

# Redefining the Role of 'Non-Professionally Affiliated' Workers in Community Mental Health Care:

## A Qualitative Exploration of Co-Worker and Client Relationships

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## Abstract

Recent changes to UK health care policy have led to a dramatic increase in the non-professionally affiliated (NPA) workforce. Despite the growing presence and importance of NPA roles as part of the 'drive for better value', until recently they existed as healthcare's 'invisible workers' (Thornley, 1997). The developing body of literature is at an early stage, with discussion usually confined to hospital wards and to consideration of the NPA-professional relationship. This study advances existing theory using an exploration of the subjective NPA experience within the novel context of community mental health services. Underpinned by an interpretivist, qualitative approach the findings are constructed using data from semi-structured interviews with workers (n=32) across a number of roles, teams and organisations, alongside interviews with team managers (n=5) and documentary analysis.

Drawing on the concept of 'community co-production', the presented findings contrast discussion elsewhere by building a picture of working life characterised by professional distance rather than professional proximity. In light of high levels of lone working, autonomy and responsibility reported by workers it is argued that worker role may be more usefully defined in terms of the position relative to the client (supporter, facilitator or ambassador) than relative to the professional. The client interaction is introduced as an under-explored but central aspect of worker experience, shown to exert considerable influence both as a positive source of worker fulfilment and as a potential source of burden arising from risk, dependency and boundary issues. Attention is drawn to the influence of workplace, organisational and political context in shaping worker role and relationships. As NPA numbers continue to rise on a rapid, global scale in combination with an increasing move towards care in the community, the findings presented here raise a number of issues for researchers, managers and policy makers.

# Table of Contents

<i>Acknowledgements</i> .....	<i>i</i>
<i>Abstract</i> .....	<i>ii</i>
<i>Table of Contents</i> .....	<i>iii</i>
<i>Table of Figures</i> .....	<i>xi</i>
<i>List of Abbreviations</i> .....	<i>xiii</i>
<b>Chapter 1. Introduction</b> .....	<b>1</b>
<i>Introduction</i> .....	<i>1</i>
<i>1.1 The UK Health Care Context</i> .....	<i>2</i>
1.1.1 Service Modernisation and Role Redesign .....	<i>2</i>
The Increasing ‘Non-Professionally Affiliated’ Workforce .....	<i>3</i>
1.1.2 Recent Developments and Current Debates .....	<i>4</i>
<i>1.2 The Mental Health Context</i> .....	<i>5</i>
1.2.1 The Origins of Care in the Community.....	<i>5</i>
1.2.2 New Ways of Working in Mental Health .....	<i>7</i>
Newly Implemented NPA Roles .....	<i>8</i>
1.2.3 The Current Study .....	<i>9</i>
Recent Developments and Current Debates: ‘New Horizons’?.....	<i>9</i>
Defining Workers as ‘Non-Professionally Affiliated’ .....	<i>10</i>
<i>1.3 Thesis Structure</i> .....	<i>11</i>
<i>Chapter Summary</i> .....	<i>14</i>
<b>Chapter 2. Literature Review</b> .....	<b>16</b>
<i>Introduction</i> .....	<i>16</i>
<i>2.1 The Origins of NPA Worker Discussion: Sociology of the Professions</i> .....	<i>17</i>
2.1.1 NPA Roles and the Professional Project .....	<i>17</i>
The Sociology of the Professions.....	<i>17</i>
The System of Professions and ‘Jurisdiction’ .....	<i>19</i>
NPA Roles as a Vertical Substitution Strategy .....	<i>20</i>
2.1.2 Shifting Divisions of Labour: The Role of NPA Workers in Skill Mix Change ....	<i>22</i>
The Role of the State: What is the Future for the NPA Workforce? .....	<i>24</i>
2.1.3 NPA Introduction in a Multidisciplinary Context: Interprofessional Working in Healthcare .....	<i>25</i>
Multidisciplinary Working in Healthcare .....	<i>25</i>

Multidisciplinary Working in Mental Health .....	27
The Bleak Picture: Are Times Changing? .....	30
Visibility of NPA Workers in the Interprofessional Literature .....	31
<b>2.2 <i>The NPA Worker Experience in Health Care</i>.....</b>	<b>32</b>
2.2.1 The HCA- Registered Nurse Relationship.....	33
2.2.2 Supervision and Training Issues .....	37
2.2.3 Recent Theoretical Developments: The Importance of Context.....	39
Workplace and Sub-Sector Variation .....	40
Categorising Worker Role.....	42
Limitations of Recent Developments .....	44
<b>2.3 <i>NPA Roles in Mental Health</i> .....</b>	<b>45</b>
2.3.1 Comparing Service User and Worker Perceptions .....	46
2.3.2 Role Clarity and Working Relationships.....	48
2.3.3 Supervision and Training.....	52
2.3.4 Limitations and Research Gaps.....	54
<b>2.4 <i>The Missing Client</i> .....</b>	<b>54</b>
2.4.1 The NPA-Client Interaction in Mental Health .....	55
2.4.2 Emotional Labour and Care Work.....	58
<b>2.5 <i>Aim and Research Questions</i> .....</b>	<b>60</b>
2.5.1 Development of the Study Aims .....	60
2.5.2 Summary of the Research Problem .....	61
2.5.3 Aim .....	62
2.5.4 Research Questions .....	63
<b><i>Chapter Summary</i> .....</b>	<b>63</b>
<b>Chapter 3. Methodology and Study Design .....</b>	<b>64</b>
<b><i>Introduction</i>.....</b>	<b>64</b>
<b>3.1 <i>Theoretical Framework</i> .....</b>	<b>64</b>
3.1.1 Asserting an Interpretivist Theoretical Position .....	65
Choosing Between the Three Major Paradigms.....	66
Commitment to a Qualitative Approach .....	69
3.1.2 Refining the Theoretical Position: Considerations within an Interpretivist Paradigm .....	69
Social Constructionism .....	69
Alternative Approaches: Phenomenology and Symbolic Interactionism .....	71

Taking a Pragmatic Research Approach .....	73
3.1.3 Methodology and Methods .....	74
Methodological and Logistical Considerations.....	74
Pragmatic Choice of Methods: An Interview-Based Study.....	76
Section Summary .....	78
<i>3.2 Ethics, Quality and Reflexivity .....</i>	<i>79</i>
3.2.1 Ethical Considerations in Qualitative Research .....	79
Informed Consent .....	80
Anonymity and Confidentiality.....	81
Protection from Harm: Study Specific Concerns .....	82
Reflections on the NHS Research Ethics Process .....	84
3.2.2 Measuring Quality in Qualitative Research .....	85
Quality, Validity and Reliability .....	85
Credibility .....	86
Transferability .....	87
Dependability and Confirmability .....	87
Authenticity.....	88
3.2.3 Reflexivity.....	88
My Background, Influences and Worldview.....	90
Expectations upon Entering the Field .....	92
<i>Chapter Summary .....</i>	<i>92</i>
<b>Chapter 4. Data Collection and Analysis.....</b>	<b>94</b>
<i>Introduction.....</i>	<i>94</i>
4.1 <i>Sampling and Participant Access Strategy.....</i>	<i>96</i>
4.1.1 Sampling Frame Development.....	96
Sampling Approaches in Qualitative Research.....	96
Initial Sampling Frame.....	97
Complexities in the Field and Criteria Development.....	98
A Consideration of Sample Size .....	100
4.1.2 Gaining Access .....	101
Initial Access Strategy.....	101
Gaining Access in Practice: Complexity, Visibility and Restrictions.....	103
4.1.3 Research Sites and Service Set-Up.....	105
The Mental Health Service Context.....	105
North East Service Set-Up .....	106
Overview of Study Sites.....	107

Team Set-Up and Referral Routes .....	110
4.1.4 Sample Demographics .....	113
Sex and Age Distribution .....	113
Worker Background and Experience .....	115
Section Summary .....	117
<b>4.2 Data Collection .....</b>	<b>118</b>
4.2.1 Developing the Interview Topic Guide .....	118
4.2.2 The Interview Process .....	120
Before the Interview .....	120
The 'Official' Interview .....	121
Building Rapport .....	122
4.2.3 Collection of Documents .....	125
<b>4.3 Analysis and Writing .....</b>	<b>127</b>
4.3.1 Overview of Analysis Approach .....	127
4.3.2 Initial Steps .....	131
Transcription and Familiarisation .....	131
4.3.3 Constructing a Thematic Framework .....	132
Identifying an Initial Thematic Framework .....	132
Indexing and the Use of Data Management Software .....	135
4.3.4 Writing as a Method of Analysis .....	136
Initial Thick Description .....	137
Re-Interpretation, Comparisons and Theoretical Abstraction .....	138
4.3.5 Reaching Data Saturation .....	141
<i>Chapter Summary .....</i>	<i>142</i>
<b>Chapter 5. Redefining Worker Role: An Exploration of Professional Proximity and Client-Centred Tasks .....</b>	<b>145</b>
<i>Introduction .....</i>	<i>145</i>
<b>5.1 Defining Worker Role in Terms of Professional Proximity .....</b>	<b>146</b>
5.1.1 Defining NPA Workers as 'Co-Producers' of Mental Health Care .....	146
Co-Production in Day-to-Day Tasks: A Deconstruction of Worker Role .....	147
5.1.2 Co-Production in the Community: Key Features of Working Life .....	152
5.1.3 Lone Working and Professional Distance .....	154
5.1.4 Autonomy and Role Responsibility .....	156
Time and Resource Management .....	157
Role Creation and Service Development .....	159

Role Promotion .....	160
5.1.5 Personal Responsibility .....	165
Section Summary .....	168
<i>5.2 Re-Defining Worker Role in Terms of Client Work .....</i>	<i>169</i>
5.2.1 A Client-Focused Categorisation .....	169
Supporter .....	172
Facilitator .....	172
Ambassador.....	173
5.2.2 Contextual Influences on Role Function .....	175
Employing Organisation .....	175
Team Specialism/Client Group.....	176
Geographical Location.....	178
Funding and Worker Numbers.....	179
<i>Chapter Summary .....</i>	<i>180</i>
<b>Chapter 6. Exploring Variation in the Worker-Client Relationship.....</b>	<b>182</b>
<i>Introduction.....</i>	<i>182</i>
<i>6.1 Individual-Level Shaping Factors.....</i>	<i>182</i>
6.1.1 The Centrality of Client Relations: Worker Motivation .....	182
6.1.2 Shared Experience and Worker Personality .....	185
6.1.3 Client Motivation and Existing Beliefs .....	186
Section Summary .....	189
<i>6.2 Role-Level Shaping Factors .....</i>	<i>189</i>
6.2.1 Overview of Role-Level Shaping Factors and Key Issues .....	190
6.2.2 The Availability of Time.....	192
6.2.3 Task Flexibility: Creating a Tailored Service.....	198
6.2.4 Accessibility.....	201
6.2.5 Formality .....	205
Section Summary .....	210
<i>6.3 Team-Level Shaping Factors .....</i>	<i>210</i>
6.3.1 Monitoring and Maintenance .....	212
Observation and ‘Spying’ .....	212
Caseload Easing and Client Maintenance.....	213
6.3.2 Waiting List Containment .....	215
6.3.3 A ‘Dumping Ground’ for Difficult Clients? .....	217

6.3.4 Immunity from Misuse and ‘Box Ticking’ .....	219
Section Summary .....	219
6.4 <i>The Wider Policy and Political Context</i> .....	220
6.4.1 Politics and the Economy: IAPT’s ‘Hidden Agenda’? .....	221
6.4.2 Funding and Policy Priorities.....	223
Section Summary .....	225
<i>Chapter Summary</i> .....	225
<b>Chapter 7. Managing the Complexities of Client Work: Preparation and Workplace Support.....</b>	<b>227</b>
<i>Introduction</i> .....	227
7.1 <i>Interpersonal Responsibility and Worker Preparation</i> .....	227
7.1.1 The Emotional Demands of Client Work .....	227
7.1.2 Worker Preparation: Training and Life Experience .....	231
Formal Training Opportunities .....	231
Personal Experience .....	234
Section Summary .....	235
7.2 <i>Shaping Factors of Workplace Support</i> .....	235
7.2.1 Overview of Shaping Factors .....	237
7.2.2 Accountability .....	239
Existence of a Caseload Moderator .....	239
Accountability for Worker Wellbeing.....	243
7.2.3 Accessibility.....	246
Physical Accessibility .....	247
Individual Aspects of Accessibility.....	251
7.2.4 Acceptance.....	252
Co-Worker Perceptions of Role Value.....	253
Wider Connotations Attached to the NPA Roles.....	256
Individual Differences and Acceptance .....	258
<i>Chapter Summary</i> .....	261
<b>Chapter 8. Discussion and Conclusions.....</b>	<b>263</b>
<i>Introduction</i> .....	263
8.1 <i>Implications for Traditional Theory: Sociology of the Professions</i> .....	264
8.1.1 Threat, Resistance and Wider Change.....	265
8.1.2 Teamworking and Workforce-NHS Conflict.....	267

8.1.3 NPA Terminology and Emerging Tensions .....	268
8.1.4 Putting Threat and Resistance into Context: An Overview of Key Aspects of Worker Experience.....	270
<i>8.2 Definitional and Organisational Contribution.....</i>	<i>273</i>
8.2.1 Adding to Knowledge on Role: Community Co-Production .....	273
8.2.2 Advancing Knowledge of Contextual and Workplace Influences .....	275
Micro-Level Workplace Factors.....	276
Wider Political Influences.....	277
8.2.3 Unofficial Use and Professional Pressures.....	277
<i>8.3 Exploring the Worker-Client Relationship: Contribution to the Literature on Emotional Aspects of Work.....</i>	<i>279</i>
8.3.1 Centrality of the Client Relationship: Weighing up Fulfilment and Burden ...	281
8.3.2 Shaping Factors of the Emotional Aspects of Work .....	283
8.3.3 The Impact and Appraisal of Unofficial Use: Implications for Emotional Responsibility .....	286
<i>8.4 Implications for Managers and Policy Makers.....</i>	<i>287</i>
8.4.1 Recognition and Preparation for the Emotional Aspects of Work .....	287
8.4.2 Accountability for Worker Wellbeing and Reliance on Informal Support.....	289
8.4.3 A Note on NPA Regulation .....	290
<i>8.5 Conclusions and Directions for Future Research.....</i>	<i>292</i>
8.5.1 Study Considerations and Directions for Future Research.....	292
Directions for Future Research .....	295
8.5.2 Personal Impact: Reflections upon Leaving the Field.....	297
8.5.3 Conclusion.....	297
<b>References .....</b>	<b>299</b>
<b>Appendix A. Overview of NPA Roles Implemented Under New Ways of Working .....</b>	<b>320</b>
Support, Time and Recovery (STR) Workers.....	320
Carer Support Workers .....	321
Community Development Workers for Black and Minority Ethnic (BME) Communities.....	322
Graduate Mental Health Workers .....	323
IAPT Workers (Psychological Wellbeing Practitioners and High Intensity Workers) .....	324
<b>Appendix B. Participant Information and Consent.....</b>	<b>326</b>

Participant Information Sheet .....	326
Participant Invitation Letter and Opt-in Form .....	326
Participant Consent Form .....	326
<b>Appendix C. Protocols for Distress, Malpractice and Lone Working .....</b>	<b>335</b>
Management of Potential Distress Protocol.....	335
Protocol for the Disclosure of Malpractice, Criminal or Unethical Behaviour .....	335
Lone Working Protocol .....	335
<b>Appendix D. Interview Topic Guides .....</b>	<b>342</b>
Interview Topic Guide - NPA Workers .....	342
Interview Topic Guide - Managers.....	342

## Table of Figures

Fig. 1.1 Timeline of the Research Process.....	15
Fig. 2.1 Assistant Role Categorisation Provided by Kessler et al. (2007) .....	43
Fig. 3.1 Overview of the Study's Guiding Theoretical Framework .....	65
Fig. 3.2 Central Assumptions of the Three Major Research Paradigms .....	67
Fig. 3.3 Overview of Study Specific Ethical Considerations.....	83
Fig. 4.1 Overview of Final Study Design.....	95
Fig. 4.2 Overview of Final Sampling Frame .....	100
Fig. 4.3 Overview of Gatekeeping and Access Strategy .....	102
Fig. 4.4 Overview of Mental Health Service Provision.....	106
Fig. 4.5 Overview of Study Sites.....	108
Fig. 4.6 Final Sample Distribution by Role and Study Site .....	109
Fig. 4.7 NPA Worker Position within a Multidisciplinary Team .....	110
Fig. 4.8 NPA Worker Position with a Uni-Disciplinary Team .....	111
Fig. 4.9 Age Distribution for Support, Carer Support and STR Workers, compared to GMHWs and Psychological Wellbeing Practitioners .....	114
Fig. 4.5 Categorisation of Worker Background: Caring Career, Life Change and Role as a Stepping Stone .....	116
Fig. 4.11 Overview of Collected Documents .....	126
Fig. 4.12 Overview of Data Analysis Approach.....	130
Fig. 4.13 Example of a Coded Transcript Section.....	132
Fig. 4.14 Initial Thematic Framework .....	134
Fig. 4.15 Example of Thematic Development: Working Relations .....	140
Fig. 4.16 Overview of Results Chapters .....	144
Fig. 5.1 Assistant Role Categorisation Provided by Kessler et al. (2007) .....	146
Fig. 5.2 Overview of Tasks Performed by Study Participants.....	148
Fig. 5.3 Key Features of Community Co-Production .....	153
Fig. 5.4 Overview of Tasks Performed by Supporter, Facilitator and Ambassador Role Functions .....	171
Fig. 6.1 Overview of Shaping Factors of the Worker-Client Interaction .....	184
Fig. 6.2 Overview of Role Level Influences and Key Associated Issues .....	191

<b>Fig. 7.1 Overview of Shaping Factors of Worker Support .....</b>	<b>238</b>
<b>Fig. 8.1 Overview of Key Aspects of NPA Worker Experience .....</b>	<b>272</b>
<b>Fig. A.1 Overview of Role Purpose .....</b>	<b>320</b>

## **List of Abbreviations**

BME	Black and Minority Ethnic
CDW	Community Development Worker (for BME communities)
CPN	Community Psychiatric Nurse
CSW	Carer Support Worker
DoH	Department of Health
GMHW	Graduate Mental Health Worker
HCA	Healthcare Assistant
IAPT	Improving Access to Psychological Therapies
NPA	Non-professionally affiliated
NWW	New Ways of Working
PWP	Psychological Wellbeing Practitioner
STR	Support, Time and Recovery (Worker)
WHO	World Health Organisation

## Chapter 1. Introduction

### Introduction

We are facing a global health care crisis. Even before the economic recession took hold an ageing population, increasing service demand and rising costs of care had led to an international nursing shortage and calls for widespread service reform (DoH, 2000; ICN, 2004; McKenna, Thompson and Watson, 2007; WHO, 2010). The lack of sufficient human resources is particularly salient in mental health care, which has been identified as both an area of intensive demand growth and a key challenge to policy makers worldwide (WHO, 2009). While interest in the promotion of positive mental health has grown over the last twenty years, there remains a major inequity in the distribution of funding and skilled workers comparative to other areas of health care, manifested in a universal shortage of professionals such as psychiatrists, mental health nurses and social workers (WHO, 2005; 2009).

