study was significant in that substantial organisational changes had taken place in and around the mental health service – internal restructuring in pre-existing agencies such as the mental health trust and the local authority, leadership change (I had no previous or recent experience of working with any of the organisational leaders interviewed for the study) and the creation of new commissioning agencies such as CCGs and HWBs. Additionally, by my perception, these changes confined my reputational legacy to the small number of ex-colleagues. Lastly, my subsequent and positive period of employment elsewhere as a senior manager within the (integrated) mental health services of another area in England provided me with a ‘buffer’ which offset a preferential stance towards the Shire. Specifically, this later employment exposed me to the different (and, in my experience, successful) conduct of organisational and professional relationships.

In relation to The Borough, my starting point would seem to be that of an outsider in comparison to The Shire as I had no previous personal or professional involvement there. However, some aspects of my identity - my professional

background as a social worker, my experience of mental health services and as a manager within them - enabled me to present sufficient 'insider' credibility so as to secure interviews of an equivalent range to The Shire with leaders, senior managers and frontline staff in all the key agencies engaged in the three examples of mandated joint working. In the process of initially recruiting participants, I made direct telephone contact in many cases and made reference to my experience in the course of the discussions. I can reflect also that a number of participants in The Borough (for example, the borough council, the mental health trust and the police service) recommended other colleagues for interview and suggested possibilities for observation in the course of their interviews without being asked to do so. Zempi (2016) considered that common points of engagement or experience with research participants conferred upon her the status of being 'a partial insider' (p7). It seems reasonable to suggest that I can claim to have occupied a similar position.

I can therefore recognise that there were greater or lesser elements of both insider and outsider positions in my approach to the study in both sites. On reflection, I became placed in proximity to the middle ground between these positions, although nearer the insider end of the spectrum in relation to The Shire and nearer the outsider end for The Borough. A number of authors consider this stance to be viable and realistic (Mercer 2007, Corbin Dwyer and Buckle 2009, Hayfield and Huxley 2015); Corbin-Dwyer and Buckle call it 'the space between' (ibid, p60). However each author offers a note of caution that the researcher needs to be able critically to reflect upon his or her subjective experience of the insider element of undertaking the research and thereby offset the potential risk of impairing data collection and analysis.

It seems appropriate to explore my personal experience in relation to interviews with the small number of previous colleagues in The Shire. Of the four ex-colleagues referred to above, I interviewed one of them jointly with another senior manager with whom I had had no previous contact. This 'other' manager was the leader for one of the key agencies, the line manager for the colleague, and took the lead in the interview. I consider that this relationship and performance offset the scope for pre-conceived assumptions on my part or that of my previous colleague and set a more formal tone to the interview than may otherwise have been the case.

Another participant had known me principally through my professional (rather than managerial) background. We had worked together in the past to address a specific professional staffing issue; in this way, our direct working relationship was short-term. Additionally the participant had made a significant change in moving to the senior manager post held at the time of the interview, thereby changing the context in which previously I had had direct contact. Again, I was able to maintain a formal structure and tone to the interview.

I had maintained an informal relationship with the two remaining colleagues whom I had met sporadically outside their (and my) work setting since leaving The Shire's employment. The interviews were the first two that I undertook in The Shire and were marked by a more informal tone than subsequent interviews, although I maintained the structure of the interview's topic areas and time-keeping. However I can recognise that there were occasions where the interviews became excessively conversational, including finishing each other's sentences, running the risk of my leading or confining the participant's responses.

A. There are still some people who are taken to police cells… The Concordat…sets out that it should only happen in exceptional circumstances…you can get lost within that discussion but exceptional should really be exceptional, as in…
B. Once in a blue moon?
A. Absolutely…There's a whole host of issues in terms of how the system works or doesn't work so well that contribute to that still.
B. This is the…
A. 136 unit when people still go into police cells.
B. So by that you mean….

I was aware of this risk and my last comment represents my successful attempt to focus back upon data collection. As importantly, this interchange was not included in the data used for analysis - and nor were the few other examples in the two interviews.

Data collection

In all the 'formal' RE texts, Pawson and Tilley (1997, 2004)) and, later, Pawson on his own (2006, 2013) make reference to the importance of developing evaluation from 'a plurality of data (Pawson 2006, p16)' in order to obtain access to 'the inner workings of interventions (ibid 2006, p86)'. Three qualitative sources of data are recommended in a number of these texts: documentary analysis, interviews and observations. This advice has been followed for this study and has enabled a limited capacity for data triangulation – the consideration of different kinds of data drawn from different perspectives (Guba and Lincoln, 1981).

As mentioned above (p96), the original intention was to have included additional methods. However, descriptive statistical analysis of incidence data for all 3 specific areas – the number of people entitled to S117 Aftercare, for example - was not possible as the systems for data collection across both sites were developed unevenly. Also, the use of focus groups as an alternative or addition to individual interviews were not used formally as intended despite, on occasions,

participants being interviewed in groups of up to eight people. The distinctive feature of the focus group method is that data collection takes a focus upon the *interaction* between group members (Parker and Tritter 2006).

> …a kind of momentum is generated which allows underlying opinions, meanings, feelings, attitudes and beliefs to emerge alongside descriptions of individual experiences. (ibid, p26)

While interaction took place between participants when interviewed together, for example in creating a supportive atmosphere, each participant addressed the questions in the topic guide in an individual response to my questions. In this way, these sessions emerged as group interviews rather than focus groups and are therefore included as such.

The three data collection methods are explained in turn in the paragraphs that follow.

Documentary analysis

This method of data collection has been carried out at two stages and with different purposes. The first stage concentrated on documents with a national focus on policy and recommended processes. The findings from this stage have been included in Chapter 3 as a contribution to the background and formation of the study. The second stage, which is the subject of this part of the chapter, has encompassed material of relevance in each of the case study sites. The purpose of doing so has been to collect data about aspects of the context or circumstances and also the most visible or explicit mechanisms of mandated joint working in each site. Accordingly, the documents used have been categorised in Figure 8 below. My original intention was to include agency 'mission statements' or 'statements of values' and practice guidance as well as formal policy statements; this follows Bryman's view (2008) that both virtual and formal documents are valid sources of

data. However, a number of the agency statements, although accessible on the organisational websites, were in a transitional state and therefore rendered data collection uneven. Practice guidance, in the form of specific inter-agency protocols for, as examples, mental health services seeking police assistance or making referrals to the police to address violent or aggressive behaviour, were available in one site but not the other. As a result, documentary analysis has been confined to the three policy documents from each site referred to below.

Figure 8 - Documentary analysis

Category	The Shire	The Borough
Policy statements	S117 policy S136 policy Mental health joint protocol (Ambulance trust and police services)	S117 policy S136 policy Mental Health Act conveyance policy and procedure (Ambulance trust and 'partner agencies', including police, local authorities and NHS Trusts)

Pawson explicitly includes documentary analysis as part of what he regards as necessary 'reconnaissance' ((2006, p83) of social programmes if a 'realist' judgement can be made about the theories which lie at their foundations. Bryman (ibid) adds a cautionary note about the nature of this appraisal:

> …documents needs to be recognised for what they are – namely, texts written with distinctive purposes in mind, and not as simply reflecting reality.' (p527)

He goes on to outline three approaches to analysing documents. *Qualitative content analysis* seeks to identify the themes in documents from repeated references either to local features or commonly expressed attitudes. *Semiotics* is described as 'an approach to the analysis of symbols in everyday life' [which may reveal] 'hidden meanings that reside in texts (p531)'. Specifically, a document may be presented with an explicit purpose but which has resonance with the local

context. This approach reinforces Bryman's suggestion that documents are reviewed most usefully alongside other forms of data. Lastly, *hermeneutics* links the meaning of a document to the perspective of its originating source 'and a sensitivity to context (p533)' and is therefore in tune with the highlighted quotation (p527) above. All of these approaches have been used for this study.

Interviews

Standard texts recommended for the Social Research Methods 1 (SRM1) training module at the University of Birmingham (Breakwell et al 2006, Bryman 2008, Robson 2011), obligatory post-graduate researcher training, provided a number of rules of engagement which acted as a guide for the interviews in this study which can be summarised as follows: clarity about the interview topics, consistency in ensuring all topics are covered in each interview, open-ended questions, no leading questions. Robson provides an apt summary.

> *Listen more than you speak; put questions in a straightforward, clear and non-threatening way; eliminate cues which lead interviewees to respond in a particular way; enjoy (or at least look as though you do)*. [italics in original] (ibid,p282)

Bryman adds a helpful reminder of the primary focus of interviewing.

> In qualitative interviewing, there is much greater interest in the interviewee's point of view; in quantitative research, the interview reflects the researcher's concerns…' (ibid, p 437)

Bryman goes on to suggest the desired outcomes of interviewing are 'rich, detailed answers' (p437) and Robson considers that the more unstructured format of interviews is suited to the collection of attitudes and opinions. Both were pursued in this study.

For one case study site, contacts for potential interviewees were made by email with managers with whom I had a previous acquaintance. For the other site, contacts with participating agencies were identified from organisational websites

and followed up by telephone calls. In both sites, these initial contacts suggested potential further participants both in their own agency and in relevant others.

The format adopted for the interviews was semi-structured. The structure extended to the arrangements for the interviews (prior appointment, private room, explicit use of a (small) recording device, set time of 1 hour) and a standard topic guide, information sheet and consent form (see Appendices 1, 2 and 3) provided to all participants in advance and at the interview itself. Further explanation of the study was offered by the author at the start of the interview session; this offer was often taken up. There was opportunity with a few participants for an informal meeting before the interview where information was provided; however, this was the exception rather than the rule.

The topic guide provided a list of broad areas of interest for the study and is reproduced here (Figure 9).

Figure 9 -Topic guide

Evaluation of current policies and practice in relation to mandated joint working in mental health services

Topic guide for interviews and focus groups

1. Individual context for participants, e.g. professional affiliation, where worked, career so far
2. Organisational and procedural context in which mandated joint working is taking place
3. What is working well and not so well (and why) – descriptions and examples
4. Similarities and differences between mandated and other joint working in local context
5. Ideas for improvement in policies, practices, training etc

Most interviews were with a single participant, 5 with two participants and one each with three, five and eight participants; details are provided in the completed interviews diagram below (Figure 10). Printed copies of the topic guides were placed in the view of participants, if they did not bring them to the interview, and

questions from the author were posed either to ensure that each of the topics were covered or to prompt participants for further explanation of their responses. Each interview lasted on average for an hour. The interviews were recorded and subsequently transcribed either by myself or by a contracted service.

For the majority of interviews, the interview was initiated by the author asking each participant to describe her or his career (Topic number 1) and then going on to introduce Topic number 2 by asking participants to give an account of the approach to joint working in either The Shire or The Borough. On occasion, these initial topics were covered by participants without prompts; the remaining topics were covered often without prompts. For these interviews, the author's primary functions were to ask questions as either 'confirmatory' or 'expansive' probes for clarification or further explanation of their accounts (Priede et al 2013, p2) and to act as a timekeeper. In a number of cases (for example, interviews of organisational leaders), the process of the interviews conformed to Gillman's description of 'the elite interview' (ibid, p64).

> They [the elite interviewees] will know more about the topic and the setting than you do: to a large extent they can tell you what questions you should be asking, what you need to know. (p64)

The ordering of each interview's content varied across the participants and therefore the interview format could be placed at the unstructured end of the semi-structured type.

A specific variation between the two sites was that I had been employed in one of them some years previously in a senior management position and was therefore known to four of the participants in that site at senior or middle management or frontline staff level.

The key difference arising from this variation that I noted was the ease in gaining initial access to participants at that level in that site.

Lastly, in accordance with the CR approach, interview participants were identified at different layers of responsibility and from the occupational or professional perspectives represented in the organisations in the two sites for healthcare, social care, and the emergency services. In addition, staff members from the agencies providing a specialist advocacy service at each site were recruited as participants at the front-line layer of operation so as to provide an independent perspective upon the contexts and mechanisms or processes in each site. Some of the more detailed organisational arrangements differ between the sites – for example, an in-patient social worker post is established at one site but not at the other and the provision of out-of-hours (EDT) services vary between the two local authorities – nevertheless an equivalent range of perspectives is achieved for each site (see Figure 10 below).

Observations

As it had done for the practice of interviews, the SRM1 module provided material which guided the practice of the observations. Each of the key texts (Dallos 2007, Bryman 2008, Robson 2011) agree on the essential purpose of including observation alongside interviews as a method of data collection, cited by Robson as ‘saying is one thing: doing is another (p316)’. Bryman and Dallos argue that talking and behaving, Dallos calls this ‘paralinguistic features (p132)’, can be

Figure 10 - Completed interviews

Accountability level	Agency type	The Shire	The Borough
Leaders/Senior managers	Health and Wellbeing Board	Board lead	Board lead
	Clinical Commissioning Group	Joint commissioning leads (2)	Commissioning leads* (2)
	Mental Health Foundation Trust	Trust lead, Executive Board members (2), Operational senior manager, Service manager, Social care lead	Trust lead, Service managers (3), Ward manager (1)
	Local authority	Adult services directorate lead, MH commissioning manager	Directorate and MH social care commissioning lead (1), Operational senior manager and social care lead (1)
	Police Service	Police lead MH leads* (2)	Police lead MH lead (1)
	Ambulance Trust	MH lead	MH lead
Interview (people) totals		**13 (15)**	**12 (13)**
Frontline managers	CMHT (MHFT)	Community team (1) CRHTT (1)	Community team (1) CRHTT (1)
	Local authority	Emergency Duty Team (EDT)*	Principal Social Worker
	Police	Training lead Control room managers* (2)	Community sergeant*
	Advocacy	Agency manager*	N/A
Interview (people) totals		**6 (7)**	**4 (4)**
Frontline staff	Community team /CRHTT	CPNs (2), OT (1) Social workers (2)	CPNs (2) Social workers (2)
	In-patient service	Social worker	N/A
	Local authority	EDT Social worker *(1)	N/A
	Advocacy	Advocates* (4)	Advocate (1)
	Police	Police officers* (8)	Police officers *(2)
Interview (people) totals		**8 (19)**	**5 (7)**

*Denotes joint interviews – EDT manager, advocate agency manager and community sergeant interviewed jointly with EDT social worker, advocates and police officers respectively

indicators either of the same person holding separated or contradictory approaches towards the issue being researched or can provide a richer, more complete picture.

This literature also deals at length with typologies of observational methods of research. Dallos suggests that there are 4 core dimensions: theory-testing vs exploratory; experimental vs naturalistic; structured vs unstructured; non-participant vs participant (p127). In addition, Guba and Lincoln (1981) use a Rubik-cube diagram (p196) to show the interactions of two wider dimensions: subject awareness (overt or covert observation) and observer interaction with subjects (natural/contrived and non-participant/participant). These last two elements are shared between the two typologies. This therefore leaves five dimensions against which the observations were designed and carried out: exploratory for all the activities; naturalistic (as the activities were regular parts of the working practice in each site); more unstructured than structured (in that a structure was imposed following observation rather than in advance); non-participant more than participant for the management meetings, a mixture of both for some practitioner activity; overt rather than covert observation for all activities.

Eight non-participant observations (four in each site) were planned as shown in Figure 11 below. Seven observations were completed and the eighth (a social care funding panel in The Borough) was substituted by an interview with the panel chairperson (who was also a participant in an earlier interview) because three previous attempts to attend a panel meeting had been cancelled due to a lack of funding requests. The interview was recorded and transcribed in the same way as

others. The discussion was structured around a list of specific questions around the operation of the panel in relation to joint working in general and Section 117 Aftercare and DTOC in particular (see Appendix 4).

As also mentioned above, the observations were arranged so as to 'fit' with the fieldwork framework of conducting interview in two phases. In this way, three management meetings and the interview referred to in the last paragraph were completed during the first 'management and policy' phase. The four practitioner meetings were completed during the second 'team and front-line' phase. I regarded the observations in each site as being paired during each phase so as to cover in turn management and front-line practitioner activity engaged in Section 117 Aftercare, DTOC and S136 use of police powers. Accordingly, in both sites, the management paired meetings comprised social care funding panels and S136 monitoring groups (for The Shire, this function was an element of the activity of the Concordat steering group). The practitioner activity included, for the Shire, a professionals' discussion reviewing the interventions provided in response to the complex needs of service users and a 'late' shift of a Crisis and Home Treatment Team (CRHTT) and, for The Borough, a ward round held in the premises of an in-patient (hospital) service and a shift of the street triage service.

Figure 11 - Observations

Level	The Shire	The Borough
Management	Concordat implementation group, Social care funding panel	S136 monitoring group, Funding panel discussion
Front-line practice	CRHT shift, Professionals meeting (community team)	Street triage team shift, Ward round
Totals	4	4

Social care funding panels are charged in each site with the responsibility of determining eligibility for social care funding of service users – and consequently for

determination of funding responsibility, if appropriate, between healthcare and social care agencies. These activities both are aspects of the joint working mandated for Section 117 Aftercare and DTOC. The title of the Concordat implementation group and Section 136 monitoring group (not the working titles of the actual groups) are almost self-explanatory; they are both multi-agency meetings involving a greater or smaller range of agency representatives with a common focus upon joint working between mental health and emergency services which includes the monitoring of S136 activity.

The practitioner observations were more varied as they depended upon availability of activity offered for observation at each site (the professionals' meeting and the ward round) or the service structure (a street triage service had not been established at both sites). The professionals' meeting in The Shire took the form of a fortnightly 'clinical' discussion for a community multi-disciplinary team chaired by an independent (that is, not a member of the team) professional member of staff, the purpose of which was to review and resolve the complex issues of addressing the needs of service users who had been detained in hospital and were entitled to Section 117 Aftercare. The Shire's CRHTT was comprised of nursing and social care staff and was charged with the responsibility of operating the hospital-based S136 place of safety in addition to an expanding remit (referred to in the findings) to address the needs of people experiencing a mental health crisis. For example, the CRHTT had started to have a presence at an A&E service. The ward round in The Borough followed the traditional model of a multi-disciplinary meeting chaired by a consultant psychiatrist with the purpose of reviewing the circumstances of service users detained in hospital – almost all of whom were entitled to Section 117 Aftercare. The Borough's street triage team was made up of police officers,

community psychiatric nurses and paramedics (an ambulance service staff member) with the purpose of providing a joint response to people experiencing a mental health crisis, including people potentially and actually falling within the remit of S136.

Apart from explaining the purpose of the observation at the start of each observation, I had no further direct involvement in the management meetings. For the practitioner activity, the lack of participation was maintained for the professionals' meeting and the CRHTT shift and for the other two observations during the periods when service users were present. However, for these three observations, I asked questions of staff present about the operation of the services in relation to joint working when service users were not present. The issue of gaining service user consent is addressed in the final section.

Brief handwritten notes were taken during all observations and in each case, more extensive handwritten field-notes were made within an hour of the observation being completed. These field-notes were typed up by myself within three or less days of the observation. The notes of the management meetings were arranged under a common set of headings: general comments; purpose; make-up (membership); process; outcomes; joint working findings. The interview substitute for the Borough funding panel covered the same areas: nature of funding applications; membership; operation; process; recent developments. The notes of three practitioner activities were also arranged under a common set of headings: context; mechanisms; outcomes; joint working findings. The notes of the fourth (the street triage team) observation covered the same areas under slightly different headings: context; how it works – staff perspective; how it works – observed practice (which included the outcomes of interventions); joint working findings.

The impact upon participants of being observed and upon the conduct of the activities can only be reported subjectively. In this way, the majority of the meeting-type activities appeared unaffected substantially as my presence was unacknowledged throughout discussions after the initial introduction and the number of participants was more than ten people. The exception was the ward round in the Borough where the staff presence was no more than five (excluding myself) and the consultant psychiatrist used the intervals between attendance of service users to explain process, procedure and service provision issues directly to me. This may have had the effect of the ward round being more tightly-structured than usual. The observations of the CRHTT and street triage team were more ethnographic and participative in nature as they conformed to Bryman's definition.

> …the participant observer/ethnographer immerses him- or herself in a group for an extended period of time, observing behaviour, listening to what is said in conversations both between others and with the fieldworker, and asking questions (p402)

My presence during these two observations may have affected the conduct of processes. In the case of the CRHTT, it was clear that the leader of the shift addressed himself to me as well as colleagues in discussions of the team's interventions during the shift observed. For the street triage team, I was included in discussions about the operation of the team and the specific interventions during the shift. I participated in the former by asking questions but not expressing opinions and maintained a non-participatory approach to the latter.

Data analysis

Data analysis developed through a staged and recursive process informed not only by the data but also by insights from literature and my professional experience. The relative power of the three points of influence varied at each stage. The primary stage involved the development of *data* themes as the outcome of coding activity

and thematic analysis. The secondary stage saw the subsequent separate development of *key findings* for each case study site. The tertiary stage brought together these findings into *common themes* which provided the basis for the fourth and final stage of analysis (in Chapter 7) which sought to bring to the surface a detailed account of the operation of mandated joint working across the two sites.

The primary stage was completed using coding of data and a framework for thematic analysis. All the approaches to qualitative data analysis share the importance given to the activity of coding data as a result of which extracts from transcripts or field-notes are drawn by the researcher as they appear meaningful to the study at hand.

> Codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study. Codes are attached to 'chunks' of varying size – words, phrases, sentences or whole paragraphs (Miles and Huberman 1994, p56).

Bryman (2008) also makes reference to the significance attached by the practitioners of narrative analysis to the accounts or stories told by research participants of events, current circumstances and their own positions within those circumstances. Lastly, the grounded theory approach, while it is founded on the practice of data analysis without a framework or preliminary theoretical positioning, places great emphasis on its central aim to generate rather than test theory and upon comparative research methods – looking for similarities and differences between data across equivalent categories (Glaser and Strauss 1999). The data analysis for this study is pitched firmly in the thematic analysis camp. Nevertheless, it is supported by each of the tools or techniques mentioned here.

Miles and Huberman propose usefully that the key analytical activities can be described as: 'data reduction' (of which coding is the key element); 'data display' (often graphical presentations of the data); and 'conclusion drawing or verification' (ibid, p10). They go on to suggest that these activities are recursive rather than linear.

Braun and Clarke (2006) pick up this suggestion in their 6-stage model of thematic analysis, much of which has been adopted for this study. Apart from the final stage (production of a report), the first five stages – familiarization with the data, generating initial codes, searching for, reviewing and defining themes – each require repeated activity. In contradiction to Miles and Huberman, Braun and Clarke refute the need for data to be mutually exclusive to each code and argue that the same codes can make up different themes. This advice has been followed. On a practical note, manual rather than electronic coding was used as a personal preference.

Both Robson and Bryman consider that 'the use of word or phrase frequencies and inter-correlations' (Robson 2002, p458) are either a primary '*quasi-statistical*' approach (Robson, ibid) or an element of thematic analysis (Bryman, ibid). Also both of these authors include 'template' (Robson, 2002, p458) or thematic analysis as a type of approach – although Bryman claims that thematic analysis does not possess 'an identifiable heritage or…a distinctive cluster of techniques (ibid, p554)' and that it draws on the techniques of other analysis approaches. However both agree that the approach can be characterised by the development from data coding of a range of themes and subsidiary themes which are placed within a framework. The framework for this study is constructed from the CR/RE alignment illustrated earlier in the chapter Figures 6 and 7 and used for the presentation of primary data findings in the next two chapters. Within this framework, the data exerted a predominant influence but theories from the literature can readily be discerned, such as organisational culture (the ways that decision-making and communication are managed), the nature of joint working (for example, integration, coordination and cooperation), historical trends from the national context (for example, pooled resources and the development of new demands) and the concept of layers of operation.

The secondary stage entailed the development of key findings for each case study site from this presentation. Each site was addressed separately and these key findings emerged from a repeated process of establishing relationships between the primary data findings and my reading of theories from the literature.

I commenced this stage with findings from the Shire and focused upon the data that I considered distinctive and, in addition, was not expecting. For the former, these data included the extent of belief in integrated (pooled) services and the complex structures for communication and decision-making between senior managers and leaders and, for the latter, the limited scope and impact of integrated community teams, professional differentiation within these teams, a disconnect between management and frontline layers of operation and exceptional areas of joint working (for example the management of intoxication in the S136 suite). My prior management experience in The Shire and my subsequent experience as a professional leader heightened my sensitivity respectively to the first two and the last two items of this latter category as they represented accords with, or contrasts with, these experiences. The distinctive findings from The Borough were largely unexpected as the data contrasted with my own experience – the degree of separation of the borough council from the mental health trust and the social work staff, the assimilation of community team staff members, the apparent acceptance of assimilation by social work staff, the style of development of the street triage service by senior managers and leaders and role-blurring of its frontline staff and the examples of innovative joint working.

The development of common themes at the tertiary stage was initiated in The Shire where the theories of culture, professional roles, leadership and the nature of joint working appeared appropriately to reflect significant aspects of its distinctive nature.

Further, it seemed possible to arrange these theories to reflect layers of operation and, at the same time, the interaction of the RE elements of contexts, mechanisms and outcomes. For example, the themes of professional roles and leadership represented in themselves layers of operation and were informed by my own direct experience as a senior manager and professional leader. In turn, findings from the very different environment of The Borough could be set within each theme and also represent an appropriate reflection of its own distinctiveness. A more detailed explanation of how the analysis was structured is provided in Chapter 7.

The final stage of the analysis is conducted by the application of relevant theories to each common theme as vehicles for comparison between the sites. The purpose of doing so is to explore within each theme the operation of the examples of mandation upon the processes (and outcomes) of joint working.

I have explained above (pp104-8) the advantages and disadvantages of my previous employment in The Shire and the consequent risk of imposing pre-conceived notions upon the data. My own assessment is that my partial 'insider' and partial 'outsider' status as well as the process of analysis provided a reasonable guard against such a risk.

The reliability and validity of these themes through 'respondent validation' (Roberts et al 2006, Bryman 2008) – affirmation by participants - received a limited degree of assurance during the study. I was offered and took up the opportunity to present the common themes at a formal multi-agency partnership forum in The Shire. This forum included representatives from all of the organisations engaged in this study. The themes were affirmed at this meeting and I have been asked to repeat the presentation at other forums. However, none of the interview participants were present on this occasion. I have approached senior manager participants in The

Borough with the offer of a presentation at equivalent gatherings but agreement was not forthcoming before submission of the thesis. I met twice in the course of interviews with a small number of senior manager or leader participants – three in The Shire and three in The Borough – and summarised the appropriate key findings; on all of these occasions, the findings were affirmed. I should concede that a more thorough assurance process, perhaps through a focus group of participants at each site, would have been valuable.

I was the sole researcher; therefore the opportunity was not readily available for inter-rater reliability checks through 'an independent assessment of transcripts by additional skilled qualitative researchers' (Armstrong et al, 1997). If some availability had been offered, the number and variety by organisational origin of participants would have been likely to be a further constraint to this form of assurance.

Governance issues and implications

Ethical concerns

Gaining the consent and preserving the confidentiality and anonymity of participants in interviews and observations, including those that may involve contact with service users, constituted the potential areas of ethical concern for the study.