In the UK attempts to find a solution to current challenges, now further exacerbated by the economic recession, have triggered a period of rapid, widespread service change across all areas of health and social care. Over the last two decades professional boundaries have shifted, the hospital has become less central to patient care and there has been an increasing reliance on workers employed in non-professionally qualified support and assistant roles (Davies, 2003; IPPR, 2003; Nancarrow, 2005; Nancarrow and Borthwick, 2005).

This period of intensive service redesign, and particularly the part played in it by the 'non-professionally affiliated' (NPA) workforce, forms the contextual backdrop to this PhD study. It tells a story of the subjective working lives of those employed within a small section of the NPA workforce, focusing on community mental health services as the research setting.

Adding to the existing knowledge base on NPA workers is vital in light of their increasing presence and importance to healthcare provision. This increase is evident worldwide, with healthcare assistants (HCAs) currently being piloted in Australia and physician assistants gradually being introduced into services in countries including Canada, Australia and Taiwan (Legler, Cawley and Fenn, 2007; Henry, Hooker and Yates, 2011; Kurti, et al., 2011). In the UK, while HCAs have been a common feature in hospital wards for decades, their numbers are increasing and additional NPA roles are being expanded into specialist areas such as rehabilitation, maternity care and community mental health (Sandall et al., 2007; Stanmore and Waterman, 2007; Dickinson et al., 2008). As will become clear in the literature review chapter of this thesis, NPA roles now form a central but vastly under-researched part of the health care workforce.

This chapter briefly outlines key service developments in UK health and mental health care which are important to the current study, highlighting the position of non-professionally affiliated (NPA) workers therein. The final section provides an overview of the layout of the thesis.

## **1.1 The UK Health Care Context**

### ***1.1.1 Service Modernisation and Role Redesign***

The UK has witnessed an intensive period of health service redesign over the last two decades, driven by policy changes introduced under the 'modernisation agenda' of the previous Labour government (Bach, Kessler and Heron, 2008). Workforce development has involved widespread change in fields as diverse as mental health, primary care, the allied health professions and older people's services (NHS Modernisation Agency, 2003). Aiming to improve staff retention and service delivery through a more flexible, integrated workforce (Department of Health, 2000), it involved an extensive period of role redesign described as:

‘Expanding the depth and breadth of roles, moving tasks up or down a traditional uni-disciplinary ladder, and crossing traditional boundaries – professional, skill mix and organisational.’ (NHS Modernisation Agency, 2004)

In addition to initiatives that altered the workforce ‘skill mix’ through shifting occupational boundaries, the modernisation agenda placed heavy emphasis on team working and inter-disciplinary collaboration. Staff were integrated into multidisciplinary teams and specific initiatives were set up to facilitate joint practice, such as the Creating Capable Teams Approach (CCTA) in mental health which provided an ‘off-the-shelf’ 5-step strategy to assist teams in implementing new ways of working and new roles (DoH, 2007: 27).

### **The Increasing ‘Non-Professionally Affiliated’ Workforce**

While existing roles were being extended or used in novel ways, completely new roles were also introduced into health care; the vast majority forming part of the growing NPA workforce. Central to their appeal was the ability to optimise the time and skills of professionally qualified staff, whilst addressing staff shortages and aiding the ‘drive for better value’ (Department of Health, 2007: 82). Thus NPA workers were identified as a key feature of labour’s workforce reform strategies:

‘Without an expanded support workforce with expanded roles, much of the rest of the NHS Plan may be jeopardised.’ (Rogers, 2002: 2)

The NHS clinical support workforce has risen steadily over the last decade to over 350,000 at the latest headcount, now representing around a quarter of the 1.2 million strong NHS workforce (NHS Information Centre, 2011). Wilson et al.’s (2004) evaluation of employment trends over a ten year period (2002-2012) illustrated ‘non-professional’ caring roles to be undergoing expansion more rapidly than any other occupation; an increase that has been predicted to increase further in coming years (IPPR, 2003). Although there is no official register of the

entire NPA workforce across health *and* social care, a recent estimate suggested that in total around a million support workers are currently employed in the UK (Saks and Allsop, 2007).

### **1.1.2 Recent Developments and Current Debates**

Rising NPA numbers and their centrality to Labour's modernisation agenda have been suggested to account for their recent rise in status from 'invisible workers' to high prominence for academics and policy makers (Thornley, 1997; Kessler et al., 2007). Nevertheless, NPA roles are notably absent from the current coalition government's White Paper on healthcare reform, *Liberating the NHS* (DoH, 2010a). Despite the promise of a 'revolution in NHS efficiency' (2010a: 45), the radical proposal features no direct reference to the NPA workforce, leaving many questions unanswered over their future contribution. As suggested in McKenna et al.'s (2007) commentary on the rise of the HCA however, in the current economic climate it seems unlikely that we will see anything other than a continuation of the upward trend in employment:

'In an era where managers and policy makers are concerned about the rising costs of health care and with a continued shortage of nurses, the HCA is here to stay. They are now core members of the nursing team and deserve to be educated, regulated/registered and better paid.' (McKenna et al., 2007: 1284)

This leads on to a brief consideration of a key current discussion around the NPA workforce: proposed regulation. Alongside a string of high profile media reports of service user neglect or mistreatment by NPA workers (e.g. Newell, 2007; BBC, 2011), professional nursing bodies have called for some form of official regulation in order to protect public safety (Griffiths and Robinson, 2010). Public and professional concerns have reportedly increased with the recent introduction of 'higher-level' Band 4 support roles such as the assistant practitioner (Spilsbury et al., 2009; Griffiths and Robinson, 2010).

A recent scoping review funded by the Nursing and Midwifery Council appeared to support the call from professional nursing bodies for NPA regulation, although the authors reported that it was not possible to demonstrate 'unequivocally' that lack of regulation presented a risk to public safety, nor that regulation would reduce that risk should it be shown to exist (Griffiths and Robinson, 2010). At the time of writing plans for regulation seem to be moving forward without opposition, however detailed guidelines on how such a system would be financed or policed are yet to be revealed.

## **1.2 The Mental Health Context**

With one in four people suggested to experience a mental health problem at some point in their lives, mental health is described as the largest 'single cause of disability' in the UK, representing 23% of the nation's total health burden (WHO, 2008, in DoH, 2011a: 10). Despite this, the UK picture reflects the funding inequity seen worldwide when compared to other areas of health, accounting for only 11% of the UK's annual secondary care health budget (McCrone et al., 2008; DoH, 2011a). Among estimates that the cost of treating mental health problems could double over the next 20 years (DoH, 2009a; 2011a), the future of mental health care provides cause for professional and public concern (Hill, 2011; Lindsay and Lester, 2011).

### **1.2.1 *The Origins of Care in the Community***

UK mental health care over the last two hundred years has been governed by the 'rise and fall of the asylum' (Rogers and Pilgrim, 2001: 157), with Enoch Powell's (then Health Minister) famous 'Water Tower' speech of 1961 signalling the start of a ten year programme of asylum closure and movement towards care in the community. Driving factors included cost efficiency as well as long-standing public and professional concern regarding living conditions and the seemingly untherapeutic environment of the large institutional asylums, combined with

what has been described as a newly optimistic, 'self-confident' NHS following the development of various psychiatric 'wonder drugs' in post-World War 2 Britain (Hinshelwood, 1998; Rogers and Pilgrim, 2001). An increase in the employment of 'unqualified staff' was identified as a key route to improved cost-efficiency during a subsequent critical appraisal of community mental health policy (Audit Commission, 1994).

'Community care' has been described as an emotive term in both policy and public contexts; something which stemmed from utopian aims but in later years became a political minefield yielding both passionate support and fierce criticism (Rogers and Pilgrim, 2001). Professional and academic critics argued the push to be a form of 'dumping' for which neither public nor inpatients had been properly prepared (Carpenter, 1994; Muijen, 1996; Rogers and Pilgrim, 2001). On the other side of the argument the newfound emphasis on rehabilitation and recovery signalled a movement away from the oppression of which the asylum had become a symbol (Sayce, 2000). As a result, Rogers and Pilgrim (2001) suggested community care to have become a 'catch-all phrase' with a number of meanings:

'It has been an abstract aspiration upheld by those seeking to remove oppressive barriers between people with mental health problems and others. It has been a description of service reconfiguration after the large institutions closed. It has been seen primarily as a cost-minimisation strategy by the state. It has been depicted by its critics as a form of neglect and irresponsibility.' (2001: 158)

Over the last twenty years, community care in mental health has extended to include the provision of specialist, residential and day care to mental health service users. Its meaning has developed to include the goal of improving social inclusion and user access to mainstream facilities, services and social opportunities; a vision in which NPA workers play a central part (Rogers and Pilgrim, 2001). The gathering momentum behind the service user movement has led to increased user and carer involvement in the planning, monitoring and

evaluation of services (e.g. Barnes et al., 2000; Telford and Faulkner, 2004; Pearson et al., 2009). The shifting discourse towards users as partners in care can be seen embedded in the strongly user-focused dialogue that surrounded *New Ways of Working* in Mental Health (DoH, 2007).

### **1.2.2 *New Ways of Working in Mental Health***

Despite the significant developments in community care, by the turn of the century another call for reform had begun amidst concerns around poor retention, burnout and overburdening caseloads for psychiatrists; a situation that was fast becoming an employment crisis (Kennedy and Griffiths, 2001). At around the same time and in consultation with the Royal College of Psychiatrists, the National Service Framework for Mental Health (DoH, 1999) and the NHS Plan (DoH, 2000) set out an agenda for the modernisation and development of mental healthcare. The NHS Plan (2000) in particular laid out plans for the substantial modernisation of community services over a ten-year period, recommending the development of a number of new community teams and staff roles. The *New Ways of Working* (NWW) initiative (DoH, 2005a; 2007), which formed part of the then National Institute for Mental Health in England's (NIMHE) National Workforce Programme, was set up in 2003 to ensure the widespread implementation of the recommended changes at all levels and across all staff groups.

NWW involved a dramatic overhaul of the existing system, with changes impacting on all workers to some degree (Dickinson et al., 2008). Described as a 'distributed responsibility' model (DoH, 2007: 14), in many ways NWW reflected skill mix changes taking place in other areas of health care but took place on a rapid, concentrated scale:

'New Ways of Working (NWW) is about developing new, enhanced and changed roles for mental health staff and redesigning systems and processes

to support staff in delivering effective, person-centred care in a way that is personally, financially and organisationally sustainable.’ (DoH, 2007: 139)

Employed as a ‘whole systems’ approach, NWW initiated change across primary, secondary and acute/inpatient services (DoH, 2007: 12). It involved extensive changes to the ways in which existing professionals worked, initially concentrating on psychiatry and then progressing to other roles including clinical and applied psychologists, allied health professionals, occupational therapists, social workers, pharmacists and the non-professionally affiliated workforce (DoH, 2007). The psychiatrist role was altered through increased delegation of more routine tasks to trainees and other members of the multidisciplinary team, in order to reduce caseload size and allow concentration on the most complex cases (DoH, 2005a). Elsewhere, the dispensing role of the mental health pharmacist for example was re-engineered to move onto wards and become more directly involved with service users and their families (DoH, 2007; Pearson et al., 2009). Change was underpinned by the Creating Capable Teams Approach (CCTA), designed to enhance and support increased multidisciplinary working (DoH, 2007).

### **Newly Implemented NPA Roles**

In addition to the development and extension of existing professional practice under NWW, a number of completely new roles were also introduced. Mirroring the wider health care situation, the vast majority of these roles formed part of the increasing non-professionally affiliated (NPA) workforce, including the Graduate Primary Care Mental Health Worker, Support, Time and Recovery (STR) Worker and the Community Development Worker (CDW) for Black and Minority Ethnic (BME) communities. Numbers of workers employed in existing NPA roles, such as the Carer Support Worker, were also increased (DoH, 2007).

These roles can be seen to form a new type of user-focused, NPA frontline staff, differing from more traditional NPA roles due to an increased emphasis on

training and education and a notable lack of attachment to any particular professional group. As the focus for the current study, a brief overview of role purpose and policy background to the NPA roles implemented under NWW can be found in Appendix A.

### **1.2.3 The Current Study**

‘Introducing new roles can often be difficult... New roles may be poorly understood or, occasionally, actively resisted; career structures may not support retention; and appropriate education and supervision may not be available. Many newer roles are not specifically linked to a single existing profession, making assimilation into services more complex.’ (DoH, 2007: 83)

The *New Ways of Working* initiative provided the contextual backdrop to this PhD study. The larger study to which it is affiliated (Pearson et al., 2009) was commissioned by the Department of Health to examine the ‘implementation and experience’ of seven key roles which were either changed or introduced under the NWW initiative. A large-scale national project, it aimed to examine the process and outcomes of these changes from a number of stakeholder viewpoints including service users, carers, workers and managers. While the research reported here was funded by the university rather than the DoH, it was envisaged that NWW would provide its central focus. Based on the background literature reviewed in Chapter 2, a subsequent decision was made to focus specifically on changes to the non-professionally affiliated (NPA) tier of the workforce.

### **Recent Developments and Current Debates: ‘New Horizons’?**

The current study developed alongside *New Ways of Working* until its implementation programme finished in 2009. Following this, a further workforce initiative, *Improving Access to Psychological Therapies* (IAPT), was also incorporated into the study design. Aiming to provide fast, primary care level access to therapy for people with mild to moderate mental health problems (DoH, 2011b),

the recent investment of £400 million into the IAPT initiative can be seen to embody the movement towards prevention, wellbeing and primary care-level mental health provision that is visible in both Labour's final strategy *New Horizons* (DoH, 2009a) and the new coalition government's first mental health publication *No health without mental health* (DoH, 2011a). Described as 'a public mental health approach', the latest policy advocates prevention and promotion with heavy emphasis on the expansion of 'talking therapies' and time-limited cognitive behavioural therapy (CBT) (DoH, 2009a: 18). This movement has received a mixed response from the user and carer community, with some cynicism around whether the care for those with severe and enduring mental health problems, estimated at around 1 in 100 people (DoH, 2011a: 8), may become marginalised as part of the process; particularly as it occurs alongside extensive closures of inpatient facilities and day centres as well as a continuing employment crisis in psychiatry (Hill, 2011; NTWSU&CN, 2011).

At the time of writing then, it would appear to be a turbulent time for UK mental health care with many unanswered questions around what future services will look like, how provision will be distributed among different user groups and what part the NPA workforce will play in the coalition government's plans for health care reform. The current service context is therefore a rapidly changing but important environment in which to examine the experiences, perceptions and contribution to care provided by NPA workers; a call upon which the rest of this thesis is constructed.

### **Defining Workers as 'Non-Professionally Affiliated'**

The term 'non-professionally affiliated' (NPA) is used in this thesis to broadly describe anyone working in a support, assistant or otherwise non-professionally qualified capacity. However there is not currently any widely agreed terminology; instead a number of phrases are used interchangeably including *unskilled, unqualified, non-professional, non-professionally qualified, paraprofessional,*

*assistant* and *support worker*. The Department of Health for example defines mental health ‘non-professionally qualified’ workers (NPQWs) in the following way:

- ‘Those employed without the requirement for a traditional professional qualification
- Those whose role is to work directly with people with mental health problems’ (DoH, 2007: 82)

Each term seems to hold subtly different connotations and the lack of uniformity has created a fragmentation in discussion which will be explored further in the literature review chapter. Although the Department of Health (2007) definition described above *does* apply to those included in the current study, the term ‘non-professionally affiliated’ (NPA) was considered to be the most appropriate, and most neutral, way to describe the roles examined here and is used throughout the remainder of this thesis.

In keeping with current thinking in the mental health field, the term ‘patient’ rarely appears in this thesis. It is replaced with ‘service user’ or ‘client’; two terms which are used interchangeably. ‘Service user’ tends to be preferred in official mental health policy and academia and so is used for clarity, while ‘client’ was the most commonly used term of reference by study participants. Both terms refer to the person making use of a worker’s particular service.

### **1.3 Thesis Structure**

The remainder of the thesis is made up as follows:

#### **Chapter 2: Literature Review**

Chapter 2 underpins the study with a consideration of the relevant academic literature, by first positioning NPA workers within the sociology of the professions and then providing a review of the findings and limitations of

existing research on NPA roles. The chapter closes with a summary of the research problem and a statement of the current study aims and research questions.

### **Chapter 3: Methodology and Study Design**

Chapter 3 describes the study's over-arching theoretical framework and subsequent choice of methodology and methods. The first section locates the study within a broadly interpretivist framework, underpinned by social constructionism as well as pragmatic considerations, and outlines the decision making process behind the choice of a qualitative, interview-based study. The second section then explores key issues related to ethics and quality in qualitative research and specific to the current study. In keeping with a qualitative, social constructionist tradition the chapter also provides a reflexive account of my own subjective position in the research process.

### **Chapter 4: Data Collection and Analysis**

Chapter 4 details how the chosen study was carried out in practice. Section 4.1 begins by outlining the sampling and participant access strategy, including how it developed in response to issues encountered in the field. It also provides key demographic information about the study sample, which is useful to compare the study to other research settings in terms of worker age, sex and background and will be drawn upon in the forthcoming results chapters. Section 4.2 provides details of data collection, including a reflexive account of the interview interaction. The final section outlines the thematic, iterative approach taken to analysis and writing.

### **Chapter 5: Redefining Worker Role: An Exploration of Professional Proximity and Client-Centred Tasks**

In light of the novel research context, the opening results chapter begins by asking a key initial question: What does the role of NPA workers look like in this

setting? The first section positions workers as 'co-producers' of mental health care within an existing categorisation provided by Kessler et al. (2007). Key features of co-production in the community context are then explored including lone working and professional distance, autonomy and responsibility. The final section proposes an alternative way of defining worker role argued to be more useful in the current study, by considering workers in terms of their position relative to the client (*supporter, facilitator or ambassador*) rather than relative to the professional.

### **Chapter 6: Exploring Variation in the Worker-Client Relationship**

Positioning the client relationship as the central aspect of worker experience, the second findings chapter uses the proposed client-centred categorisation as a framework to explore variation in the nature of the worker-client interaction. A number of shaping factors are identified, including individual characteristics, role-level factors including time and flexibility, team-level influences and the wider political context. Through its exploration the client interaction is highlighted as both a major source of potential fulfilment and also a source of burden arising from issues such as dependency and boundary maintenance. Perceived outcomes for both worker and client are considered.