The measures to obtain informed consent from participants to being interviewed included: gaining initial consent either through direct telephone or email contact; emailing the project documentation - topic guide, participant information sheet and consent form – to individuals or (in the case of participant groups) their line managers before each interview session; checking at the start of each interview whether further explanation of the study was required; asking for the consent forms

to be signed at the beginning of each interview (with a copy to be kept by the participant).

Consent to the observations of management activity was sought and obtained by direct contact with the chairpersons of the meetings (who were also interviewees). Adapted information sheets were provided for the meeting participants (see Appendix 5) either in advance through circulation with the agenda or were distributed at the meeting. In each case I provided a brief explanation of the purpose of the observation at the start of the meeting and emphasised that personal details of service users which were subject to discussions would not be included in findings.

Consent to the observations of front-line practitioner activity was addressed in various ways. At the request of the chairperson of the professionals' meeting, an additional approval was applied for and obtained from The Shire's research governance management 'to observe joint working in action without having to intrude on service users and carers…' as the personal circumstances of service users were the focus of discussion at the professionals' meeting. An application was made in writing to the research governance manager, emphasising that the purpose of the observation was to observe the processes of the activity and not the personal circumstances of service users. The application was formally agreed in writing. For The Shire, observation of a crisis and home treatment team shift was agreed by the line managers of the team manager and subsequently by the team manager and for observation of the professionals' meeting by the team manager. If observation occurred of direct contact with service users, it was agreed that each service user would be asked for her or his consent. (Direct contact with service users did not take place during the shift that I observed.) For the observation of the professionals' meeting, the participants signed an adapted (joint) consent form (see Appendix 6).

For the Borough, consent to observations was agreed in principle as part of the approval process for both the NHS Trust and the police service. The observation of a street triage team shift was agreed by the (police service) line manager of the team. The same stipulation about consent was made if direct contact with service users occurred; this was carried out on the one occasion that arose. Observation of a ward round meeting in the in-patient service was agreed by the consultant psychiatrist following my application in writing on condition that each service user was asked for his or her consent. Consent was given by each service user. In each case, I gave an undertaking that the observations were of the processes and would not make reference to the personal details of the service users.

The issues of confidentiality and anonymity of interviewees were addressed principally through an explicit clause in each consent form (see Appendices 3 and 6). In relation to anonymity, further safeguards were provided in the findings chapters by ascribing pseudonyms to each case study site and management meeting and by giving generic rather than exact titles to posts held by individuals and to teams. These measures therefore also covered observations. The interviews were recorded and subsequently transcribed either by myself or by a contracted service. To maintain confidentiality, the recordings and transcripts were referenced by numbers.

Approvals and documentation

A number of parallel approval processes were required for the study.

The study was approved by each of the research governance authorities for the NHS mental health trusts (MHTs) in the two sites as an *evaluation* using the criteria set out by the NHS Health Research Authority (HRA 2016). The criteria relevant to this study include:

- ‘designed and conducted solely to define and judge current care

- measures current service without reference to a standard
- usually involves analysis of existing data but may include administration of interviews or questionnaires
- no allocation to intervention
- no randomisation' (ibid, p3)

The key criteria for this approval status were the last two in this list which embargoed experimental activity that would have altered the treatment or care offered to individual people – criteria with which this study complied.

For the NHS research governance process in each site, application for approval was made by submitting the University of Birmingham Ethical Review format accompanied by the project documentation (which is described below) to research governance leads or managers within the mental health trusts. Formal approval was obtained in writing either by letter or email. Ambulance services approval was not obtained from the specific trusts as participants from these services were satisfied that this was covered by NHS research governance processes.

Approvals for the study were also obtained from each of the police services and local authorities in the case study sites. For one police service, the application and approval was conducted through straightforward exchange of emails with the Chief Constable's office. For the other, a research application protocol specific to the service was completed which was then submitted and approved by email. For the local authorities, the approval process consisted, in one case, of a research governance protocol specific to the agency and approval by email and, in the other, the ADASS Research Group research application protocol was completed and approved verbally.

In order to foreground the perspectives and concerns of service users in relation to

the processes which are the subject of this study, the University of Birmingham (UoB) ethical review format and the documentation were reviewed prior to submission for UoB sponsorship with members of the In-patient Care Forum within Suresearch - a network for survivors and others with experience of mental health services which is linked to the Institute of Applied Social Studies at UoB.

Lastly, following achievement of these approvals, the study was sponsored through the UoB ethical review process and legal liability cover (Clinical Research Insurance) was confirmed formally on 16th July 2014. Project documentation for interviews (see Appendices 1, 2 and 3) was attached to the application for UoB's sponsorship

Conclusions

Mandated joint working and its implementation processes are not straightforward features of public policy. They both share with joint working in public services the responsibility for a mixture of explicit and implicit policy objectives and ascribe this responsibility to a range of local organisations which are placed within distinctive settings. As a result, a number of issues emerge which merit a research approach which has the capability of accommodating them. Realism provides the potential for doing so.

The overall approach for this study has drawn from key shared aspects of realist research philosophy and practice. Realism re-interprets the experimental method of 'conjunctions of events' as the 'tendencies of things' by placing emphasis upon 'generative mechanisms'. In addition, the nature of reality is perceived as sufficiently complex and profound to support its separation into layers. This study has applied CR's concept of layers as representing different realities to the mechanisms and outcomes which emerge from formal policies and the layers of operation of senior

managers and leaders and of teams and front-line professionals. The RE model of dynamic relationships between mechanisms, outcomes and the contexts in which they are set has been incorporated into this layered concept. The case study design has been utilised to capture the scope, detail and depth of the issues inherent in mandated joint working. Further, the mixed data collection methods are intended to enable some triangulation of data to generate findings and analysis of commensurate quality.

The realist approach for this study developed iteratively in response to the emergent themes of the data. The alignment of CR and RE has been crafted into a combination so as to place emphasis upon the processes of mandated, and non-mandated, joint working. The potential strength and originality of this combination is that it can bring to the surface both successful and limiting aspects of the policies and processes surrounding S117 Aftercare, DTOC and S136 which have not emerged from previous research. I was keenly motivated to include consideration of the impacts of mandated joint working for service users as outcomes and was disappointed not to be able to do so. However, I consider that my decision to concentrate upon the impacts of policy for senior managers and leaders and frontline staff has produced valuable insights for actors at these layers of operation in the case study sites and beyond.

The study has a number of actual and potential limitations. First, my decision to focus evaluation of the impact of mandated joint working upon the processes of organisations and their staffs has inevitably constrained the scope of the study. However, as mentioned above, such intermediate outcomes have significant relevance for policy implementation and can offer a fruitful basis for future research into service user experience. Secondly, assurance of the reliability and validity of the

study's findings and analysis is not supported through inter-rater reliability due principally to my position as a sole researcher. The 'tests' of respondent validation are uneven. The level of detailed data – 'thick description' – made possible by the research design and framework, however, provides the opportunity for the findings and analysis to be recognisable and therefore transferable for readers in considering their own organisational settings. Thirdly, the potential for my previous work experience in The Shire and my professional experience as a senior manager and professional leader to be limitations has been acknowledged and minimised in relation to my previous experience and has been acknowledged also for my professional experience but is suggested as a positive influence upon the research design, process and outcomes. Lastly, the lack of a quantitative element to the methodology imposes a limitation to understanding the scale of the examples of mandated joint working.

With these considerations in mind, the following two chapters respectively present the findings which have been generated from the application of this study's bespoke realist approach to the contexts and organisational processes of The Shire and The Borough.

CHAPTER 5

Findings:

The Shire - contexts, mechanisms, outcomes and layers of operation

Introduction

The purpose of this chapter is to present the distinctive approach in The Shire to the conduct of mandated joint working. As outlined in the previous chapter, the findings of this study are arranged within a design structure that seeks to capture this distinctiveness. This structure is designed to achieve this aim in two ways. First, the contextual backdrop of The Shire is suggested through local characteristics, including local interpretations of national developments. Second, the processes of joint working are subjected to a detailed and layered examination.

Accordingly, the chapter is divided into two parts. The first part provides an account of the contextual influences in The Shire upon the two groups of organisations: health and social care services for Section 117 Aftercare and delayed transfers of care (DTOC) and mental health and emergency services for S136 use of police powers. These groups share some elements of the local context, while other features of The Shire's environment affect each group differently to a greater or lesser degree. The second part of the chapter is concerned with the operation of each of these groups, the explicit and implicit mechanisms and the intended and experienced or reported outcomes of mandated joint working, across three layers of activity – policy and procedure, senior managers and leaders and frontline staff. The final section presents the key findings of the fieldwork so as to provide a foundation for further analysis in Chapter 7.

Context

The geographical landscape of The Shire is predominantly rural, interspersed with centres of population around principal urban localities and a number of smaller towns of varying sizes.

Organisational configuration

Nearly all of the principal statutory organisations with involvement in joint working in mental health services in The Shire have co-terminous boundaries which mostly have remained unaltered for many years. The county council and the police share the same catchment areas. For the NHS, there is a single Health and Wellbeing Board (HWB), Clinical Commissioning Group (CCG) and single provider trusts for mental health, acute hospital and community health services, each bounded or defined[5] by the same countywide remit. The ambulance foundation trust is the exception; in common with the other ambulance services, its scope extends over several county council areas.

There is a consensus among leaders and senior managers in The Shire that this feature is helpful in a number of respects. Police participants in particular consider that The Shire has a 'wholeness' due to its relatively small size as a police service and thereby a fertile environment for the formation of effective inter-organisational relationships. For the police also, mobility of senior and frontline officers is limited by the size of the service; this is seen as helpful to its continuity and stability. Participants from all of the NHS organisations believe that co-terminous boundaries simplify inter-organisational interaction, and provide opportunities for leaders to meet regularly and to gain a shared understanding of each other's services 'and value

[5] The mental health trust, in common with other foundation trusts, also has responsibility for services in a neighbouring local authority locality.

each other's roles'. In the words of a Health and Wellbeing Board (HWB) participant, shared boundaries promote a confidence in joint working.

> Well, if we can't make it happen, then 'Who can?' is my philosophy. Because we are one, one big county, one CCG, we're co-terminous with the county council. We have one acute hospital, one mental health trust, one care, you know, community trust…(HWB leader)

Some participants express a reservation about this positive image in relation to NHS provider services which they see as having had a tendency to be 'inward-looking' and thereby not being sufficiently open to forming robust links with, or developing the role of, the third sector.

History of joint working for mental health services

Health and social care services. Commissioners express approval of the integrated nature of service provision and commissioning for adult mental health services which is formalised within a legal framework, initially Section 31 of the Health Services Act 2000 and subsequently Section 75 of the Health Service Act 2006. It is these services which take up the focus of this study. At the outset (in the early 2000s) of the integrated services, county council staff transferred to the adult mental health services of the trust, becoming full NHS employees. There is a sense of pride that this kind of joint working which is described by a CCG commissioner as 'towards the more integrated end of the spectrum in comparison to many other areas', has been sustained and developed since its inception.

> I'm not sure there's that many other areas in this part of the world that has got both integrated provision and service delivery through a health and social care trust and integrated commissioning from the local authority with the health authority…that brings together the resources of both organisations to commission through a single process. (CCG commissioner)

The development of organisational arrangements for the commissioning and service provision of other mental health services for older people, children and adolescents,

people with learning disabilities and people who misuse substances have taken a different course and differ between each service sector.

Commissioners and a mental health trust (MHT) manager attribute the survival of the integrated service provision to a shared perception between senior managers of its key benefit of sustaining 'a context where people see the person with the mental health as centre to what we're doing…(MHT senior manager)' and as a reflection of necessary flexibility:

> '…so many needs …could go either way…a health need [or] a social care need (social care professional lead)'

More specifically, integration is seen to bring together systems which support service users and lead to a comprehensive delivery of care.

> …there's a simple benefit like only telling your story once…you have a named key worker… and…people have that rounded view of somebody including any physical needs that they might have but know who the networks are, know who the connections are…can knit the whole thing together. I think that is a massive benefit. (County council leader)

In relation to the integrated commissioning function, a commissioning participant views its main advantage as being the direction of the effort of organisations away from conflict and towards mutual accommodation, particularly in the prevailing economic circumstances.

> …we're better together…because the strains upon both organisations are immense. And we could put all our time…in playing ping-pong with services and lives. But actually if you think about the energy that that takes up, you could expend less energy and go further forward than if you actually stopped playing ping-pong and started trying to understand each other's worlds… (CCG commissioner)

At the same time, participants recognise persistent and potential tensions between health and social care organisations. A CCG commissioner views mental health services in The Shire to be 'over-medicalised…but in parts…actually you'd want some of your mental health services to be quite medicalised.' A MHT manager concludes that The Shire has 'a very strong sort of consultant leadership presence'

due to the high number of medical staff – 'I've never seen so many doctors' – in contrast to other parts of the country. A county council participant considers that there are drawbacks to the integrated arrangements in The Shire stemming from the imbalance of health and social care resources – 'in an integrated health and social care arena, social care is always the poor relation because it always has fewer bodies and less money' - and of relative power – 'It [social care] may have an equal impact but I don't think you can get away from the predominance of the consultant psychiatrists' world..'

The health and social care services group of organisations therefore has been cast firmly in the integrated model for adult mental health services, characterised principally by the pooling of resources.

Mental health and emergency services. The history of joint working for these services seems to have been characterised over the past decade by significant and specific initiatives which have developed and to some degree have re-directed existing patterns of joint working between local organisations which remain separate.

A healthcare place of safety (HPoS) suite was opened some 6 years before the study on the site of a MHT in-patient service, following a successful bid for central government funding. Previously The Shire had no alternative formal places of safety to police cells for all S136 detainees. The suite attracts commendations from participants across the agencies to which it provides a service – it is described by a police participant as 'a superb facility'. Staffing support to the HPoS is provided by a qualified member of staff and a support worker from crisis resolution and home treatment teams (CRHTTs) following notification of a S136 detention.

Another milestone is represented by a multi-agency group which has been in place in The Shire since the 1990s. This group has a predominantly (but not exclusively)

statutory membership made up of a range of criminal justice, healthcare and social care organisations. The brief of this group, while varying in emphasis over the years, has been to address cross-cutting issues between the agencies with a particular focus upon the operation of S136. Following the introduction of the Mental Health Crisis Care Concordat (Concordat) - 'the new show in town if you like…(MHT senior manager)', the existence of this group has been accepted by participants as a significant opportunity for service coordination across the mental health and emergency services, '[it's] the engine that drives forward some of the work that's been done around [the] Crisis Concordat'. A number of participants view the activity of developing the mandated Concordat action plan as 'a current success' because of the widened range of statutory and third sector agencies which contributed to it, including for example ambulance and military and transport police services. A HWB leader considers the 'success' is due to a combination of mandated joint working and local energy and engagement.

> …it helped to focus our minds by it being mandated and it helped in a way as a commissioner to be able to hold people to account more…it gave us some grit in it. But I think we were already in a good place where everybody realised we've got to change and we've got to sort this out… it worked very well. And it, you know it...also worked very well because…we had a co-chair…who was a service user.

A cooperation model of aligning more closely the practices of mental health and emergency services through the HPoS and the multi-agency group therefore has been followed in The Shire with a view to moving towards a coordination model through the work of the Concordat. This is explained later in the chapter.

Local 'cultures' of joint working

The models which underpin both groups of organisations appear to share the same cultural foundation. As is indicated in the account of the positive impact of co-terminous boundaries, there is a consistently-positive attitude amongst the leaders of the organisations about the importance of joint working. This is expressed in various

ways as an enduring force. A county council participant considers that, for health and social care joint working, there is a collective belief 'in the spirit of integration despite the tough economic times.' A CCG participant similarly sees that the distinctiveness of the Shire's approach to joint working is that 'both parties want to do it' – referring to the CCG and the local authority. Leaders from the emergency services speak of 'good will' and 'absolutely superb relationships with the statutory partners'. A MHT trust senior manager concludes that 'for some reason…there exists some organisational memory' which sustains joint working between the mental health and emergency services and which can be seen in 'continuously reviewed' policies. Perhaps most strikingly, another CCG participant is clear that:

> there's an undoubted set of values and cultures within The Shire that recognise that working together is a duty…we're actually public servants and whilst you might really irritate me, in fact you irritate me a lot…there's an over-riding, y'know, we've got to keep getting round the table and work together…and that isn't just about mental health, that's a broader overarching agenda really.

Austerity

Health and social care services. While implicitly critical of the Coalition Government policy of 'austerity' – a dramatic reduction of more than 25% in local government budgets - some leaders regard the consequences of the policy as providing both constraints in the form of evident budgetary pressures and potential or actual positive influences upon joint working. A CCG participant considers that 'austerity' was combined with the notion of localism, espoused by the Liberal Democrat contingent of the Coalition Government, so as to 'pass down' to local commissioners the impact of reduced resources 'and work that up for theirselves…' Another joint commissioner participant feels there to be a moral imperative to assist the local authority 'because whilst our money is flat cash in the NHS, you know, social care has taken a nose dive'. From the MHT, a leader claims that joint working, if mutually-

supported in local areas irrespective of whether mandated or not, will be more likely to sustain itself 'as the money shrinks…'

> …you require even more on … the soft side of the relationship because…the mandated bit if I haven't got values aligned and I haven't got the relationship and now I've got a row, actually I'm just going to go to war in the row.

Mental health and emergency services. Police services also have been required to make significant reductions in their resources through the Coalition Government's austerity policy. While an impact of austerity has been to change previous patterns of joint working – a police participant at executive level considers that previous Crime and Disorder Partnerships had been 'decimated' as a result and their replacements are 'much leaner' – participants are clear that the strength of local relationships has been retained. A MHT leader drew a link between reduced police resources and the drive within the trust to recognise the pressures upon those resources and to improve response times.

> So, I'll give you an example of [the] Constabulary recently. So they've had massive cuts. Actually we had a very clear AWOL [Absent Without Leave] policy about phoning them the moment anybody would disappear.
> …[now] we have a risk assessment approach to this…we will only phone you for the ones who we are really worried about so you can't just say we'll come when we can…

<u>New demands</u>

Health and social care services. Participants reported a significant shift in the demands made upon the community mental health teams and assertive outreach teams over the past three years. This was expressed by a number of the participants as having an impact upon the nature of their interventions with the majority of service users:

> So when we go and see people at home we don't really they're not really, don't really know how to treat them. (Community team participant)

The scale of this change was expressed as being '60-70% of the people who are referred to us' who, in contrast to the previous service focus for people with 'clearly-

defined problems of a serious and enduring nature', often have a personality disorder, are experiencing 'immense and incredibly debilitating trauma' and whose experience can be marked by substance misuse, mental health issues and chaotic living circumstances. Two participants from an assertive outreach team (AOT) considered that the approach by the Trust to the introduction of the mental health clustering approach (referred to in Chapter 3) had 'to an extent' accounted for and reflected this change. Specifically, the remit of the AOT encompasses two clusters, 16 and 17, defined as respectively, service users with 'Psychosis and Affective Disorder (High substance misuse and engagement)' and 'Psychosis and Affective Disorder - Difficult to Engage' (NHS England, 2016).

There are varied impacts upon joint working of this shift, which has been applied to all community teams within the trust. The role of nurses and, to an extent, occupational therapists (OTs), 'has become a little bit grey' as they become engaged with the majority of service users referred to the teams. By contrast, social workers have smaller caseloads and have developed 'a very clearly-defined role within our services' which encompasses the exclusive arrangement of purchased social care (particularly following the introduction of the Care Act 2014), supported accommodation and Mental Health Act and Mental Capacity Act issues. This has led to a shift in shared workloads between nurses and social workers.

> …there's probably about a 30% overlap, 40% overlap whereas it probably used to be about 80%.' (MHT senior manager)

A positive effect is perceived to have been upon the sharing of risk issues between all disciplines within the trust teams, although this was experienced to be more difficult and variable with teams and services based at other locations and in other organisations.

Mental health and emergency services. A shift in demand upon CRHTTs has taken place in recent years. At their establishment in the mid-2000s the CRHTT remit was confined to 'people with a severe and enduring mental illness at the point of, at risk of hospital admission'. More recently, referrals to the CRHTTs are also 'around people's emotional distress', not necessarily people who may require admission to hospital. While the original remit has been maintained, the proportion between the initial and the newer remits is estimated by a CRHTT manager as 'about 50:50'. The broadening of responsibility is reflected in the contact arrangements for CRHTT. Previously, a telephone contact number was available to a limited range of agencies. An 0800 number is now provided on the Trust's website to which members of the public have access. During the shift observed, this number was used by a relative of a service user. The CRHTT manager reported a significant rise in telephone requests for advice from ambulance service staff as an additional feature of this shift in demand.

During interviews and the observation, participants explained that CRHTT staffing is arranged on a 24 hour shift system. 5 or 6 team members are available between 7am and 10pm in each of the 3 CRHTTs in The Shire and (at the time of the study) 3 team members during night-time hours for the whole locality. A separate mental health liaison service is available at the A&E department of one of The Shire's acute hospitals during the day until 10pm. From 10pm until 7am, the 3 CRHTT members pick up this function. This is a recently-introduced additional service.

This shift in demand appears to be reflected in the police service too. A police participant at executive level considers that 'I would challenge [the prominence of] 136, I think it's people in – the term that's used sometimes in policing – EMD,

emotional mental distress, is a significant challenge in policing…despite everything that's occurred in terms of policies and practices and concordats'.

External scrutiny and oversight

The impact of external scrutiny from the Independent Police Complaints Commission (IPCC) appears to carry greater weight for the police service than the equivalent bodies for the other agencies and to influence police engagement in joint working with mental health services.

The external scrutiny regimes for the organisations in the study are similar in structure. For the NHS organisations and the local authority, the Care Quality Commission (CQC) conducts regular inspections. For the police service, annual Police Effectiveness, Efficiency and Legitimate (PEEL) inspections have been carried out by Her Majesty's Inspectorate of Constabulary (HMIC) since 2014. The outcomes of this activity have varied across the organisations in The Shire with mixed findings of good practice and the need for improvement in specified areas. The MHT is also subject to scrutiny from Monitor, the NHS service regulator for foundation trusts. A participant from the trust considers that the trust has maintained a favourable profile with Monitor.

> So, that's not to say that we're not under the same scrutiny as everyone else, it's just I think we're seen as a low risk compared with other places. (MHT senior manager)

There are also national organisations which act as final arbiters for complaints about the conduct of the locally-based statutory healthcare, social care and police services in individual circumstances – respectively the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and the Independent Police Complaints Commission (IPCC). None of these bodies address routinely all the occasions where a complaint may be made about the conduct of a local service; the majority of complaints are dealt with through internal procedures. However, the

involvement of the IPCC is mandatory in certain circumstances such as deaths, serious assault or serious injury which occur during the involvement of the police; these circumstances do not apply for the Ombudsman bodies. As the risk of these incidents will be higher for the police than for health care and social care services, it is not surprising that participants made no reference to the Ombudsman but the IPCC was familiar not only to the police but also their colleagues in mental health services. A police service participant asserted that the IPCC 'will step into, normally we'll self-refer actually, any incident where we feel they might have an interest. For instance, any death after police contact will be automatically referred to the IPCC for a review.'

The IPCC was described by a police participant as a 'pressure on the police to respond for fear of being pilloried by the media and the regulatory body.' This 'pressure' seems to have a tangible impact on the day-to-day practice of the police which is not replicated in the other organisations, particularly those of the NHS, as practitioners consider they can call upon professional values for support. As an example, one of the CRHTT participants gave an account of an incident referred to the team by police of a person who had expressed suicidal intentions.

> The poor police…I mean we thought it would be just best left. For everyone to leave and leave her. You know, positive risk-taking. She has taken a lot of overdoses but she always phones someone or has always contacted someone, she's taken an overdose. And she always ends up in A&E and then is back again.

However, the police officers, advised by a senior officer, did not feel able to take this line of action - 'No we can't do that because you know we've got to have a clear plan.' The CRHTT participant agreed to visit the person and was able to agree a plan of action with her until the following day, including management of medication.

> So…the police were happy with us…we fully understood their problems. They're not allowed to leave until there's been…some sort of plan.

Mechanisms and outcomes

1. Health and social care services (H&SC)

Policy and procedures layer – Section 117 Aftercare (S117)

Mechanisms

A local policy statement for delayed transfers of care (DTOC) in mental health services does not appear to be in place. The DTOC monitoring processes are explained in the next section. In the absence of a discrete DTOC policy, the findings presented here will be confined to the Shire's policy and procedures document for Section 117 (S117) Aftercare which incorporates both general policy statements and practice guidance. It therefore has application to both of the senior managers/leaders and frontline staff layers of operation. It is a document jointly 'owned' (the term used on the front page) by the CCG and county council.

At the time of the study, the document (referred to below as the S117 policy) is in a draft form awaiting formal sign-off and the agreement of an implementation training programme. It is complex both in structure and in content. It is made up of 39 substantive paragraphs, the content of which suggests that 3 mechanism categories are intended to support best practice of mandated joint working for S117: policy stipulation (paragraphs 1-9, 37-38), procedures for joint working (paragraphs 10-15, 34) and local guidance in relation to funding issues (paragraphs 16-33, 36).

The *policy stipulation* category includes the following headings or subjects: policy statement, purpose (of document), scope (of staff for whom the document is relevant), definitions of terms used, legal context (for example, amendments to S117 made by the Health and Social Care 2012, updated commissioner guidance issued in 2013 and the Care Act 2014), mandatory procedures, purpose of aftercare, scope of aftercare, engagement of carers, policy implementation and review processes,

complaints and dispute resolution. The *procedures for joint working* category includes assessment, care planning, care review, recording and ending S117 entitlement. The *local guidance for funding issues* category addresses funding responsibility (as affected by residency, inter-agency remits, NHS Continuing Healthcare, 'top-up' payments[6] and social care provisions such as direct payments and self-directed support), exemption from charging for social care and liability for prescription (of medication) costs. In addition, 4 appendices provide guidance on case reviews and case law and formats for recording S117 discharge and determining joint funding responsibility between the CCG and the county council.

Much of the content of the first category, *policy stipulations*, summarises the current legal provisions of S117, including, for example, the definition of aftercare introduced by the Care Act 2014. The legal context paragraph also proposes a distinction between provisions of 'legal or overriding duty and principle' - that is to say, *mandated* requirements – and provisions 'where the duty or principle may not apply in all situations' – in other words, *discretionary* circumstances – by designating the terms '**will**' and '**should**' respectively to indicate the former and the latter. For example, 'Service users who are subject to S117 and receiving community services **will** be offered an IMHA [Independent Mental Health Advocate] to support them at reviews'. It would be reasonable to assume that the paragraph which follows immediately, with the heading of 'Mandatory procedures', would designate all of its 9 sub-clauses (one of which is quoted in full above) with the use of the term '**will**'. However, it uses a mixture of terms ('will', 'should', 'must' and some with none of these terms);'**will**' is used in 3 sub-clauses.