### **Chapter 7: Managing the Complexities of Client Work: Preparation and Workplace Support**

In light of the complex negotiations involved in the worker-client relationship highlighted in Chapter 6, the final results chapter asks: How are workers prepared and supported for the complexities of client work? The first section explores formal and informal aspects of worker preparation including training, life and career experience. The second section considers shaping factors of workplace support under three main themes of accountability, accessibility and acceptance. In doing so attention is drawn to the informally negotiated nature of

available support structures, their importance to worker wellbeing and how they are influenced by professional perceptions and the working context.

## **Chapter 8: Discussion and Conclusions**

The final chapter draws together key contributions and discussion points from across the presented findings. Implications for the academic literature are discussed in relation to traditional NPA theory, recent developments and the worker-client relationship. Practical implications for managers and policy makers are then briefly summarised, before providing a consideration of limitations, key questions raised and directions for future research.

A timeline of the research process indicating key milestones across the 4 year period can be found in Figure 1.1.

## **Chapter Summary**

This introductory chapter has positioned the study within the relevant policy and service context and has outlined the origins of the PhD studentship as part of a wider exploration of *New Ways of Working* in mental health (Pearson et al., 2009). The current study has been set against a backdrop of extensive health care reform and a rapidly increasing NPA workforce. As will become clear as the findings unfold, the changing social and political context itself plays an important part in worker experience.

Chapter 2 will now move on to provide a review of the available academic literature relating to the non-professionally affiliated (NPA) workforce.



## Chapter 2. Literature Review

### Introduction

The introductory chapter of this thesis laid out the contextual backdrop for an exploratory study of NPA working life. It portrayed a health care system undergoing a period of substantial, widespread change, within which the growing non-professionally affiliated workforce plays a central part. This chapter moves on to explore the available academic literature related to NPA workers in health care.

The structure of this literature review mirrors how the thesis developed. It begins by positioning NPA workers within the existing sociological theory related to professional power, inter-occupational relations and skill mix change, before providing a consideration of existing research on the NPA workforce including limitations, knowledge gaps and a critical analysis of recent theoretical developments. Finally it provides a brief consideration of the 'missing client' in much existing literature; an exploration that arose iteratively from emerging findings. The chapter concludes with a summary of research gaps and key questions raised by the existing literature, before outlining the aim and research questions addressed in the current study.

The literature explored in this chapter was gathered as part of an ongoing, iterative process throughout the study's duration. Rather than following a structured process as is common in systematic reviews, a flexible approach was necessary to deal with developments including shifting terminology and the identification of additional discussion fields that consider the NPA worker.

The process began by searching databases Scopus, Medline and CINAHL for both inter-occupational and NPA literature. For the NPA studies that form the main body of the review, the final list of search terms included 'assistant',

'support worker', 'non-professional' and 'paraprofessional', in combination with the fields of 'mental health', 'health care', 'social care' or 'public services'.

Additional papers were found by examining reference and citation lists, and citation/publication alerts were set up for key search terms and authors. As the client relationship emerged as a key area of interest, the literature was re-visited using the search terms 'client', 'service user', 'patient', 'user' and 'carer' in combination with 'work\* relations\*', 'communication' or 'interaction'.

Conference presentations provided a further source of information as well as books and book chapters identified in reference lists or recommended elsewhere. The 'grey literature' was also explored by searching these databases, websites of professional bodies and the popular media.

## **2.1 The Origins of NPA Worker Discussion: Sociology of the Professions**

### ***2.1.1 NPA Roles and the Professional Project***

#### **The Sociology of the Professions**

In order to explore existing discussion of the NPA workforce, it is important to first consider its theoretical origin within the sociology of the professions; the body of literature concerned with how certain occupational groups have come to achieve and are able to maintain the privileged position in society, monopoly over specialist knowledge, market control and subsequent financial rewards that define what we commonly call a 'profession' (MacDonald, 1995; 2006).

A profession has been described as an occupation 'based on advanced, or complex, or esoteric, or arcane knowledge' (Murphy, 1988: 245). The study of professional work forms a long-standing area of sociological discussion which has moved through various developments over the last century. In the early days of the sociological dialogue for example, functionalist authors such as Durkheim

(1957) proclaimed the professions as protectors of a social order which was threatened by society's moral breakdown. Elsewhere, symbolic interactionist writers began to assert a more cynical view, with professional characteristics such as altruism and public service argued to be flawed social constructs, and the professions themselves driven by a desire for power and financial gain rather than the social good (Hughes, 1958; Becker et al., 1961). Other sociological stances have included the 'traits' approach (MacDonald, 2006) which is concerned with examining what defines a profession and how professional status is achieved (e.g. Freidson, 1970; 1994), and the 'power' approach which, linked to the work of Michel Foucault (1977), came to dominate the sociology of the professions from the late seventies onwards (MacDonald, 2006).

The most useful perspective in relation to the current study developed during the late 1970s and served to shift the focus of discussion towards a consideration of *how* the professions organised themselves in order to attain and then protect their autonomy and market power (Freidson, 1970; Larson, 1977; Weber, 1978).

Described as the 'professional project', Larson (1977: xii) examined 'what professions actually do in everyday life to negotiate and maintain their special position'. Larson's work emphasised the requirement for abstract knowledge and market potential to restrict access to it, followed by the maximisation of opportunities for income and for the exclusion of outsiders, as key steps in a profession's strive for 'collective social mobility'. Later authors, including Halliday (1987) and Abbott (1988), continued within this area of discussion by further exploring how a profession's monopoly over knowledge and power is negotiated and maintained through its 'special' relation with the state.

The sociology of the professions is crucial to the study of NPA roles because it allows a theoretical grounding as to why they were 'invented' and their subsequent implications for professional groups, as well as an insight into the power dynamics and tensions inherent in the working context into which they

are integrated. Three inter-related areas of thinking are therefore important to this thesis: the purpose and positioning of NPA workers as part of wider professional advancement processes (the professionalisation/power literature); how tasks are divided up between and within different occupational groups (the skill mix literature); and finally how members of different occupations interact when required to work together (the interprofessional/power literature). The work of Abbott (1988) provides a key development in the sociological literature which is central to each of these considerations.

### **The System of Professions and 'Jurisdiction'**

Both Larson's professional project (1977) and Abbott's (1988) later thesis *The System of Professions* shared an argument that the maintenance of high social standing requires almost continuous work to protect and negotiate professional boundaries, however Abbott's (1988) work marked a key development that is central to the consideration of NPA workers. This is because he placed heavy emphasis on how occupational groups interact and compete *with each other* through disputes over what he terms 'jurisdiction':

'The central phenomenon of professional life is thus the link between a profession and its work, a link I shall call jurisdiction. To analyse professional development is to analyse how this link is created in work, how it is anchored in formal and informal social structure and how the interplay of jurisdictional links between the professions determines the history of the individual professions themselves.' (1988: 20)

Abbott's (1988) work focused on how, once a monopoly had been secured, an occupation is then forced to compete for its share of the market against others which offer a similar or substitute service. In order to survive, the profession is therefore bound into a continuous process of defending and attempting to increase its current scope of practice - or *jurisdiction* - so that it can maintain its position in the occupational hierarchy.

Theoretical developments of Abbott's (1988) original thesis have provided insight into different types of 'boundary work' used to defend, maintain and enhance professional jurisdiction. Boundary work tactics include the use of specialist language as a 'depoliticising' strategy to exclude outsiders, stressing the scientific basis of practice and unique level of expertise required to perform it, and emphasising the profession's contribution to organisational efficiency and patient-centred care (Abbott, 1988; Larson, 1990; Leonard, 2003; Nancarrow and Borthwick, 2005; Sanders and Harrison, 2008).

### **NPA Roles as a Vertical Substitution Strategy**

In the context of the medical profession, Abbott (1988) described the development of non-professionally affiliated (NPA) groups, such as physician assistants and laboratory technicians, as an emerging boundary work tactic:

'Today subordinate groups are often directly created as the divisions of labour below dominant professions elaborate, and so subordination without contest is more common. The direct creation of subordinate groups has great advantages for the professions with full jurisdiction...' (Abbott, 1988: 72)

The proposed advantages of creating subordinate groups include the ability to delegate 'dangerously routine' work as well as the opportunity it provides for professions to create legal and public lines of distinction between itself and the subordinate occupation. Described as an advantageous and not particularly threatening strategy, the introduction of NPA roles is mentioned only briefly in Abbott's (1988) original work. A more recent conceptual development of his work by Nancarrow and Borthwick (2005) however has provided valuable further discussion which is of particular relevance here. In this paper, the authors examined types of boundary work that rely on other occupational groups and directly impact on the job remit held by both the profession and neighbouring occupations. Such tactics were identified to include the expansion of professional boundaries through diversification or specialisation, for example by encroaching

on the role of other occupations or finding 'new' tasks that become part of the professional remit, or by discarding unwanted tasks onto lower status workers or other occupational groups through horizontal or vertical substitution (Watts, Jones and Williams, 2001; Nancarrow, 2004; Nancarrow and Borthwick, 2005). The latter of these - vertical substitution - refers to the creation of subordinate groups and thus is central to discussion of the NPA workforce.

Non-professionally affiliated (NPA) workers have been described as 'a bit player in the professional project' (Kessler et al, 2006: 670). Conceptualised as a vertical substitution aspect of boundary work, NPA groups are described as a tool used by the professions to offload the dangerously routine tasks that risk the dilution of an otherwise specialist professional domain (Abbott, 1988: 72; Hugman, 1991; Nancarrow and Borthwick, 2005). During this approach, the professions discard unwanted or low status tasks onto lower grades of worker, thus freeing them to take on new, specialist or higher status roles (Hugman, 1991; Nancarrow and Borthwick, 2005). This is suggested to hold an advantage over horizontal substitution strategies - whereby tasks are offloaded onto neighbouring occupational groups - as it allows greater control over delegation and has less associated threat due to the low status of workers (Nancarrow and Borthwick, 2005).

Vertical substitution strategies nevertheless have risk attached, as professional boundaries risk encroachment from lower status groups (Nancarrow and Borthwick, 2005). Delegation to NPA workers also allows health care providers an opportunity to replace expensive practitioners with lower cost workers (Francis and Humphreys, 1999; Nancarrow and Borthwick, 2005). Once unwanted tasks have been discarded, control over them is lost to other practitioners. If it then becomes necessary to regain ownership, for example if demand drops for the new, more specialised role, the profession is forced to compete with other occupational groups for a share of work over which it once

had jurisdictional control. In the case of vertical substitution, the profession is unlikely to be successful when those who have adopted the tasks provide a cheaper service (Nancarrow and Borthwick, 2005).

### **2.1.2 Shifting Divisions of Labour: The Role of NPA Workers in Skill Mix Change**

Sociological theory suggests that for NPA workers to remain a useful and non-threatening tool to the professions they must remain low status (Nancarrow and Borthwick, 2005). The image of NPA workers however is no doubt changing as they become more prominent within teams and more 'qualified' in their own right as they are encouraged to access education and training opportunities (Cuthbert and Basset, 2007). The risk of delegating to HCAs is perceived to have increased alongside their growing numbers and increasing involvement in direct patient care (Grimshaw, 1999; Nancarrow and Borthwick, 2005; Bach et al., 2008).

Discussion of the shifting remit boundaries between professional and non-professional groups forms part of rapidly growing, related body of literature around 'skill mix' change. The skill mix literature specifically examines how the balance of skills is distributed within a team and thus focuses on how tasks are divided up between and within different occupational groups (Halliwell et al., 1999).

Descriptive terms such as 'delegation', 'substitution', 'diversification' and 'dilution' are all used in relation to the broad concept of skill mix change (Young-Murphy, 2006). Halliwell et al. (1999) suggested two contrasting ways that skill mix can be perceived: firstly as *delegation* or *substitution* which focuses on the transfer of tasks from highly qualified to cheaper workers and has negative connotations of cost reduction, and secondly as *diversification* which is generally viewed more positively as a route to service enhancement through the 'recruitment of a variety of different professionals to meet identified health needs or by training existing staff to enable them to acquire new skills' (1999: 4).

Examples of skill mix change in the current health care system include the way in which doctors are delegating more administrative and technical tasks to nurses, while the nurses themselves delegate 'non-core' parts of their role to healthcare assistants (HCAs) (Grimshaw, 1999; Thornley, 2000; Bolton, 2003; Bach et al., 2008; Currie, Finn and Martin, 2009). A similar situation can be seen in mental health, where consultant psychiatrists are delegating more routine parts of their role to trainees and other occupations within the CMHT, thus allowing them to concentrate on the most complex cases (Pearson et al., 2009). As will be explored in Section 2.2, skill mix studies - which make up the bulk of the NPA literature - primarily examine how tasks are divided up between different groups, the process of delegation and worker reactions to it.

Although the skill mix and professionalisation/power literatures often appear as separate bodies of discussion, the examination of how tasks are transferred between and within occupations can be effectively located as the 'boundary work' tactics of vertical and horizontal substitution already described as a potential way to protect professional jurisdiction (Abbott, 1988; Nancarrow and Borthwick, 2005). A key advantage of the skill mix literature is the attention it pays to the political and workforce pressures that underpin the transfer of tasks between occupations, something that is often missing from the power literature:

'Skill mix is a determinant of, and determined by, organisational and system context... therefore requires the capacity to analyse the context, identify appropriate solutions, and manage sustained change within the system.'  
(Buchan and Dal Puz, 2002: 579)

The growing body of discussion has however been open to criticism; Spilsbury and Meyer (2001), Buchan and Dal Puz (2002) and Crossan and Ferguson (2005) have all argued that the evidence base is limited and vague due to poor study design, focus on description rather than interpretation and inconsistent terminology used by authors. Furthermore, Crossan and Ferguson's (2005)

literature review raised questions around the use of a predominantly US-based literature to underpin important policy decisions in the UK. More specific criticisms in relation to this study, such as the lack of application to community working contexts, will be considered further in the following section.

### **The Role of the State: What is the Future for the NPA Workforce?**

The wider societal context plays an important role in the skill mix disputes between professional and non-professional groups identified in existing literature. Increasing NPA numbers have occurred alongside the 'destabilising' of professional authority through an increasing emphasis on public involvement in service development and a loss of public trust in the medical profession following a string of high profile scandals (Davies, 2003: 181; Cuthbert and Basset, 2007). A growing body of research illustrating the value of NPA support to service users and carers (e.g. Murray et al., 1997; Huxley et al., 2005; Pearson et al., 2009) provides an additional, indirect challenge to the professions, who are 'perceived as having lost the ability to relate to service users as people rather than patients' (Cuthbert and Basset, 2007: 6).

The role of the state is clearly important here, as delegation becomes increasingly threatening should professionals be forced to give away central aspects of their role rather than menial or unwanted tasks. Yet as Nancarrow and Borthwick (2005) have pointed out:

'This is the first time in the history of the current professions that the state has explicitly supported non-medical practitioners to encroach on traditionally medical roles.' (2005: 913)

Authors suggest that this is a fundamental issue in the nursing workforce, where the policy requirement to take on increasingly technical and managerial duties is forcing nurses to give away patient-focused tasks that previously made up the core of the profession (Spilsbury and Meyer, 2004a). Even distinguishing between

core and non-core tasks can prove difficult in the field of health, due to the holistic nature of the ideal care package (Kessler et al., 2007).

It would seem then that the professions are under increasing threat from NPA encroachment. At present however, there seems to have been limited conceptual development within the sociological literature in relation to longer term or more abstract predictions for the future of the NPA workforce. As raised in Chapter 1, given their centrality to workforce reform initiatives it seems unlikely that we will see anything other than an upward trend in employment. Whether this will be absorbed as part of the 'ebb and flow' of the normal functioning of the professions as they adapt to market pressures (Abbott, 1988; Derber et al., 1990; Freidson, 2001; MacDonald, 2006: 370), or provides a more serious challenge to professional jurisdiction, is unclear at present:

'The impact of these roles on professional status remains to be seen.'  
(Nancarrow and Borthwick, 2005: 913)

Section 2.2 will examine the tangible consequences of these uncertainties for those caught up in jurisdictional disputes in the workplace.

### ***2.1.3 NPA Introduction in a Multidisciplinary Context: Interprofessional Working in Healthcare***

#### **Multidisciplinary Working in Healthcare**

Sections 2.2 and 2.3 will consider the extent to which the sociological predictions raised in this section have been supported, by providing a critique of existing research on the NPA workforce. Before moving on to this however, it is important to note that the settings into which NPA roles are being introduced are not neutral territory. Given that boundary work often depends on the exploitation of other occupational groups, the protection of professional jurisdiction creates an almost continuous system of competition and conflict with neighbouring occupations (Abbott, 1988; Nancarrow and Borthwick, 2005).

Suggested to be exacerbated in health care settings due to the extreme dominance of medical power and increasingly complex, changeable nature of the workforce (Parry and Parry, 1978; Sanders and Harrison, 2008), the emphasis on multidisciplinary team working in recent modernisation initiatives has been acknowledged as one of the greatest barriers to successful outcomes (DoH, 2000). Critics argue that the 'unhealthy rhetoric' of positive team working in government policy leaves newly qualified professionals (and presumably NPA workers) unprepared for the 'messy reality' of working practice (Stark, Stronach and Warne, 2002: 417).

The multidisciplinary settings into which NPA workers are introduced have been construed as occupational battlefields. While positive outcomes of team working have been documented to include improved planning, a more clinically effective, responsive and patient-focused service and more satisfying roles for healthcare professionals (Caldwell and Atwal, 2003; Atwal and Caldwell, 2005), a vast body of research highlights difficulties and failures associated with interprofessional collaboration attempts. Professional divides, power hierarchies and conflicting underlying agendas have been illustrated as barriers to shared communication and effective leadership, creating a working culture described as tribalism (e.g. West and Poulton, 1997; Rushmer, 2000; Larkin and Callaghan, 2005; Shaw, de Lusignan and Rowlands, 2005; Cole and Crichton, 2006; Lymbery, 2006; Weller et al., 2008). Collaboration initiatives have also been shown to have 'unintended divisive effects' (Finn, 2008: 125) by actively promoting boundaries between the professions, increasing structural inequality and making team members more insistent on separate professional identities (Brown, Crawford and Darongkamas, 2000; Finn, 2008; Finn, Learmonth and Reedy, 2010).