[6] These are payments for preferred care arrangements by service users or their representatives, which supplement funding agreed by the county council

The second category, *procedures for joint working*, includes 35 sub-clauses of which 4 are designated by '**will**' (for example, the requirement to arrange a care plan review) and the remainder by a similar mixture of terms as the first category. The use of the nationally-mandated care delivery process for mental health services, the Care Programme Approach (CPA), is designated 'for the planning and implementation of aftercare services' by '**should**'. The paragraph which defines the circumstances of ending S117 entitlement is particularly lengthy – 16 items of which 1 is designated by '**will**' – and primarily offers guidance rather than instruction.

The third category, *funding issues*, seeks to address funding responsibility for treatment or care in a number of circumstances which have generated test cases or local dispute and confusion. This category presents local interpretation or local agreements in relation to these issues. The content of this category is the most complex as it covers the relationship of S117 with issues such as residency (the area where the service user is deemed to reside 'usually' or 'ordinarily' and therefore where funding responsibility is located, if the funded service is provided from outside the area of residence), respective funding responsibilities of the CCG and the council, NHS Continuing Healthcare (CHC) and exemption from prescription costs. For example, local interpretation of the implications for practice of the changes to residency 'rules' made by recent (separate) pieces of legislation is presented in detail. A local agreement for the respective funding responsibilities of the CCG and the council for 'placements' is set 'on a 50:50 basis' (previously funding responsibility was agreed on a case-by-case basis). Also, a format, attached as an appendix to the policy, has been developed to indicate joint funding responsibilities specifically in relation to Section 117 between not only adult mental health and other domains of adult social care such as learning disabilities but also CCGs or local authorities

outside The Shire where services have been identified as appropriate to meet the needs of service users.

Outcomes

Explicit outcomes intended for the *policy stipulation* mechanism are drawn from external sources – the Mental Health Act (MHA) 1983 itself and the MHA Code of Practice (DoH, 2015). In the former, outcomes are expressed, in a quotation from S117(5), as positive impacts upon the circumstances of service users: 'to meet the need of the individual's mental disorder'; reduce the risk of deterioration'; to minimise the need for repeated admissions'.

In the latter, the explicit intended outcomes can be linked, with one exception, to their use in this study as defining impacts upon organisations and frontline staff. These outcomes are expressed as follows: a clear process for S117 care planning; timely review and clear recording of decisions; equal partnership with service users and carers; avoidance of delays to care planning from disputes over responsibility for aftercare.

I indicate above that the distinction between the mandatory and discretionary requirements of the policy, through the use of 'will' and 'should', is not followed in subsequent provisions. It seems reasonable to suggest that the consequent blurring of the distinction could have an *actual* outcome of causing confusion for frontline staff. Indeed, this may be an appropriate outcome in view of the complexities linked to S117 Aftercare.

The provisions of the two other policy mechanisms – *procedures for joint working* and *funding issues* – are framed as guidance or local interpretation. The level of detail for these complex provisions suggests that the overall intended outcome is the reduction of scope for discretionary decision-making by frontline staff.

The overall potentially-experienced outcome of the policy may be that the mandatory nature of S117 Aftercare is limited and that the implementation of the organisational obligations which it confers is driven primarily by judgement rather than instruction.

Senior manager/leader layer

As shown in Figure 12 below, the 10 participants interviewed are split between commissioning and organisational leadership and senior manager functions. The participants had been employed in their current posts for varying periods of up to 10 years. Data are drawn from these interviews and from fieldnotes of the observation of the social care funding panel.

Figure 12 – Shire H&SC senior manager and leader participants

Commissioners	Organisation leaders and senior managers
• Clinical Commissioning Group (2) • Health and Wellbeing Board (1) • County council (1)	• Mental health trust (5 – executive, 2 senior managers, social care professional lead, middle manager) • County Council (1)

Mechanisms

The fieldwork activity was completed, with one exception (a MHT middle manager), over a period of 6 months. The interview with the middle manager took place after an interval of approximately three months. The original intention was for this interview to form part of the second phase of interviews but it became clear that its content fitted better with the first phase.

The central theme of this section is that the organisational processes in The Shire for mandated and non-mandated joint working are sustained by formal arrangements for decision-making, face-to-face communication opportunities and an underlying belief in the value of collaborative activity.

Channels of decision-making

The installation or development of formal channels of decision-making constitutes the most overt mechanisms of implementing S117 and DTOC provisions. Two commissioning participants consider that for both of these provisions, the integrated commissioning process 'works well because the trust manages both sets of the process'. As the S117 policy indicates, the issues of funding responsibility for S117 aftercare may be complicated. The Shire's approach to these issues can be seen in 'boundary-spanning' or discrete posts and a network of funding allocation panels, mostly sited within the mental health trust, which appears to reflect this complexity. An example of boundary-spanning is provided by a social care commissioning manager for mental health services, who is employed by the county council but effectively managed from the CCG and has been in post for some years:

> They wanted someone within the council…with some mental health experience and expertise…think there was a feeling [in the county council] that since the integration a lot of the knowledge and experience had been passed over to [the MHT] and there was a loss within the council.' (county council commissioner)

At community team level, a number of senior practitioner social work posts have also been maintained since the integration to work across a 'patch' within the MHT services to support social work practice and to contribute to team management.

A social care professional lead explains the nature of the panel network. A 'regular community care funding panel' meets on a monthly basis to allocate funding for social care services[7] for 'adults either when they are being discharged from hospital or when they are in the community'. A separate panel reviews these funding allocations. Another 'complex care' panel allocates funding for healthcare services, the budget for which is devolved to the trust by the CCG – 'So it's all your out-of-county placements and people that are subject to [the] Mental Health Act or have

[7] Allocation of social care resources has been devolved to the mental health trust while budget-holder responsibility is retained by the county council.

high health needs'. Lastly, a 'joint complex care' panel is made up of senior representatives of wider funding 'interests' which encompass complex mental health and 'high physical health needs': the county council, the CCG in relation to CHC [NHS Continuing healthcare], the community care panel and the complex care panel:

> …key people at the meeting [who] have the ability to say, 'Yes, we can fund this from our budget. Yes we'll fund this. We want to fund this'. So, it's a conversation at that level and it brings together all those different budgets to have the discussion really. (social care professional lead)

Two mental health trust participants refer to the processes used in the Shire for DTOC monitoring and management – the monthly submission of 'Sitreps' (Delayed Transfers of Care Situation Reports) statistics to NHS England, a DTOC review meeting at the trust's in-patient site and the appointment of an in-patient social worker specifically for adult mental health services. 'Sitreps' submissions are a national requirement; these show a low DTOC figure for The Shire at the time of the fieldwork. The review meeting and social worker appointment are local arrangements. The meeting takes place on a weekly basis at the in-patient service made up of:

> …the bed manager, the matron, [the social care professional lead] and the social worker that does the discharging and the operational manager… So, it's a relatively small group, but it does enable an opportunity to discuss who's a delay and what's going on and where do we direct this…It just makes things happen and enables an oversight of what's going on. (social care professional lead)

The social work post was created in response to 'a [DTOC] spike a few years ago' to steer the process of hospital discharge and to provide a link between the in-patient service, where the post is based, and the community teams. Both county council and mental health trust participants give a positive account of the effectiveness of this post.

> …to make systems work really well, it's about, not the number of people…It's where you place them to facilitate the process. And having [the postholder] there has really facilitated the process. (Mental health trust senior manager)

Some participants share reservations about the effectiveness of these channels between this layer of operation and the team and front-line layer. A HWB leader has noticed that 'sometimes what's going on on the ground doesn't get back up to the chair and chief exec [of the NHS organisations]'. The county council commissioner referred to above is concerned about a 'disconnect between the policy side of things and the practice…because nobody knows about any of them [policies]'.

Face-to face communication

If decision-making channels provide a structure to implement Section 117 and DTOC, the style or method of communication – face-to-face meetings - is viewed by participants as being a vital mechanism for sustaining inter-agency relationships in strategic and senior manager spheres of activity and thereby *managing* the challenges to joint working engendered by these areas of mandated joint working. The joint complex care panel was described by a participant as:

> …a vehicle that enables you to have those face to face conversations, the meeting, key people at the meeting have the ability to say, 'Yes, we can fund this from our budget…So, that's been quite useful in moving things forward from a delayed transfer of care point of view, but also from a joint working perspective. (social care professional lead)

Another participant contrasted the approach to 'discharging someone with very complex needs' within The Shire of 'everyone getting together and working out what the best option is…' with other areas where 'they don't have the same relationships and…the same integrated approach…'

The notion of 'everyone getting together and working out what the best option is…' can be seen across the strategic and senior manager spheres of activity. A distinctive example is the development of a local mental health strategy. The CCG and HWB has taken the opportunity of a 'far less top-down, micro-managed agenda from central government' to steer the development of a local strategy explicitly modelled on the 6 strategic aims of the Coalition Government's national mental

health strategy - No Health Without Mental Health (NHWMH) – 'because local players wanted to do something about it'. The method of driving the strategy has taken the form of a network of groups matching the NHWMH strategic aims with representation from local organisations, service users and carers in addition to statutory partners.

This mechanism also operates in other leadership settings and at various levels of governance. Organisational leaders speak approvingly – 'really great partnership working' - of the regular meetings of a forum of leaders across health and social care statutory organisations 'which drives the general direction of travel'. Indeed, during the period of the study, one of the members of this group was seen to act inappropriately by issuing an individual public statement which was critical of the organisations of other members in relation to DTOC. Another grouping of senior clinical and professional leaders across the range of health and social care provider organisations (in the main, statutory agencies) is described as one of a number of 'really good multi-agency meetings'. In both the mental health trust and the county council, similar clinical or professional governance groups have been running or are planned to start – in the former, across professional disciplines and in the latter across key areas of focus such as mental health, adults, learning disabilities and safeguarding. Again, for the former, emphasis is placed upon regularly bringing people together.

> …you have to put energy into maintaining [joint working]… So, all the heads of professions, all the lead nurses, head of social care meet every single month together and we have an agreed clinical approach, clinical social care approach to different things. (Mental health trust senior manager)

Perception and beliefs

While perceptions and beliefs contribute to the context in The Shire for mandated joint working, they seem also to act as mechanisms which direct the manner of its

interpretation – and in turn, how it is managed and implemented. A number of participants perceive that the *enforcement* aspect of S117 and DTOC provisions is not experienced principally as applying to local joint working relationships. A CCG participant considers that the 'problems' addressed by each of the specific mandated joint working areas are primarily instrumental.

> And I think that the examples that we've got on joint working – 136, 117 and delayed transfers of care – where they're not in a place where you can say 'Ah, they're sorted now, 100% of the time, for everyone it's fixed.' The problems aren't related to the joint working, the problems are broader than just the actual joint working of it…they tend to be wider systems issues that the system hasn't dealt with.

Similarly, a MHT leader views a core issue for frontline staff as being 'frustration' with the 'processes…and the resource limitations' of, for example, S117 rather than the notion of having to work together.

> So I think the frustration isn't with the principle, I think it's with the enactment.

On the other hand, when asked to identify if being mandated to work together 'as opposed to areas where you may do so voluntarily' made a difference, other participants view the act of being mandated as providing assistance in resolving problems in some circumstances. One MHT middle manager recounts the experience of a DTOC sanction – a formal notice from the hospital trust of a proposed date for a patient's discharge from hospital – as being 'a tool for the job'.

> …I don't ever believe the intention was to control or to force us to work together, it was just a tool to use to get things moving.

A MHT senior manager agrees that 'It helps to have the frameworks…' but goes on to confirm the source of effective joint working as being an attitudinal approach.

> I think it [being mandated] does help. Is it the key driver? No, I don't think it is. I think it's about do we understand.

Leaders from the county council and the MHT appear to share a belief that joint working is of equal value whether mandated or voluntary. A county council leader

holds to ‘the point of view that integrated work is the right thing to do…’ irrespective of the differing conditions in which it is applied.

> I think the mandated areas are clear because…there are proscribed roles for people in them and therefore they are there to deliver duty. I think in the informal or the day-to-day integration there is room for other developments and other ways of working…’

The MHT leader asserts that ‘there is no future for isolated practice that is not connected into broader systems’ and goes on to reflect that joint working is most effective if characterised by ‘jointly-held or synergistic and certainly not contradictory values’ and not by requirement alone.

> I can't mandate you to love me and so you can't mandate, in my view, effective partnership working…
> It’s got nothing to do with regulations, it’s got nothing to do with pointy heads, it’s to do with frontline attitudes…

Outcomes

A number of outcomes of these mechanisms were referred to or suggested in the course of the discussions above.

The boundary-spanning roles and funding arrangements which make up the channels of decision-making appear to be designed to bring together at least some of the relevant interests engaged in the implementation of S117 Aftercare and DTOC. The reported outcome of this mechanism is expressed directly in the final sentence of the quotation on p136(?) which is focused upon the operation of a ‘DTOC meeting’.

> It just makes things happen and enables an oversight of what’s going on. (Social care lead)

Similarly, the creation of the specialist social worker post is seen as having an allied outcome.

> …having [the postholder] there has really facilitated the process. (Mental health trust senior manager)

It seems feasible to propose that the overall intended and reported outcome of these processes is effective decision-making.

The directly-reported outcomes of the mechanism of face-to-face communication are sustaining and managing the challenges of joint working between organisations. Although not given overt reference above, the mechanisms of perceptions and beliefs, which make up an attitudinal approach, appear to serve the same purpose through the demonstration of understanding or 'synergistic' values. A fundamental outcome of emotional commitment is indicated also by participants as being crucial to joint working, whether mandated or voluntary. A CCG participant refers to the development of 'emotional capital' in The Shire from the long-term practice of joint working. A MHT leader places emphasis on 'the soft side of the relationship' (p139) as being able to mitigate 'going to war' with peers.

However, there is an acknowledgement that not all outcomes of these mechanisms are positive. It seems clear that, from differing perspectives, commissioners observe there to be 'a disconnect' between policy and practice or uneven communication between frontline staff and senior management (p151).

Team and frontline staff layer

Figure 13 – Shire H&SC team and front-line participants

Community teams	'Other' services
• Team Manager (for both teams) • Social care locality lead • Team 1: 1 nurse • Team 2: 1 social worker, 1 OT	• Specialist social worker • Advocacy service: team manager, 4 team members

As shown in Figure 13 above, of the 11 participants interviewed, 5 are drawn from 'community teams' located in the same work base. 6 participants are drawn from 'other teams' based in different locations with specialist functions of working alongside or coordinating the work of community teams and services. The mechanisms presented below which sustain or impair joint working and outcomes

are identified from these interviews and the observation of a professionals' meeting for one of the community teams (Team 2).

Mechanisms

The fieldwork activity for this section was completed, with one exception, during a period of approximately 3 months following the first phase.

The theme for this phase of the study is that the degree of close joint working characteristic of integrated community teams differs from the coordinated joint working relationships between team members and peers from other services or organisations.

Integration

The setting of the integrated community teams acts as a mechanism for the operation of S117 Aftercare in the sense that it is not viewed by some participants primarily as a legal requirement but rather as a reflection of team working. A participant from an assertive outreach team has a prosaic view of Section 117 as providing a standard framework for service users engaged with the team ; 'everybody's 117, they'll all on CPA, they're all going to be followed up, they've all got the aftercare.' A number of participants interviewed from two community teams give a positive account of the nature of integrated working where professional differences are both acknowledged and respected, described by one participant as 'a little bubble in mental health that you have the disciplines that work with you' and where there is a sense of mission of 'working towards the same thing for the same person' and that 'everybody there has got the best interests of the service user at heart.' More specifically, another participant views the care planning process of S117 as a natural expression of this mission.

> I think most of the people that you'll meet in mental health…they don't want to see that person back in hospital and they want the best for that person. So when you're having

> a 117 meeting…you're reviewing every aspect of that person's life to make sure that when they go out there, they're not going to fail. (social care locality lead)

Some participants consider that the legal basis of S117 is useful in supporting multi-disciplinary team working and in sustaining relationships with service users. A team manager muses that the difference made by S117 is that as 'a statutory requirement' the involvement of a social worker is 'perhaps' more likely 'and where there isn't [a requirement] you might not'. A team member recognises that '117 allows people to get entitlement to things as they continue on their journey after hospital…' and, particularly if service users resist engagement with the teams, 'the aftercare…justifies our ongoing support to them.'

Observation of the professionals' meeting for the community teams, which included doctors, nurses, OTs, psychologists, social workers and support workers, substantiate these accounts of mutual professional recognition. The meeting was taken up with a review of a service user's circumstances and was focused not only upon the service user's medical diagnosis but also upon family circumstances and interaction and the social impact of that person's behaviour. Differing perspectives upon the circumstances were offered - not always along professional lines. For example, a social worker contributed an opinion that developmental delay should be included as a possible factor to be addressed.

Co-ordination

Participants give more critical attention to relationships between integrated teams and other services both within the trust, such as in-patient services, and externally, such as housing agencies, in considering the impact of S117 and DTOC. From these accounts, it appears that the perceived separation of these interests or working groups is such that co-ordination is required as a mechanism to achieve the common focus upon the interests of the service user claimed for integrated teams. Further,

the presence of S117 or DTOC appears not to be sufficient to guarantee joint effort in these circumstances.

A participant from the advocacy service considers that S117 did not exert a positive influence upon joint working between the staff of differing services, particularly in a climate where funding for aftercare services is limited 'because they've got their own restrictions, their own ideas…more often [a stronger influence] it's the funding…and it always comes down to that now'. Another advocate gives an account of working with service users who are in a position to be able to leave hospital (in circumstances where S117 and DTOC is applicable) where agencies appear to be operating in isolation from each other.

> …my experience is that services seem to be working by themselves…[the client] might have a housing support agency involved and a social worker and someone else, the benefits agency for example…and everyone does their own thing and they don't know what the other person is doing.

Some community team participants also highlight how the factor of S117 does not prevent unrealistic expectations developing between trust and county council teams, for example in working with young people, and indeed promotes difficulties in joint working when 'you feel like your hand is being forced' because of the level of risk involved as well as a S117 requirement.

> I've attended meetings before where obviously people have had an expectation of me of stuff that I can do, and I just physically would not be capable of seeing this person as frequently as they wanted me to…

A specialist social worker confirms that, for service users of working age, the formal DTOC sanctions are rarely applied to require the county council to reimburse the mental health trust when otherwise eligible delays occur [see Chapter 2 for the DTOC definition] 'because the majority of people that come through to [the hospital] are detained under the Mental Health Act and are therefore identified as having a health need'. However, this participant considers that the trust's senior management

seeks to emulate the mandated nature of DTOC through regular scrutiny of the 'length of stays in hospital'. A community team member confirms that 'there's immense pressure…on all community teams…to not have people…with very long hospital stays' and describes the experience as being 'hideous'.

Despite this scrutiny, a similar level of separation to that described above, which serves to hinder joint working, seems also to persist between in-patient and community team services,. The specialist social worker considers that traditional intra-organisational rivalry is one of the unhelpful factors.

> You know it was always, you know, you're sat in a community team, it was like us v them. They think they're busy, we're busier. Everybody's busy aren't they?

Strikingly, the 'bubble' image used above as a positive reflection of integrated team working has a pejorative meaning for an advocate as preventing effective communication between these services : 'They tend to be quite in their own bubble don't they? That's the trouble… they tend to blame it onto the wards…'

Also the separation can lead to a lack of understanding of required systems. For example, an inpatient nurse may believe that completion of assessment will lead imminently to discharge from hospital.

> So they only hear a certain phrase and they think that's the only thing that needs to be done. from a ward perspective 'Well we've done specialist assessment of nursing needs, why can't that go to panel? Why hasn't that gone to panel?'
> 'Well, that's an assessment, it doesn't tell me what you want to purchase, what you need public funding for… It's a wider thing than that.' (Specialist social worker)

Outcomes

In reflection of the two mechanisms identified for this layer of operation, their reported outcomes differ markedly. Ironically, the image of a bubble is used in the description of both outcomes by frontline staff.

The key experienced outcome linked to the integration mechanism as mentioned above is effectively the redundancy of the mandated nature of S117 Aftercare as a

result of sustained and defined inter-professional community team relationships. Indeed, the apparent clarity of these relationships could represent an experienced outcome of S117 Aftercare implementation in its own right as an example of joint problem-solving. There appear to be a number of elements which contribute to both the mechanism and the outcomes. The opportunity for frequent interaction between professional staff - 'informal corridor conversations' (social care professional lead) - who share the same workbase is seen as enabling communication. A social worker in a community team considers that the supportive nature of teamwork is instructive.

> And that encourages me, I learn more from others. Different ways of doing things. Different ways of looking at things. (SW)

Another participant (a nurse) from the same team who uses the positive bubble image mentioned above (p141) goes on to explain that the protective nature of teamworking in this instance can withstand and support differing professional perspectives.

> So, I've recently taken on some patients that were being care-coordinated by one of our OTs. And their approach was very different to mine. But I think maybe my approach was slightly more, or at least what the patient and his wife said, was more on the personal side, maybe more motivating towards 'You can get better and interact with your life differently.' rather than 'You can function in different ways.'

In relation to the coordination mechanism, the principal experienced outcome of mandated joint working for S117 Aftercare and DTOC is the need for external reinforcement where services are differentiated either by physical location, function – in-patient and community services – or by organisation – mental health trust and local authority. As described above, the bubble image is used as a description of a barrier. Both the specialist social worker for the mental health trust and advocates are examples of this reinforcement. Advocates argue that coordination of separated groups of staff does not occur naturally without the intervention of an external

agency to achieve a common focus upon the needs of the service user, despite pressure from senior management to avoid delayed transfers of care.

> So if you work with the client…and they say 'No-one is doing really what I want to do' or 'No-one is listening to what I want'. So an advocate comes along and suddenly everyone goes 'Oh, hang on a minute. Oooh we'd better work together then.' (Advocate)

2. Mental health and emergency services (MH&E)

Policy and procedures layer – Section 136 (S136)

Findings are drawn from the draft versions of two multi-agency documents: the Shire's S136 policy and procedures (referred to below as the S136 policy) revised in 2013 and a mental health joint protocol (referred to below as the protocol) issued by the ambulance service in 2015. The protocol is selected for analysis as the specific responsibilities of the ambulance service are not covered in detail in the S136 policy, in contrast to those of the police and mental health services.

Mechanisms

The front page of the S136 policy bears the logos of the MHT, the county council, the police service and the previous ambulance service. The protocol is described in the document as 'a joint working agreement' between the current ambulance service and the police services (including that for The Shire) within its catchment area – the organisational logos of all these parties are placed on its front page. Both documents make reference to a previous version of the Mental Health Act Code of Practice. The protocol also 'takes into account' the Mental Capacity Act and the Mental Health Crisis Care Concordat (referred to below as the Concordat). Apart from introductory paragraphs and appendices, the document is divided into two substantive sections, focussing respectively upon crisis care and capacity. The capacity section and the appendices, which provide guidance on capacity assessment, are not included for analysis here.

Both documents, while in draft form, are reported by participants from the county council and ambulance trust to be in use. At the meeting of the Concordat implementation group (see below for further details) which was observed, a review of the S136 document was included in the Concordat formal action plan as work to be completed. Reference at the same meeting was made to the protocol as the basis for the development of a common policy for conveyance (of service users with mental health issues to hospital) between mental health and emergency services in The Shire.

The S136 policy

The document is made up of 16 paragraphs, the first 12 of which address the operation of S136 (the final 4 paragraphs are concerned with the document's review, references, other documentation and agency contact details). The 12 'operational' paragraphs can be divided into two categories – provisions which apply to all the signatory agencies (paragraphs 1-4) and procedural guidelines (paragraphs 5-12) which present the distinct 'roles and obligations of each authority' (quotation from paragraph 3 of the document) and also indicate areas of joint working – which respectively suggest intended mechanisms for joint working best practice as being *a sense of shared purpose* and *coordination and cooperation*.

A sense of shared purpose is reflected in a statement of the aims of the S136 policy: that the service user receives attention and care according to need and in recognition of individual rights; that the attention and care 'is provided in the most appropriate place and by the people best qualified to provide it'; that this service is provided in a timely manner. Also duties of managers for ensuring the implementation of the policy are laid out, followed by the key S136 provisions, quoted from the MHA 1983.

Coordination and cooperation can be construed as the main theme(s) of paragraphs 5 to 12, as the guidelines are framed as separate detailed instructions to police and mental health services as individual procedural contributions to the processes of S136. These paragraphs cover in turn general procedural guidelines, specific procedural guidelines for the police place of safety (PPoS), the HPoS, assessment at the HPoS and ending S136, and some general issues such as arbitration between agencies and complaints. In the main, each guideline uses the imperative term 'will' or 'must'. For example, for police officers:

> If the person is detained in a police station as a Place of Safety, they have a right of access to legal advice under PACE. The condition of detention and treatment of the person must be in accordance with PACE Code of Practice C.

And for mental health staff:

> On receipt of initial contact from the police the Suite Coordinator must complete the Place of Safety Receipt Form …

Joint working guidelines are framed in more permissive language which recognises the separated functions of professionals and agencies.

> The registered medical practitioner and the AMHP have a separate function to carry out. The contribution of each should complement that of the other in the interests of formulating a plan of action…
>
> To ensure that Service Users are cared for in the least restrictive environment…involved agencies need to work in co-operation.

The protocol

The contents of this document used for analysis comprise 3 introductory paragraphs, 7 crisis care paragraphs and an appendix which presents 'Red Flag' criteria for emergency department (A&E) admission to be used by the emergency services. Across the 10 paragraphs, similar mechanisms for joint working best practice as the S136 policy are evident.

A sense of shared purpose is provided by the prominence given to the Concordat as informing the overall aim of the protocol 'to ensure that services provided to patients

in mental health crisis are managed in accordance with the Mental Health Crisis Care Concordat'. For crisis services, 'parity of care to those whose need is medical' is cited as a key principle. It also specifies provisions for supporting appropriate use of, and conveyance to, places of safety, response timescales and information-sharing. For example, the protocol gives an undertaking for the ambulance service response in relation to S136.

> All calls outside of life threatening emergencies made following application of section 135 and section 136 will be categorised as a Green 2 call. This will automatically dictate a thirty minute response.

Coordination and cooperation is reflected in paragraphs which address the use by each of the emergency services of restraint, protocols for requesting assistance and 'transport for definitive care'. In each circumstance, the responsibilities of each service are presented as being closely aligned but with distinguishing features. For example, the use of restraint for 'patients who are lacking capacity' by ambulance staff and police officers is presented as being subject to the same provisions of the Mental Capacity Act – 'the use of reasonable force to ensure that patients lacking capacity receive care that is in their best interests…'. However the need for cooperation between ambulance and police services is suggested by the limit placed upon the use of restraint by ambulance staff of 'patients who are in a threatening or violent manner'; the limit is explained by the conditions of ambulance service training 'to provide minimal restraint [where] there is no perceived risk of harm to [ambulance staff] or the patient'. As for the S136 policy, the use of the imperative term 'will' is frequent not only to specify specific individual tasks – 'following arrival of the police at scene [sic], the ambulance staff will provide the police officers with the following [itemised information]' – but also co-operative activity:

> The ambulance staff and police officer will…work together, undertaking a joint dynamic risk assessment…This will not be a formal written process but a supportive and

> collaborative discussion…The thought process and rationale should be recorded with due regard to the relevant ambulance and police documentary processes.

These documents share a dual approach to the policy and processes of S136. On the one hand, statements of principles set a direction for joint working through a sense of joint purpose. On the other hand, presentations of the local S136 processes show a preference for instruction and procedure specification for joint working which suggests that the experience of local joint working is seen to require proscription within a closely-defined framework.

Outcomes

Both documents formally introduce S136 with explicit intended outcomes in their statements of purpose or overall aims. As mentioned above, these outcomes encompass both direct impacts upon service users – the delivery of care according to need, including parity between physical and mental health care and the least restriction possible – and impacts upon the responsibilities of organisations and their staffs – the provision of timely intervention and professional assessment in an appropriate setting.

That the explicit outcome of 'working together' between organisations and their staffs is linked to the mechanisms of coordination and cooperation is hardly surprising. Reference to this outcome appears at a number of points in both documents. However, in contrast to the judgement emphasis of the S117 policy, the tone of both documents is congruent with an enforcement interpretation of mandated joint working which is applied to the staffs of both mental health and emergency services, including doctors. The expected overall outcome of the policy therefore can be seen as compliance with its provisions.

Senior manager/leader layer

As shown in Figure 14 below, data are drawn principally from 8 interviews which include 4 participants from the emergency services and 5 from mental health services. The mental health trust participants are a heterogeneous group made up of mental health service commissioning managers (with the exception of the HWB participant) and mental health trust leaders and senior managers. The functions of some of these participants are common to both groups of organisations and therefore are included here, although only interviewed once, and indicated with an asterisk in the diagram below. Data are also drawn from the observation of the Concordat implementation group.

Figure 14 - Shire MH&E senior manager and leader participants

Mental health services	Emergency services
• Clinical Commissioning Group (1*) • Health and Wellbeing Board (1*) • Local authority commissioning (1*) • Mental Health Trust (2 – executive*, senior manager)	• Police (3 - executive, 2 mental health leads interviewed together) • Ambulance services (1 - mental health lead)

Mechanisms

The fieldwork activity for this section was completed during the same 6-month-period for health and social care service organisations.

The theme here is that the response to mandated joint working in relation to S136 is one of incremental development and alignment of existing resources and structures and problem-solving of issues as they arise.

Building on progress and current structures

There are a number of factors which suggest that building on acknowledged progress and current structures is a key mechanism for managing and implementing S136 in particular and joint working between mental health and emergency services in general.

As mentioned above, the establishment of a healthcare place of safety (HPoS) in recent years in The Shire is regarded by many participants as a significant mark of progress in addressing the requirements of S136.

Further, a HWB leader considered the mandated Concordat process of submitting a formal declaration and subsequent action plan to the Department of Health was given extra impetus within The Shire by a critical incident, 'where [a professional] nearly got killed', which demonstrated a common lack of joint working by 'lots of different organisations'.

> …we had started on the journey already, acknowledging as organisations that, in this case, there were lots of red flags that nobody talked to each other and joined them up and hence we got into that situation…(HWB leader)

It is striking that the joint working undertaken in response to the Concordat attracts enthusiastic responses from across relevant agencies which has been sustained beyond the initial mandated phases of activity. A police participant makes repeated reference to it: 'I know we keep going back to the Concordat…it's the first time we've had something absolutely positive'. A MHT leader links explicitly the perceived 'fast progress' with previous positive developments.

> …some of the ingredients of joint working were already in situ…some history of good working, some history of progress having already been made and success that you could then build on success. Plus a notion in the system collectively of wanting and needing to do something different and extra…

An ambulance service participant considers that the mandated nature of Concordat implementation in The Shire in particular has shifted positively the previous multi-agency arrangements away from exclusion and towards wider engagement.

> So for me as the ambulance service, we quite often get forgotten or dismissed in relation to a whole host of things…So in the past you may have had a working group put together to look at mental health and they wouldn't necessarily have involved the ambulance service. But because we're a mandatory signature on the Crisis Care Concordat Declarations, it's forced people around the table…I think certainly since the Concordat it's improved greatly.
> And [The Shire's] probably one of the most engaged areas in relation to mental health.

Aligning systems and processes

Data from the fieldwork indicate that system and process alignment is perceived by many participants as an effective mechanism for operating S136.

In common with the health and social care joint working group, S136 is interpreted primarily as a systemic challenge to joint working – 'wider system issues that the system hasn't dealt with' (see p138 above) – rather than a problem arising from inter-agency relationships. The commissioning participant who makes this observation, also views the main cause of difficulties in implementing S136 as being rooted in organisational or cultural misalignment.

> …you've got a misalignment across those 4 different organisations – mental health trust, police, ambulance trust and you could probably throw EDT (Emergency Duty Team) into the mix there as well in terms of out-of-hours AMHP work –that have got a role to play…[and] will all have different access thresholds and criterias…

Participants from the police service define different aspects of this misalignment. Police participants at executive and middle management level define readily the 'access threshold' of the police in comparison to other organisations – in essence that it is the fall-back or last resort option which enables 'other services [to] have the option of refusing or maybe not being quite as involved as they should be because they know the police will always pick up the pieces at the end of the day'.

> There is a sense in the police service of a resource shift. So, health contracts in its various forms, whether it's ambulance services or provision of care services. *And policing is the only 24 hour crisis response service* [my emphasis] that has a statutory duty around protection of the public. (Police executive)

Other police participants focus also upon the 'task-orientated' culture of police work which regards their activity as a series of one-off events which need speedy resolution which contrasts markedly 'with some of our partners'.

> …we're more task-and-finish orientated than some organisations. And you see this in our response you know in our response to things like 136…we'll go along, we'll detain somebody, we take 'em to the HPoS, over to you, thank you very much, job done, we're off ready for the next call – and that's our culture. (Police mental health lead)

An ambulance service participant has a different cultural conception of rapid response in that ‘a paramedic views an emergency as an 8 minute response’ which imposes a priority upon the calls made to the service and, unless there are urgent physical health issues to be addressed, conveyance to a place of safety is unlikely to be first on the list, ‘if they then become the nearest vehicle to a higher priority of call’.

There are a number of indications that this systemically-focussed mechanism is being applied to address a number of issues. The inclusion in the protocol of a 30 minute ambulance response target for S136 detentions, mentioned above, is an example. The chair of the Concordat implementation group has shadowed a night-time shift of police officers ‘going down to the custody suite, understanding what it was like to be booked in, seeing people being booked in, suspected mental health problems…’ At the time of the fieldwork, the funding of a triage system of mental health nurses placed in the police control centre to provide advice to police officers had been agreed and was proceeding towards recruitment of staff.

The agenda of the Concordat implementation group which was observed included the review of a number of detailed joint processes such as common standards for assessment ‘in a mental health crisis’, a policy and procedure for mental health trust staff when requesting police assistance and a draft information sharing agreement. The chair of the group sees its function as being primarily operational.

> …we didn’t want it to be a strategy group. It had to be about operational services coming together and saying…‘This has happened, this hasn’t gone well, how can we do it differently?’ from a very hands-on, front line operational perspective.

A MHT senior manager is able to substantiate this claim in relation to a specific operational concern.

> I do think the [group] is a forum where we can discuss stuff and look at solutions. I raised the issue last time about ambulance waits…Came away with an audit to do. Actually the current audit hasn’t really thrown it up as being such a problem as we thought it was being presented as.

Continual problem solving

Data also supports the suggestion that a mechanism of continual problem solving is sustained by cautious optimism. The optimism is vested by participants from all organisations in the strength of the overall joint working culture in The Shire. The caution stems from a perception by the emergency services in particular of the apparent intractability of issues such as 'EMD' (emotional mental distress) and information-sharing. It seems that progress, such as the introduction of the HPoS, also throws into relief and gives additional urgency to the issues that remain in operating S136. A police participant who acknowledges the HPoS as a 'superb facility' also considers that it has brought only 'some slight improvements'…it doesn't cater for anything like as many of the detentions as it should'.

A police participant at middle management level gives a specific example – the scenario of a person who makes frequent 999 calls expressing suicidal intentions – which illustrates both of the intractable issues mentioned above. From the police perspective, incomplete prior information-sharing reinforces the cultural differences between the police and mental health services – the task-orientated police focus vis-à-vis the imperative to maintain patient confidentiality.

> I do think suicide is quite a good example… the police go there, negotiate them down, detain them on 136 and then that's it, job done, police come away…there needs to be that kind of multi-agency strategy around that particular individual to involve all the relevant agencies rather than us just…job done, walk away. (Police mental health lead)

The initiative of establishing a triage service in the police control centre is seen as a potential opportunity to provide 'immediate access to both sets of data…at an early stage being able to divert a lot of people away from…136 because it's actually not necessary.' However, a discussion surrounding a draft information-sharing agreement at the Concordat implementation group demonstrates the sensitivity of the issue. The draft agreement proposed a protocol of categories for information-

sharing which distinguished between specified circumstances where information 'must' be shared, 'may' be shared or 'may only with consent' be shared. One of the mental health trust representatives at the meeting considered that information-sharing remained a dilemma for nursing staff who would perceive a conflict between the distinctions being proposed and the Nursing and Midwifery Council standards of confidentiality with implications for their professional registration status.

Outcomes

A key experienced outcome of mandated joint working linked with the mechanism of building on progress and current structures can be described as cumulative benefit. It is clearly considered to be founded on the basis of a receptive joint culture. A MHT senior manager views the service provided by the HPoS as itself being the outcome of effective joint working between mental health and police services.

> If we take the 136 suite, then they set [it] up in a way to be a joint piece of work so it was set up that mental health practitioners would work alongside police and it would be staffed by our staff.

The mandatory Concordat requirements are seen as supporting this outcome through the identification of shortcomings (from a critical incident) and through mandatory wider inclusion of organisational interests, in particular the ambulance service. The quotation from the interview with the ambulance service participant on p151 is one of many on the same theme of the progress made as a result of '[people] forced…around the table'.

> So without the Concordat would the money [for improved joint working] have become available? Would we have thought about it? Probably not. I don't know. So I think the Concordat's kind of a catalyst for making things work.

The same participant commends The Shire for its capacity for joint working.

> But it feels different. It feels that people are engaged. You know? That there is a genuine desire to try to make a difference. And that's probably more so in The Shire than most counties…[Another county] will focus on the problem, rather than focusing on the solution. Whereas The Shire, I think, are very focused on the solution rather than the problem

This view suggests that an experienced outcome in The Shire is that this capacity is enhanced rather than impaired by enforced joint working.

The mechanisms of system and process alignment and continual problem-solving appear to share a specific experienced outcome that could be seen as a feature of the capacity for engagement – the recognition that 'intractable' inter-agency issues require long-term collaboration. These issues have been referred to above – the challenges of providing a response to people in emotional mental distress, the issues of information-sharing, the dissonance between police and 'health' cultures and the wider misalignment between mental health and emergency services. It is not too fanciful to include the maintenance of optimism as an outcome implicit in the observation that The Shire 'are very focused on the solution rather than the problem'.

Team and front-line staff layer

As shown in Figure 15 below, of the 16 participants interviewed, 11 are drawn from the police service (the 8 police officers were interviewed as a single group). 5 are made up of 3 staff from a single CRHTT and 2 staff from the Shire-wide EDT (who were interviewed together). As for the other joint working group, the mechanisms which sustain or impair joint working and their outcomes are identified from these interviews and the observation of an evening CRHTT shift.

Figure 15 - Shire MH&E team and front-line participants

Police	Mental Health teams
• Training manager (1) • Control centre coordinators (2 staff, interviewed together) • Police officers (8 interviewed together)	• Crisis and Home Treatment Team (CRHTT): 3 - team manager, I social worker, I nurse • Social care emergency duty team (EDT): 2 - team manager, 1 team member

Mechanisms

Again, the fieldwork activity for this section was completed, with one exception, during the same 3 months as for health and social care services. The 'outlying' activity was the observation of a CRHTT shift which occurred within the month which followed the 3 month period.

The theme for this phase of the study is that the joint working surrounding S136 is characterised by dynamic processes of developing working practices, the management of conflicting and ambivalent staff attitudes, resource pressures and information flows.

Developing working practices

The data collected from interviews suggests that the continuing development of agreed working practices is a preferred implicit mechanism for managing and implementing S136 in particular and the relationship between mental health and police services in general.

Participants from the CRHTT and police share a view that, following the availability of the HPoS, S136 helpfully imposes a discipline for each of the services to follow which has become reflected in working practices. A CRHTT manager considers that the team's responsibility for staffing the HPoS which was set and has been maintained following its opening, is fulfilled successfully 'well over 85% of the time…most of the time we're actually there before the police'. In addition, the attendance of AMHPs, which the CRHTT arranges, is not seen as problematic either during the daytime working hours or out-of-hours – 'the 136 is not a problem, we phone the AMHPs, the AMHPs come in, EDT out-of-hours…'

> If somebody has been detained under Section 136 of the Mental Health Act, nobody has got any other option than to see that process through… You haven't got all the other environmental factors that are around which in itself makes the assessment

> process easier…And it works really well. Generally EDT respond very quickly. (CRHTT manager)

Police participants view the 'agreed protocol for detaining under 136' as being used appropriately - 'on the whole we know when to take them there [the HPoS] or not' – and successful in reducing 'the number of detainees who come to the police station'. The CRHTT manager believes that the HPoS has led to increased contact between the team and the police and a 'gradual shift' of improvement in relationships.

> And I think that because the relationships are improved, we're much more receptive to helping them and they're much more receptive to helping us.

CRHTT and EDT participants, however, are concerned that the establishment of the HPoS has also led to an increase in the use of S136 and, further, to its inappropriate use 'because there's a place of safety unit that the police can just pick someone up and take them and then they're off.' A research paper, unpublished at the time of the fieldwork, showed that S136 use in The Shire had increased by 60% in the 5 years that the HPoS had been open, using mean monthly figures. In relation to inappropriate use, many participants point to 'frequent attenders in the 136 suite' for whom detentions appear to be ineffective.

> …the sort of evolving 136 patient who comes in, is a deliberate-self-harmer, goes up to the …car park. Police are called, they bring them in, they're discharged from 136 back home and then it happens again and again and again. (EDT participant)

CRHTT and police participants confirm that there are occasions where an individual pathway is agreed usefully for a person who has been detained frequently but which is difficult to replicate for other people or for the same people in different circumstances.

> But it tends to be an informal arrangement between us and other agencies that will kick in response to certain incidents as opposed to an across-the-board agreement and structure. And it's a difficult thing to put into a structure as well…And that's a, it's always going to be a difficult one… (Control centre coordinator)

The management of people who are intoxicated with alcohol or drugs is an issue that shows a sharp distinction in The Shire between people detained under S136 and those whom the police come into contact with, for example, in their own homes and for whom seek the assistance of CRHTTs. For the former, people too intoxicated for a Mental Health Act assessment are accepted for detention in the HPoS 'unless they're being too violent to the point where they cannot be managed in the suite…' or require medical attention. This is a relatively recent amendment to previous working practice, introduced through the Shire's Concordat action plan, which requires 2 CRHTT staff remaining with the person until she or he is sober enough to interview – which in turn can take several hours and limit the availability of staff to meet other demands. In relation to people encountered in their own homes and therefore not eligible for detention under S136, a CRHTT participant considers that intoxication continues to pose dilemmas both for the team, the police and other services.

> I don't think anybody really knows the answer… I suppose it comes down to a little bit of who takes responsibility for that…If you go out to somebody's house, you see somebody and you can't make any sense, you can't admit them to a psychiatric hospital because they're drunk. And I suppose the police think 'We can't arrest them just because they're drunk' and A&E think 'Well, this isn't a suitable place for them to be just because they're drunk.'

This mechanism can also lead to innovative proposals. The Concordat implementation group has considered, but not proceeded with, the development of a specific service for people detained under S136 who are too intoxicated for interview – referred to by a CRHTT participant as 'some sort of sobering up place' – managed by an independent agency. As mentioned above, a further innovative development of S136 working practice, also an item within The Shire's Concordat action plan, is awaiting implementation – the proposal to place CRHTT staff in the police control centre as a variant on the street triage services introduced in other areas.

Managing perceptions, expectations and scarce resources

While there appears to be an emphasis in The Shire on processes, there is evidence that the management of perceptions and expectations of frontline staff is also an implicit mechanism for implementation of day-to-day joint working. An example from the observation of a CRHTT shift is illustrative of the importance of this sphere of activity. Team members reviewed an intervention which occurred during the previous day's shift at an A&E department where the CRHTT had attended following the conveyance there by the police of a person who had been acting incongruously in a public place. In the discussion leading up to the conveyance, CRHTT had advised that the police detain the person using S136. However, the police were reluctant to do so as they considered the person not to be 'dangerous' and opted for assessment at the A&E department where the person was found to be suffering from an infection which may have generated the incongruous behaviour. The outcome of the CRHTT attendance was an agreement to undertake a mental health assessment following treatment of the infection. The observed discussion between team members (in addition to a conclusion that the episode had a satisfactory outcome) juxtaposed the team expectation that the S136 process should have taken its usual course and the perception of police officers on this specific occasion that S136 detention was a response to 'dangerous' behaviour.

A perception shared by police participants is that positive joint working at senior management level between mental health and police services is not matched at front-line level for a variety of reasons, one of which is the need for rapid resolution of issues.

> It's a strange thing. I think, at management level, we probably have a really good understanding and a really good exchange of information with the mental health professionals. But actually, translating that down to a day-to-day level in terms of foot-

> soldiers on the ground sometimes there's more conflict there…at a grass-roots level, there is a worry about the here-and-now, isn't there? (Control centre coordinator)

Data from an interview with police officers suggests that their attitudes towards engagement with mental health issues may not be uniform but are buffeted by a range of strongly-held and sometimes contradictory beliefs – resistance to or resentment at involvement with such issues as well as support for closer joint working. During the interview, the same participant asserted that:

> …the country still thinks the police can deal with mental health. We shouldn't be anywhere near it, shouldn't be anywhere near it.

and, later in the interview, that:

> I'm all for, because we are ourselves, social services, ambulance, we're all doing the same sort of job, even the fire service to a certain extent. We should all be together. I'm absolutely an advocate of that. All in one room, all in one building.

Both CRHTT and police participants consider that attitudes can act in varying ways as barriers to effective joint working. A police participant recounts his experience of liaising with mental health nurses during the establishment of the HPoS who appeared to think that 'because they had stood next to police officers…people were viewed as a police's issue...rather than this person is now in need of medical assistance'. A CRHTT team member perceives that, despite improvements in working relationships between the team and the police, there is still a 'them and us' undertone to joint working which influences attitudes and expectations.

> Well, not in a nasty way. It's that they're so tied to their bureaucracy and you know and their complaints procedures and their awful inquiries that they have to do… they're stuffed in serving mental health patients.

Many participants refer in different ways to the overarching context of limited resources which they consider accentuates divisions of attitude and expectation.

> And it's a very difficult process. And of course we're battling with other agencies because they've all got the same finite resources, the same resourcing problems that we've got – and perhaps we don't understand each other's situations very well - and it just causes constant conflict (Police participant)

Managing information flows

The issue of information sharing between mental health and police services has already been referred to in the senior manager layer of operation. During interviews, it emerges as a significant issue for CRHTT members, EDT members and the police because of a shared concern that the flow of information has a strong influence upon effective frontline joint working between their agencies. Their attempts to address this concern in relation to S136 in particular, as well as more widely, can be viewed as explicit mechanisms for managing and implementing joint working.

A police participant considers that the flow of information with and from healthcare services in general is problematic.

> …there's all sorts of issues around the sharing of information, particularly information of a medical nature. We do struggle with information-sharing, even with the ambulance service, let alone with ongoing other mental health professional or medical professionals.

There appear to be specific areas of concern about information flow both prior to and following S136 detention. CRHTT and EDT participants argue that, too frequently, police officers make contact with mental health services *after* the decision to use S136 powers has been taken, when prior contact could avoid the use of detention. A CRHTT participant is confident that this is already occurring to some degree.

> I think we've definitely avoided some 136s, yeah. And there is the potential for a lot more 136s to be avoided if the police just phoned us first.
> We do get a lot of frequent attenders in the 136 suite which, you know, I can think of 2 or 3 people that I know if the police phone me first I'm 100% confident that…the senior practitioners and myself would be able to avoid those 136s.

The proposal to place CRHTT staff in the police control centre is seen by both CRHTT and police participants as providing an opportunity to 'close that gap' in communication between the making of an emergency 999 call received at the control centre and conveyed 'straight to the police, the police respond and then there's all that time really when we're out of the picture'.

With regard to completed episodes of S136 detention, police participants appear to have a different perspective about the 'gap' of information-providing, particularly for people who frequently come to their attention.

> …when we take somebody…to the 136 suite, it's almost a handover process, isn't it…you give them information about what you're doing, they accept them or not and then you go, don't you?, – but then there's no follow-up after that is there? And we hear the next day they're out and about and causing the same concern for the public or concern for themselves and then we're back to square one without any further information as a result of what happened. (Control centre coordinator)

This view and that of the CRHTT participant cited above appear at first sight to be in direct contradiction of each other. However it seems that information exchange is not as straightforward a process as these accounts suggest. A police participant points to the influence of separated locations upon information flow – 'it certainly does slow down or stop when you've got departments or groups of people who are separate, in separate buildings' – as the opportunity for informal communication are limited. The 'task-and-finish' focus of the police role provides interruptions to engagement. The need for the police control centre to build up intelligence to overcome such interruptions appears to be in conflict with the healthcare tradition of confidentiality in respect of an individual's care and specific treatment. A CRHTT participant feels able to provide broad details about whether hospital admission occurred or not following assessment 'because you're not really breaking confidentiality by saying that, are you?' and to pass information to other mental health staff but is hesitant about giving a more detailed response.

> Sometimes we get calls from the police, they just want some information as a follow-up and they're ones we find tricky…the police would call maybe and say 'Oh, we detained somebody in a 136 the other day, we're just wondering what happened to them?'… They want more specific details…obviously people do feel a bit more wary about providing that really… you also don't want to be sharing that information if the patient didn't want it shared and there's actually no reason for them to know about it.

Outcomes

The reported experienced outcomes that flow from the mechanisms at this layer of operation are mixed as they promote service improvements but also present challenges. On the one hand, improved processes (the management of intoxication) and plans to improve processes (the triage arrangement in the police control centre) are recognised by the organisations. On the other hand, tensions (a mismatch of mutual understanding between the operational layers of joint working) and conflicting interests and values (the continuing difficulties surrounding information-sharing) persist between mental health and emergency services. It seems reasonable to suggest that the nature of change encompasses both improvements to processes and the management of differing beliefs and values.

Key findings

These findings suggest that implementation of mandated joint working in The Shire is, in the main, not a straightforward matter of compliance with requirements. The apparent exception is the favourable environment for Section 117 Aftercare created by integrated community mental health teams – although this facility is limited, it seems, to internal interactions within the teams themselves.

For joint working between health and social care services, there appear to be clear supportive features in the context and most mechanisms that have been identified in this chapter. These features include the prevailing culture with its emphasis upon decision-making and communication networks and a capacity for accommodation of new demands, particularly in relation to professional roles. However, the outcomes for Section 117 Aftercare and DTOC show that the impacts of these assets are not consistently experienced across senior manager/leader and frontline staff layers of

operation and require degrees of reinforcement and, on occasions, enforcement, for compliance.

For mental health and emergency services, the positive cultural environment is also evident in its application to organisational dynamics which, however, differ to those between health and social care services due to the histories and distinctive core functions of the agencies involved. For both mechanisms and outcomes, there is a gradual progression towards closer joint working in relation to S136 driven by the organisational and professional tensions that emerge from its implementation in the frontline layer of operation and by external enforcement in the shape of the Concordat. Indeed enforcement more nearly captures the nature of S136 implementation. Despite their differences, this group of organisations appears to share a degree of disconnection between layers of operation with health and social care services.

It seems reasonable, for the purpose of comparison with The Borough, to pull out a number of key findings from these evaluations in The Shire.

Commitment to and apparent confidence of joint working is persistent and is the default culture

It seems clear that there exists in The Shire an enduring contextual and cultural commitment to joint working between the primary organisations engaged in the collaborative activity which underpins S117, DTOC and S136. This is expressed most clearly as ‘a duty’ and as a source of pride by commissioners. This commitment also is reflected in the perceptions and beliefs of senior managers and leaders as apparent confidence in the strength of this activity between health and social care services and as a sense of cautious optimism in the progress of such activity between mental health and emergency services. For the former, the challenges for

mandated joint working are seen to lie not in joint working itself but in systems and processes. For the latter, challenges are perceived as wicked issues which require continual attention and adjustment. For teams and front-line staff, joint processes and working practices are sustained and at the same time are variable, characterised by both integration and coordination, and dynamically evolving.

The experience of joint working differs between the policy, senior manager and leader and team and frontline layers of operation.

The considerable joint effort expended by senior managers and leaders into the development and improvement of systems and processes does not appear to be matched consistently at the team and front-line layer of operation. This apparent mismatch is indicated by the tensions that exist between the 'bubble' of integrated community teams and other teams separated from them by function or organisation. Also the issues of joint working between mental health and emergency services, such as information-sharing and consistent commitment to addressing mental health needs, retain currency. The emphasis here, however, is upon the more subtle concept of (the presence or absence of) congruence between layers of operation rather than the impression perhaps given by the use of the term 'mismatch'.

Professional roles tend to be distinct for both groups of organisations engaged in mandated joint working.

The conduct of professional roles in the implementation of Section 117 Aftercare, DTOC and S136 in The Shire can be characterised as sophisticated expressions of different professional perspectives in joint working between health and social care services and acknowledgement of distinctive pressures for mental health and emergency services. The gradual separation of the roles of nurses and social workers and a 'mature' attitude towards medical predominance within integrated

community teams suggest a level of sophistication in sustaining joint working in the face of potentially divisive tensions. The understanding and increasingly-flexible approach of CRHTT staff to the distinctive pressures faced by emergency services, in particular police officers, reflect an evolution towards a changing style of joint working.

Frequent, face-to-face peer communication through formal channels/settings is the norm for senior managers and leaders

In the management and leadership sphere, there appears to be an almost instinctive reliance upon a plethora of decision-making and face-to-face communication processes between organisations. In this way, emergent issues such as funding allocation and other organisational pressures are responded to. Also, innovative activity can be supported, for example in the form of the local implementation of the national mental health strategy and the Concordat. This characteristic suggests that leadership in The Shire is conducted principally through formal organisational networks in which styles of interaction vary according to the make-up of the networks.

The dimensions of mandated joint working vary according to the settings in which they occur.

The findings suggest that The Shire can accommodate, for health and social care services, both Leutz's conception of integration as an advanced organisational form of joint working and coordination - a 'lesser' (by Leutz's definition) level of joint working between separate organisations. Additionally, for mental health and emergency services, a progression from cooperative arrangements between organisations appears to be moving incrementally towards coordination through the development of inter-organisational working structures and practices, such as the

development of the mental health liaison service at The Shire A&E department and of the management of intoxication at the HPoS.