Collaboration difficulties are often attributed to the acute dominance of medicine over more socially orientated professions such as social work and nursing (Huntington, 1981; Hiscock and Pearson, 1999; Kharicha et al., 2005). The 'deep

rooted prejudices and poor personal relations' observed in the literature (Hiscock and Pearson, 1999: 191) are in part explained by contrasting socialisation processes as well as stark differences in the personal profile and motivation of who enters each profession, argued to create distinct occupational cultures, language differences and conflicting perceptions of the care process (Huntington, 1981; Sadler, 2003; Garman, Leach and Spector, 2006). Effective collaboration requires these 'diverse worldviews to be reconciled' (Garman et al., 2006: 842). Interestingly, in both social work and nursing the resultant outcomes for team working appear to be conformity rather than conflict (Mackay, 1997; Manthorpe and Iliffe, 2003; Atwal and Caldwell, 2005; Kharicha et al., 2005).

### **Multidisciplinary Working in Mental Health**

The mental health workforce has received much less attention from researchers than areas such as general nursing, primary or emergency care, but what findings do exist tend to follow a similar pattern with particular tensions reported between social workers and psychiatrists, occupational therapists and nurses, and clinical psychology and psychiatry (Hughes, 2001; Pilgrim and Rogers, 2001; Cooper, 2010). The future of psychiatry is the central tenet for much current professional concern, with a 'creeping devaluation of medicine' perceived to have resulted from weakened powers of treatment and detention (Craddock et al., 2008: 6). Combined with increasing public and professional interest in social and psychological perspectives, this is perceived to have led to the rising dominance of clinical psychology (Craddock et al., 2008; Pilgrim and Rogers, 2009; see also reply to Craddock et al., 2008 by Barker et al., 2008).

Studies of multidisciplinary working in community mental health to date have tended to rely on survey data to highlight working difficulties and inequities between team members. High emotional exhaustion and burnout has been demonstrated across all occupational groups, with social workers highlighted as the profession to suffer most extensively alongside lower reported levels of job

satisfaction, role clarity and perceived input into decision making (Onyett, 1997; 1999; Carpenter, Barnes and Dickinson, 2003; Evans et al., 2006).

A recent review of updated literature on CMHTs (Onyett, 2011) returned more mixed findings than the author's original (1997) survey, suggesting that while some data supports higher than average emotional exhaustion and burnout, other studies have found low or average scores for CMHT members compared to other areas of health (e.g. Nelson, Johnson and Bebbington, 2009; Crawford et al., 2010). The contradictory findings were attributed to shortcomings of the quantitative approaches used by researchers, including small sample sizes, low response rates, inconsistent use of dependent variables and the lack of contextual details. These design issues were argued to have prevented insight into unexpected findings, for example why high burnout and high job satisfaction tend to occur together, with the author concluding that qualitative research in community mental health is rare yet increasingly necessary:

'At a time when morale... is more critical than ever, it may be timely to consider more qualitative study... of how community mental health work is experienced, particularly if it can focus on how people stay effective and resilient in hard times...' (Onyett, 2011: 205)

The number of qualitative studies available in the literature does appear to be slowly increasing. Peck and Norman's (1999) early work established an interprofessional dialogue between CMHT members and highlighted differences in culture and values as well as role clarity and power issues similar to those expressed in the wider health care literature. Particular tensions were described for social workers, who felt that 'social work is under siege' (1999: 237). In a further paper, Norman and Peck (1999) reported a general consensus among professional organisation representatives that multidisciplinary collaboration *is* possible but faces a number of barriers including strong occupational cultures and the absence of a unified philosophy of care, as well as a loss of faith in the

mental health system and mistrust of 'managerial solutions to the problems of interprofessional working' (1999: 221). The authors called for the development of a strong, user-centred philosophy of care as well as clearer articulation of role, accountability and responsibility within the multidisciplinary team.

A small number of further qualitative studies have supported the idea of occupational divides presenting problems for collaboration (Salhani and Coulter, 2009; Leach and Hall, 2011). In Salhani and Coulter's (2009) ethnographic account of one multidisciplinary mental health team in a Canadian hospital, the team's social worker, pharmacist and rehabilitation counsellor all reported to feel marginalised, 'outsiders'. Substantial divisions were observed between all occupations including conflict between OTs and nurses, psychiatry and psychology and an 'inconsistent and cautious' relationship between nurses and the team psychologist (2009: 1226).

Elsewhere, other studies have suggested a more balanced view and possible shift in attitudes, for example Carpenter et al.'s (2003) interview-based study found that CMHT staff identified more strongly with their team than with their profession and held a positive, shared philosophy of care. Lankshear's (2003) interview-based study of 55 CMHT members in one UK case study site illustrated that despite tensions over 'inequitable' caseloads and some loss of identity felt by social workers, otherwise positive personal relationships existed with workers displaying sympathy for excessive workloads and reciprocal attempts to help co-workers manage this. Similarly, Donnison et al.'s (2009) study of seven CMHT professionals using Interpretive Phenomenological Analysis (IPA) suggested that pragmatic, practical issues involved in managing demand were of greater importance to team members than issues around power or identity. Furthermore, despite Pilgrim and Rogers' (2009: 953) suggestion that New Ways of Working 'came for psychiatrists to symbolise encroachment from other professions', Pearson et al.'s (2009) qualitative evaluation found

psychiatrists to be supportive of the introduced workforce changes and their outcomes in terms of reduced workload and enhanced role flexibility.

### **The Bleak Picture: Are Times Changing?**

It would seem then that there is at least hope for a more optimistic model of multidisciplinary working. The wider health care literature has also displayed growing interest in a possible shift from 'old' professionalism, based on mastery of knowledge, self-management and a view of the patient as dependent, to a 'new' professionalism model based on reflective practice, collective responsibility and the patient as empowered (Davies, 1996; Hudson, 2007). This has been strengthened by studies of long term interprofessional education (IPE) that demonstrate positive effects on team integration and shared practice as long as such programmes are well designed and supported (Carpenter et al., 2006; Pauze and Reeves, 2010).

Contextual factors appear central to the more optimistic model of joint working. For example Hudson's (2007) case study of a large-scale integration of primary health care, social care and council based housing services highlighted that socialisation to an immediate work team can override professional differences so long as the team is co-located and well-prepared, with enough inter-organisational commitment and planning (Hudson, 2007). Molyneux's (2001) longitudinal, qualitative study of a stroke rehabilitation team also highlighted the importance of time; working relationships were shown to become closer and professional boundaries less significant as the study progressed, as staff adjusted to their new roles. Nancarrow's (2004) interview-based case study of two intermediate care teams added the importance of communication and individual factors. Instances of conflict or feeling threatened were rarely reported and practitioners described negotiating their differences effectively through listening to each others' perspectives. The positive findings were largely attributed to

workers feeling confident in their own role and holding a clear understanding of the role of other team members (Nancarrow, 2004).

### **Visibility of NPA Workers in the Interprofessional Literature**

Despite some positive findings, the interprofessional literature outlined in this sub-section has suggested that difficulties around multi-disciplinary working are still clearly visible at the forefront of many workers' experience. Unfortunately, a historic lack of visibility of NPA workers within the interprofessional literature makes it difficult to predict how those employed in NPA roles experience the team environment. As the name would suggest, research on interprofessional working tends to focus on interactions and barriers between *professional* roles; non-professionally affiliated (NPA) workers have rarely formed part of the study sample when a whole-teams approach has been taken to research (e.g. Brown et al., 2000; Atwal, 2002; Lankshear, 2003; Atwal and Caldwell, 2005; Larkin and Callaghan, 2005; Miller et al., 2005; Donnison et al., 2009). Peck and Norman's (1999) study of community mental health teams included support workers in the study sample but their views did not feature in the subsequent paper published by the authors, citing the reason:

'As a group without the traditional characteristics of a profession, there are issues concerning the relationship of community support workers within CMHTs both to the approach described in this paper and, more importantly, to their colleagues within those teams which require further exploration.' (1999: 240).

The call for further exploration appears to have been slow in coming. While there has been a recent explosion in interest on skill mix negotiations between nurses and HCAs (discussed in Section 2.1.2), the increase has not been matched within community MDTs or for wider NPA roles such as traditional support workers. One recent exception is Leach and Hall's (2011) mixed methods case study of joint working in mental health provision to university students which involved interviews with both professional and non-professional staff; however the

authors' subsequent discussion focused on a more general overview of issues around primary-secondary care divides and barriers to collaboration between professional groups (including psychiatry and nursing, and psychiatry and psychology) rather than commenting on how NPA workers experienced multidisciplinary working.

Whether the historic lack of interprofessional interest in NPA roles is due to NPA workers not being present within multidisciplinary teams at the time of study is unclear and can not be easily inferred from the majority of authors' study descriptions. However critics argue that there has always been an extensive NPA workforce, but it is only newly developed roles or those with other significant implications for professionals, such as the recent extension/expansion of the HCA remit, that receive academic attention (Redfern, 1994; Thornley, 1997; Spilsbury and Meyer, 2004; Cuthbert and Basset, 2007). Unfortunately this leaves us heavily reliant on the skill mix literature upon which to draw inferences, despite such studies generally taking place in a different - and often more homogenous - type of working environment. Section 2.2 will now provide an overview and critical evaluation of existing findings on the topic of the NPA workforce, including consideration of how they may apply to more multi-disciplinary contexts.

## **2.2 The NPA Worker Experience in Health Care**

The first key point to note in relation to existing research on the NPA workforce is the evident *lack* of available findings. Described as 'a shared neglect of the assistant role' across the sociological and organisational literature (Kessler, Bach and Heron, 2007: 1650), until recently little was even known about the numbers of support workers employed in the UK or what such roles entail (Thornley, 2000; Nancarrow, 2005; Cuthbert and Basset, 2007). Despite a recent surge in interest, what research does exist has a number of theoretical and methodological

limitations that need to be addressed. As will become clear as this section unfolds, studies are often confined to:

- Consideration of the health care assistant (HCA) role
- Hospitals and other clinical settings
- Small scale, often 'one-ward' samples
- Discussion of the NPA-professional relationship
- Viewpoints other than those of the NPA workers themselves

Existing discussion of the NPA health care workforce tends to fall within two main themes: examination of the relationship between NPA worker and the delegating professional, and/or consideration of practical issues, particularly related to training and supervision arrangements. The former thread tends to be strongly situated within the skill mix literature while the latter often draws upon evaluation studies of the implementation of a specific new role and tend to concentrate on practical issues rather than engaging heavily with academic theory. In addition, a third emerging theme led by Kessler et al. (2006; 2007) has recently drawn attention to the impact of organisational and workplace factors on worker role, addressing some of the limitations outlined above by using multi-site, large scale samples and comparisons outside of health care.

### ***2.2.1 The HCA- Registered Nurse Relationship***

The relationship between healthcare assistants (HCAs) and the registered nurses (RNs) they are employed to support is the most discussed aspect of the NPA experience available in the literature. In keeping with sociological theory, it has been depicted as a relationship based on conflict and misunderstanding, whereby registered nurses undervalue and underestimate the role of HCAs (e.g. Reeve, 1994; Rhodes, 1994; Baldwin et al., 2003; Spilsbury and Meyer, 2004a). Authors have highlighted vast differences between the two occupations in their perceptions of what the HCA role entails and its place within the care process

(Cole, 1989; Savage, 1998; Baldwin et al., 2003). Whether this is due to HCAs over-estimating their own role or nurses playing down the support worker contribution is unclear, although observational and interview-based studies have suggested that the actual duties performed by the two roles are very similar (Ahmed and Kitson, 1993; Thomas, 1993; Redfern, 1994; Thornley, 1997; Carr-Hill and Jenkins Clarke, 2003)<sup>1</sup>.

As predicted, tensions between the two groups are observed to be increasing alongside expansion of the HCA remit. Thornley's (1997) large scale survey of HCAs illustrated that they carry out a large number of registered nursing tasks including invasive procedures and wound care. In a further survey by Duffin (2001) over half of HCAs reported taking part in the formulation of patient care plans, with a small number also providing injections, supervising other staff and training student nurses. Given that accountability for HCA tasks remains with the registered nurse, the process of delegation is described as 'fraught with moral and legal difficulties' (McKenna, Thompson and Watson, 2004: 456).

Spilsbury and Meyer's (2004) interview and observation-based case study of one hospital ward described a tense but co-dependent relationship, whereby both tiers of the workforce were reliant on each other for fulfilment of their own role. Delegation from nurse to HCA was illustrated to be largely *informally* negotiated, leading to potential exploitation of the HCA when called upon to undertake tasks for which they had not been trained.

By examining differences between reported and observed practice, the authors demonstrated frequent examples of 'hidden work' carried out by HCAs, for example to cover gaps in junior nursing care. In doing so, it was argued that the

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<sup>1</sup> Crossan and Ferguson (2005) argue that this perceived similarity may be due to observational research techniques failing to take into account the therapeutic context of nursing tasks, leading to an oversimplification of qualified nursing activities. Davies (1992) had previously illustrated that qualified workers use more sophisticated discourse strategies than NPAs, including providing choice and explanation to patients and eliciting feedback; aspects suggested to enhance the therapeutic relationship and improve patient experience.

lack of opportunity for formal communication and knowledge sharing between the two groups has not been acknowledged at an official policy or management level. In a second paper of the same year, Spilsbury and Meyer (2004b) added to their argument by illustrating the informal negotiations to contain 'dynamic patterns' (2004b: 411) of use, misuse and non-use of HCAs by registered nurses. Examples of HCA 'exploitation' (2004b: 415) included blood glucose monitoring and assisting in the operating theatre, often combined with a 'non-use' of pre-existing skills and experience.

Perhaps unsurprisingly given the underlying sociological theory, registered nurses are reported to feel threatened by support workers, with findings pointing to 'an ongoing struggle for power and professional prestige' (Baldwin et al., 2003; Redfern, 1994; Workman, 1996; Daykin and Clarke, 2000; Jervis, 2002). The nature of tasks that are being delegated, usually those focused on direct patient care and interaction, appears central to this. Authors suggest that the loss of these formerly core tasks risks the erosion of nursing's long standing focus on the delivery of essential patient care (Davies, 1995; Bach, Kessler and Heron, 2008). The introduction of HCAs has been shown to contribute to role intensification for nurses alongside increased managerial, supervisory and administrative responsibilities and decreased patient contact time (Adams et al., 2000; Petrova et al., 2010).

As HCAs become more visible and important to patients, it is therefore argued that the HCA-patient relationship is becoming what the nurse-patient relationship once was, before registered nurses were forced to leave the patient bedside to follow a more managerial role (Spilsbury and Meyer, 2004a, 2004b). Giving up patient-centred tasks is an issue about which nurses express both regret and unease (Spilsbury and Meyer, 2004a, 2004b; Bach et al., 2008). A similar situation was described by Mackey and Nancarrow's (2004) focus group evaluation of the introduction of the occupational therapy assistant. Conflict was

observed due to professional reluctance to delegate tasks to assistants, reportedly because the tasks they were being forced to give up - those involving direct care and interaction - were the reasons for which they had entered the profession. The introduction of the assistant role was perceived to devalue occupational therapy by acknowledging that less qualified workers could perform aspects of the role, rather than being seen as a positive opportunity to discard unwanted tasks (Mackey and Nancarrow, 2004).

A few recent studies have hinted at a more positive response from professionals. For example, Petrova et al.'s (2010) interview-based study of nurse and GP views on the employment of primary care HCAs across 16 general practices suggested a mixed but overall positive attitude towards HCA introduction, with benefits reported in the form of more appropriate use of registered nurse skills and waiting time reductions through an increased availability of appointments. Despite the reported benefits however, the authors noted that associated challenges and demands including time commitment to HCA training and support, understanding the limits of the role and resistance from existing staff were discussed more heavily than perceived benefits. Some initial insecurities were reported to have decreased over time while others, particularly where HCA introduction was attributed to a more general sense of the devaluation of nursing, were considered to be 'more persistent and deep-seated' (2010: 307). Interestingly, and in keeping with jurisdictional theory, GPs were less likely than nurses to perceive tensions or see the HCA role in negative terms.

As is clear in the discussion so far, there is a notable lack of visibility of the NPA worker themselves in much existing literature on HCAs, which often examines professional concerns rather than those of the assistant. Spilsbury and Meyer's (2004a, 2004b) work formed a valuable advancement by providing an insight into the subjective HCA viewpoint. Interviews with hospital-based HCAs expressed frustration at the inconsistent, fluctuating level of responsibility they were

afforded depending on demand and registered staffing levels. Delegated more complex tasks at times of staff shortages, responsibility was then revoked once demand eased. Workers reported feeling under-utilised and undervalued in terms of their past experience and available skills (Spilsbury and Meyer, 2004a).

The most recent studies of nursing skill mix change have shifted discussion to the introduction of the 'higher-level' Band 4 support role of assistant practitioner. At present academic evaluations are at an early stage, limited to mapping exercises and preliminary reports (Spilsbury et al., 2009; 2010), but the role's implementation raises some interesting questions around its implications for registered nursing, particularly in light of early suggestions that the assistant practitioner role shares more similarities with the registered nursing remit than that of HCAs (Spilsbury et al., 2010). Mirroring the early HCA literature, initial findings have pointed to confusion around role boundaries and purpose, alongside a perceived paucity of national policy guidance and consideration of the role as a 'work in progress' (Spilsbury et al., 2010). In addition, findings have suggested a 'general feeling of anxiety about where the role is going and what these workers will do' (Spilsbury et al., 2009: 623). Echoing earlier commentary, it is not yet possible to tease out teething problems of the role's implementation from more deeply rooted underlying issues.

### ***2.2.2 Supervision and Training Issues***

The second key area of discussion related to the NPA health care workforce is practical issues around supervision and training, with the majority of studies highlighting this to be a major problem for workers. Savage's (1998) early survey of one general hospital reported that as little as 38% of support workers in acute care believed that they were sufficiently trained to perform their role effectively. In Thornley's (2000) case studies of health care assistants in the NHS, half of support workers reported having little or no supervision. Baldwin et al.'s (2003) review of 12 empirical studies pointed to inadequate preparation and subsequent

supervision for support workers in hospital and nursing home settings. In Spilsbury and Meyer's (2004a) hospital ward study, HCAs reported and were observed working predominantly alone, with tasks usually undertaken 'behind closed doors' (2004a: 75) and without any direct support or supervision from nurses. Nurses confirmed that supervision was often lacking due to registered staff shortages. Likewise, Mackey and Nancarrow (2004) evaluated the introduction of occupational therapy assistant practitioners and identified a lack of access to appropriate training and ambiguous supervision and accountability relationships.

Issues have been shown to extend outside of the hospital ward; Fleming and Taylor's (2007) study of home care workers (HCWs) in Northern Ireland highlighted a perceived lack of management support and failure to recognise the increasing job demands in training as the primary factors influencing poor retention. McDonnell and Lynch (2004) also demonstrated supervision and on-the-job support problems to extend to voluntary sector family support organisations, where they found no formal support structures in place.