The experience of joint working differs between the policy/senior manager and leader and team and frontline layers of activity.

The considerable joint effort expended by senior managers and leaders into the development and improvement of systems and processes does not appear to be matched consistently at the team and front-line layer of operation. This apparent mismatch is indicated by the tensions that exist between the 'bubble' of integrated community teams and other teams separated from them by function or organisation. Also the issues of joint working between mental health and emergency services, such as information-sharing and consistent commitment to addressing mental health needs, retain currency. The emphasis here, however, is upon the more subtle concept of (the presence or absence of) congruence between layers of operation rather than the impression perhaps given by the use of the term 'mismatch'.

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These key findings provide the basis for themes for further analysis which will be developed in Chapter 7.

CHAPTER 6

Findings:

The Borough - contexts, mechanisms, outcomes and layers of operation

Introduction

This chapter has the same purpose and format as the previous chapter. That is to say, its purpose is to suggest the distinctive approach to the conduct of mandated joint working in a case study site, in this case The Borough, by arranging findings from data in two broad groupings – contextual backdrop and joint working processes. Accordingly, this chapter, like its forerunner, is divided into two substantive parts. The first part provides an account of the contextual influences in The Borough upon mandated joint working for two groups of organisations: between health and social care services for Section 117 Aftercare and delayed transfers of care (DTOC); between mental health and emergency services for S136 use of police powers. The second part of the chapter is concerned with the operation of each of these groups, the explicit or implicit mechanisms and intended and experienced or reported outcomes of mandated joint working, across three layers of activity – policy and procedure, senior managers and leaders and frontline staff. The final section of the chapter, as in Chapter 5, proposes key findings as a basis for further analysis in the chapter that follows this one.

The relationship between and within health and social care service organisations in The Borough was undergoing significant changes during the period of this study. The findings for this area of mandated joint working reflect retrospectively the perceived operation of mandated joint working leading up to the changes as well as those of the services in transition. Findings for mental health and emergency services for the

Borough are drawn from a current ‘steadier’ state for the organisations involved, although the recent introduction and impact of a street triage service is the main point of focus.

Context

The geographical landscape of The Borough is mostly urban. It is a densely-populated locality with the local population unevenly spread across a number of towns within its metropolitan borough council boundaries.

Organisational configuration

There is currently little formal co-terminosity between the boundaries of the key organisations with responsibilities for mental health services in The Borough. The borough council and the Health and Wellbeing Board share a common boundary. The mental health trust, the clinical commissioning group (CCG), the police service and the ambulance service all cover different localities from this common boundary and from the boundaries of each other’s organisations.

For health and social care services, this organisational arrangement is a reflection of changes that have taken place within the 4 or 5 years preceding the study. For example, during this period, the mental health (foundation) trust (MHT) extended its remit for mental health and other services by adding responsibility for neighbouring authorities; previously its catchment area had been co-terminous with the local authority.

However, mental health services within the Borough appear to have retained an informal local identity within the organisation. While some MHT managers consider that the ‘family atmosphere’ [MHT senior manager] of the trust has changed with its

expansion, they express a sense of residual identity and achievement that has links to the period when it was 'quite a small trust'.

> …I felt that joint working within the trust worked within the trust quite well. Because it was a small trust, everybody knew each other and I think when familiarity it breeds that you want to help people. So if you've got a patient, a difficult patient, and you need them put on a section, you'd ring a social worker and 'Oh, it's you, L…, yeah, I'll be up in an hour.' It's almost because it's such a small trust, it worked well. (MHT middle manager)

Another MHT senior manager links this expression to staff retention.

> Well, people in the Trust tend to come here and stay here. They've got long memories. So, our retention rate's good. Basically, we're, it's quite, loss/vacancy rate's quite low.

In addition, the predecessor organisation to the CCG, The Borough's primary care trust (PCT), also shared the same boundaries with the borough council and the mental health trust prior to expansion; this changed when the CCG started operation in 2013 with the implementation of the Health and Social Care Act 2012. The CCG now covers both the PCT's former remit and a neighbouring locality, which is acknowledged as a significant development by a CCG participant.

> …we have lots of challenges, because obviously we've got two local authorities, two Health and Wellbeing Boards; we've got two very different populations. We've got a young population at the [new] end, and an ageing population at [The Borough] end…

The recent expansion of NHS commissioning provides the CCG with a boundary which does not match the catchment areas of any of the other Borough organisations.

In this way, for health and social care services, the move away from coterminous boundaries is recent when set in the context of the history of joint working in The Borough since the 1990s, which is covered in more detail in the following section.

For mental health and emergency services, co-terminosity has never been a feature for local services in The Borough. Both emergency services organisations have had a much wider remit than the boundary of The Borough since the 1970s and the ambulance service extended its scope further in the mid-2000s. Both organisations

therefore encompass the catchment areas of numerous statutory health and social care agencies. The boundaries of police and ambulance services are not co-terminous with each other.

History of joint working

Health and social care services. A period of over 20 years of integrated adult mental health services in The Borough was adjusted immediately before, and then brought to an end during, the timescale of the fieldwork for this study.

In relation to joint working between these services, a MHT senior manager with over 20 years' experience of working in The Borough recalls that the locality had 'a really good reputation for a long time of being quite progressive.' This track record is confirmed by a CCG commissioner, who picks up and develops the view expressed in the previous section of the joint working environment within The Borough.

> The Borough has an exceptionally 'can do' mentality and you see it in all its organisations…there's a much greater community spirit here….it's got much more of a family atmosphere and a willingness to listen to people's ideas and have a go and test and pilot and learn and make decisions as a result.

A CCG colleague, who participated in the same interview, confirms this view and links this profile with the engagement of The Borough in specific initiatives such as Health Action Zones (HAZs) introduced by the Labour government in the late 1990s. HAZs were designed to act as exemplars of joint working and specific funding was allocated towards this end.

> I think that's right actually and I think that goes quite a long way…that probably goes back to Health Action Zone days and before… there was an awful lot of Health Action Zone money that came into the borough and that required the organisations to work jointly, to work collaboratively to deliver a set of defined outcomes…the Health Action Zone money started to disappear out of the borough…but there was a core of services that we continued to commission jointly with local authority colleagues.

Further the MHT achieved the formal status of a care trust in the early 2000s – again an initiative of the Labour government - which was granted to a small number of health trusts. In the view of a borough council senior manager, prior to this

development, the establishment of community teams comprising nurses and social workers since the early 1990s had been positive as '…there was a clear demarcation in the roles within the [community mental health] team'.

This participant, who was working in mental health services at the time in The Borough, marks the creation of the care trust as the point 'where the issues started going awry' because of the combination of two factors: the transfer of employment of community care staff and the secondment of social workers into the trust – 'that's when the Section 75 agreement came into play' – and a progressive assimilation of social care staff into a health service environment.

> …staff who weren't Approved Social Workers at the time got TUPE'd over into the trust...the Approved Social Workers couldn't be transferred over as well……. because it was the legal rationale…
> So, then I'd say there was a general erosion of social care. They had a restructure and…the way it worked really in the main it was just health managers. So you got mainly where health-led teams and then the roles kind of became more generic. So there wasn't that demarcation…

The process of assimilation was observed also by this participant as occurring in the integrated primary care teams where the workload of staff with a social work background was indistinguishable from nursing colleagues.

> In the primary care liaison teams, staff are mainly doing CBT…staff have left because basically they thought when renewing their registration they wouldn't have the evidence to support their re-approval.

This view is supported by a borough council executive who considers that neglect by the local authority compounded the lack of differentiation in role.

> …certainly what happened here, is that the mental health workers from the local authority…went into the trust and became very health focused and lost a lot of the social care aspects, and the local authority forgot about them largely.

The key area of concern for both borough council participants is the absence perceived by them of 'the outcomes I'd be expecting in terms of social work outputs…' in the practice of community teams within the MHT.

> There was a significant over-reliance on residential care rather than supported living or using community based services, there was very little personalisation that I could see. There was some evidence of direct payments but not one personal budget within mental health services. (Borough council executive)

The borough council executive describes a process that has taken place 'over the last couple of years…which has effectively resulted in our ending our Section 75' and subsequently re-assuming the management of social work staff, initially leaving them co-located in community teams and then a year later re-locating them in borough council premises.

> …we didn't just do it to the trust, because they were basically saying to us, look the management of the social care teams has just got lost and effectively we've got pseudo-nurses within our teams, and what we want is social workers… and the only way that we could see to do it was to reclaim the management structure of mental health services back into the local authority.

In addition, a Section 75 joint mental health commissioning agreement expired in 2014 and was not renewed leading to the separation of commissioning roles between the local authority and the CCG.

The borough council senior manager considers that the movement towards complete separation 'was a gradual decision' influenced by a number of progressive pressures: the new requirement for social workers to use the council's recording system (for which computer terminals were not available in community team bases); training for this new requirement and for new responsibilities such as the Care Act 2014; the decision that 'a lot of our work will be more task-centred' so as to focus upon 'actual social work activity' and cease duties such as 'medication drops', 'care clustering – because it's all medical' and contributing selectively to the crisis and home treatment team workload.

> And what we've said is they won't really participate much in the home treatment side. But obviously in that team the nurses don't do any Tribunal reports.

This senior manager views the concept of recovery as providing a clear sense of purpose to social work activity following the separation and that this concept has not been accepted sufficiently within the MHT.

> Well, for me, social work is about enabling, empowering. The recovery concept actually I think embodies what we should be doing…there are some very good workers in Health that are very recovery-focused. But I think as a whole people are doing things for people rather than with them or giving them the skills to learn.

Mental health and emergency services. A MHT executive considers that joint working between the trust and police has a long history in The Borough which was interrupted as a result of budgetary restraints before being restored more recently.

> …going back to the Reed Report[8] we've always done psychiatric liaison, court diversion services, going back many, many, many years…So on the ground as well as at more senior level we've always had quite strong partnerships with the police and have done joint training with them as well…
> …unfortunately there was such a change in the police organisation… a lot of the people that we'd got these partnerships and working relationships with went overnight.
> …you've got a Chief Constable now…who is … very keen on partnership working and sees the potential of not duplicating things around our common areas…

The executive also recalls that a hospital-based S136 place of safety (HPoS) was developed using capital funding made available by the Department of Health within the previous ten years – 'we were straight on it and we were the first to open in the region.' The HPoS is located at the trust's in-patient service. A CRHTT participant explains its operation:

> In-patient staff will accept the 136 patient when they come in. It's attached to one of the wards… They'll contact us immediately and our staff will go over to take over that assessment if you like. It's not actually 24-hour-staffed, it's just covered by us and inpatients.

The absence and subsequent reappearance of joint working indicated by the MHT executive above appears to be reflected in the perspectives of emergency service participants who have more recent experience in The Borough. An ambulance service middle manager considers that there has been a significant change in the

[8] The 1992 report of a joint Home Office/Department of Health review of services for mentally disordered offenders.

approach of CCG commissioners to joint working and speculates that this may be due to the planning activity of the Concordat.

> …I quickly established which CCG areas were engaging with all partners. And The Borough wasn't one of the areas that was engaging fully with all partners. They'd not engaged fully with the police, not engaged fully with the Fire Service, social services, social housing, ourselves as a partner organisation. But that very quickly changed. And I don't know whether that was because of the Concordat work and they're mandated to involve partners… but regardless, they are engaging now, they are engaging with us a partner…

Similarly, a police middle manager considers that 'everyone has historically been very silo-oriented' in The Borough but attributes change to the influence of the Health and Wellbeing Board that 'is starting to bring that structure together slightly differently'.

> So what you've now got, I think, is that you've now got police, health sitting alongside starting to think about things differently.

A significant outcome of recent joint working has been the creation of a street triage service in The Borough which was generated as a local initiative modelled upon the service in place in a neighbouring area. The police middle manager considers that his own influence was the key element in providing the drive needed.

> If I'm really cheeky…it's me…I'm not taking any praise for it.
> And what I was able to do was from an evidence base, take that [street triage model] to the commissioners to say 'Actually you need to think about doing this [here]' And what we've done is, I've sat down with the commissioners, the local authority, the mental health trusts, to say 'Actually, let's think about this as a cost-effective position to improve the service delivery…

This service shares most of the characteristics of the pilot projects funded by the Department of Health in 2013/14 whereby mental health nurses accompany police officers when they are called to incidents of people experiencing a mental health crisis in community settings. In The Borough, the service is operated by a paramedic, 1 or 2 police officers and a mental health nurse using a vehicle (usually a car) provided by the ambulance service. The Borough was not, however, one of the sites chosen for a pilot project; the funding for the vehicle was provided locally by a

consortium of CCGs (as the service covered a number of localities in addition to The Borough) and staff members were seconded from each of the three services. The service specification defines the primary function of the service as avoiding the admission to acute hospital emergency departments (EDs) of people who experience a mental health crisis (NHS winter pressures funding was used to initiate the service) but also includes an objective to reduce S136 detentions. By the account of participants from the local authority, the CCG, the MHT and the ambulance service, this objective has been achieved at the time of the interviews, which occurred during a period when the service had been operating for 6-8 months. A MHT senior manager who chairs a joint Police/NHS forum meeting was able to quantify this reduction.

> …we've seen a massive decrease in our 136s. We averaged, [last year] probably about eight a month, which doesn't seem that many anyway, but in January we had one.

There are other recent examples of non-mandated joint working between mental health and emergency services in The Borough. A discrete service sited alongside a local ED is in place to provide emergency mental health services for people who would otherwise have attended or been conveyed to the ED. The joint Police/NHS forum involving the police and health and social care staff had been in operation for approximately two years at the time of the study to review specific issues for frontline services that occurred in the previous month, including S136 detentions. Additionally, joint funding was agreed between the MHT trust and the police to improve perimeter security of the in-patient site and so reduce the incidence of hospital inpatients being reported as missing to the police.

Local cultures of joint working

Health and social care services. From the account of recent history in the previous section, joint working between these services can be described as being in a state of re-formation at the time of this study. The previous formal arrangements for integrating both commissioning and service provision have been dismantled and have been replaced by separated structures and processes which are being developed. Specifically, a discrete local management structure for social workers is now in place, made up of a senior operational manager and team managers, who are all located now within local authority premises. Also, the commissioning budget arrangements for individual social care arrangements have been returned to local authority control and are managed by the senior operational manager who chairs a monthly funding panel.

The theme of this section is to suggest that the underlying culture of joint working between statutory health and social care organisations in The Borough is characterised by separate rather than conjoint operation. It appears that, for The Borough, the social care contingent of the integrated community teams came to operate almost without reference to the borough council, apart from the secondment arrangement for social workers, through a process of assimilation, loss of social care leadership and diminished responsibility for resources. These factors are explored more fully below. The new arrangements also reflect this culture by dispensing with the intention to integrate services and, depending on the eventual outcome of the changes, moving to either cooperation or coordination between the separated organisations.

The term ‘progressive assimilation’ was used in the previous section with reference to the position of social care staff in general within the trust following the Section

31/75 agreement in the early 2000s. In the view of the borough council participants, the effect of this process was to remove the distinctiveness of a social work approach or role. This view is confirmed by mental health trust managers at senior and team layers of operation. On the one hand, there appears to exist in The Borough a stream of opinion that favours assimilation. A mental health trust (council) senior manager considers that over time the creation of integrated community teams meant that 'all the walls came down' and led to 'a homogenous group of staff working together and working very well'.

> So I think after years of kind of working out that you know we didn't have clear-cut boundaries anymore and have merged all our roles together, apart from social workers who obviously did Mental Health Act assessments and nurses dealt with medication

A Health and Wellbeing Board participant, with experience of working in mental health services, is dismissive of professional differentiation because it leads to 'professionals protecting their roles' rather than delivering 'a holistic approach to the individual'. This participant considers that 'a fully-integrated team' should be made up ideally of 'generic mental health workers – somebody who is both a nurse and a social worker because many of [a nurse's] duties…were social'.

On the other hand, a number of other trust managers express critical views about the former position of social workers within the trust 'They've just lost their way…' or 'when they sat in our CMHTs, they were glorified nurses…' A MHT team manager recalls his reservation about the trust employing social workers at the outset of the Section 31/75 agreement.

> And I remember having this thing of 'That's wrong. I want them to have that challenge for the consultants, to come from that different background to us…' Because it's then, it's more of a robust system if we're all able to do that. Whereas if we're all in the same boat, and headed by the consultant, to me we'd have lost a lot in that.

One of these managers makes an observation that both confirms the effect of assimilation and indicates the degree to which the borough council and the MHT operate as separate entities.

> …it just seemed that when people sit in local authority, they become then 'local authority'. Whereas when they come over to the trust, they then become 'trust'. (Mental health trust middle manager)

Alongside the development of 'a homogenous group of staff', a number of participants from both the MHT and the local authority note that supporting structures for social care diminished or disappeared over time. As mentioned above, through internal trust reorganisation shortly after the Section 31/75 agreement came into force, the salary grading of a trust team manager post was changed which acted as a disincentive for potential applicants from a borough council background.

> One or two social workers might have applied for the posts but actually they'd have been worse off in terms of terms and conditions. (Borough council senior manager)

Also, initially a principal social worker (PSW) post was placed within each community team. However, the local authority senior manager considers that the postholders became often interchangeable with team managers and '….were running the team because of long-term sickness or whatever…' Also, as a MHT senior manager recalls, the number of these posts reduced 'as people left, they weren't replaced over time'.

In addition, over time, key professional social care leadership roles –a Director of Social Care and a lead Approved Mental Health Professional (AMHP) - lapsed following the retirement of postholders. A MHT senior manager considers that their absence is significant in both joint working areas in that a social work perspective at senior level and support for links with other agencies such as the police was diminished.

> …[Director of Social Care] was sort of our guru…he was a social worker by background but was within the Trust now. And he retired and that string of presence

was never as strong again since. Each of the local teams always had a PSW still, but there was never that professional line throughout the organisation after he went.

Historically, we used to joint-train with the Police and Health staff with 136, but we don't do that anymore.
Why the change?
It was the lead AMHP that used to work here; he retired...and when he went nobody had really got the time or the inclination to provide this teaching…

Lastly, the commissioning budgets for care arrangements for individual service users were pooled by the Primary Care Trust and the borough council and devolved to the MHT. Two MHT participants claim that care was taken to contain expenditure within the pooled budget. It appears that as long as the budgets were not overspent, the scrutiny of expenditure was minimal. A borough council executive, who moved to the Borough to take up post in the latter stages of the integrated arrangements, considers that the respective agencies' funding responsibilities had become unclear and, indeed, were considered unimportant.

I was quite used [at the place of previous employment] to going into a war zone with the CCG on funding arrangements… And when I came to The Borough it was all very amicable and we'd go, well is this person CHC [Continuing Health Care] or not? …And what I'd found was that, for whatever reason, everything was being consumed within a pool budget but never based out, so we had no idea who was paying for what. And we had to say, well hold on a bit, this needs rebasing out. And that was the major concern and why we had to sort out where we were with things like CHC and Section 117 and work very closely with the CCG.

This participant suggests that this was an additional indication of neglect by the borough council of its responsibility for mandated joint working.

And although we have mandated responsibilities, certainly around the Mental Health Act and other aspects of it, it became almost secondary and let the trusts deal with it all.

A discussion focused upon the new (borough council) arrangements for adult mental health social care funding panel for services was arranged with the chairperson of the funding panel, a borough council senior manager. During this discussion, the chairperson confirms that 'there was very little applications for joint funding' during the integration period and that early work of the new panel has sought to establish a

general distinction between the funding for healthcare and social care responsibilities which appears to have absent formerly.

> …a lot of the care packages would have clearly have been, or should have been, funded at that stage by…well not out of social care budget. An example of that…[a recent funding application] was turned down…because it was clearly a request for someone to go in twice a day to administer medication which was quite clear 'Well, that would be health rather than a social care need'. And the Trust kind of contested that…
> But in the meantime because I'd directed them 'You need to apply within CCG'. The CCG said 'Ooh, we've never been asked to do this before.' Which basically explains the Trust used to just sign it off. [laughs] And they funded it. Set a precedent!

In relation to the funding of S117 Aftercare, the chairperson is developing an approach with the CCG that '…now anyone subject to 117, it's automatically a 50:50 split' which will need some refinement as 'that seems a bit simplistic to me'.

A MHT executive considers that the reduction of borough council budgets during the coalition government was a primary factor in bringing the culture of neglect to an end and with it a combined or integrated vision of mental health services.

> I mean my opinion is it's absolutely been driven by money, the loss of it if you like, absolutely driven by trying to manage resources.
> ….we inherited, when we became a care trust…an enabling service, for want of a better description, and about 15% of those clients were with severe and long enduring mental health issues…it was a drop-in facility, it was somewhere to meet people, it was somewhere to get help and support….so it would be holidays, it was taste, libraries, horticulture…they would give them tasters and get them out of the system and into some purposeful occupation. That all went. The local authority cut all those, they all disappeared.
> So what those joint units did for me was see a pathway, see the beginning and end of someone's journey through a system and out, not needing anything. And that was the loss I think. Nobody really saw that anymore. They only saw bits, their bits of the world.

In summary, the trust and the borough council appear to have operated in isolation while integrated teams were in place and have continued to operate separately, albeit in a different form, following their dismantlement.

Mental health and emergency services. It seems less easy to gain a sense of the culture of joint working between mental health and emergency services. This may be partly a result of the contrast between the significant changes have occurred locally

and recently in the Borough for the health and social care elements of mental health services and the relative organisational consistency of the emergency services. The catchment area of the police services organisation has remained largely unchanged since the 1970s and the ambulance service has been in its current form for much of the last decade. This section suggests, however, that the local culture in The Borough enables discrete, and often innovative, integration or pooling of resources at the frontline while the organisations at the executive and senior manager layer of operation preserve separated positions as their default position.

Some cultural indications have been given in previous sections. The 'family atmosphere' of The Borough may be a contributory factor in the generation of the distinctive initiatives referred to above – the specialised service alongside the ED and the joint funding of enhanced perimeter security for the trust's in-patient site. The former is described by an ambulance service participant as 'effectively…a mental health emergency department…and they're the only one [mental health service] currently that does that…' Further this participant considers that the service was commissioned through the effort of a particular individual manager.

> …a really good dynamic manager that decided actually that she was tired of seeing…breaches in excess of 12 hours for people in crisis or with mental illness and they wait in their departments for hours and hours and hours and it was a risk to her.

The MHT participant who highlights the perimeter security initiative also gives other examples of frontline cooperation to address difficult behaviour within the in-patient service and of informal information-sharing.

> …we've got a beat bobby for this hospital. If a patient starts playing up and we think 'Hmmm, we can't get him arrested', [she] comes and has a word with 'em. 'Listen, this can't happen here.' And they issue fixed penalties here for breaking windows and stuff. And I think, working with the police as well, when we get people in now, we've got a contact… I'd ring [the contact] and say 'I've got this patient in, I'm worried, is there any danger to the staff?' and she'd get all his profile up and go 'Right, it's just minor stuff. No, there's nothing to say he's aggressive'

Informal information-sharing appears to work also to the benefit of the police through the 'beat bobby'. A police officer considers that this link enabled the engagement of mental health professionals to address an intractable neighbourhood issue involving a person with apparent mental health problems.

> And the only reason it ever got dealt with is because I've got an officer, we've got the mental hospital, on our beat, so we've got a good working relationship with them. So an officer went down and said 'I want you to do something for me'. So we managed to get a doctor and a team to go out to see [the patient]…

A meeting of the police/NHS forum, mentioned above, was observed as part of the fieldwork. The chairperson described the nature of the forum as informal; this description was borne out by the explicit format of the meeting in that there was no agenda produced or reference made to notes of previous meetings. However, the meeting was held regularly on a monthly basis and the issues for discussion were clearly understood by the membership of the meeting as detailed data collection for each issue, including the use of S136, was submitted.

Another strong influence upon the culture of joint working in The Borough may derive from its organisational configuration and, more specifically, the need for the emergency services to resolve the difficulty of forging effective links across a range of localities. The ambulance service has a single manager who provides a lead for mental health issues who considers that, while engagement in localities has to be scheduled carefully, the breadth of the ambulance service remit can enable a useful contribution to locality planning.

> …we're such a vast organisation, there's one of me, for the whole of the region…I will only attend a 136 meeting once a quarter, for each area…
> Which is interesting because…, as an ambulance service, it makes us experts in what they're trying to do because we've listened to it already around the rest of the counties…

A police service executive considers that the variation of local patterns of service is a considerable challenge.

> So, we have [several] local authorities to deal with. And each of them wants to do things in a slightly different way which then makes that quite difficult in policy terms…

The favoured approach of the police service for dealing with this challenge is 'to think about a [police service] piece and if I can try and get everything to operate in the same way across all [local authority areas], then that's better' [police service executive]. As indicated above, the introduction of the street triage service in The Borough reflects this approach.

For emergency services, other more recent influences such as 'austerity' and the Mental Health Crisis Care Concordat (Concordat) are of assistance in promoting standard joint working practice in localities. Indeed, it may be significant that neither of these factors received more than passing reference by mental health service participants. Police participants regard 'austerity' as

> …an opportunity...because people don't have the same capacity within their organisations to do things differently anymore. And, actually, because there is less resource in an organisation, they're more willing to accept an answer…rather than necessarily come up with their own version…people are going 'D'you know what, yeah, OK, give it us like that, we'll make that fit'. So that is actually really positive, really helpful. [Police service executive]

For both ambulance service and police participants, the Concordat provided 'a bit of a turning point….we've been mandated to work together as partnership organisations'. Specifically, the Concordat is viewed by a police middle manager as promoting a holistic view of 'the individual who is in front of us' and gives a hypothetical example of how standard processes such as S136 detention can be avoided.

> 'a student…who's had a bust-up with her boyfriend…having had half a bottle of wine…saying 'I'm going to kill myself'.
> Is that right and proper? Or does our process now enable us to have a conversation with her to say 'Actually we don't necessarily need to 136 you, we can take you home to family and provide adequate support and put relevant safeguards in around you.'
> And the Concordat piece has been really helpful to try and drive that through.

Mechanisms and outcomes

1. Health and social care services (H&SC)

Policy and Procedures layer – Section 117 (S117 Aftercare)

In common with The Shire, there appears to be no local policy for delayed transfers of care (DTOC) in mental health services. The findings presented here are therefore confined to a Mental Health Act (MHA) Procedure document for Section 117 Aftercare. This document is provided by a local authority senior manager as the S117 Aftercare policy statement which had been in use during the period when integrated commissioning and community teams were in place in the mental health trust. Due to lapse of both of the Section 75 commissioning and service provider agreements, the procedure was obsolete at the time of this study. The senior manager, a participant in the fieldwork, confirms that the document will be renewed 'in line with the Care Act, making it a bit more of a robust procedure than what it was'.

Mechanisms

The procedure carries the logo of the MHT and, in the (paper) format provided, is undated. The procedure is numbered and is therefore likely to have formed part of a series of MHA-related documents. An appendix makes reference to a Healthcare Sector Briefing[9] issued by the Department of Health in 2010. Reference is made in the procedure to the CCGs that operate within the organisational boundaries of the MHT but makes no mention of the Care Act 2014. This indicates that the procedure was compiled or updated in the period between the introduction of CCGs in 2013 and of the Care Act in 2015.

The procedure's contents covers 5 pages and the appendix a further 2 pages. The substantive content is arranged across 10 numbered paragraphs which, with the

[9] Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care Services, England', 30.3.10

exception of the first paragraph, provide operational guidance on the following issues: responsibility (of the relevant agencies for Aftercare services); implementation; CPA status; nature of services; duration (of Section 117 Aftercare responsibility); refusal of services (by a person entitled to Aftercare); discharge; residence and the responsible authority (for purchasing and/or providing Aftercare services); charging (for Aftercare services).

The first paragraph cites, from the MHA, the joint duty of healthcare and social care commissioners in relation to aftercare services – the formal mechanism of *shared purpose*.

The 'Responsibility for the purposes of sec 117' paragraph confirms where this duty is placed for the commissioning agencies across the localities where the trust provides mental health services. The procedure lays out an exceptional arrangement for The Borough whereby the MHT exercises the S117 Aftercare duties of the local social services authority (LSSA) – that is to say, the borough council - and the 'delegated responsibility' of the CCG for people up to the age of 65 [years of age]'. The LSSA duty is held by the borough council for 'people over 65 [years of age]'. This dividing line between the S117 Aftercare duties of the CCG (held by the trust) and of the local authority is replicated across the other areas of the trust's operation for people of all ages.

Essentially, this paragraph defines the mechanism of *pooled resources*.

The remaining paragraphs provide more specific procedural guidance as indicated above. Joint working best practice, where it is made explicit in the paragraphs designated below, is phrased in permissive terms with the use of the term 'should'.

> The after-care plan should normally be agreed at a multi-disciplinary CPA planning meeting… [Implementation]

> Any decision to formally discharge from Section 117 should be confirmed at a multi-disciplinary review. [Discharge]
>
> Any discharge should be confirmed in writing by a senior officer of both the MH Trust and the Local Authority [Discharge]

This permissive tone is also applied to the issue of residence and the circumstances where a service user's place of residence may change and thereby determine which organisations are responsible for S117 Aftercare duties. With addition of an appendix, this issue has the most detail devoted to it in the procedure.

These provisions represent the mechanism of *coordination*.

Mandatory best practice, designated by the use of the term 'must' or 'will', is applied to individual or general duties – to identify a care coordinator [Implementation paragraph] or to 'be on CPA' [CPA status paragraph].

The specific funding arrangements for S117 Aftercare do not form part of the procedure for the differing settings or arrangements of S117 responsibility. Brief references to financial issues are made in the 'Charging' paragraph. S117 Aftercare 'must be provided free of charge…this includes prescription costs…' Also 'Continuing Healthcare' [which places a financial responsibility upon CCGs for care that meets an assessed primary health need] is considered 'irrelevant' for S117 Aftercare 'but that does not take away the responsibility of the CCG to provide healthcare if the person is eligible' The document ends with this statement; it does not include details of how healthcare eligibility is determined.

These provisions promote a mechanism of the *efficient use of resources*.

The procedure is concerned principally with elements of the care planning process and there is no direct reference to the outcomes of that process, other than the direct citation from the MHA that S117 Aftercare should remain in place 'until such time…that the person concerned is no longer in need of such [aftercare] services'.

The brevity and content of the document suggests that its intention is to trace the broad requirements of care planning and to indicate where joint working is needed, in discretionary terms. For adult mental health services in The Borough, this discretionary emphasis is congruent with the mental health trust acting as the community care budget holder for both healthcare and social care commissioners without a requirement to account separately for individual items of expenditure.

Outcomes

While the procedure is concerned principally with the features of the S117 Aftercare care planning process, a number of explicit intended outcomes of the process are presented. The introductory paragraphs include a direct citation from the MHA that S117 Aftercare should remain in place 'until such time…that the person concerned is no longer in need of such [aftercare] services'. The implementation section includes requirements for the pre-discharge timing of care planning and that the quality of care planning should be equal 'to those drawn up for patients without the eligibility [for S117 Aftercare]'.

In general, the document is characterised by its brevity, permissive tone and the absence of detailed guidance, with the exception of the issue of residence, for complex issues such as the interaction of S117 Aftercare and Continuing Healthcare. Accordingly, it seems reasonable to suggest that the intended outcome for this procedure is to minimise its impact upon the devolved budgetary responsibilities of the mental health trust.

<u>Senior manager/leader layer</u>

As shown in Figure 16 below, the 9 participants interviewed are split between commissioning and organisational leadership and senior manager functions. The commissioner participants have been employed in The Borough for 2 years or less,

with the exception of a CCG participant (over 15 years' employment). The organisational leaders and managers have each been employed in The Borough for over 20 years. Data are drawn from these interviews and from a recorded discussion with the chairperson of the social care funding panel (as an observation could not be arranged within the timescale of the project).

Figure 16 - Borough H&SC senior manager and leader participants

Commissioners	Organisation leaders and senior managers
• Clinical Commissioning Group (2) • Health and Wellbeing Board (1) • County council (1*)	• Mental health trust (4 – executive, 2 senior managers, 1 middle manager) • Borough Council (2 – executive*, senior manager and professional lead,)

*Combined role held by a single participant

Mechanisms

The interviews were conducted, with two exceptions, over a period of 2 months. At that time, the first change in management arrangements (resumption of management responsibility by the borough council and continued co-location of social workers in community team premises) had been in place for some 2 to 3 months. One interview was delayed by the individual circumstances of the participant and took place after an interval of two months. Another interview was conducted with the borough council senior manager just after the second change (re-location of social workers in local authority premises) had occurred about 8 months later. This participant had been interviewed earlier.

The theme of this section is that, during the period of integration, the mandated nature of Section 117 Aftercare in relation to joint working between health and social care services was rendered irrelevant by the mechanisms of encapsulated pooling of resources. Since the integration arrangements ended, these mechanisms have been

replaced by systems that place emphasis upon difference. The circumstances surrounding the data collection for delayed transfers of care appear to differ from those in The Shire. Consequently, it is covered as an individual issue at the end of this section.

Encapsulated pooling of resources

Some of the contextual features laid out in the cultures of joint working section above could also be viewed as the mechanisms for joint working in The Borough – the progressive lack of differentiation between the roles of social workers and healthcare professionals and the absorption of healthcare and social care funding for individual care arrangements into what appears to have been in effect a single cost centre/budget heading. These are both examples of pooling resources in such a manner that their differences are minimised or ignored.

Additionally, the lack of distinction shown by both healthcare and social care commissioners to the provenance of the needs of individuals for community-based healthcare and social care was alluded to above in the perceived absence of 'a war zone' over funding. This perception is supported by a MHT participant with previous experience of the community care funding panel, who recalls that funding for S117 Aftercare was not a challenge for joint working.

> Did things like 117 come up as a problem…?.
> No. Because we were allocating the money…So it was very much if a patient needs a placement…then we'll pay for it. (MHT middle manager)

A borough council senior manager considers that a lack of rigour in establishing health or social care needs was evident in the allocation of funding and was reinforced by the obligation conferred by S117 Aftercare to address assessed needs for aftercare.

> But what I've seen is I think it was taken as an assumption if somebody was entitled to 117 they'd get the funding paid for, but some of the thing should have been funded by CHC, it wouldn't have come within the local authority's responsibility to pay. It just

> appeared to be translated because someone from the Trust who was chairing or part of the Panel was going, 'But the 117, you've got to approve it'.

It seems reasonable to suggest that these three mechanisms collectively represent a 'soup' model of integration, referred to in Chapter 3, which served to remove potential professional or organisational points of conflict or tension within the Borough's mental health services.

Further, the view of a borough council authority executive that the council 'forgot' (see above) about social workers who were seconded to the trust suggests that a potential method of assurance was disabled. This perception is shared by a MHT senior manager.

> I think the local authority forgot that they'd got social workers out here as well, so that's how it feels. But I think they were considered as being part of our Trust and, 'Off you go and you do what you need to do,' but certainly very generic practitioners down here.

The borough council executive considers also that as a result of the widespread move of borough council staff into mental health trusts in England in the early 2000s 'there aren't many of us left at a senior management level with background or experience of mental health services' which suggests that a sense of separation and distance between the borough council and the trust persisted until his move to The Borough.

> I grew up through mental health services…talking to the [trust's] chief executive and the directions of operations and whatever, I guess it really helped that they could see that I'd got a background…

It seems that The Borough's model of pooled resources nullified the issues which mandated joint working in general, and Section 117 Aftercare in particular, is designed to address by removing the differences between professions and organisations (pooling resources) and effectively by obscuring the responsibilities of commissioning agencies (encapsulating the processes within the trust).

Delayed transfers of care (DTOCs)

Delayed transfers of care (DTOCs) in adult mental health services are not regarded by participants as having been matters of concern during the integration period. Therefore it has not been possible to identify relevant DTOC mechanisms prior to the changes. Adult mental health DTOCs continue currently to have a low profile both for the local authority or the CCG following the lapse of integrated arrangements. The borough council executive perceives that the main factor for this is a limited requirement for expensive forms of care.

> We have very few DTOCs associated with social care to do with mental health...generally speaking in mental health, people go home rather than anywhere else.

A CCG participant confirms the lack of concern for adult mental health DTOCs but speculates that this may be because of being overshadowed.

> Mental health delayed transfers of care very, very rarely come up…And that may be because all of the oversight and pressure, political or not, is on your main Acute provision rather than on Mental Health.

A MHT senior manager confirms that DTOCs do occur, usually due to the lack of available supported accommodation and they are reviewed at 'a weekly bed management meeting with the ward managers here'. The borough council senior manager has arranged that a PSW attends this meeting to ensure effective communication of any concerns, which in her experience are rare.

> …they have a meeting, a weekly meeting… one of our principal social workers, from mental health side, she attends. And…the hospital service manager will contact us to let us know if there's any cases there that we should be aware of. In fairness, from that end, there hasn't been many issues at all.

Further, consideration is being given to recruiting a local authority staff member with designated responsibility for 'the [hospital] discharge process…so that we can kind of prevent any unnecessary delays'.

These current and planned arrangements make up a mechanism for channelling communication and decision-making.

The lack of organisational boundaries between the resources of health and social care services suggests that the intended outcome was, in the words of HWB Chair, ‘a holistic approach to the individual’. However, the lack of attention to professional differentiation between health and social care, both in staffing and financial terms, and isolation from the borough council, seem to have led to a uniform rather than multi-disciplinary approach to the needs of service users.

Outcomes

The absence of professional and organisational boundaries between the resources of health and social care services and a clear sense of separation and distance between the borough council and the trust, as a result of which ‘all the walls came down’ (p177), suggest that the intended outcome of encapsulated pooling of resources was, in the words of the HWB Chair, ‘a holistic approach to the individual’ (p177).

Indeed, it appears that the actual and experienced outcome reflected the vision of ‘holistic care’ proposed by the HWB Chair whereby a lack of importance was attached to professional differentiation between health and social care. This in turn seems to have led to a singular rather than multi-disciplinary approach to the needs of service users with staff in community teams thinking the same way rather than providing a variety of perspectives.

Additionally, it seems that a further experienced outcome of organisational separation and professional assimilation was that potentially useful or creative tensions between participating agencies and professional staff were diminished.

Finally, it seems that these outcomes of the Borough's model of pooled resources effectively nullified the purpose and impact of mandated joint working in general, and Section 117 Aftercare in particular. In removing the differences between professions and organisations and obscuring the responsibilities of commissioning agencies, the sharpness of focus upon the needs of service users appears to have been blunted by organisational needs.

Team and frontline staff layer

As shown in Figure 17 below, of the 4 participants interviewed, 1 is drawn from a Trust community team, 2 from borough council mental health staff and I from an advocacy service. The participants have been employed in The Borough for, respectively, over 10 years, over 5 years (both staff members) and over 2 years. Findings presented here are drawn from these interviews. An observation of a ward review meeting at The Borough's in-patient service took place but did not produce data of use to this study.

Figure 17 – Borough H&SC team and front-line participants

Trust community team	Borough Council staff	'Other' services
• Deputy Team Manager and nurse (1)	• Principal social worker (1) • Social worker (1)	• Advocacy service: 1 team member

Mechanisms

Three of the interviews were conducted over a period of 2 months; at that time, the first change in management arrangements had been in place for some 9 months. The second change took place 1 or 2 months later; the interview with the trust community team participant took place just after this change had occurred. As for the senior manager and leader layer, the data from these interviews focuses upon the period of the integrated service.

As in the previous section, the operation of S117 Aftercare is the primary focus of the mechanisms presented here. A similar theme is suggested – that mandated joint working becomes a superfluous concept at this layer of operation as a result of mechanisms of assimilation, each of which have been replaced by mechanisms which promote distinctiveness. Delayed transfers of care (DTOCs) were not recognised as significant examples of mandated joint working – data which support this conclusion are set out below.

Three mechanisms appear together to have ignored key differences between social workers and healthcare colleagues within community teams – a common sense of purpose, role blurring and leadership –represented by developments such as care clustering and the Care Act 2014 and, ironically, promoted the separation that has ensued.

Erroneous sense of purpose.

A mistaken common assumption about the purpose of S117 Aftercare - that it is a social care or social work responsibility - appears to have been accepted at this layer of operation. An advocate views S117 Aftercare as conferring an obligation principally upon social workers.

> Do you feel that makes any difference at all having that Section in place, Section 117? Yeah, I mean, it kind of, it does mean that social care have to do what they're kind of meant to do

Further the advocate perceives that this obligation can be accepted by healthcare professionals as singular rather than joint.

> Because I just think sometimes Health like 'Well it's 117 now, you know, social care…'thinking particularly of one where it was almost like kind of 'It's your job now'. Like a thing of 'We've done our bit.' It doesn't always feel like a very joined-up process sometimes, you know.

The principal social worker (PSW) confirms that funding for S117 Aftercare could be coded as a social care cost irrespective of the nature of the service and that this

assumption went unchallenged at the funding panel, despite the presence of a healthcare commissioner.

> …we discovered, which apparently we shouldn't have been, was that 117 panel was funding things like medication drops and a lot of medication monitoring. Well, apparently, we weren't supposed to be, that was the CCG and they hadn't argued about it, they'd accepted that but it's their responsibility.

This participant uses the term 'agenda' to illustrate how the previous common sense of purpose for community teams in general has undergone 'a huge transition' from 'multi-disciplinary working' to 'joint working' since the resumption of borough council management for social workers. A practical example of this change can be seen in the nature of care plans.

> …the agenda of the [community] team is quite different to that of the local authority. So there's conflict consistently… So the big issue at the moment is care plans. So the local authority want a care plan to look one way, the Trust want it to look another. The Trust is very clinical-led…I'm not bothered about clusters – they're meaningless to me and to social workers….the stuff in the Care Act about breaking down costs in care plans, I think that's excellent…

The participant recognises that 'social workers weren't necessarily doing social work and that did need to change' and considers that the management change has marked a shift from common purpose to separate tasks.

> …multi-disciplinary working is, you're in the team with lots of different professionals,…You've got the same agenda but it should be that you've got different roles… Joint working is…it's a task isn't it really…this needs doing, the different agencies will go out, will go at it separately as opposed to multi-disciplinary.

Role blurring.

It seems clear that roles within the greater part of the workload of community teams became interchangeable between healthcare and social care professionals to the degree that a uni-disciplinary service was the norm. The trust community team participant gives a positive account of this style of teamworking which was combined apart from specific duties related to the Mental Health Act or medication.

> It did work well… We all became more generic workers, and if there was something to do with, the big one for us is it was always a joke, 'Do they need sectioning 'til we can

> come around? Or do they need something with meds 'til you can come around?' And everything else in between, we muddled through and did it all together in that way.

The social worker (interviewed in the period before social workers were re-located), while taking the view that working within the community team was ‘really good and close’, considers with approval that the management change is restoring the distinctiveness of the social worker role which had become overshadowed.

> I'm taking my identity back as a social worker. Because I think that over the years, this has got eroded.
> …we're not really clear what our roles are…you've got the fact that the doctors keep asking us 'What medication is this person on?' 'Do you feel an increase in meds'd be okay?' I'm a social worker, not a clinician.
> So I think it's good that we're pulling back and becoming social workers again rather than being pulled into that condition role as they were trying to do.

Leadership erosion.

The leadership of community teams before the recent changes provides a further example of (unintentional) assimilation which appears to have disabled the original intention to place a clear social work management presence in each community team. The PSW confirms the view of the local authority senior manager that the post developed by default into shared team management up to and during the period of management change.

> …it wasn’t deputy managing. It was sort of shared management. The team managers and I…when I wasn’t around, she’d manage the social workers. She was off long-term sick for 12 months, I managed the nurses as well as the social workers.

Additionally, as also mentioned above, the number of posts diminished over time as they were not replaced when postholders left.

Delayed transfers of care (DTOCs)

The trust community team participant and the advocate both confirm that ‘delayed discharges’ are a concern but that this does not take on a mandatory form. The former reports that in-patient managers follow up discharge planning with community teams.

> the hospital matrons and the managers will be looking to team leaders to say 'I need some feedback on this person.', 'What's happening with this?', 'When's your expected discharge date?'

The advocate also considers that disagreements over funding cause ‘a big chunk of waiting when they’ve finished their treatment programme and they’re ready to look at look at accommodation to move on’.

However neither of the borough council participants claims to have had experience of being mandated to address this issue. The PSW claims that ‘…delayed discharges…it’s not on the agenda’. The social worker has a similar account.

> I haven't heard of a case where someone's been stuck in hospital for, shall we say an excessive amount of time due to just funding or whatever.

Outcomes

The key common experienced outcome of the mechanisms which shaped the implementation of S117 Aftercare appears to have been assimilation of community-based staff within their teams at this layer of operation. Striking features of this assimilation are the degree to which it had become accepted within teams by social workers and by their management and the relative ease of subsequent acceptance of its replacement.

Assimilation also can be suggested to have had the impact (outcome) of making Section 117 Aftercare superfluous, mirroring and reinforcing the impact at the senior manager and leader layer.

2. Mental health and emergency services (MH&E)

Policy and Procedures layer – Section 136

Findings for this layer of operation derive from analysis of two documents: a multi-agency protocol for the use of Section 136 places of safety (S136 protocol); a Mental Health Act conveyance policy and procedure (conveyance policy).

Mechanisms

S136 protocol

The cover of the S136 protocol carries the logos of the police service and the 'NHS' which explicitly refers to the MHT (in large font) and the ambulance service (in smaller font), is designated as the final version and dated in March 2013. The document covers the catchment area of the MHT, therefore wider than the Borough.

The protocol has 36 pages of substantive content and 20 pages of appendices. The substantive content is arranged across 20 headed and un-numbered paragraphs which can be divided into 3 categories. *Common provisions* (which apply to all signatory agencies) are laid out in the first 5 paragraphs. *Procedural guidance* is provided in the following 14 paragraphs. The final paragraph covers *monitoring* arrangements of the procedures.

The *common provisions* category includes: a brief introduction which defines the purpose of the protocol – '[to] support the provision of multi-agency services to individuals who are likely to be patients under (S135/6) of the Mental Health Act'; an 'executive summary of intentions'; glossary of abbreviations; equality impact assessment; 'oversight'. The oversight paragraph presents a number of mandatory duties – that the signatory agencies have a joint responsibility towards detainees, that commissioners 'will' provide 'sufficient' places of safety, that each agency 'will' nominate an individual to carry responsibility for strategic and overall operational management and that 'problem solving…will be managed in a regular and minuted forum [with] attendance by key staff including the designated NHS Manager and police inspector'. (This is the meeting that was observed and referred to above.) These provisions embody the mechanisms of a *sense of shared purpose*.

The *procedural guidance* category covers the chronological stages of the detention process frequently annotated with PACE[10] and MHACOP[11] references - initial action, conveyance, placement in, or transfer to, the appropriate places of safety, the needs of 'specialist groups' (such as people with a learning disability or children and adolescents) and guidance on specific issues (for example, assessments in private premises, the handling of criminal offences and monitoring Section 136 incidence). Detailed timescales are provided also for the management of delayed assessments and a person who '…absents themselves from detention…' While much of the protocol provides direction as opposed to instruction, the responsibilities of front-line police officers, ambulance staff and Approved Mental Health Professionals are mandated in specific circumstances (for example, requesting an ambulance or addressing physical health issues).

The 10 appendices include flowcharts to assist in identifying the appropriate place of safety and in undertaking risk assessments, formats for conveyance authorisation and for informing detainees of their legal entitlements.

The distinctive feature of this protocol is its attention to detail both in the coverage of the formal processes of Section 136 detention, communication between the staffs of mental health (for example doctors and AMHPs) and emergency services and in the practical guidance offered to address issues which may arise. These paragraphs and the appendices support explicit mechanisms of *successful communication and efficient use of resources*.

Conveyance policy

This document carries the logo of the ambulance trust. The document's implementation date is 2013, with a review set for the following year. A 'change

[10] Police and Criminal Evidence Act 1984
[11] Mental Health Act Code of Practice 2008

history' table confirms agreement to the policy and procedure by 'ALL partner agencies' [emphasis in document] which are specified as 'mental health trusts, police forces, local authorities'. The policy's geographical remit is defined as 'the region of the…Ambulance Service Trust'. The policy indicates the circumstances where conveyance by the ambulance service will be required and the substantive content covers each of these. Only one is relevant to this study - 'taking patients to and from places of safety' and the analysis is confined to this circumstance.

The document has a substantive content covering 16 pages with a further 8 pages of appendices. The substantive content is divided into 23 paragraphs of which 5 are excluded as they are either applied to detention provisions other than S136 or to ambulance service governance processes such as policy review. As with other documents, this content can be divided into categories: *common provisions* which apply to all signatory agencies; *procedural guidance* for joint working.

The 8 appendices include a number of formats, of which 7 are relevant to S136: risk assessment; conveyance request; identification of appropriate place of safety; conveyance authorisation.

Common provisions applicable to S136 are spread across the first 9 paragraphs and include the policy's purpose – 'to provide all staff involved in the delivery of care to mental health patients with the necessary information to ensure that the care of patient subject to conveyance is delivered in line with current legislation and other guidance.' Other common responsibilities for each 'partner organisation' are to provide training, for policy compliance and to monitor its 'efficacy '. As with the other policy or procedure documents, these provisions represent a mechanism of a *sense of shared purpose.*

Procedural guidance which has a bearing upon joint working take up much of the remainder of the policy and include detailed processes for requesting conveyance (a risk assessment decision tool, a grading matrix - S136 is set at the highest priority – and a checklist). Completion of the decision tool is a mandatory task while the grading matrix and checklist 'should' be used. Also the decision tool specifies response times by the ambulance service to requests in accordance with the risk assessment. Other guidance covers the responsibilities of primary care trusts and the police service. For the latter, the use of a flowchart and matrix to establish the need for medical treatment of people detained through S136 is mandatory. Lastly, a paragraph provides permissive guidance on the circumstances in which either ambulance staff or police officers may use 'reasonable force' or request assistance to do so.

The distinctive features of the procedural guidance provisions are an emphasis upon organisational responsibility and the detailed processes for communication and coordination between the ambulance and police services which support mechanisms of *shared responsibility, effective communication and coordination.*

Outcomes

Intended outcomes of the S136 protocol are laid out explicitly in the 'executive summary of intentions' paragraph. Specific practical outcomes are defined, including efficient, effective and 'dignified' processes of assessment and conveyance to and use of designated places of safety. Broader joint working outcomes also are allocated – the multi-agency responsibility for 'oversight of Place of Safety arrangements' and 'to work across organisational boundaries' for the implementation of the protocol.

‘Dignity and privacy’ of patients are identified explicitly as the ‘underlying aim’ of the conveyance policy ‘and its associated procedures’. This ‘aim’ therefore can be interpreted as the policy’s primary outcome. The policy also includes a specific outcome in relation to the ‘accountabilities of partner organisations’ – expectation of employees of compliance with the policy.

Indeed this intended outcome of compliance can be suggested as the common theme of both documents as they each place detailed emphasis upon organisational and professional responsibilities and clear communication processes. A hermeneutic perspective of this outcome suggests that it has an origin or resonance with the ‘command and control’ nature of the management of both emergency services (see p72).

Senior manager/leader layer

As shown in Figure 18 below, data are drawn principally from interviews with 3 participants from the emergency services and 6 from the mental health sector. The mental health services participants are made up of commissioning managers and mental health trust leaders and senior managers. The functions of some of these participants are applied to both joint working groups and therefore are included here and indicated with an asterisk in the table below. Data are also drawn from the observation of a meeting of the joint police/NHS group.

Figure 18 – Borough MH&E senior manager and leader participants

Mental health services	Emergency services
• Clinical Commissioning Group (2* - interviewed together) • Local authority commissioning (1*), mental health trust (3 – executive*, senior manager, middle manager*)	• Police (2 - executive, mental health lead) • Ambulance services (1 - mental health lead)

Mechanisms

At the time of the interviews and observation, the street triage service was viewed by all participants at this layer of operation as the primary method of addressing the circumstances in which S136 detention could be used. The street triage service had been in place for only 6 to 8 months. The focus of senior managers and leaders during the interviews is directed by them principally towards the establishment of the service. This is reflected in the mechanisms identified here.

The theme of this section is that S136 use of police powers is intended to be addressed by senior managers and leaders in The Borough as an aspect of whole system planning for mental health crisis care; by doing so, the mandated nature of the S136 provision is placed in a wider context and is intended to be minimised by the use of preventative activity.

Setting S136 in a wider context

The service specification for the street triage service provides a number of indicators that the exercise of S136 police powers is viewed as a relatively minor part of a bigger set of issues. First, the service that is specified is entitled 'Mental Health Crisis Car'. Secondly, the aim of the service is to encompass mental health emergencies in general.

> The Mental Health Crisis Car will be funded to provide a service to those who have called 999 or 111 in respect of a mental health issue. The care will be operationally led by [the police service] and will have Paramedic and CPN staff support to meet the needs of people who have a mental health issue that is suitable for this response as a result of call triage. (Extract from service specification)

Thirdly, an 'indirect' aim of the service is to 'demonstrate compliance with the aims of the mental health concordat'. Fourthly, the remit of the service includes both the S136 power 'to detain people…in a public place' and scope to 'see people in their own homes or other private dwellings…' Lastly, the service 'will lead to more timely

intervention by mental health professionals and avoid unnecessary detention either in a police station or hospital'.

Participants from both of the emergency services confirm that their engagement with S136 is a limited part of their activities. An ambulance service participant views the involvement of his service as being confined solely to transportation – which he sees as an inefficient use of resources.

> …we don't really do much under a 136 as an ambulance service. We just provide a pair of monkeys [laughing] in a £500,000 a year ambulance and get them to go and pick somebody up and put them in the back and take them to a treatment centre and that's it.

The police middle manager sets S136 at the easier end of police involvement with mental health issues as it is defined clearly - in contrast to the circumstances where S136 does not apply, such as 'people in their own homes'.