It is important to note however that not all studies have found such negative provisions to workers. Nancarrow and Shuttleworth's (2005) descriptive study of support workers in intermediate care painted a more encouraging picture. Although the authors expressed concern at the wide variation in supervisory arrangements between organisations, over half of the support workers studied held a formal qualification and sources of training such as National Vocational Qualifications (NVQs) or in-house training were accessible to the majority of workers.<sup>2</sup>

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<sup>2</sup> A potential criticism of the findings is that they may have been a product of the criteria used to select participating teams; for example they had to demonstrate evidence of strategic support within the local region, inter-agency support and a plan to develop the role and spread it across the whole organisation. These could arguably be more optimistic conditions than the 'typical' intermediate care team.

### **2.2.3 Recent Theoretical Developments: The Importance of Context**

Despite some limited optimism, the picture painted by existing NPA research so far has been a fairly bleak one. It also holds some clear limitations. Whilst forming the majority of discussion into NPA worker experience, the extent to which discussion of the relationship between HCAs and registered nurses can be applied to other roles and settings is questionable; a consideration made even more complex by the small, often one-ward samples upon which findings are usually based. The hospital setting itself is also problematic, given its long-standing reputation as a 'hierarchical tradition with professional divides' (DoH, 2005b: 24) which may well emphasise power inequalities and tensions between assistant and professional. Whether similar findings can be demonstrated outside the hierarchy of the hospital ward remains to be tested in any depth; an important observation given the current study's focus on community mental health care. As Davies (2003) has pointed out, sociological analysis of the health care system has traditionally taken place in the hospital, clinic or asylum; yet the role of these institutions is becoming less central to both the patient experience and to government health care policy. Sociologists must act accordingly by moving the discussion into more historically and culturally relevant settings (Davies, 2003).

The importance of context has been brought sharply into focus by a series of recent theoretical developments led by Kessler et al. (2006; 2007; Bach et al., 2007; 2008). Providing a strong commentary on the applicability and relevance of much existing literature, the authors focus on two key methodological limitations: the lack of consideration of the subjective NPA worker (or in this case, *assistant*) viewpoint, and the lack of attention to organisational, workplace and policy influences on worker role (Kessler et al., 2007; Bach et al., 2008). This reflects a broader discussion of the widening 'gulf' between the researchers of health

policy and organisations and the sociologists of health and illness (Davies, 2003).

As Davies (2003) argues:

‘It is time for sociology to re-engage with the formal organisations that are being created and transformed to adapt to a new climate of ‘modernisation’ and to tease out the impact of this.’ (Davies, 2003: 181)

### **Workplace and Sub-Sector Variation**

Utilising a large scale, interview and observation-based study of HCAs across two acute NHS Trusts, Bach et al. (2008) highlighted how workplace variation can create different outcomes for workers. In one of the Trusts studied, it was illustrated that health care assistants took on a role in line with the ‘professional’ nursing ethos (Thornley, 1996) whereby HCAs took on a relief, ‘helper’ role, structured and directed by registered nurses under a strong rejection of the idea that it could form the first step towards registered status. This reflects the model commonly found in the HCA literature and advocated by the Royal College of Nursing, whereby strict boundaries are placed around the nursing role in an attempt to justify its distinctive contribution and seek occupational closure (Bach et al., 2008).

In contrast, the second trust adopted a more ‘radical’ approach (Thornley, 1996), in line with newer, ‘grow-your-own’ style management approaches. Here the HCA took on an ‘apprentice’ role, benefiting from a clearly defined career pathway that emphasised competencies and prior experience over educational attainment. This step away from the traditional view of the nursing workforce was reported by both HCAs and managers to increase HCA performance, job satisfaction and self-esteem while findings from the ‘professional’ Trust mirrored earlier literature, with HCAs reporting conflict with registered nurses and relatively low job satisfaction, combined with frustration at being unable to make the most of their skills (Bach et al., 2008). Thus, the authors argue that while the professional model may be the most prevalent nursing ethos, and the most

commonly researched working environment, it is dependent on context and, importantly, is not the *only* possible outcome of the HCA-registered nurse relationship (Bach et al., 2008).

The broader study of which Bach et al.'s (2008) HCA consideration formed part was also used to consider the influence of sub-sector variation on worker role (Bach, Kessler and Heron, 2007). Using Labour Process Theory's concepts of degradation and empowerment (Braverman, 1974) the authors examined the impact of social work assistants and teaching assistants on the professionals they were employed to support. In contrast to the assumption that the empowerment of one role (i.e. the professional or the assistant) can only occur at the expense of the other's degradation, as implied by much of the sociological literature, in both sectors the professional *and* assistant were shown to be 'empowered by the emergence of the assistant role' (2007: 1288). Both teaching assistants and social work assistants showed fairly high job satisfaction and reported that their working lives were enriched by role expansion and opportunities for career development. Professionals reported to feel empowered through the assistants providing significant relief from administrative 'burdens', without greatly adding to managerial responsibilities.

However rather than a straightforward positive sum game, the authors illustrated a complex picture of blended outcomes whereby benefits sat alongside aspects of degradation that varied by sub-sector, leading to contrasting outcomes between the two settings. Social work assistants reported difficulties controlling their workload, while teaching assistants reported relatively less role overlap with professionals, less opportunity for career development and generally lower job satisfaction. Differences were largely attributed to sub-sector factors including variations in workload pressure and regulation of the respective workforces (Bach et al., 2007).

### **Categorising Worker Role**

Perhaps the most useful work in terms of theoretical advancement of our understanding of NPA roles is Kessler, Bach and Heron's (2007) proposed classification of the assistant role. Based on an integration of findings across health, social care and education, the authors propose four possible roles that the assistant worker may take, depending on sub-sector, organisational and workplace influences. Definitions of each proposed category are provided in Figure 2.1.

**Fig. 2.1 Assistant Role Categorisation Provided by Kessler et al. (2007)**

<b>Role</b>	<b>Key Features</b>
<b>Relief</b>	The assistant performs non-core tasks previously undertaken by the professional, thus allowing the professional to focus on core tasks. Similar to skill mix as promoted in health care policy, in order to ensure that tasks are carried out by the most appropriate worker. Implies that professionals are happy to give these tasks away.
<b>Substitute</b>	The assistant undertakes core, professionally 'owned' tasks, driven by financial considerations and professional staff shortages. An 'opportunistic response' to the 'economic reality of skill mix'.
<b>Co-Producer</b>	The assistant contributes alongside the professional in a distinctive, complementary way, adding distinct skills and providing a service that would otherwise not be carried out. The role is policy directed, with emphasis on provision to the service user.
<b>Apprentice</b>	The assistant role forms the start of a pathway into professional training and subsequent registration, therefore providing preparation for a professional career. Described as a 'grow your own' strategy. The government often markets NPA roles in this way, for example through claims of improved career pathways and the 'skills escalator' introduced as part of NHS Agenda for Change.

Figure 2.1 above provides a definition of the four NPA role categories developed by Kessler et al. (2007): *relief*, *substitute*, *co-producer* and *apprentice*. The authors argued that the existing NPA literature's preoccupation with the professional perspective has led to discussion dominated by the consideration of assistants as relief or substitute.

In the same work, Kessler et al. (2007) merged the definitional categorisation with contextual influences by proposing an analytical model to illustrate the relationship between sub-sector and the development of assistant roles. Three levels of influence were suggested to explain why and how differences in development occur: work process (the range of activities involved in service delivery), job design (the way these activities are grouped together into workplace roles) and workforce and professional regulation (rules governing the distribution of tasks and responsibilities). These factors are suggested to interact with both local conditions and personal attributes of the post-holder (including background and personality characteristics) to create the variation observed when examining a specific role in its specific context (Kessler et al., 2007). The model therefore raises a number of influences on role development that are usually outside the realm of sociological NPA discussion including individual, workplace, organisational and policy factors.

### **Limitations of Recent Developments**

Kessler et al.'s (2006; 2007; Bach et al., 2007; 2008) recent body of work has provided a necessary and highly valuable shift in focus; signalling a move towards placing the NPA worker at the centre of the analysis, reconsidering what workers actually do and positioning the whole discussion more firmly within the political and historical context. Nevertheless, it holds some limitations. Although the authors advocate the subjective NPA viewpoint, the research focus remains undoubtedly professionally-orientated, in that it retains the NPA-professional interaction as its central focus albeit from the workers' own viewpoint. This assumption of professional centrality seems grounded not in the subjective NPA worker experience but in the sociological theory underpinning traditional thinking. Essentially we don't know whether the professional relationship really *is* the central defining feature of worker experience, or whether a sense of its importance has been constructed somewhat artificially through academic

discussion. In order to fully consider the role of the NPA worker, 'in its own right and from the vantage point of those performing it' (Kessler et al., 2007: 1652), it may be more useful to start with a holistic approach to understanding what the workers themselves see as important.

Secondly, although Kessler et al.'s (2006; 2007) work moves the discussion into an arena outside the confines of the hospital ward, it stays firmly within settings where notably 'traditional' assistant-professional relationships exist. Because of this, while the 'co-producer' is raised as a potential role performed by NPA workers, this aspect of the categorisation remains under-developed. How the authors' classification system and related discussion would apply to contexts such as community mental health care, where newly developed NPA roles are less 'attached' to any particular profession, remains to be seen. If the co-producer role becomes more prevalent here, this raises some interesting questions around status and interprofessional relations that are yet to be developed. Finally, 'other workplace actors' and worker background/profile are raised as key influences on role development, yet are not detailed in any depth.

### **2.3 NPA Roles in Mental Health**

The importance of sub-sector and workplace variation holds implications for the lack of available discussion in the mental health field. Mental health NPA workers represent a vastly under-researched group, particularly those based in community services. It is unclear how the community working context shapes working life, how recent theoretical developments can be applied to roles that are not attached to a specific profession, and whether the tensions reported elsewhere can be replicated outside of the clinical arena. Mirroring other areas of health, what studies do exist in mental health care tend to examine the implementation of a new role into the workforce and as such are often small scale studies with a discussion focus on practical issues rather than sociological theory.

One advantage over the HCA literature is that authors have considered a wider range of stakeholders, perhaps reflective of the strength of the user movement in mental health.

### ***2.3.1 Comparing Service User and Worker Perceptions***

There are three key exceptions to the small scale studies that make up the most common research approach: Murray et al.'s (1997) large scale, mixed methods study of mental health community support workers; Huxley et al.'s (2005) evaluation of the introduction of STR workers at three pilot sites and Pearson et al.'s (2009) national workforce change evaluation which included STR workers, carer support workers and community development workers as part of the study focus. All three national studies benefited from the inclusion of a range of viewpoints including service users and carers, post-holders and professional co-workers/managers, through the use of a range of methods including interviews, focus groups and survey techniques. A comparison of the three studies leads to some interesting observations. While all three studies reported clear findings of the positive impact that NPA workers can have on the lives of services users and carers, findings were much less consistent when addressing the views of NPA post-holders and their co-workers.

Murray et al. (1997) found high levels of job satisfaction for support workers alongside high perceived value by all team members including managers and only a few cases of workers feeling under-appreciated. Huxley et al.'s (2005) STR evaluation yielded more mixed results with vast support from service users but a more 'cautious response from some professional groups' (Huxley et al., 2005: 16). Findings illustrated that some team members showed a fairly negative response towards the new role whilst others, particularly occupational therapists, expressed appreciation and support. From the perspective of the STR workers themselves, some felt that they were a significant, valued member of the multidisciplinary team while others expressed concerns about communication

and how the status of the role was regarded by professionals. One clear finding was that for many professionals the reason support workers were expected to be team members was so that the content of their work could be controlled by more powerful team members, suggesting a strong status hierarchy within some teams (Huxley et al., 2005).

In Pearson et al.'s (2009) NWW evaluation, interviews with workers in newly introduced NPA roles (including STR workers, carer support workers and community development workers) showed a mixed but generally positive response to their integration into the workforce, with benefits to professional staff and service users reported alongside concerns about limited career progression opportunities and a lack of role clarity in some cases. In addition, while expressing clear perceived value attached to the new roles, user and carer discussion groups highlighted a number of funding and employment issues reported to form barriers to new NPA roles being implemented to their full potential. These issues were suggested to be indicative of conflicting priorities between service users and policy makers.

Findings that the introduction of STR Workers has been positive for service users but more mixed for the workers themselves (Huxley et al., 2005) was supported by a local user-led evaluation of the Gateshead STR Worker service (GMHUF, 2006). Although limited to structured interview questions, findings reflected that the majority of services users held positive views of the service, while a third of workers reported the transition to STR Worker from their previous role to have been difficult. Differing workplace cultures, unclear guidance and poor management were cited as underlying reasons. Those who found the transition easy suggested it was because 'nothing has changed'. Only 12% of STR respondents described their relations with other staff as positive, with concerns raised over the perceived lack of understanding of their role by other team members (GMHUF, 2006).

One potential limitation of the emphasis on user satisfaction in evaluation studies, although arguably the most important outcome measure for any kind of service change, is that positive user outcomes can draw attention away from issues relating to the experience of the workers themselves. As an illustration, Huxley et al.'s (2005) report is quoted frequently in the Department of Health's (2007) STR Workers Final Handbook as evidence that the implementation of STR workers 'appears overwhelmingly positive' (Huxley et al., 2005, cited by DoH, 2007: 43). User and carer views are discussed in depth while the subjective worker viewpoint receives little attention, citing only that there is a 'generally high level of job satisfaction and respect' (Huxley et al., 2005, cited by DoH, 2007: 43)<sup>3</sup>. Given the observed differences in stakeholder views, it is vital to ensure that attention is also paid to the subjective worker viewpoint in order to fully understand the complexities of NPA working life.

A few other, smaller scale studies provide an opportunity for this as well as allowing a comparison to the wider healthcare literature. What research does exist illustrates a slightly different focus to that elsewhere, albeit under the same major themes of professional relationships and practical issues. As we will see, in the current context role clarity issues appear to take centre focus rather than power and skill mix tensions.

### ***2.3.2 Role Clarity and Working Relationships***

McCrae et al.'s (2008) 18-month mixed methods case study of the introduction of four support workers into older adults CMHTs in London over 18 months highlighted role clarity issues as a major over-arching theme. Interviews with post-holders and professional co-workers illustrated a disparity between official intentions and professional assumptions related to role function, resulting in the support worker remit varying widely depending the referring professional's

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<sup>3</sup> The lack of attention to worker-related issues and difficulties fits with Kessler et al.'s (2006) observation that problems related to working relationships and staff anxieties about the consequences of modernisation tend not to be acknowledged in any depth within official policy documentation.

understanding of the role and present need. Support workers reported frustration at this inconsistency and feeling under-utilised. In an accompanying work satisfaction survey, support workers gave lower ratings than professional colleagues on almost all items including peer cohesion, supervisor support, autonomy, involvement and role clarity. At the study's 18 month follow up, two workers had left, one was on prolonged leave and the remaining worker declined to be interviewed, perhaps illustrating a potential issue that can emerge from small-scale qualitative studies.

The support role's proposed cross-disciplinary nature appeared central to difficulties reported by workers, with perceived threat suggested to arise from its attempt to merge medical and psychological approaches. Additional problems were reported to originate from the role's requirement for substantial change to the team's existing ways of working, by bringing assertive outreach style approaches into an otherwise nursing-dominated team. As the authors commented:

'It may have been unrealistic to rely on a single non-professional worker in taking this new model forward.' (McCrae et al., 2008: 741)

Two recent studies of the introduction of 'higher-level', graduate NPA roles into mental health care illustrated similar issues. Brown, Simons and Zeeman's (2008) qualitative study of 18 ward-based mental health practitioner (MHP) trainees (similar in position to the assistant practitioner in general healthcare) highlighted role clarity problems and worker difficulties in preventing themselves from being absorbed into the mental health nursing remit as an HCA-type role. Although the official intention was a trans-disciplinary, therapeutic interventions-based role, the MHP was largely perceived by professionals as general nursing support, creating dissonance between worker expectations and their experience in practice. In addition, workers reported feeling unwanted, rejected and isolated due to interprofessional tensions and resistance from other staff, describing

themselves as 'aliens' and 'orphans'. The authors also highlighted a wide variation in MHP remit across teams described as an 'inequality of opportunity' to deliver the psychosocial interventions for which they had been trained (2008: 828). Staff shortages, needs of the particular client group and ward staff not seeing therapeutic interventions as a priority were cited as barriers to worker opportunity, alongside variation in the level to which clinical psychology was involved in collaboration. It was however noted that in cases where professional team members *did* embrace the role, MHPs described a supportive and optimistic working environment (Brown et al., 2008).

Similarly, Bower, Jerrim and Gask's (2004) earlier examination of professional expectations of the graduate mental health worker (GMHW) remit using semi-structured interviews found a lack of role clarity and disagreement over the nature of the role and its relation to other mental health professionals, leading to disputes over GMHW 'ownership'. (2004: 340). Professionals were illustrated to hold wider expectations of workers than the official role remit, expecting the role to fill perceived gaps in services. As such expectations varied greatly across localities and client groups.

The difficulties faced by newly implemented NPA roles have elsewhere been attributed to more deeply rooted ambiguity and insecurities held by the mental health nursing profession (Warne and McAndrew, 2004). In their discussion paper the authors describe the introduction of assistant practitioners as a 'replacement approach' (2004: 181) that threatens both mental health nursing's already fragile professionalism and also future service quality, added to further by the burden of teaching, supervising and mentoring new roles. With both authors mental health nurses themselves, it could be argued that deeper insecurities may well exist underlying the observed role clarity issues.

That said, a small number of studies have depicted a more positive - or at least balanced - view. Weinburg and Huxley's (2000) evaluation of voluntary sector mental health family support workers from the viewpoint of professional colleagues and carers reported very high levels of satisfaction from both stakeholder groups, both in terms of the contribution of the role itself and working relationships. The role was described as unique and valuable through its provision of a service that had not been available previously due to workload pressures and lack of resources.

Gilbert and Russell's (2006) interview-based evaluation of a first cohort of 13 graduate mental health workers (GMHWs) gave a mixed but generally positive response. Interviews with professionals suggested that the majority valued the role while some remained 'apathetic', with the authors unable to single out any particular profession as having an overall positive or negative view. Health professionals were described as having been ill-prepared for the GMHW initiative, and while relationships were perceived to have improved over time, it was acknowledged that a large amount of promotion work and effort was required on the GMHW's part in order to build effective working relationships.

In Farrand, Duncan and Byng's (2007) interview-based GMHW evaluation from the viewpoint of clients, managers/supervisors and GPs across four counties in South West England, all groups interviewed described the GMHW contribution positively in terms of the provision of previously unavailable interventions (i.e. short-term interventions for milder mental health problems), an associated reduced caseload for GPs and a more accessible service to clients. However despite GP appreciation, findings suggested that they nevertheless held a fairly ambivalent attitude towards the role's usefulness. Concerns were raised for example that further developments of the role may take resources away from other areas of primary care mental health perceived to be more useful, such as cognitive behavioural therapists.

In addition, concerns were raised by managers and supervisors around inappropriate referrals from GPs. While a lack of role clarity was raised as a perceived reason for this, interviews with GPs suggested that they were purposefully referring inappropriate clients out of frustration that the GMHW role had not been tailored to those with greater perceived need. As GMHWs did not form part of the study sample it was not possible to gain insight into the impact of this on the workers themselves, however one exceptional client report highlighted by the authors hinted at potentially negative outcomes of this mode of referral. Having been diagnosed as too complex for GMHW support by the GP, this client described both herself and the GMHW to then have been 'used' as part of a 'holding operation' while she awaited a more suitable intervention (2007: 491). The client described her condition to have worsened as a result, through her original symptoms being added to by feeling angry and patronised upon an unnecessary re-assessment by the GMHW (Farrand et al., 2007).

Even in more positive reports of new role implementation then there seems to be a clear image of professionals attempting to mould new roles to current service need, regardless of the official role remit. In an HCA-nurse delegation relationship this may be fairly straightforward, however in the multidisciplinary arena perceived need appears to vary between occupational groups. At present there is only limited consideration of the implications of this for worker experience. As evaluation studies often take place during, or immediately after role implementation, it is also difficult to tease out teething problems from more deeply rooted issues.

### ***2.3.3 Supervision and Training***

The state of training provision and supervision for support workers in mental health care is particularly important in light of early findings that support workers within CMHTs have the highest proportion of severe and acute clients on their caseload comparative to professional workers and the least training to

deal with such cases (Onyett et al., 1997). Newly developed roles such as the STR Worker and GMHW have a 'specified education and training pathway' as a core policy objective, in an attempt to improve on previous conditions and prospects for NPA workers (DoH, 2003). This emphasis on training as a distinction between new and old support roles was confirmed by workers in Huxley et al.'s (2005) STR evaluation. Training arrangements were viewed positively by workers, despite reported concerns over lack of funding and the disappearance of a specialist mental health NVQ. Supervision for workers was reported to be generally well thought out and well developed, particularly in teams where senior STR worker roles were in place (Huxley et al., 2005). These positive findings were supported by Murray et al.'s (1997) earlier review of community support workers that found the majority of NPA workers to be well educated and happy with their supervision arrangements.

For 'higher level' NPA roles, Gilbert and Russell's (2006) GMHW evaluation suggested a high degree of satisfaction with clinical supervision regardless of the professional background of the supervisor, although some workers felt it necessary to seek out additional supervision for specific interventions, usually from a clinical psychologist<sup>4</sup>. Brown et al.'s (2008) MHP evaluation illustrated positive perceptions of the academic and peer support gained through the role's postgraduate education programme, however provision was reported to have changed substantially once in practice. Around half of respondents reported meeting with their supervisor less than once a month upon graduation (Brown et al., 2008).

Career progression problems were also raised by McCrae et al.'s (2008) study of CMHT support workers. Findings suggested a lack of potential for training or existence of a career stepladder other than movement into professional training

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<sup>4</sup>It may be worth noting the relationship of the authors to the interviewees (head of GMHW programme and primary care/programme lead) and the presence of both at each interview, in terms of its potential impact on the interview interaction.

such as nursing or social work. Posing difficulties for retention, professional interviewees agreed on the need for a more stimulating and challenging remit if the role was to become more than merely a 'springboard' for a professional career elsewhere (2008: 739).

### **2.3.4 Limitations and Research Gaps**

The literature reviewed in this section has highlighted a number of limitations of NPA studies in mental health care, particularly those based in community services. Few studies exist and those that do tend to feature small sample sizes and limited attention to contextual detail. NPA worker views have not always been included and where they have, interviews tend to have been undertaken by figures of authority and/or members of the professions with whom they are required to discuss their relations. Finally, as predominantly early evaluations of new roles, some of the problems encountered may be well be a result of 'teething problems', which links to Molyneux's (2001) finding that positive outcomes require time to adjust. Whether this is the case or whether findings relate to deeper underlying issues that will prevail over time remains to be seen. It is vital to build a more substantial evidence base in order to clarify early findings and integrate them with sociological and organisational theory.

## **2.4 The Missing Client**

Aside from studies that feature client satisfaction as an outcome measure (e.g. Huxley et al., 2005; Pearson et al., 2009), little attention has been paid to the service user in the occupational literature. This is perhaps surprising given that the loss of direct patient care has been considered so central to skill mix disputes for professions such as nursing and occupational therapy (e.g. Mackey and Nancarrow, 2004; Bach et al., 2008). Similarly, many of the studies of emotional exhaustion and burnout in CMHTs described in Section 2.1.1 cited patient interactions as a key source of reported job satisfaction for mental health

professionals (e.g. Onyett et al., 1997; Reid et al., 1999; Wilson and Crowe, 2008; Onyett, 2011). Despite this, the client interaction seems to have received little follow-up interest, with no exploration found for example on whether a particular *type* of client interaction is most protective to workers. Warne and Starke (2004) provided a useful consideration of how this relationship can be considered to vary between different occupational groups. Metaphors created during focus groups with mental health service users were used by the authors to illustrate how perceptions of the interaction can vary, with occupational therapist as 'teacher', nurse as 'go-between', psychiatrist as 'fixer' and NPA worker as 'friend' (Warne and Stark, 2004).

#### **2.4.1 The NPA-Client Interaction in Mental Health**

Usefully for our current research interests, three of the most recent papers found relating to mental health NPA roles have paid more attention to the client interaction than encountered in past studies. Asserting that the complexities involved in relationship work often go unspecified in official documentation, Huxley et al. (2009) provided a valuable discussion of the relationship between STR workers and their clients, drawing on Biestek's (1957) Casework Relationship Framework from early social work literature and Weiss' (1974) more general Social Relationship Theory. Weiss' (1974) framework put forward six provisions of supportive and reciprocal social relationships: guidance, reliable alliance, reassurance of worth, attachment, social integration and opportunity for nurturance. On a similar theme but in an occupational context, Biestek (1957) set out central principles specific to effective relationship *work*, including treatment of the client as an individual and acceptance as a person of worth, provision of opportunities to express feeling and to make own decisions, expression of a non-judgemental attitude and adherence to confidentiality.

Based on findings from the earlier described national STR evaluation (Huxley et al., 2005), client and worker interview responses were used to illustrate the STR-

client relationship to deliver each aspect of the two frameworks. In doing so the authors argued the relationship to be central to client progress, emphasising the availability of time to build trust and respect, and the formation of companionship whilst encouraging client independence. The relationship was suggested to be of a 'different or superior quality' to that between professional and client (2009: 113), drawing a point of inequity with the 'professional arrogance' with which some STR workers felt they were treated within the multidisciplinary team (2009: 109). In conclusion, a call was made for further examination of influences on the client relationship as well as consideration of how it can be nurtured and made more visible in official documentation.

'It would appear that the time is right to revisit the nature of relationship in the world of social care and social work, so that what Biestek called the 'soul' of help is not diminished or extinguished altogether...' (2009: 115)

Huxley et al.'s (2009) work has opened an important discussion around the perceived and acknowledged value of the relationship between worker and client, and - adding to Warne and Stark's (2004) metaphors - how it may be experienced differently by professional and NPA groups. By focusing on the relationship's value to client progress however, the authors said relatively little about its impact on the *worker*; other than suggesting it to be a source of fulfilment and raising some professional concerns around the potential for dependency. Questions remain therefore around worker outcomes and how the relationship is negotiated and maintained.

A second paper from the same year by Gensichen et al. (2009) adds a short but valuable insight to our understanding of potential worker outcomes. Drawing on an interview-based study of 26 HCAs in primary care mental health in Germany, worker role perceptions were described in terms of patient relationships as well as professional positioning. In addition to general 'looking after', workers were

reported to display a strong and varied role including confidant, advisor and communication facilitator between professional and patient.

Considered in terms of 'burdening' and 'enabling' factors, the relationship was illustrated to be a source of professional and personal enrichment. However findings also highlighted a tension between keeping professional distance and simultaneously retaining an 'intimate and empathic' interaction (2009: 515).

Difficulties were also raised in terms of the emotional burden of working with depressed clients, described as 'exhausting' and 'unpredictable' (2009: 516).

Supervisor support and life experience as well as the relationship with the patients itself were described as mechanisms to help ease this burden, while factors including caseload pressure and lack of understanding from co-workers and managers were reported to exacerbate it. The authors concluded with a call for training in elements such as counselling principles and strategies to prevent 'overburdening', concluding that for mental health NPA workers:

'The strain resulting from interaction with the patients should not be underestimated.' (Gensichen et al., 2009: 517)

The balance and potential tension between worker fulfilment and burdening factors was further supported by a recent examination of HCAs in UK older people's mental health care. Schneider's (2010) ethnographic study of three inpatient dementia wards highlighted the importance of the patient relationship to worker motivation, job satisfaction and to the creation of a therapeutic ward environment. The need for engagement was however highlighted alongside a simultaneous need for detachment as self-protection against the emotional strain of the work. The study also brought into consideration two additional relationships; with families of the cared for, for whom the workers were observed to be a key source of advice and support, and with other HCAs through shared workload, mutual support and the development and protection of a team identity. In conclusion, the author advocated a movement from discussion of

patient-centred care to conceptualisation of *relationship*-centred care, in order to bring staff relationships, the patient relationship and family relationships into a unified care dynamic.

### **2.4.2 Emotional Labour and Care Work**

Whether these recent affirmations of the importance of the worker client-interaction indicate a wider shift in discourse remains to be seen, however the surge in interest can be found mirrored elsewhere in the emerging body of literature concerned with the concept of *emotional labour* (Hochschild, 1983). While consideration of the patient-professional interaction in health care has tended to focus on power inequalities, professional prejudice and the use of the client relationship as a tactic to protect jurisdiction (Bury, 2004)<sup>5</sup>, by primarily examining low status service workers the emotional labour literature has largely focused on an *opposite* power dynamic in which the worker is exploited and the ‘customer’ and employing organisation hold ultimate control.

The discussion of emotional labour in its originally intended form is slightly outside the scope of the current study<sup>6</sup>, however emerging attempts to apply it to care work and particularly home care are valuable due to their community setting and emphasis on the nature of one-to-one client work. Although few in number, studies of home care workers have tended to focus on either the close, affectionate relationships built between worker and client *or* the burden and

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<sup>5</sup> Bury (2004) provides a useful critique of existing sociological research on the professional-client interaction in health care, which he suggests to be a long-standing discussion but one of ‘limited substance’, with both UK and US literature dominated by discussion of the doctor-patient relationship in GP surgeries and outpatient hospital wards. See also Fleischer et al. (2009) and Shattel (2004) for recent reviews of research into the nurse-patient interaction.

<sup>6</sup> Originating from the work of Hochschild (1983), emotional labour refers to occupations in which workers are required to manage their emotions in order to adhere to organisationally defined ‘feeling rules’, through the use of ‘surface acting’ (displaying a different emotion to what is privately felt) or ‘deep acting’ (attempting to alter what is privately felt). Most commonly applied to service settings such as the airline industry and fast food outlets, there is currently much dispute over whether the concept can or should be applied to caring occupations, or whether an alternative term, such as the ‘emotional labour process’ would facilitate a more useful discussion of the complexities involved in this type of emotional work (e.g. Bolton, 2000, 2009; Bolton and Boyd, 2003; Lopez, 2006).

difficulties involved in these relationships (Neysmith and Aronson, 1996; Stacey, 2005; Wharton, 2009).

On the negative side, researchers have depicted an exploitative relationship similar to that described in other areas of service work, illustrating a combination of low pay, devalued social status and high emotional demands in addition to high levels of 'invisible' responsibility and decision making (Neysmith and Aronson, 1996: 5; Stacey, 2005; Taylor and Donnelly, 2006; Wharton, 2009). On the positive side, researchers have likened client-worker relationships to that of friendship or family, illustrating the interaction to be an important source of job satisfaction and worker retention (Piercy, 2000; Ball et al., 2009). Concerns have been raised however over the potential to 'romanticise' care work by suggesting that intrinsic rewards may somehow counteract poor pay and exploitation by employers; a situation made worse by the two sides of the debate often appearing pitted against each other (Stacey, 2005: 838).

Similar to the suggestion made by Gensichen et al. (2009), Stacey (2005) argued that for home care workers the reality lies somewhere in between; a role in which rewards, constraints and burdening factors sit alongside each other and require a 'unique caregiving skill set' (2005: 847). Scheid (2004, in Stacey, 2005) goes further to suggest that it is the *suppression* of emotional labour that causes burnout, not emotional over-involvement as is the common assumption, concluding that emotional aspects of work should be supported rather than restricted or regulated. Emotional interactions are argued to be desired by workers and perhaps even necessary to their wellbeing (Scheid, 2004). The attachment of the discussion to the negative connotations of Hochschild's (1983) original concept may therefore be stifling our consideration of the potential co-existence of benefits and burdening aspects (Lopez, 2006); a sentiment echoed by Wharton's (2009) comment on the lack of theoretical advancement visible in a review of the literature:

‘The concept of emotional labour has motivated a tremendous amount of research, but it has been much less helpful in providing theoretical guidance for or integration of the results generated by these bodies of work.’  
(Wharton, 2009: 161)

Between the professional and emotional labour literatures then we can see two very different ways that NPA workers are construed in sociological theory: firstly as a resource that can be useful to - but also undermine the status of - more powerful occupational groups; and alternatively as low status workers who are heavily exploited by both the employing organisation and the ‘customer’. The two literatures rarely overlap; instead NPA roles that work alongside professionals tend to be considered in entirely professional terms, while NPA roles that work alone tend to be considered entirely in terms of the emotional aspects of client work. As will become clear as the findings chapters unfold, NPA workers in the current community mental health context may be most usefully considered somewhere between the two, required to deal with both the complexities of autonomous client work *and* the complexities of inter-occupational negotiations.

## **2.5 Aim and Research Questions**

### ***2.5.1 Development of the Study Aims***

Initially, the study aims were heavily embedded in the background research literature, reflecting the ‘traditional’ view of NPA workers described in Sections 2.1 and 2.2. This viewpoint considers the implementation of NPA roles primarily in professional terms, with a central focus on working relationships, shifting divisions of labour and professional reactions to the growing NPA workforce. As such, the initial research questions were predominantly concerned with worker responsibilities (including the delegation process and comparison to the professional remit), role and relationships within the multi-disciplinary team, and attitudes towards other team members.

Early in the fieldwork process however, it became clear that a wider approach was necessary. Many aspects of working life *outside* the professional relationship emerged as central to workers' stories, including client relations and practical issues around pay and training, even though they were not directly asked about during interviews. Through supervision discussions and engagement with the emerging data this led to a reassessment of the study's focus and a reformulation of the study aim to become more holistic, in order to take these wider - but seemingly crucial - aspects into account. In light of emerging findings, the initial research questions suddenly appeared to constrain the discussion rather than facilitate its development.

This early reassessment enabled further reflection on the existing literature base, resulting in the identification of a number of the limitations which have already been outlined. While the professional literature remained an important underpinning to the role/responsibility and teamworking elements of the findings (which are prominent in Chapters 5 and 7), its incorporation into a more holistic overall aim was deemed to provide a more useful framework for exploration of the data. It also prompted the wider exploration of related discussion - including the emotional labour literature and examinations of the doctor-patient interaction - which have been overviewed in Section 2.4 and will be drawn upon in later chapters.

The more general aim and research questions which developed as part of this reassessment process are outlined below.

### **2.5.2 Summary of the Research Problem**

A number of limitations of existing research on the non-professionally affiliated (NPA) workforce have been highlighted, including a general dearth of knowledge and the confinement of what does exist to small samples, clinical settings and consideration of the NPA-professional relationship. Recent

developments have shifted the discussion outside of hospital wards and towards a more pronounced consideration of contextual factors, however it is unclear how current theory can be applied to community contexts or NPA roles that are less 'attached' to a specific profession. The lack of available research in the mental health field is of particular concern in light of rising worker numbers and findings that suggest the importance of sub-sector and workplace variation in shaping worker experience (Kessler et al., 2007; Bach et al., 2008). Furthermore, aspects of working life outside of the professional relationship, including client relations, remain vastly under-researched. Despite the recent surge in interest we therefore still know little about the subjective NPA worker experience.

There is a specific need for research that examines:

- The subjective NPA worker viewpoint
- More holistic aspects of worker experience, including additional relationships and worker characteristics
- Working contexts outside of clinical settings, particularly community mental health care
- Research that covers more than one role or more than one context, in order to reconcile the widening 'gulf' between organisational and sociological literature (Davies, 2003; Bach et al., 2008)

In order to address the research problem asserted here, a fairly pragmatic study aim and set of research questions were developed.

### **2.5.3 Aim**

The purpose of this study is to provide a qualitative exploration of the role and working relations of non-professionally affiliated (NPA) workers in community-based mental health services. It aims to examine the subjective worker viewpoint, paying particular attention to perceptions of their role in services, working

relationships (including those outside the professional relationship) and any other aspects of working life raised as important.

#### **2.5.4 Research Questions**

- How do NPA workers describe their role in community mental health services?
- What tasks and responsibilities make up day-to-day role?
- How does worker role compare to the professional remit in terms of overlap, similarities and differences?
- How do workers describe their experience of team and working relations?
- What factors shape the NPA worker experience?
- How can any observed differences between individual, role, workplace and sub-sector be explained?

### **Chapter Summary**

This chapter has provided a review of existing research into the non-professionally affiliated (NPA) healthcare workforce, by firstly positioning workers as a professional boundary work tactic within traditional sociological discussion and then examining available literature on the workers. This included an exploration of methodological and theoretical limitations and a consideration of neglected aspects of worker experience including organisational context and the client relationship. A particular research gap was noted in relation to community care settings, specifically mental health. Based on the research problem put forward, a study was then proposed to provide a holistic exploration of the subjective NPA worker experience across a number of different roles, teams and sectors in community mental health care. Chapters 3 and 4 will move on to describe how the articulated study aim was put into research practice, starting with methodological considerations and followed by more specific details of the data collection and analysis strategy.

## **Chapter 3. Methodology and Study Design**

### **Introduction**

The first two chapters of this thesis highlighted the importance of conducting an in-depth exploration of NPA working life within the context of community mental health services, in light of increasing worker input and the introduction of new roles alongside a limited body of academic discussion.

This chapter sets out the guiding theoretical and methodological framework that was chosen to underpin a study of the subjective NPA worker experience. It is made up of two sections. The first outlines decisions that led from the asserted study aims to the final choice of methodology and methods. Section 3.2 then describes early considerations of ethics and research quality that further influenced the study design. In keeping with a qualitative, constructionist tradition this includes a reflexive account of my own subjective position in the research process.