> …our 136 policy, our information exchange policy, they're all clear. They're really simple… we've been working on that process for a long long time, that's daily business. So I'd say, actually, we get that pretty well. The bits we don't do though is the bit that are the causational pieces that says 'Why actually have we had to detain an individual on a 136? Why haven't we been able to do something downstream and deliver that in a different way?'

As mentioned above, the impact of the street triage service in its earliest months has been to reduce significantly the use of S136 powers and to find alternative responses to mental health issues of people in crisis.

A MHT senior manager considers that the success of the street triage service can be measured not only by this reduction – 'it's only in extreme circumstances that they'll need to implement a 136' - but also by a different use of resources such as the HPoS which at the time of the interview provided a setting for informal mental health assessments.

> …there's just one official 136 [in a particular month]… All the others, the uses of the place of safety have maybe just been when Street Triage has just brought somebody in, to say, 'Look, we're just going to run through; it's safer than standing on the motorway bridge and can we just sit in here and see this person?'

Both police service participants consider that this practice stems from a more flexible – the police service executive uses the phrase 'lawfully audacious' - interpretation of the mandated terms of S136 which in turn has been made possible by the new service model.

> …to take someone to a place of safety, you don't necessarily have to have been detained under the Act. So, and this is working with the legislation, I think in a creative way……why do we need to detain under 136 if that person is happy to come with us to be assessed and have some form of intervention without having the power of being detained used. (Police middle manager)

In addition, other service models are being considered in The Borough. The borough council executive sees the scope for commissioning, jointly with the CCG, a community-based service 'for people to have some crisis intervention at a lower level…' which would reduce the use of hospitals.

> We do need to think more strategically about how we respond to Mental Health Act assessment, 136, and other aspects to tier it down to give people the opportunity not to go into hospital…

The interviews suggest also that S136 is placed within a wider context as a result of the urgent concern of both emergency services for the management of risk of harm to individuals. Both of the police participants and the ambulance service participant refer to local individual circumstances where loss of life occurred as potent examples of inappropriate service responses to mental health issues. In all these instances, the participants consider that more immediate joint working could have prevented the deaths.

Network of relationships

In the contextual review of joint working between mental health and emergency services, it was suggested that the local culture of The Borough is characterised by innovative frontline joint working. This section supports this suggestion in relation to the street triage service. It is proposed that a 'virtual' network of relationships between influential managers and leaders coalesced to establish the service. The

term ‘virtual’ is used here to indicate that the network was generated for this particular purpose rather than the product of a formal arrangement.

At first sight, the creation of the street triage service can appear almost miraculous. The MHT executive does little to dismiss this image.

> …one of our directors meets with [the police middle manager] as do the other mental health trusts and he commented that [street triage] was working so we’ve just kind of picked it up and talked to each other and made it, well, we’re up for it… so yeah just organise it really. Where there's a will there's a way. And of course the ambulance thought it was a great idea so they’ll provide the vehicle. We provide someone from our crisis team on a rota basis and then the police do their normal thing. I mean it’s not rocket science is it really when you think about it but it’s so effective

However, it seems that a number of influences came together, or were assisted to come together, to generate the initiative. Some of these influences have already been alluded to. The term ‘family atmosphere’ is applied by managers with long experience of working in the MHT to their own organisation. However the same term is used by CCG and MHT leaders to apply across organisations. Indeed these participants also use the expression ‘can do’ that seems to act as a (non-legal) mandate for joint working.

> [The Borough]’s never been particularly wealthy and has always been fairly strapped for cash it’s never been very profligate either. So it’s forced a creativity. It’s forced a ‘can do’ culture perhaps that looks in the best interest of clients rather than individual organisations. That might sound a bit overly altruistic but it’s not meant to be. [Mental health trust executive]

> It’s not so much about the processes as the personalities and the individuals. [The Borough] has an exceptionally ‘can do’ mentality and you see it in all its organisations… You don’t have the same egos to deal with… there isn’t that same ‘us and them,’ so it starts with the culture in [The Borough]. [CCG participant]

Another influence mentioned above by the police middle manager - that of the Health and Wellbeing Board (HWB) – is also picked up by a CCG participant and is linked to the assertion in the second quotation that ‘personalities and individuals’ assume an importance. The Chair of The Borough’s HWB is cited as having given mental health issues a high profile.

> …the Chair of the Health and Wellbeing Board… he's a former CPN…so he knows a lot about mental health…[the HWB has] called us in for detailed discussion around mental health and assurance that we are doing the right things and that we're doing them together. And so that's just put a little bit more emphasis as a system…Has it had a massive influence? I'm not sure it has. Has it got a group and is it now more focused on Mental Health? Absolutely.

Equally, the personal influence of the police middle manager, who had experience of a street triage service elsewhere, is acknowledged not only by the MHT but also by the ambulance service participant – 'he's pretty good at putting his case forward. I think that's the reason why it's such a drive'.

The impact of specific tragic incidents, referred to in the previous section, also has had a local significance in The Borough. The ambulance service participant confirms that the incident with which his service was engaged – 'we were the last agency that had contact with [the person] – involved a person who lived in The Borough and it acted as the principal driver for joint working with both the CCG and the MHT.

> …a tragic story but it was on the back end of that particular case where we drove forward the engagement with the trust to say 'We need to do something' and actually it was picked up by commissioners … and from that it was driven forward.
> What I will say though is as we started to engage with trusts, The Borough was the dominating trust in driving the street triage programme forward…

Also, the unusual remit of the CCG – covering two discrete local authority and HWB areas – meant that a street triage service had been established in one half of its organisation's catchment area, was acknowledged as successful and therefore provided a ready-made model.

> Again, I suppose it's a bit ironic, the fact that we actually cross two big areas, we were able to look across to [the other area] and look at some of the things they were doing really, really well, and they've taken on board a pilot to reduce the use of 136s, and it was a cooperative pilot with the Ambulance, the Police and the Acute provider, known as Street Trio [sic]. So brought it straight across…

In summary, an accumulation of factors contributed to a shared resolve to address an issue which had resonance with each organisation – and was not driven by an external mandate.

Outcomes

The previous section has suggested that an accumulation of factors contributed to a shared decision to address a common issue which had resonance with each organisation – that is to say, the appropriate response to people with mental health issues - which, significantly, is a voluntary enterprise rather than primarily being driven by an external mandate. In particular the 'can do' nature and virtual network of relationships of organisational joint working in The Borough seem to act as non-legal, non-mandated stimuli for joint working. A broad experienced outcome therefore, as for S117 Aftercare (although in very different circumstances), is that the enforcement aspect of mandated joint working is sidelined.

As a consequence, S136 use of police powers in The Borough is addressed by senior managers and leaders as a subsidiary aspect of whole system planning for mental health crisis care. In placing the mandated nature of the S136 provision in a wider preventative context of the Concordat (p202), the reported outcome of the street triage service 'in its earliest months has been to reduce significantly the use of S136 powers', as evidenced by the statistical data made available to the police/NHS forum (p200), 'and to find alternative responses to mental health issues of people in crisis' (p222)

A MHT senior manager considers that the reported outcomes of the street triage service can be recognised not only by this reduction – 'it's only in extreme circumstances that they'll need to implement a 136' - but also by a *different use of existing resources* such as the HPoS which at the time of the interview provided a setting for informal mental health assessments.

> …there's just one official 136 [in a particular month]… All the others, the uses of the place of safety have maybe just been when Street Triage has just brought somebody in, to say, 'Look, we're just going to run through; it's safer than standing on the motorway bridge and can we just sit in here and see this person?'

A police participant sees addressing and reducing risk as being the essential ethos of the (police) service '…because you know we joined the service with a fundamental line that says protecting the public and saving them from harm and protecting life'.

The police middle manager considers that the street triage service primarily is focused upon an outcome of *a shared approach to risk* which encompasses potential S136 detention alongside other circumstances.

> So, the starting point was that we had cops who were waiting at jobs for a long time holding a level of risk…
> I've got a cop, a paramedic and a nurse in a car to be able to respond to crisis on the street and in people's home…That's a real shift in ability. What the biggest win from out of all of this though is our ability to share risk and manage people through a proper information exchange process.

Team and front-line staff layer

As shown in Figure 19 below, the 8 participants interviewed were made up of 3 police officers who were interviewed as a single group, 3 staff from a single CRHTT (one of whom is a nurse currently seconded to the street triage team) and two staff also interviewed for the health and social care services group of organisations (identified with an asterisk below). As for the other joint working group, the findings presented here are drawn from these interviews and the observation of a street triage shift operating during the late evening and into the early hours of the morning.

Figure 19 – MH&E team and front-line participants

Police	Mental Health teams
• Police officers (3 interviewed together)	• Crisis and Home Treatment Team (CRHTT): 3 - team manager (nurse background), I social worker, I street triage nurse • Principal social worker* • CMHT social worker (with experience of CRHTT)*

Mechanisms

All but one of the interviews were completed over a period of just over one month – the 'outlying' interview was completed after an interval of two further months. During this period, the street triage service completed its first year of operation. The interview with the street triage nurse and the observation of a street triage shift provide a contrast with the experience of police officers and mental health services staff in more traditional roles and expose enduring areas of conflict such as the management of mutual expectations, the conduct of effective communication and information exchange and the scope for flexibility of roles. Each of these areas can be expressed as mechanisms which determine the nature of joint working between mental health and emergency services in both mandated and voluntary forms.

The theme of this section is that in its use of an integrated model of joint working the street triage service has shown the potential to address these areas of conflict and thereby adopt the same approach to both mandated and voluntary joint working.

Managing mutual expectations

Mental health social workers and police officers can quickly point to negative episodes of joint working in relation to S136. The PSW considers that 'very different agendas' can be followed by social workers and police officers in the use of S136 leading to unrealistic or inappropriate expectations.

> Police like to set up things that they then look at things through the police's lens and they can't understand why we're saying 'Hang on a minute, there's going to be issues here. No, we won't come running…'

A CMHT social worker points to the positive impact of the joint training for AMHPs and police officers, that was available previously but ceased on the retirement of the lead AMHP, for promoting 'a better understanding of each other's roles'.

> That joint working just seems to be falling apart. Because the police there think that we're just avoiding the work. Well, I'm under the impression that the police are avoiding the work.

This social worker supports this 'impression' by alluding to the perceived inappropriate practice of the police in using S136 detention to resolve difficult situations.

> …the general feeling from the crisis team to do with the 136s is that sometimes the police can abuse that, that they'll arrest someone on a 136 and bring them in when they're high on drugs, alcoholics, and generally don't know what to do with someone.

A CRHTT social worker considers that an area for improvement in joint working with the police is the knowledge of some police officers of their legal responsibilities.

> I realise that the police have quite a wide range of responsibilities, but in mental health sometimes you have to find that people don't quite understand what their role or responsibility actually should be within that particular Act. So sometimes, you're having to coordinate, and instruct…

The CMHT social worker has also had a similar, if more overt, experience.

> Now, this police sergeant's got not idea about mental health law, because she said to me, the one thing she said was "Well, really, mental health law, it's not proper law, is it? As the police we don't have to abide by that."

Similarly, police officer participants express critical perceptions about the process or outcomes of joint working which they consider apply generally to the mental health issues that they encounter.

> …we go to mental health cases from the start really…whether it's going to be that they're violent, wandering the streets sometimes or whether we get calls from mental health teams…
>
> I think that's the whole thing, it's just conflict.....it's just a battle no matter how they come to our attention or how we're brought in to any situation, there's always this battle.

A police officer gives a specific example, in the context of increasing involvement in mental health issues, of the frustration of using S136 powers which do not result in effective action.

> …I definitely think now it's almost a daily occurrence where we're speaking to [the in-patient service] or being involved in…the triage car.
> I think it's frustrating for us in terms of we're able to 136 somebody or if somebody gets sectioned, we tend to be back with them the week after. So, it's like…there's something not right and they need help yet…and we do something about it…and then the next week we're back being called back to the same people over and over again. It's like a vicious circle where nothing really seems to be done.

The PSW contrasts the nature of joint working that is possible when professionals are co-located in the same premises with circumstances where this does not occur .

> …working together physically when you're based in the same team, …it's been on the ground very good… it's much more problematic with statutory agencies. And I think that's about the police and the ambulance for one.

The observation of a street triage service shift confirms that co-location enables a different style of joint working. The team members who participated in the shift perceive that being based in the same office has made possible a mutual understanding of the particular cultural or professional aspects of each other's organisation of they were previously unaware.

A street triage nurse confirms that working together closely fosters awareness of different perspectives which become helpful rather than obstructive.

> I don't think I know anyone that's a police officer…. but the police are normal people… You know, the police officer's primary role is just to make sure everything's safe and, as a nurse in home treatment, that's invaluable because often you turn up at someone's house, you know 'What's behind the door'…
> I think the relationship with the paramedics as well, it's good because, again, I don't know any paramedics. I didn't know how highly skilled paramedics were.

Effective communication and information exchange

The drive to achieve effective communication and information exchange appears to continue to act as a (faulty) mechanism of joint working, although the street triage service is perceived to have brought about some improvement.

Police officers view communication difficulties as posing the most consistent barriers to joint working. These barriers become evident both prior to the police use of S136 powers and in the follow-up stage.

> I think for me the lack, it's the communication, there's no real single point of contact you can sort speak to [and] say 'Can you tell me, has he been mentally assessed, has he got mental capacity?' It's really difficult.

> We never really get the result of mental health assessment anyway, do we? So we never find out what's happened.

The police officers describe how the street triage service can act as an additional source of information; this is confirmed by the street triage nurse who explains that an information-sharing agreement is in place 'and I've been given clearance to give information to police officers regarding people they've inquired about.' The nurse gives a hypothetical example of a request for information from a police officer that can take place.

> 'We've seen this person…I don't think they need the triage team but, you know, there's something not quite right. We were going to 136 them but are they open to services in order that we can advise them to see, should they have seen someone? Is there someone that you can contact just to say that we've seen them.'

During the observation of the street triage service shift, each of the staff was critical of the consistency of their agencies' recording systems. However, the information that is available is shared between team members.

Role flexibility

It appears that the street triage service can enable role flexibility between both its team members and for police officers working in traditional settings. Further, it seems that this is not impaired by line management of the frontline staff being retained by their separate organisations – the police service, the ambulance service and the mental health trust.

A significant aspect of the street triage role is that assessment of need in circumstances where S136 is being considered can take place simultaneously instead of the traditional sequential process of the police being alerted, making initial contact, using S136 powers and conveying a person to a place of safety.

During the observation of the street triage shift, the team (made up of a nurse, a paramedic and a police officer) went to the home of a person who had expressed suicidal intentions. S136 detention was a possibility on their arrival as the person was standing in the road outside the person's home. However, the team decided to

conduct an assessment inside the house. All team members were present at, and participated in, the assessment. There was some differentiation in the roles of each team member – the police officer was concerned for the risk of an overdose and was able to reach agreement that the person should give stored tablets to a family member, while the mental health nurse and the paramedic completed a mental health and physical assessment. A plan was agreed with the person and family members that contact would be made with the person's community team the following morning and in the meantime a family member would remain in the house overnight.

The key difference from the traditional sequential process was that team members came to an agreement about the assessment of risk as a result of joint participation in the assessment and subsequent planning.

The street triage nurse confirms that assessment processes for the team are 'quite fluid. There's no 'OK. I'm going to ask X,Y and Z and you do that and you do that.' While each team member has a particular brief – the police officer for safety, the paramedic for physical health issues and the nurse for mental health issues – roles can be interchangeable.

> I was with B who's a very experienced paramedic and the person we were trying to assess obviously responded better to her…and I'll be happy for B to conduct that because she knows after being with us for many months some of the questions that we want to know. You know, if a person does hear voices, if they're at risk, they've harmed theirself and she can undertake it and I can make some notes. And then (soft voice) 'Maybe family history, B …'

Further, the street triage nurse considers that the service has contributed to a shift in police practice in the Borough in that the use of S136 powers may become an option rather than a standard response.

> …with a 136 I don't think police really used to have a discussion, it's their judgement call. You know 'I'm worried about this person in a public place, this is going to happen.' Whereas when they call us, we're like 'What are they doing? Where's their family?

> Have you spoken to their friends? Have they got a carer?' They're like 'Oooh, I'll ask that'.

Outcomes

The observed broad impacts of the integrated model of joint working developed by the street triage service are that it has enabled persistent areas of inter-agency conflict to be addressed and to adopt the same approach to both mandated and voluntary joint working.

These broad experienced impacts encompass a number of outcomes. The observation of a street triage service shift confirms that co-location enables *a different style of joint working*. The team members who participated in the shift perceive that being based in the same office has made possible *a mutual understanding* of the particular cultural or professional aspects of each other's organisation of they were previously unaware.

A street triage nurse confirms that working together closely fosters *awareness of different perspectives which become helpful rather than obstructive*.

> I don't think I know anyone that's a police officer…. but the police are normal people… You know, the police officer's primary role is just to make sure everything's safe and, as a nurse in home treatment, that's invaluable because often you turn up at someone's house, you know 'What's behind the door'…
> I think the relationship with the paramedics as well, it's good because, again, I don't know any paramedics. I didn't know how highly skilled paramedics were.

It appears also that the street triage service can enable *role flexibility* between both its team members and for police officers working in traditional settings. Further, it seems that this is not impaired by line management of the frontline staff being retained by their separate organisations – the police service, the ambulance service and the mental health trust. The key difference from the traditional sequential process was that team members came to an agreement about *the assessment of risk as a result of joint participation in the assessment and subsequent planning*.

Further, the street triage nurse considers that the service has contributed to a shift in police practice in the Borough in that the use of S136 powers may become an option rather than a standard response.

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Key findings

These findings suggest that implementation arrangements of Section 117 Aftercare and S136 in The Borough strike as much of a contrast with those in The Shire as do their respective geographical and organisational configurations. As DTOC does not appear to promote issues for mental health services in The Borough, it will not be included in the further analysis of the findings. Nevertheless, it seems worth noting in passing that this finding is yet another point of difference between the sites. A marked contrast can be discerned also *within* the Borough in relation to these examples of mandated joint working. Both internally and externally, the key findings which are presented below reflect the impact of mandated joint working upon the services concerned.

For health and social care services, the impact of S117 Aftercare for joint working appears to have been submerged as a result of the history of minimal formal engagement between organisations and by the nature of commissioning arrangements. This position appears to have been reflected for both financial resources and professional roles within community mental health teams.

For mental health and emergency services, the impact of S136 is explicit at the frontline layer of operation, especially in the context of the Concordat and the development of the street triage service. At the same time, it is more nuanced or

subtle in the senior manager and leader arena. The ‘tradition’ of minimal formal engagement at this layer is evident here but in contrast to health and social care services, space has been created for innovation by leaders and by professional staff.

The points of focus identified above by the key findings for The Shire can be matched in The Borough as apposite reflections of the impact of mandated joint working and as a useful format for comparison. Accordingly, key findings for The Borough focus upon local joint working culture, its nature, the relative positions in relation to mandated joint working of senior managers/leaders and frontline staff and the differences that emerged between their layers of operation.

Silo-orientation is the default cultural state for organisations

The police middle manager described The Borough’s organisations as having a ‘silo-orientation’. This trait constitutes a significant additional element, an underlying tendency to maintain or preserve separation, in the inter-organisational environment of The Borough. Aspects of this tendency appear to lie in the encapsulated nature of the integration arrangement and in the lack of formality in the relationships between organisations.

Professional roles have tended to be blurred or flexible for both groups of organisations engaged in mandated joint working.

The encapsulated nature and assimilation of pooled health and social care resources has obscured, or blurred, multi-disciplinary working in community teams to the point of uniformity and to have rendered jointly-commissioned resources into a single entity with little or no acknowledgement of its separate origins. As a result, the very notion of joint working between health and social care services, whether mandated (in this instance through S117 Aftercare) or not, seems to have been made redundant. Yet, the pooled arrangements which have enabled the creation of the

street triage have shown, at the time of the fieldwork, a level of flexibility while maintaining professional distinctiveness.

Differing cultures between health and social care services and between mental health and emergency services influence the activity of layers of operation.

During the period of integrated health and social care arrangements, joint working ironically disappeared both in relation to active relationships between senior managers and leaders of the borough council and the MHT and effective inter-disciplinary interchange at the team and frontline layer of operation. In contrast, the positive nature of close inter-professional joint working demonstrated by the street triage service is not matched at the senior manager and leader layer as organisations remain formally separated.

Collaborative leadership of joint working seems either to be or have been absent, or informal – for the latter, leaving scope for innovative joint working initiatives.

There is a long history or culture in The Borough of taking advantage of opportunities, provided usually by national governments, for joint working initiatives – for example, gaining the status respectively of a Health Action Zone and a care trust, forming integrated arrangements for commissioning and community teams for mental health services, and developing a hospital-based S136 place of safety at an early stage. Indeed the establishment of the street triage service can be viewed as another illustration of this culture, as it was inspired, if not directly funded, by national innovation. The description of this history by a commissioner as ‘a willingness to listen to people’s ideas and have a go and test and pilot and learn and make decisions as a result’ seems, largely, apt (although the learning element may not be evident). In relation to joint working between mental health and emergency services,

an informal network of relationships between the leaders of organisations is suggested here to have been a recent formative influence.

Pooled resources have been the favoured form of mandated joint working.

Further, the nationally-endorsed scheme of pooling resources so as to integrate health and social care services and to create street triage services has taken distinctive courses in The Borough albeit with similar impacts upon mandated joint working. These impacts form a complicated picture with markedly different outcomes for organisations and service users. These differences can be seen on either side of the dividing line between the two groups of organisations. On the one hand, the pooled health and social care arrangements seem to have devalued inter-agency and inter-professional collaboration which, as mentioned above, undercut the mandated provisions of Section 117 Aftercare. On the other hand, the street triage service, from the accounts of the participants and from the observation, appears to demonstrate the value to service users of pooling (staff) resources as being the provision of a responsive, flexible and holistic service as long as care is taken to recognise and preserve the contributions of key players – and, in the process has subsumed S136 within its operating style.

CHAPTER 7

Analysis:

The impact of mandation[12] upon joint working

Introduction

This chapter provides an analysis of how the processes and outcomes of joint working are influenced by the mandates contained in S117 Aftercare, DTOC and S136. While this analysis reveals complicated issues, my overall conclusion, expressed simply, is that sometimes mandation makes a difference and sometimes makes little or no difference. I reached this view by comparing the key findings presented at the end of the two previous chapters and forming them into four common themes (see Figure 20 below). I then split these themes into two groups. Accordingly, 'locality cultures' and 'professional roles' are viewed as aspects of the *contexts* of the case study sites and 'leadership' and 'nature of joint working' as representations of *mechanisms*. This enables me to explore how contexts influenced mechanisms of joint working, how the mechanisms influenced outcomes and in both cases what impact was brought to bear, if any, by mandation. I also take the opportunity to explore examples of joint working in the two sites where mandation is not a factor to see if there is any difference from the mandated joint working of interest to this study.

The three substantive sections of this chapter address these issues in turn. The first section looks at the relationships between contexts and mechanisms. The second examines the links between mechanisms and outcomes. The third covers the differences between mandated and non-mandated joint working.

[12] While 'mandation' may be questioned as a correct grammatical term, it is used here as hopefully clear shorthand.

Figure 20 - Common themes from key findings

Common themes	Key findings
Locality cultures of joint working	Commitment to and apparent confidence in joint working is persistent and is the default culture (Shire) The experience of joint working differs between the policy, senior manager and leader and team and frontline layers of operation. (Shire) Silo-orientation is the default cultural state for organisations (Borough) Differing cultures between health and social care services and between mental health and emergency services influence the activity of layers of operation. (Borough)
Professional roles - identities, values and tensions	Professional roles tend to be distinct for both groups of organisations engaged in mandated joint working. (Shire) Professional roles tend to be blurred or flexible for both groups of organisations engaged in mandated joint working (Borough)
Leadership	Frequent, face-to-face peer communication through formal channels/settings is the norm for senior managers and leaders (Shire) Collaborative leadership of joint working has been absent or informal – for the latter, leaving scope for innovative joint working initiatives. (Borough)
Nature of joint working	The dimensions of mandated joint working vary according to the settings in which they occur. (Shire) Pooled resources have been the favoured form of mandated joint working. (Borough)

How contexts affect mechanisms of joint working in the presence of mandation

Figure 21 provides a summary of the issues that emerge from the discussion that follows.

Figure 21 – Contexts, mechanisms and mandation

Themes	Findings	How contexts influence mechanisms	Whether being mandated makes a difference
Locality cultures of joint working (Senior manager and leader layer)	SHIRE: Commitment to joint working Layers differ for joint working	Health and social care (H&SC): • Collaborative, collective, yet anxiety to avoid uncertainty through detailed guidelines/policies • Tendency to top-down direction	H&SC • For S117, direction-setting • For DTOC, enforcement emphasis
		Mental health and emergency services (MH&E): • Incremental and continuing improvements • Emphasis upon clear and detailed processes for decision-making and communication	MH&E • For S136, allied with Concordat, forceful direction-setting
	BOROUGH: Silo-orientation Different layers of culture for H&SC and MH&E	H&SC: • Individualistic, dominance, lack of acknowledgement of ambiguity • Absence of active joint working at SM&L layer	H&SC • For S117, no difference because nullified • For DTOC, no difference because not an issue
		MH&E: • Informal networks of relationships • Scope for middle manager involvement	MH&E • For 136, some direction-setting combined with Concordat
Professional roles – identities, values and tensions (Team and frontline layer)	SHIRE: Distinct roles	H&SC: • Preservation of integrated teams and differentiation of professions – the right way to do things • Tensions between professions in different organisations and services	H&SC • For S117, in community teams, direction of effort • For DTOC, enforcement and direction setting
		MH&E: • Small, gradual advances • Maintenance and acknowledgement of tensions	MH&E • For S136, positive enforcement
	BOROUGH: Blurred or flexible roles	H&SC: Blurred roles: • Abdication of joint working • Predominance of single uni-disciplinary team culture	H&SC • For S117, no impact
		MH&E: Flexible roles: • Role blurring but clear functions	MH&E • For S136, limited impact because avoided mostly

Locality cultures of joint working

For *health and social care services*, the impact of S117 Aftercare in The Shire could be seen as enforcement of its requirements for joint working. The key cultural indicators for this conclusion are: the detailed attention and commitment given to a joint policy and procedures; the communication networks of senior managers and leaders. The level of policy detail is very substantial, indicating a strong drive for compliance of team and frontline staff. The communication networks have been sustained over time. They also can be productive. For example, the CCG has been willing to share resources with county council colleagues in the light of central government budget reductions. That being said, the substantial policy and procedural conflicts with other provisions (such as continuing healthcare and residence conditions) reduce the impact of mandation to one of *direction-setting* for joint decision-making between organisations.

DTOC implementation in The Shire provides a clear *enforcement* emphasis to joint working, even though it shares the same organisational conditions with S117 Aftercare. By my perception this is due to its use as a criterion for organisational performance monitoring, which gives the provision an ‘edge’. This ‘edge’ seems to be justified locally. A specialist social worker has been required to address the division of interests between inpatient and community team staff. Also, by the perception of advocates, collaboration between the frontline staffs of separate agencies is not consistently forthcoming.