### **3.1 Theoretical Framework**

This section provides an overview of the framework choices and methodological decisions made during the study's development. The three key elements discussed are:

- Paradigm choice and commitment to a qualitative approach
- Choices within an interpretivist framework: Social constructionism and pragmatic influences
- Final choice of an interview-based study

Arrival at the final study design began with considerations at an abstract ontological and epistemological level, which then filtered down to shape more

concrete decisions around methodology and methods. Figure 3.1 provides an overview of the guiding theoretical framework which arose from this process.

**Fig. 3.1 Overview of the Study's Guiding Theoretical Framework**

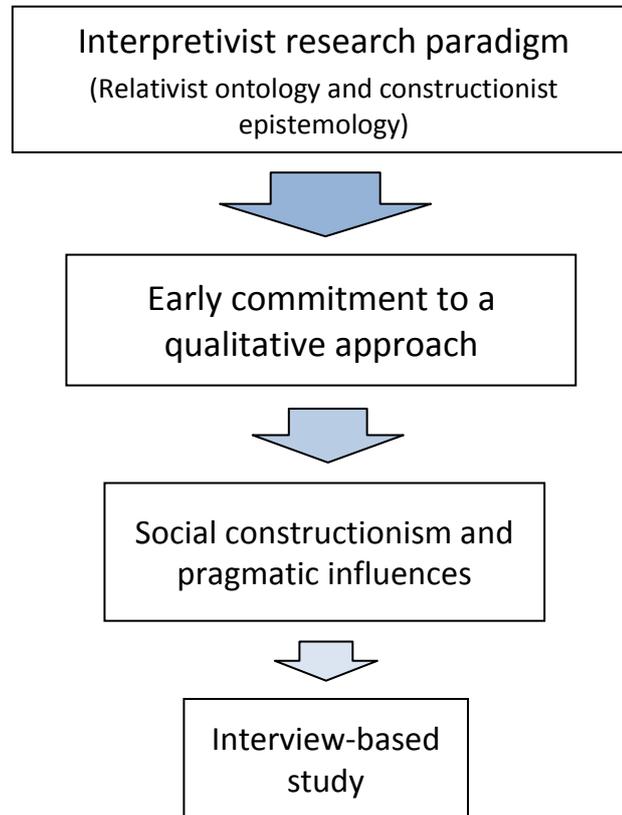


Figure 3.1 above summarises the outcomes of considerations made as the study developed, moving from an early commitment to an interpretivist paradigm and qualitative approach to the final choice of an interview-based study. The key decisions involved in this process will now be considered.

### **3.1.1 Asserting an Interpretivist Theoretical Position**

Bryman (2008: 6) draws a useful distinction between the 'middle range' theories that have been drawn upon in the literature review chapter such as the sociology of the professions and the broader, 'grand' theories that serve to orient a study within a particular set of philosophical assumptions. Engaging with an overarching theoretical position enables the researcher to assert what they bring

to the study, which in turn enhances the reader's understanding of its origins, process and claims made by its findings:

'At every point in our research—in our observing, our interpreting, our reporting, and everything else we do as researchers—we inject a host of assumptions... Without unpacking these assumptions and clarifying them, no one (including ourselves!) can really divine what our research has been or what it is now saying.' (Crotty, 1998: 17)

These assumptions are concerned with the nature of reality (ontology) and consequently the nature and justification of knowledge (epistemology) (Crotty, 1998; Patton, 2002).

Despite the applied, service-led aims, engagement with a wider theoretical perspective was considered to be crucial 'scaffolding' to the current study, providing valuable 'stability and direction' upon which the findings could be built (Crotty, 1998: 2). Elsewhere the theoretical framework has been described as a kaleidoscope through which the research landscape can be filtered and shaped (Ely, 1991; O'Brien, 1993)<sup>7</sup>.

### **Choosing Between the Three Major Paradigms**

The first assertion a researcher must make relates to their position within three broad paradigms: *positivism*, *interpretivism* (also commonly known as relativism) and *critical inquiry*. Each presents an alternative way of thinking about reality and about what constitutes knowledge. Consequently, each paradigm favours certain research approaches over others (Crotty, 1998). Central assumptions of the three major paradigms are summarised in Figure 3.2 below, which positions the current study within a broadly interpretivist paradigm.

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<sup>7</sup> Despite the positive metaphors used to describe the guiding theoretical framework, authors have also acknowledged that the host of paradigmatic options can appear 'more like a maze than as pathways to orderly research' (Crotty, 1998:1), particularly given the inconsistent and sometimes contradictory terminology used by different authors (Crotty, 1998; Silverman, 2010). Even the term 'theoretical perspective' has a number of alternatives, with 'model', 'paradigm', 'perspective' and 'orientation' used interchangeably by different authors (Crotty, 1998; Patton, 2002; Silverman, 2005, 2010; Bryman, 2008).

**Fig. 3.2 Central Assumptions of the Three Major Research Paradigms**

<b>Positivism</b>	<b>Interpretivism*</b>	<b>Critical Inquiry*</b>
<p>A concrete reality exists which can be measured and <i>discovered</i> (Realist ontology)</p> <p>Knowledge is <i>objective</i> and independent to the researcher (Objectivist/dualist epistemology)</p> <p>Positivist perspectives include traditional <b>positivism</b> and <b>post-positivism</b></p>	<p>Reality is subjective and <i>constructed</i>, therefore multiple realities exist (Relativist ontology)</p> <p>Knowledge is <i>subjective</i> and interactively constructed (Constructivist/constructionist epistemology)</p> <p>Interpretivist perspectives include <b>symbolic interactionism</b>, <b>phenomenology</b> and <b>hermeneutics</b></p> <p>*Also referred to as naturalism, relativism, constructivism</p>	<p>Emphasis on taking a <i>critical perspective</i> to societal injustices and power inequalities</p> <p>Holds a <i>political agenda</i> to represent perspectives of the less powerful and bring about <i>social change</i> and empowerment</p> <p>Critical perspectives include <b>feminist inquiry</b> and <b>critical theory</b></p> <p>*Also referred to as emancipatory, participatory</p>
<p>Favours deductive, fixed study designs and quantitative approaches</p> <p>Experiments, surveys, statistical analysis</p>	<p>Favours inductive, flexible study designs and qualitative approaches including ethnography, grounded theory, discourse analysis</p> <p>Observation, interviews, narratives, focus groups</p>	<p>Favours iterative, cyclical study designs that highlight inequalities or action change including action research, critical ethnography</p> <p>Collaborative interviews, focus groups, narratives</p>

(Sources: Crotty, 1998; Denzin and Lincoln, 2000; Lincoln and Guba, 2000; Patton, 2002; Bryman, 2008; Silverman, 2010)

Although the different theoretical positions, particularly positivism and interpretivism, are often depicted as ‘rival armed camps’ (Silverman, 2005: 106), the development of post-positivist approaches such as subtle realism have offered something of a middle ground. As such, rather than the three distinct paradigms depicted here for ease of comparison, the picture may be more

usefully considered as a *continuum* between various extremes rather than distinct groupings (Hammersley, 1992; Snape and Spencer, 2003).

As illustrated in Figure 3.2, the current study can be seen to fall within the interpretivist research paradigm. In contrast to the positivist assertion that an objective reality exists, independent of subjective perception and open to the discovery of objective 'truth', the current study places emphasis on reality as socially and culturally constructed. Knowledge gained about reality is considered to be subjective, based on individual perceptions rather than existence of observable 'facts' (Crotty, 1998; Denzin and Lincoln, 2000; Silverman, 2010). Rather than deductive research designs based on empirical hypothesis testing, the interpretivist paradigm advocates the subjective generation of knowledge through *inductive*, exploratory processes (Bryman, 2008). The purpose of research is therefore to:

'Interpret and understand the actor's reasons for social action, the way they construct their lives and the meanings they attach to them as well as to comprehend the social context of social action.' (Sarantakos, 1998: 38)

Given the broad study aim to explore subjective perceptions of NPA working life - an aspect of the social world - within its wider context, the choice of an interpretivist framework seemed fairly straightforward. By taking an interpretive stance I acknowledged that worker experience was made up of multiple subjective realities, none of which could be considered an objective 'truth' and all of which were a product of - and therefore inseparable from - the actions, interactions and meanings that made up an individual's social world. In doing so, I rejected the positivist mode of enquiry as well as the *critical inquiry* or *emancipatory* paradigm, in which the researcher is positioned as advocate or activist on behalf of and alongside participants. While social and political inequalities did form an aspect of the study's contextual background, a

commitment to outcomes based on iterative, instigated action or empowerment were not a central tenet of the research motivation.

### **Commitment to a Qualitative Approach**

As interpretivism elicits a preference for research approaches which account for individual experience, subjective meaning and the social context, the paradigm is closely allied with qualitative approaches and exploratory, flexible study designs (Snape and Spencer, 2003). In asserting an interpretivist position I therefore also made an early commitment to the likelihood of an inductive, qualitative methodology as the most effective research approach. The backdrop of the study as an under-researched area requiring substantial exploration was central to this decision making process.

‘Qualitative enquiry cultivates the most useful of all human capacities: the capacity to *learn*.’ (Patton, 2002: 1, emphasis in original)

#### ***3.1.2 Refining the Theoretical Position: Considerations within an Interpretivist Paradigm***

Rather than forming a single, unified approach the interpretivist paradigm is made up of a number of different positions that can inform the research approach taken. As will be briefly considered here, while social constructionism was found to be a useful framework, a number of additional refinements were explored but then discounted in favour of a more pragmatic approach, deliberately kept broad in order to address the applied, service-led study aims.

### **Social Constructionism**

Most interpretivist approaches can be considered as founded on some form of constructivist/constructionist epistemology, which regards meaning and knowledge as constructed rather than discovered (Crotty, 1998). Constructionism refers not to the construction of reality itself, as advocated by the less widely held

*subjectivist* or *radical constructivist* standpoint (Schwandt, 1997; Crotty, 1998), but to the construction of knowledge *about* reality:

‘According to constructionism, we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and objects in the world.’ (Crotty, 1998: 43-44)

This constructed knowledge is not stable and is largely dependent on our worldview, which in turn is shaped by context and interaction (Neimeyer, 1993, in Patton, 2002). While the terms ‘constructivism’ and ‘constructionism’ are often used interchangeably, there is a subtle yet important difference in their mode of focus (Shadish, 1995; Crotty, 1998; Gergen, 1999; Patton, 2002). Gergen (1999) argues that while both approaches assert the construction rather than discovery of knowledge:

‘... you can recognise a fundamental difference: for constructivists the process of world construction is psychological; it takes place in the head. In contrast, for social constructionists what we take to be real is an outcome of social relationships.’ (Gergen, 1999: 237)

Echoing this view and drawing on earlier work of Gergen (1985), Crotty (1998) highlights the emphasis placed by constructionism (or *social* constructionism as it is often termed) on interaction and other social processes such as language and culture. As a result he urges social researchers to:

‘Reserve the term *constructivism* for the epistemological considerations focusing exclusively on the ‘meaning-making activity of the individual mind’ and to use *constructionism* where the focus includes ‘the collective generation [and transmission] of meaning.’ (Crotty, 1998: 58)

Social constructionism can therefore be considered a specific mode of interpretivist thought which places the spotlight firmly on the importance of interaction and social context in the construction of knowledge and meaning about the world. This provides a useful way in which to frame the current study, given its aim to examine worker perceptions and how they are constructed

through the experiences and interactions that make up daily working life. In addition, as already introduced in Chapter 1 the cultural, historical and political context is a crucial part of the story told within this thesis.

In asserting a social constructionist viewpoint it is acknowledged that the understanding gained through this research is socially and contextually forged, constructed through the interaction between workers and their environment and then also through interaction between myself as researcher and the study participants. Social constructionism places emphasis on the researcher and the research interaction itself as key influences on the creation of knowledge. These elements will be explored further through a reflexive account of my own subjective worldview (Section 3.2.3) and of the interview interaction (Section 4.2.2 in Chapter 4).

### **Alternative Approaches: Phenomenology and Symbolic Interactionism**

The available literature appears to hold a lack of clarity over whether social constructionism should be viewed at an epistemological level underpinning more precise modes of thought, or whether it forms a specific theoretical perspective in its own right; although the earlier distinction made between constructivism and constructionism would suggest that it *can* be utilised as a specific guiding theoretical framework (Crotty, 1998; Patton, 2002).

Two further refinements were considered and subsequently discarded in favour of a more pragmatic approach: phenomenology and symbolic interactionism. Phenomenology is a specific mode of interpretivist inquiry that involves capturing the 'lived experience' of a particular phenomenon (Crotty, 1998; Patton, 2002; Bryman, 2008). While phenomenology's emphasis on taking a critical approach to 'taken for granted knowledge' and reinterpreting the social world from the participant's point of view seemed well suited to the current study aims, the preference for presenting in-depth descriptive data without placing

additional meaning on it was considered to restrain the possibilities of analysis. The requirement for *retrospective* insight from participants and strong preference for ethnographic methods (Van Manen, 1990; Crotty, 1998) also proved problematic in light of logistical issues related to access that will be considered in the following Section 3.1.3. In addition, it held a notable lack of fit with some of the study's more practical aims:

'From a phenomenological point of view, we are less interested in the factual status of particular instances: whether something happened, how often it tends to happen, or how the occurrence of an experience is related to the prevalence of other conditions or events.' (Van Manen, 1990: 10)

Therefore while some of phenomenology's underlying principles did provide inspiration for the study's focus, it was not considered the most effective way to address the research problem.

The second possible alternative explored in depth was symbolic interactionism, which aims to interpret the symbolic world of those studied and is described as a 'social-psychological' approach (Patton, 2002: 112). Most commonly associated with ethnographic methods, it:

'...seeks to uncover meanings and perceptions on the part of the people participating in the research, viewing these understandings against the backdrop of the people's overall worldview or 'culture'. (Crotty, 1998: 7)

Initially, symbolic interactionism appeared as a potentially valuable theoretical lens due to its attention to contextual aspects of the social world and to the subjective meaning placed upon interaction (Patton, 2002). The perspective has been iterated elsewhere in the study of relationships between HCAs and registered nurses (Spilsbury, 2004a) and is considered an effective approach in organisational and applied fields because it can uncover what different groups of people hold as important and provide insight into the negotiated order of the workplace (Crotty, 1998; Patton, 2002).

However, symbolic interactionism also raised a number of potential difficulties. The requirement for extensive emersion in the participant's world through unstructured interviewing and non-directive questioning (Crotty, 1998) was again pitted against logistical access issues as well as a pragmatic desire to gain information about more concrete aspects of working life such as perceptions of training and supervision, rather than focusing solely on workplace interaction. As such, symbolic interactionism's 'foundational question' was considered to elicit a more abstract approach than was required by the current research problem:

'What common set of symbols and understandings has emerged to give meaning to people's interactions?' Patton (2002: 112)

Both phenomenology and symbolic interactionism were therefore discounted as useful 'scaffolding' (Crotty, 1998) for the current study, as in both cases they appeared to narrow the focus that could be taken rather than facilitating the holistic, exploratory approach that was considered so crucial to knowledge advancement. As such, the decision was made to pursue a more pragmatic approach to study design.

### **Taking a Pragmatic Research Approach**

In contrast to heavily philosophy-based approaches, pragmatism is described as a 'toolkit' approach to research, based on 'practical realities' rather than epistemological positioning (Snape and Spencer, 2003: 14). Authors suggest a growing acceptance of pragmatism as a mode of enquiry in its own right, underpinned by rising concerns that philosophical complexities may be undermining the ability of researchers to address the practical considerations that form an integral part of the research process (Silverman, 2006; Patton, 2002; Snape and Spencer, 2003; Bryman, 2008). Patton (2002) argues that it is acceptable to undertake qualitative methods because they are appropriate to a specific applied aim, without explicitly working within a defined theoretical perspective:

‘One might simply conduct interviews and gather observational data to answer concrete program and organisational questions... Well-trained and thoughtful interviewers can get meaningful answers to practical questions without making a paradigmatic or philosophical pledge of allegiance.’  
(Patton, 2002: 145)

Common to studies in health care, education and organisational settings, Patton (2002) describes various types of pragmatic approach broadly divided into quality assurance and program evaluation. A pragmatic, quality-focused approach for example would be likely to consider the following of participants:

‘What is their daily life like? Who do they interact with? How do they perceive their lives? How do they make sense of what they experience? What do they say about the path they are on?...’ (Patton, 2002: 150)

By asking these sorts of practical questions, it is argued that pragmatic research approaches hold the capacity to ‘illuminate’ the lives and perspectives of participants holistically and in their own terms, in a way that can not always be achieved by heavily philosophical approaches (Patton, 2002: 150-1). Given the current study’s service change backdrop and subsequent desire to address practical questions *in addition to* workplace interactions and relationships, the affinity between my own holistic research questions and those described above confirmed such an approach to be the most effective for use here. A pragmatic research stance was therefore taken, albeit underpinned by an interpretivist, social constructionist viewpoint and inspired by phenomenology’s call for a critical re-evaluation of ‘taken for granted’ knowledge (Crotty, 1998).

### **3.1.3 Methodology and Methods**

#### **Methodological and Logistical Considerations**

‘All social research is a coming together of the ideal and the feasible.’  
(Bryman, 2008: 27)

Methodology describes the research strategy employed within a study which guides the researcher's subsequent choice of methods (Crotty, 1998). A number of potential methodologies sit within a broad interpretivist framework and preference for qualitative enquiry, including ethnography, heuristic enquiry, grounded theory and discourse analysis. As with the overall theoretical framework, choice of methodology in the current study was governed by a combination of philosophical and pragmatic considerations. Heuristic enquiry and discourse analysis were ruled out due to their emphasis on the symbolic meaning of what people say or how they say it, rather than the *content* of participants' accounts. Grounded theory was initially considered but then discounted as the primary intention of the current study was not to generate theory *per se* or to start from a blank slate. Rather, the research questions and subsequent approach were considered heavily embedded in existing theory and previous considerations of the NPA workforce.

Given the study aim to consider NPA worker experience holistically and with attention to the working context, an ethnographic approach may have provided an effective methodology to address the current research problem. However the opportunity to carry out such in-depth levels of fieldwork was pitted against a number of logistical and managerial considerations. During initial consultations with service managers and workers prior to my application for ethical approval, considerations were raised about the level of time commitment available to workers. This in turn raised questions about the potential impact of prolonged involvement on who would be able to take part in the study, for example it may have restricted participation to workers with the smallest caseloads, or the most enthusiastic managers. While building a large or representative sample was not a principal concern given the nature of qualitative enquiry, I nevertheless felt there were ethical implications around the possibility of excluding a large proportion of the target sample from participation. Given the pragmatic aim to capture

variation in experience across teams, organisations and locations it seemed counterproductive to narrow the inclusion strategy in this way.