Both S117 Aftercare and DTOC share a ‘top heavy’ emphasis. A disconnect was noted between senior managers and frontline staff and between policy and practice. This will be picked up in the discussion below about leadership.

In the period when integrated teams were in place in The Borough, the S117 Aftercare mandate could gain little purchase and became *nullified* as, in effect, joint working had ceased to exist. The most notable example occurred at the senior manager and leader layer of the borough council. Joint engagement of this layer with healthcare peers in the mental health services appeared to be minimal if not absent. Further, this layer of operation developed a distanced position from the seconded team and frontline staff in the community mental health teams. The oversight of joint commissioning arrangements became focused upon budget balance to the neglect of allocation to social care requirements such as direct payments or personalised budgets. In addition, the complexity and ambiguity of S117 Aftercare received scant acknowledgement in the local policy.

In relation to *mental health and emergency services*, S136 can be seen as contributing substantially to a *forceful direction* for developing closer joint working arrangements in The Shire through system and process alignment. A number of factors support this impact. The Shire's characteristic attention to detailed procedures and communication processes is evident in its engagement with the Concordat implementation process. At the time of the study S136 remained a substantial issue due to the continuing increase in its use since the establishment of the HPoS (see p177). It retained a high profile in the wider Concordat discussions about mental health crisis care. At the same time, the cultural difference in the management of risk between the police and mental health services placed obstacles in the way of progress. This is demonstrated in the continuing difficulties around information sharing. It is also reflected in the police's particular experience of external scrutiny arrangements. This may partially explain why improvements in joint

working proceed at a more gradual and incremental pace. Nevertheless, the improvements in problem-solving keep coming.

For The Borough, S136 contributes to the *direction* of joint working between mental health and emergency services as one of a number of pressures for change. These other pressures include, principally, the Concordat drive to improve with mental health crisis care in general and a local response to pressures upon acute hospital emergency departments. S136 occupies a lower service profile than in The Shire (see p227). Its incidence was noted in the NHS/Police joint working group as being usually low (p196). The prevailing cultural orientation towards silo operation of the local organisations, as noted by the police middle manager, does not represent a unvarying trend. Paradoxically, an informal 'can do' network of relationships between senior managers and leaders is also a persistent cultural feature. It can be activated by middle managers – to 'have a go' - to address and link common issues through, for example, the creation of the street triage service.

Professional roles – identities, values and tensions

For *health and social care services* in The Shire, it was clear that the role played by the mandates of S117 Aftercare and DTOC varied alongside professional roles and mechanisms of joint working. S117 Aftercare *directed the effort* of integrated teams by upholding the principle of entitlement. Joint working itself was not affected because it did not need to be. The differentiation of professional roles within the integrated teams marked a shift in attitude from the previously-accepted 'soup' team model where 80% of professional roles overlapped. It enabled social workers to maintain a specialist focus alongside the more generic functions of nursing and occupational therapy colleagues – a very clear shift to the 'salad' model. Beyond the confines of integrated teams, the impact of both S117 Aftercare and DTOC changed

to one of *enforcement*. The scope for tensions between professional staff of differing or separated services and organisations were immediately greater when services needed to be coordinated.

In very different circumstances, the impact of S117 Aftercare's mandate on The Borough's integrated teams was confined, like The Shire's, to ensuring an entitlement to services . *The influence upon joint working was negligible* because a uni-disciplinary team culture had evolved. The interpretation of pooled resources – the soup model - was the key contextual factor in the blurring of professional roles. The power of this interpretation was reflected by the positive emphasis given to statements such as 'all the barriers came down'. More strikingly, the model was reinforced by the apparent compliance of social workers with the amalgamation of professional roles within teams. In addition, the safeguarding of social care interests by lead professionals declined progressively over time.

As The Borough's community teams were in a process of dissolution and reformation at the time of the study, I can only speculate that S117 Aftercare, if not DTOC, will assume a more assertive enforcement profile for joint working between professional roles in their separated organisations.

For *mental health and emergency services*, The Shire's maintenance of distinct professional roles supports the context for S136 to exert *positive enforcement* on the extent of joint working. There is often no perceptible or immediate mutual benefit to joint working at the frontline layer of operation. This can be seen in the practice of accommodating people too intoxicated for interview in the HPoS suite. On the one hand, this appears to be a generous arrangement which solves problems for the police service. On the other hand, CRHTT staff are diverted from their normal duties, sometimes for several hours. This tension is seen throughout the performance of

professional roles. Frontline police officers can instinctively feel that mental health issues do not fall within their remit. They are critical of the speed of response from mental health services staff. Mental health staff often feel unable to offer suitable solutions to the concerns of police officers for individual safety. However, professionals from both services share increasing frustration with the outcomes of S136 – its time-consuming nature and the extent of repeated detentions. The example cited above contains co-existing forces from S136 – an understanding of the pressures faced by other professionals and the experience that it remains a thorn in the side. Nevertheless, it remains a fixture and, in the circumstances of The Shire, promotes continued attempts for resolution.

In The Borough, the mandate of S136 is allotted a minority status to the extent that it becomes largely, if not entirely, *redundant* in the operation of joint working. The street triage service represents a strong congruence of interests between the roles of professional staff. The service's staff members have been enabled to develop flexible working relationships and communication processes. Yet each professional retains a clear view of her or his primary professional responsibility. Support for this clarity is probably provided by line management being retained by each participating organisation. The service is placed 'downstream' of S136 in recognition of its shortcomings as an effective measure. As a result, at the time of the study, the already low incidence of S136 detention is reduced to being minimal. There is a lack of formality about the nature of inter-professional engagement and therefore a willingness to experiment with professional roles. This can be seen in the inter-changeability of lead responsibility in the assessment processes. This is not to deny that professional roles outside or alongside the street triage service do not remain divided by their mutual perceptions. However, it seems that the service is exercising

a positive influence beyond its formal remit through the provision of advice to their peers.

How mechanisms influence the outcomes of joint working in the presence of mandation

Figure 22 provides a summary of the discussion that follows in this section of the chapter.

Leadership

For *health and social care services*, the mandates of both S117 Aftercare and DTOC in The Shire act as a supplement to the joint drive by senior managers and leaders for *direction-setting* for the former and *enforcement* for the latter. Joint leadership for health and social care organisations is intense as well as exercised continuously and through formal channels. The intensity can be attributed to the nature of the organisational network in this joint working group. The strongest relationships are confined to this network which is tighter than the links with, for example, housing or third sector agencies. Energy is deployed to synthesising or strengthening the joint arrangements that exist. Outcomes of this energy include the elaborate panel network and boundary spanning posts such as the social care commissioner. Some participants have discerned a disconnection between this layer of operation and the team and frontline staff layer. My presentation to the group of senior managers and leaders in The Shire prompted a strong concerted response from the participants, without solicitation from me, that my findings demonstrated a top-down style of local joint management. In these circumstances, this suggests that the role of mandation adds relatively seamlessly to this style.

Figure 22 – Mechanisms, outcomes and mandation

Themes	Findings	How mechanisms influence outcomes	Whether being mandated makes a difference
Leadership (Senior managers and leader layer)	SHIRE: Face-to-face communication and formal channels	H&SC: • Top-down leadership • Formal, continuous, synthesising, hierarchical	H&SC • For S117 and DTOC, supplements direction-setting and enforcement emphasis
		MH&E • Top-down leadership • Formal, continuous, mobilising, enclave	MH&E • For S136, supplements direction-setting emphasis
	BOROUGH: Absent or informal joint leadership – scope for innovative joint working	H&SC • Absent • (In new circumstances) formal and separate	H&SC • For S117, no difference, nothing to mandate • All the difference in new circumstances, stimulus for radical action
		MH&E • Informal membership of leadership network • Episodic, entrepreneurial, middle upwards,	MH&E • For 136, in Concordat context, stimulus for innovation
Nature of joint working (Team and frontline layer)	SHIRE: Dimensions of joint working vary	H&SC • Integration incorporates all types of joint working • Coordination includes hardly any types of joint working	H&SC • For S117, integrated settings none • For S117 and DTOC coordinated settings, enforcement emphasis
		MH&E • SM&L and T&FL of a piece – incremental improvement • Substantial remaining tension and conflict	MH&E • For 136, with Concordat supplement, enforcement mphasis
	BOROUGH: Preference for pooled resources	H&SC • Amalgamation but no coordination or alignment of any type	H&SC • For S117, no impact
		MH&E • All types coordinated or aligned	MH&E • For S136, no impact

In The Borough, the impact of S117 Aftercare mandation remained *negligible* during the previous absence of active joint leadership arrangements during the era of integrated teams. However, S117 Aftercare provided at least part of the stimulus for a return to separated community services and to an *enforcement* of its provisions. Social care funding arrangements, as well as their diminished social care outcomes, played an important role in bringing about the change. For example, the borough council executive and the senior manager perceived that S117 Aftercare provisions had either been misused or insufficiently used. Funding allocations had been made erroneously to healthcare interventions. There was little or no evidence of the use of social care provisions which promoted the independence of service users.

For *mental health and emergency services*, the mandate provided by S136 supplemented the *direction-setting* activity of senior managers and leaders in The Shire. In this way, there are some similarities of the leadership mechanisms with those of the health and social care group. Leadership is experienced by frontline staff as top-down. Joint working is consistently spoken of in a positive manner by senior managers and leaders. This consistency often is not reflected by frontline staff, particularly police officers. Also, the Concordat implementation group follows The Shire's inclination for formality in its production of detailed procedures and development of systems. An important difference is that the leadership network has a wider active membership than for health and social care services. For example, senior managers in the emergency services showed commitment to the (extremely detailed) Concordat action plan and to participation in the implementation group. At the time of the study, the proposal to establish a triage

function staffed by nurses in the police control centre was being mobilised. This planned outcome of joint activity was regarded by senior managers as a significant opportunity for changed joint practice. A key target of this function was the reduction in the use of S136 through preventative joint engagement.

In The Borough, S136 contributed to *stimulating* the leadership towards innovative and productive change. It was a catalyst for local activity, especially in the context of the Concordat. The informal 'can do' network of leadership was notable for its ability to support the entrepreneurial effort of individuals such as the police middle manager in the speedy adoption of the street triage service. This manager explicitly promoted the service's primary function as preventative, of acting 'downstream' of the formal S136 process. Further, the flexible operating style of the street triage service, particularly its seamless needs assessment process, indicates bottom-up creation of policy generated by frontline staff members. The establishment of the service itself is an outcome of episodic activity which is of a piece with other non-mandated joint development projects in The Borough such as the improvement of hospital perimeter security and the development of the specialist mental health liaison service.

Nature of joint working

Two aspects of the nature of joint working – degrees and types - are referred to in this section. For the purpose of the discussion below, both aspects can be understood as mechanisms. Integration and coordination (degrees) have already been used as such in the findings chapters and in the preceding sections of this chapter. It may be helpful to reproduce here for easy reference the definition of joint working types cited in Chapter 2:

- 'Systemic, where policies, rules and regulatory frameworks are aligned

- Normative, where shared values and cultures are nurtured across professional boundaries
- Organisational, where structures and governance are coordinated
- Administrative, where functions such as finance and information technology are aligned
- Clinical, where patient care is integrated in a single process with information and services coordinated (Bamford 2015, Shaw et al 2011).'

For *health and social care services* in The Shire, the outcomes from the mechanisms of integration and coordination at the team and frontline layer presented in Chapter 5 (pp158-163) resemble the impacts of mandation (see Figure 22 above). So, S117 Aftercare has no impact upon joint working in integrated (team) settings. This statement only tells a 'headline' story. The more specific outcomes of the types of joint working that combine to make integrated teams productive provide the details. The clinical type engenders effective care planning. Organisational and administrative types provide single organisational structures which maintain efficiency and effectiveness of teamworking. The normative type ensures that teamworking is comprehensive. The systemic type aims to provide clarity and direction. All of these outcomes were evident for the integrated teams in The Shire. For coordinated joint working, both S117 Aftercare and DTOC need to be enforced because none of these types and their outcomes can be as easily assured. Clinical care has parallel systems across separate organisations, as do organisational and administrative processes. There will be greater scope for dissonance between organisations of shared perceptions of professional values and culture. The systemic influence upon joint working has also to negotiate organisational barriers.

For The Borough, the 'headline' story is the same as for The Shire – S117 Aftercare has no impact in the face of the professional assimilation that developed over time. However, a review of the types of joint working that emerged in the

findings reveals the specific mechanisms and outcomes to be faulty. Systemic activity lacked rigour – the S117 Aftercare policy contained only brief reference to the issues of implementation. Also, regulatory frameworks were, in effect, outsourced by the borough council to the CCG and mental health trust. The loss of distinctive professional norms and amalgamated (as opposed to aligned) organisational, administrative and clinical functions did not support sufficiently comprehensive care planning. Service users were not provided with sufficient access to direct payments or individual budgets. It could be claimed that efficiency in the use of human and financial resources was pursued successfully; the trust placed a high premium on achieving a balanced budget. However, as has been seen, this was to the cost of joint working itself.

For *mental health and emergency services*, S136 assumes a *forceful* profile in The Shire as a result of its high incidence and examples of problematic practice, supplemented by the Concordat. Continuous effort is required to ensure continued incremental progress. By necessity, coordination has been the adopted medium for joint working as tensions, conflict and differences in emphasis persist in all joint working types. Regulatory frameworks are tricky to align, although attempts have been made to do so - for example, in the flexible approach taken by the mental health trust to AWOL reporting (p140). In the normative sphere, the sharing of values and cultures in practice remain uneven; the 'task-and-finish' orientation of the police continues to grate against the clinical emphasis of mental health professionals. The Concordat has provided a format for coordinating organisational structures and governance and some progress has been made. Administratively, there appears to be little alignment of finance and information technology functions. While there exists a single process for the care of people

detained through S136, it remains largely in a sequential mode – although the triage proposal may allow for the move towards simultaneous joint working. Information-sharing appears to be a stubborn sticking point as demonstrated by the discussion at the observed Concordat implementation group meeting.

In The Borough, S136 mandation has no perceptible impact upon the nature of joint working in the street triage service. In this way, this impact matches that for The Shire's integrated teams – although The Borough's implementation style is distinctive. The key features of both integrated settings include the presence of all joint working types along with active participation of all the agencies. The street triage service model enables these joint working types to be aligned, albeit with characteristically informal outcomes. Both of the observations substantiate this claim. Systemic issues are addressed at the police/NHS forum. Professional values and culture are respected in the team setting. Organisational and administrative functions are kept separate but coordinated – for example, the line management of team members. A single process of care is clearly in place (see pp236-237) – strikingly, this includes information-sharing.

Do differences emerge between the settings for mandated and for non-mandated joint working?

Six examples of non-mandated joint working were referred to in the findings chapters, three in each site. For The Shire, these included the local mental health strategy, a mental health liaison service sited mostly in an A&E department of an acute hospital and the CRHTT response to requests for advice or assistance from emergency services. For The Borough, the examples were the previously-integrated primary mental health services, a discrete assessment service located

alongside the local A&E department and joint funding for improvements to perimeter security at the trust in-patient service.

In The Shire, the local mental health strategy has a number of similarities with Concordat implementation. The former is made up of The Shire's characteristic mechanisms of detailed processes, a hierarchy of formal decision-making and face-to-face communication in the six groupings matching the NHWMH strategic aims. Joint working is sustained through stakeholder conferences and a reporting schedule to the Health and Wellbeing Board. In the same manner as the Concordat, active participation in these groupings is considerably wider than statutory health and social care services. Stakeholders include service users, carers, other public services (such as housing) and third sector representatives. This initiative, or rather this collection of initiatives, has resulted in the development of formal frontline links between the statutory mental health services and a young carer service, district council housing services and local employers.

The mental health liaison service operates within the A&E department each day until 10pm, supplemented by a CRHTT staff member during night-time hours. The service is designed to address mental health issues of A&E department users identified by medical or nursing staff. The arrangement is formal; its remit is defined by a service level agreement between the statutory health and social care agencies. While it is not defined by a formal agreement, the CRHTT responses to requests for engagement from police and ambulance services share the same service pattern with the liaison service. They are mostly flexible, being individually negotiated.

In The Borough, the primary mental health service was staffed by health professionals and social workers until shortly before the dissolution of the

integrated arrangements. All of the staff of this service shared engagement predominantly in therapeutic activity– 'they were mainly doing CBT'. As a result of concern both from social workers and the borough council that their professional registration was at risk, they were withdrawn from this service and were re-located in secondary community teams. This assimilation of social workers is of a piece with the integrated arrangements in community teams.

The development of the A&E service is a discrete initiative negotiated between the mental health trust, the acute hospital trust and the emergency services. It is available exclusively to service users with mental health issues who are referred from these statutory agencies. The improvement of perimeter security was a 'one-off' funding agreement between the mental health trust and the police as a means of reducing the high number of people who were 'absent without leave' from the in-patient service. Both of these examples of non-mandated joint working were generated by influential individuals who sought and obtained agreement from their agencies – again a pattern of service development which characterises the creation of the street triage service.

In summary, the local conditions surrounding most of the examples of non-mandated joint working in each site were driven by similar mechanisms as their mandated counterparts. The Shire's A&E liaison service and CRHTT response to emergency service referral can appear at first sight to be exceptions. However, both can be attributed directly or indirectly to the impact of the Concordat implementation group. The night-time CRHTT cover for the former resulted from a proposal from the group. For the latter, CRHTT joint working practice with emergency services shifted to become more flexible since the Concordat's inception.

Conclusions

The analysis presented here indicates that mandated joint working in mental health services for the three examples selected in this study varies between having negligible impact, being a steer for local progression and development or a forceful measure. The mandates of S117 Aftercare, DTOC and S136 are not present in circumstances that are consistently propitious. All three examples presented here contain or promote inherent limitations, dilemmas or tensions.

The common themes have provided a variety of perspectives from which to consider the impacts of mandated joint working. Locality cultures across the two sites provide contexts that have distinctive influences upon the mechanisms of joint working and upon the role of mandation. The deployment of professional roles adds complexity to these influences which can mitigate mandation or stimulate tensions for its implementation. Leadership styles in the two sites differ markedly. Nevertheless, each have positive outcomes when combined with mandation. The nature of joint working is used as an umbrella term for a variety of mechanisms which provide the most complex picture of how outcomes are or are not generated in circumstances where mandation is applied. Active alignment of these mechanisms can make the impact of mandation largely invisible. The need for a mandated approach can be seen where these mechanisms have been diminished or are surrounded by uncertainty and ambiguity. For the examples of non-mandated joint working, the differences in operation from the mandated equivalents seem to be either minimal or by degree rather than substance.

CHAPTER 8

Conclusions

The benefits and shortcomings of mandated joint working

Introduction

The research questions provide the underlying agenda for much of this brief chapter. It therefore seems helpful to restate them here for easy reference.

How is mandated joint working in mental health services conducted between health and social care services in relation to the areas of Section 117 Aftercare and delayed transfers of care, and between mental health and emergency services in relation to the area of Section 136 police powers, in two differing sites in England?

- How do the national and local contexts influence these examples of mandated joint working at each of the sites?
- How are these examples managed, interpreted and implemented in the sites by managers and front-line staff?
- What evidence is there of positive outcomes for the mandated joint working processes between organisations?
- What differing practices are revealed in the study between mandated joint working and joint working in other circumstances or settings?
- What policy, practice and research implications are suggested by the findings of the study for the future?

The chapter is divided into three sections. The first section identifies the key points of learning from the study about the impact of mandated joint working upon local organisations, with reference to nearly all of the subject matter of the research questions with the exception of future research opportunities, which forms the content of the second section. The third section provides final comments on the

findings of the study which provide a summary response to the principal research question.

What are the key learning points from the study?

Mandated joint working is not just about enforcing national government policy. As the last chapter is devoted to demonstrating this, it seems superfluous to take up much of the space of this chapter to discuss this key learning point further. However, it is a helpful starting point for this part of the chapter as it indicates the complexities of implementation. A short answer to the principal research question therefore is that mandated joint working is conducted in various ways within and between the case study sites.

The examples of mandated joint working of interest to this study represent the often longstanding concerns or the imperatives of national governments. These concerns may be at their root a matter of principle, like S117 Aftercare, or of perceived necessity, like DTOC, or of a mixture of issues such as public order and individual safety, like S136. However, while the concerns pose issues for local services, solutions to them are often not readily available or of high priority, irrespective of the extent of their collaborative orientations or capacities. It therefore seems useful to view mandated joint working as attempts by government to focus the resources and commitment of local areas. The lack of substantive difference between mandated and non-mandated joint working in the two sites seems to support this conclusion. The difference seemed to lie principally in whether local focus was compelled or voluntary rather than in the extent or nature of joint working itself.

Further, all of the concerns have been longstanding, if not in the case of DTOC

always formally, and are features of the period when they were introduced formally. The passage of time has varying effects. The impact of S117 Aftercare was reasonably straightforward at its inception. Over the subsequent three decades, it was surrounded by competing requirements which impaired its implementation and continues to do so. DTOC, due to its short life, has had a consistent enforcement influence. S136 has been also surrounded by changing national circumstances but which appear in recent years to have combined to generate a powerful thrust for change. The potential for mandated joint working to drive improvements in mental health services varies accordingly. For S136, at the time of the study, the influence of mandation appears to be positive. DTOC seems also to provide a single focus for disparate services. However, the position of S117 Aftercare in relation to the Care Act, continuing health care and residence provisions, among others, disables its capacity to make a powerful positive impact upon mental health services.

Local contexts have been found in the study to be significant in influencing the nature of their local processes. However in both sites these contexts were found to have shortfalls, inconsistencies and internal variations. For The Shire, joint working capacity is at its strongest and most consistent at the senior manager and leader layer. This consistency was not matched at the team and frontline layer. In The Borough, joint working declined at both layers for health and social care services prior to structural separation. However, for mental health and emergency services, joint working seemed stronger at the team and frontline layer yet episodic and informal at senior manager and leader layer. In these circumstances, the impacts of mandated joint working also varied. Each site possessed distinctive assets for joint working – The Shire for clarity and formality, The Borough for

innovation and flexibility. The key lesson from these findings is that organisations in local areas are likely each to have conducive and obstructive features within them, sometimes not easily perceptible, which will change the nature of the impacts of mandated joint working. In turn, this variation needs to be recognised and addressed.

Functional or organisational separation of services seems to create the setting for the enforcement mode of mandated joint working due to the erection of barriers often caused by the limits of mutual understanding or of misperceptions between professional staff. However, the existence of such distinctions may have positive aspects. These issues seem to be overcome relatively easily by integrated team or service settings and the concerns underlying mandated joint working can be addressed without perceptible obstruction. However, a degree of explicit separation between professionals, as practised in The Shire' community teams and The Borough's street triage service, seems at the same time to be desirable if 'real' joint working, the combination of different perspectives so as to reflect the needs of service users, is to be achieved.

Further, the experience of The Borough is that the 'soup' model of joint working was not only the reflection of organisational neglect on the part of the health and social care commissioners but also of the predominance of the healthcare environment in the mental health trust and of a consequent institutional pressure for uniformity. This allowed S117 Aftercare to be neglected also. This pressure additionally was not sufficiently recognised to be resisted by the social care staff of the teams. The lesson here is that professional difference and indeed tension can be creative and, to that end, should be preserved.

Lastly, my perception of Hudson's notion that mandated joint working is usually

negative, or is applied in the face of local obstruction or resistance does not seem to be borne out. S117 Aftercare seems to have had varied impacts upon the nature of joint working in integrated teams in response to local conditions. The regulations that surround DTOC are viewed pejoratively by teams in The Shire as much because hospital discharge is a difficult process as because it is mandated. However, the recent experience of S136 in both sites, particularly in the (mandated) environment of the Concordat, demonstrates that a common regime of requirement can be productive. As described in the last chapter, the Concordat seemed able to build upon the assets of each site to develop or work towards new service models. The lesson seems again for local areas to recognise and value such assets.

Future research opportunities

The outcomes, both benefits and shortcomings, of mandated joint working for service users seems a fruitful area for research. A possible option could be a comparative qualitative study of users who experience mental health services subject to the mandation examples of this study alongside service users in non-mandated circumstances, using a range of localities. Another option would be to include a focus upon carers, either in the same or a parallel study, although this would be confined most consistently to S117 Aftercare and DTOC. The findings from such research into outcomes of S136 for service users, usually in specific localities, are available. However comparative studies have not been feasible until recently with the advent of triage services. Further, people described as being in emotional distress have presented challenges for the mental health and emergency services in the case study sites. The practical difficulties of recruiting

participants from this cohort would be substantial. Nevertheless,it would be helpful to gain an improved understanding of the range of needs of people in these circumstances and the outcomes for them of their engagement with mental health services.

The organisations engaged directly in this study made up a limited range – future research could take a wider perspective. There are a number of directions that could be followed. S117 Aftercare and DTOC apply equally to the mental health issues experienced by older people and people with physical or learning disabilities. Like The Shire and The Borough, many local authorities have confined their models of integrated services only to adult mental health services. Indeed due to the trend for abandonning S75 arrangements, the health and social care organisational arrangements for all mental health services are becoming standardised, making comparative studies more straightforward. Housing authorities are notable omissions from the study as are healthcare trusts responsible for acute healthcare, not least in the provision and management of emergency services. On a similar theme of joint working between a larger range of stakeholders, research into the progress of the Concordat since the time of the study could usefully examine the joint working between participating organisations and interests with a view to assessing the benefits and challenges of wider membership.

It would be useful to gain an understanding of the impacts upon mandated joint working specifically of withdrawing from integrated arrangements in mental health services. This withdrawal now appears to be commonplace which opens the possibility of conducting quantitative studies through surveys of a larger number of geographical areas, perhaps followed up by case studies.

Lastly, the research design used in this study, or an adaptation of it, could be used in other complex multi-agency arenas of mandated joint working such as safeguarding children or vulnerable adults.

Summary

The principal research question for this study is an expression of my motivations for undertaking it, presented in Chapter 1. To deal with my personal preoccupation with the use of power first, the study has developed my thinking to enable me to arrive at the position where I can conceive that a positive balance between the agency of individuals and local organisations and the power of governments is probably the only way to make the best fist of things. I consider that this study has shown that this understanding can be applied more broadly – that a dynamic relationship between national and local organisation is usually helpful. It has also recognised that the concerns that brought the examples of mandated joint working into being are not amenable to resolution. They represent continuing issues for society which persist in the face of changing social trends. Importantly, through this dynamic energy, mandated joint working can promote productive outcomes from the organisations that are engaged in mental health services. It is in this overall finding that this study lays claim to originality, an addition to knowledge and development of the practice of joint working.

APPENDIX 1

Evaluation of current policies and practice in relation to mandated joint working in mental health services

Topic guide for interviews and focus groups

1. Individual context for participants, e.g. professional affiliation, where worked, career so far

2. Organisational and procedural context in which mandated joint working is taking place

3. What is working well and not so well (and why) – descriptions and examples

4. Similarities and differences between mandated and other joint working in local context

5. Ideas for improvement in policies, practices, training etc

_____	_____	_____
Researcher	Signature	Date

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Chapter 4 – Methodology

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