In addition, issues were raised during an initial Research Ethics Committee (REC) meeting about the ethics of shadowing workers in the community working context. The requirement for service user consent created in such a situation raised further, complex ethical issues around the ongoing assessment of capacity as part of any role observation process. The prospect of embedding myself in the participants' working world for prolonged periods of time therefore seemed out of line with both ethical and logistical considerations.

### **Pragmatic Choice of Methods: An Interview-Based Study**

The result of these various considerations was a pragmatic, negotiated methodology. The chosen methods comprised of one semi-structured interview with each participant in order to minimise service disruption and increase the likelihood of access being granted by the relevant gatekeepers. In order to retain some grounding in context, this was combined with extensive field notes relating to workplace and geographical location, alongside an analysis of documents relating to role and team including job descriptions, team reports and service promotion material. In addition to interviews with NPA workers, a small number were also undertaken with team and service managers in order to gain background knowledge about wider services and role implementation. This combination of methods formed a pragmatic attempt to retain the study's subjective yet holistic focus.

Semi-structured interviews were favoured over an unstructured approach as they retain enough flexibility to explore participant responses and introduce alternative discussion topics, while simultaneously allowing the researcher to guide the conversation to specific areas of interest. They also require a lower time commitment than unstructured or depth interviews (Kvale, 1996). Interviews

were chosen over alternative methods such as focus groups due to the logistics of travel time and worker commitment, given the geographically dispersed nature of the study setting. In addition the aim to explore subjective perceptions and the potentially sensitive nature of conversations about working life and employment relationships seemed more appropriately suited to individual discussions.

The use of interviews as a primary source of qualitative data has received mixed reviews in the methodological literature. From a positivist approach they are often claimed to be 'unscientific', while those who have mastered interview techniques argue them to be a complex, technical art (Kvale, 1996: 285). Tensions in the qualitative methodological literature often relate to the relative merits of interviewing compared to other ethnographic methods, specifically observation. Some authors argue observation to be the most 'complete' form of data; a 'yardstick' against which other methods, including interviews, should be tested (Murphy et al., 1998: 118). This is echoed in Rapley's (2004: 29) citation of Strong (1980: 27-8):

'No form of interview study, however devious or informal, can stand as an adequate substitute for observational data. The inferences about actual practice that I or others may draw from those interviews are therefore somewhat illegitimate.' (1980: 27-8, in Rapley, 2004: 29)

On the other side of the argument, interviews can allow access to issues that are 'resistant' to observational approaches, such as underlying perceptions and motivations or the reconstruction of past events (Bryman, 2008: 466). Criticism or favour of interview approaches seem therefore to depend considerably on what the researcher considers to be legitimate data and the extent to which interviews are intended to give direct access to 'real' experience (Dingwall, 1997; Rapley, 2004; Silverman, 2010). As such, such criticism was not an extensive concern in the current study, as it was precisely the worker's subjective *interpretation* of their working life that I was interested in constructing knowledge about. This

resonates in some ways with the feminist standpoint on the merits of in-depth interviews, often favoured for their ability to articulate the participant's own perspective, *in their own words* (Bryman, 2008). In the current study, the workers' own words and own versions of reality, including how they felt about their role, preparation and working relationships, formed the central point of research interest.

### ***Section Summary***

So far this chapter has described the current study's philosophical and theoretical perspective, including the explorations and decisions underpinning the final choice of approach outlined in Figure 3.1 at the start of the chapter. Central to the study's overall guiding framework was the rejection of positivist modes of thought in favour of an interpretivist theoretical perspective, with an early commitment to a qualitative, exploratory study design. Within the interpretivist paradigm a pragmatic approach was taken, informed by social constructionism but deliberately kept broad enough to address the applied research problem and respond to logistical and managerial considerations. This resulted in a pragmatic, negotiated methodology made up of semi-structured interviews as the primary data source, with the addition of documentary analysis to aid the exploration of contextual factors. A full overview of the final study design can be found in Figure 4.1 at the start of the following chapter.

The remainder of this chapter will consider issues related to ethics and research quality which further underpinned the study's overall design. In keeping with the social constructionist mode of thought, this includes a consideration of my own subjective position within the research process.

## **3.2 Ethics, Quality and Reflexivity**

### **3.2.1 Ethical Considerations in Qualitative Research**

Every researcher regardless of their underlying discipline must attend to a host of ethical considerations at each stage of the research process, from initial design to data collection to the dissemination of findings. The flexible and socially embedded nature of qualitative inquiry brings its own unique set of considerations, by creating a research environment which is often unpredictable and left open to unanticipated situations (Bryman, 2008). In addition, the depth of qualitative study often requires 'intimate engagement with the public and private lives of individuals' (Mason, 1996: 166-7, in Silverman, 2005: 257). This unpredictable and intimate nature heightens the importance of ethical codes of practice to qualitative researchers (Lewis, 2003).

Key ethical considerations associated with qualitative research practice can be grouped into four main areas:

1. Informed consent
2. Anonymity and confidentiality
3. Protecting participants from harm
4. Protecting the researcher from harm (Lewis, 2003: 66-70)

Other authors make use of slightly different categorisations however there seems to be agreement on the same broad issues. The key variation is that not all authors discuss harm to the researcher as an area of ethical consideration in itself (e.g. Silverman, 2005; Bryman, 2008: 118-121), however it was a key concern raised by the Research Ethics Committee in the current study. This section will now outline how each area of ethical consideration was addressed.

### **Informed Consent**

Informed consent refers to the provision of information to potential participants relevant to their decision about whether or not to take part. As such it is central to ensuring that participation is voluntary and fully understood (Silverman, 2010).

Fully informed consent is considered to include explanations of the following:

- The overall purpose of the study, who is undertaking it and the kind of information being sought
- The role of participants in the study including procedures involved and the amount of time required
- Potential risks or discomforts
- The voluntary nature of participation and the right to withdraw at any time
- Who will have access to the collected data
- How anonymity/confidentiality will be preserved

(Adapted from Diener and Crandall, 1978 and Gray, 2004)

Each of the above points were addressed in the Participant Information Sheet which was sent to potential participants by post or email attachment, depending on manager/worker preference, alongside an invitation letter and an 'opt-in' form. Each of these documents can be found in Appendix B.

Further to this, at the start of each interview the study was described verbally including the overall aim of the project, my background and reasons for undertaking the study. Participants were asked to confirm that they had read the information sheet and were given the opportunity to ask questions. I stressed the voluntary nature of participation and also made clear how the collected data would be used and stored. Participants were then asked to sign a consent form to confirm their understanding and agreement; this can also be found in Appendix B. At the end of each interview workers were asked whether they had any further

questions following their participation and were offered the opportunity to fill in a contact details form should they wish to be sent a summary of research findings. I also ensured that they had a copy of my contact details.

### **Anonymity and Confidentiality**

Anonymity and confidentiality are two separate concepts often used interchangeably by researchers. Lewis (2003) draws a useful definitional distinction; anonymity means that the identity of participants is not known outside the research team, while confidentiality means that the data collected is not attributed to an identified participant (for example when using quotations in presentations or reports). Good practice requires the researcher to ensure that every attempt possible is made to uphold the anonymity and confidentiality of participants (Bryman, 2008). This was done in a number of ways.

Anonymity can be difficult to uphold in research settings where participation is arranged by a third party (Lewis, 2003) and this was the case in the current study due to the requirement for information to be sent to workers via a gate-keeper, usually the worker's manager. Nevertheless attempts were made to uphold anonymity as far as possible. In almost all cases, once information had been passed on to workers no further contact was made with gatekeepers other than to request a reminder email to be sent to workers or to arrange a manager interview<sup>8</sup>. Managers were not provided any information about who had taken part in the study. In addition a number of possible venues were offered to participants, including the option of meeting at the university or an alternative location of the worker's preference. Five out of thirty seven participants chose to

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<sup>8</sup> One exception was the Site 2b STR team where due to team size the manager was involved in arranging interviews and so was aware of who had agreed to take part, however this was the only feasible way to gain access.

travel to the university, while the majority preferred to be interviewed on work premises<sup>9</sup>.

After the field work had been completed, contact details were only stored for those who opted in to receive a summary of research findings. In accordance with the Data Protection Act (1998), attention was paid to ensure that personal data was not excessive, not kept for longer than necessary and stored securely. Names were replaced by a respondent number in all transcripts, notes and field diaries. In addition the audio recorder, transcripts and contact details were stored separately in locked filing cabinets. As the findings developed, attention was also paid to any potentially identifiable information, for example in transcript extracts or participant descriptions. Any concerns were discussed with supervisors, and no quotations or specific examples were featured in the summary of findings that was sent to participants.

### **Protection from Harm: Study Specific Concerns**

Considerations relating to informed consent, anonymity and confidentiality are common across all social research. In addition, researchers must consider any potential harm as a result of the specific study design. The NHS Research Ethics process requires the consideration not just of physical or psychological harm to participants but also the potential for inconvenience or disruption to service delivery. A number of specific ethical considerations arose from the current study design. Figure 3.3 provides an overview of key issues and details of how they were addressed.

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<sup>9</sup> In practice, workers were often based across more than one workplace and so were able to choose their preferred venue from several options. As a result other team members were rarely encountered during the course of the fieldwork.

**Fig. 3.3 Overview of Study Specific Ethical Considerations**

<b>Ethical Consideration</b>	<b>Strategy to Address Concerns</b>
<p><b>Inconvenience to workers</b></p> <p><b>Disruption to service delivery</b></p>	<p>Flexible options for date, time and interview venue, tailored to worker preferences and service priorities</p> <p>‘Opt-in’ participation strategy; voluntary nature of participation emphasised</p> <p>Flexibility during the interview interaction to allow for interruptions, phone calls etc.; interviews shortened if necessary</p> <p>Specified participation time kept to a minimum - one interview per worker of around 1 hour</p>
<p><b>Distress to participants</b></p>	<p>Drew on personal experience, reading and discussions with experienced researchers; developed written strategy to satisfy REC concerns</p>
<p><b>Disclosure of malpractice</b></p>	<p>Consulted NHS ‘Whistle-blowing’ policy; developed written strategy to satisfy REC concerns</p>
<p><b>Risk to researcher – Lone working</b></p>	<p>Consulted Trust and University lone working policies; developed written strategy to satisfy REC concerns</p>

As can be seen in Figure 3.3, key ethical issues related to the current study design included worker inconvenience and disruption to service delivery, the potential for distress to participants or disclosure of malpractice given the work-related and potentially sensitive nature of discussions, and possible risk to myself as researcher due to the community research context. While each of these issues had been considered during initial study design, the NHS Research Ethics Committee

(REC) requested further assurance on a number of counts due to my lack of professional or prior research experience. In response to the committee's concerns, written strategies outlining how I would deal with participant distress, the disclosure of malpractice and my own safety while lone working were submitted to the REC. These can be found in Appendix C.

### **Reflections on the NHS Research Ethics Process**

As a novice researcher I found the process of completing an NHS research ethics application to be a valuable and thorough introduction to the breadth of considerations involved in undertaking research. Although the questions appeared heavily aimed at clinical studies and as such were sometimes difficult to answer, the depth of detail required around aspects such as data storage and confidentiality were highly useful to ensure that I had covered every detail of ethical research practice. I arrived at my initial REC meeting, which took place on 21<sup>st</sup> May 2008 (Newcastle 2 REC, ref 08/H0907/52), feeling confident and well prepared. This was added to by the knowledge that the larger *New Roles in the Mental Health Workforce: Implementation and Experience* (Pearson et al., 2009) project to which my PhD was affiliated was employing similar methods and they were proving successful.

Sadly the meeting was an incredibly negative experience and resulted in my original study proposal, which involved a user and carer component in addition to worker interviews, being rejected outright by the committee. The decision not to approve the study was primarily based on my lack of professional experience working with users and carers which left me unqualified to undertake formal capacity assessment procedures. My substantial voluntary experience within the local user and carer community - including the co-facilitation of support groups - appeared to have little influence, which seemed painfully ironic given the study's focus on what it means *not* to hold a professional qualification.

Midway through my re-application in the new I-RAS system, which involved extensive research into the Mental Capacity Act (2005) and consultation with managers and workers to confirm their preference for my originally proposed methods, my first annual PhD assessment took place. This resulted in a difficult decision to remove the user and carer aspects of the study altogether and focus on the NPA worker viewpoint in depth. Consequently a third ethics application was then worked on. The tone of the second REC meeting, which took place on 18<sup>th</sup> March 2009 (Newcastle 2 REC, ref 09/H0907/19), was notably different to the first. With two supervisors present, it lasted a matter of minutes with no concerns raised.

In total the approval process took over a year from submission of my first application, with a further two months later in the fieldwork in order to secure an amendment to include the newly introduced IAPT roles. Similar difficulties have been raised elsewhere (Gill, 2009) and are echoed in Bryman's (2008: 126) commentary on research students opting not to conduct research, particularly qualitative research, within the NHS:

'Three points should be noted about the system by anyone thinking of conducting social research that will require clearance by a REC. First, it is a slow process... Second, only around 15 per cent of applications are given clearance without further consideration... Third, RECs frequently raise issues about the quality of the research.' (Bryman, 2008: 126)

Implications of the approval time lapse for the study's access strategy, in light of changing gatekeepers and service restructuring, will be considered further in Section 4.1.2 of the following chapter.

### ***3.2.2 Measuring Quality in Qualitative Research***

#### **Quality, Validity and Reliability**

The concepts of ethics and quality are closely linked in qualitative research and can be considered as interdependent concerns (Spencer et al., 2003; Bryman,

2008). For the quantitative researcher, measurements of reliability and validity are central to the assessment of research quality, however there is much debate around whether these concepts can be applied to qualitative research (Kvale, 1996; Bryman, 2008). Some authors have attempted to adapt the two constructs by lessening the emphasis on measurement but retaining their other defining features; for example Mason (1996) argues that validity can be discussed in relation to qualitative research because it is possible to consider the extent to which 'you are observing, identifying or "measuring" what you say you are.' (Mason, 1996: 24).

Other authors have argued for the development of alternative quality measurement criteria for use in qualitative fields. Guba and Lincoln (1994) provide a useful framework for judging the quality of qualitative practice, within two over-arching criteria of 'trustworthiness' and 'authenticity'. The four key criteria of research trustworthiness - *credibility*, *transferability*, *dependability* and *confirmability* - are summarised below in relation to their application to the current study.

### **Credibility**

Research credibility is built up through ethical research practice, peer review processes, prolonged engagement in the field and specific techniques including respondent validation, triangulation and attention to negative instances (Guba and Lincoln, 1994).

Techniques used in the current study included:

- *Respondent validation* (also referred to as member validation or member checking) by providing a summary of findings to participants and encouraging feedback, as well as engaging in informal discussions with NPA workers elsewhere. This ensures a high correspondence between researcher interpretation and participant perceptions (Bryman, 2008)

- Exposure to peer review through conference presentations, monthly supervision meetings and annual progression procedures
- Attention to ethical considerations as described in Section 3.2.1
- Attention to negative instances during analysis and writing

### **Transferability**

Research transferability refers to the provision of a detailed description of the research setting, in order to allow readers to judge the transferability of findings to alternative contexts (Guba and Lincoln, 1994).

Techniques used in the current study included:

- Detailed description of the research context as provided in Section 4.1.3
- Description of the wider policy, historical and political context, as described in Chapter 1 and revisited in the discussion chapter

### **Dependability and Confirmability**

Research dependability and confirmability are enhanced through the use of an 'auditing approach', involving extensive documentation, decision trails and the provision of a reflexive account (Guba and Lincoln, 1994). This echoes the emphasis on *transparency* by other authors (e.g. Yardley, 2000; Spencer et al., 2003)

Techniques used in the current study included:

- Extensive records kept of all phases of the research process; underwent official audit by R&D at one of the research sites
- Transparent theoretical and methodological decision trail
- Decision trail across data collection, analysis and writing, including research diaries and reflections notes, supervision discussions, ideas development and thesis development

- Provision of a reflexive account to position myself clearly within the research process (see following Section 3.2.3)

### **Authenticity**

The second over-arching criterion for research quality in qualitative practice described by Guba and Lincoln (1994) is 'authenticity', which is increased through the representation of multiple perspectives. Authenticity criteria include *ontological authenticity* (advancing understanding of the phenomena), *educative authenticity* (advancing understanding of individuals' perspectives), *catalytic authenticity* (motivating action) and *tactical authenticity* (empowering action). Generally concerned with the research's wider impact and overall contribution, these aspects of quality form the basis of the discussion chapter. Some aspects such as 'fairness', which describes whether the findings represent different participant viewpoints, were also an inherent part of the analysis process by looking for exceptional instances or outliers, and by revisiting data summaries and individual transcripts to ensure that the final thesis reported a fair and varied viewpoint.

The use of reflexivity to clearly position the researcher with the research process is central to the articulation of research trustworthiness and authenticity (Guba and Lincoln, 1994). A reflective account of my own subjective worldview forms the focus of the final section.

### **3.2.3 Reflexivity**

Reflexivity is described as a way of bringing political and cultural consciousness, self-awareness and ownership of one's perspective to the forefront of research practice; a process which involves 'self-questioning and self-understanding' (Patton, 2002: 64). It provides:

'A way of un-concealing our own tacit world, including the constraints that we have self-imposed.' (Steier, 1991: 7)

Reflexivity is a commonly used technique to enhance the trustworthiness and authenticity of qualitative research findings, by openly positioning the researcher within the social world they are studying (Guba and Lincoln, 1994). It is particularly important to social constructionists because the relationship between researcher and researched is placed as central to the co-creation of knowledge (Crotty, 1998).

Authors discuss two key ways of bringing reflexivity to the forefront of qualitative reporting. The first is reflexive voice, which is described as the use of an active, first person voice that indicates mutuality, honesty and places emphasis on human factors and relationships (Patton, 2002). Given its opposition to how researchers have usually been educated in academic writing, this presents a unique challenge to the qualitative researcher (Patton, 2002; Wolcott, 2009). The second common technique and focus of this section is to provide an in-depth reflexive account as part of the writing process. This encourages researchers to engage with their own 'personal epistemologies' (Rossman and Rallis, 1998: 25) by examining their beliefs, values and the social and cultural context which has informed them. In doing so it allows the audience to articulate what impact the researcher may have had on the study and use it to inform their own subjective interpretation of the findings (Ely, 1997).

Different authors offer a number of potential ways to structure the reflexive account. Patton (2002) for example suggests three key aspects: self-reflexivity, reflexivity about those studied and reflexivity about the audience. Pellat's (2003: 29) ethnography of patient participation in rehabilitation utilised the following questions:

- How have I affected the research process and outcomes?
- How has the research affected me?
- Where am I now?

Aspects of reflexivity will be woven throughout forthcoming chapters, including reflections on the interview interaction in Chapter 4 and on how the research has affected me in Chapter 8. This initial account will concentrate on my 'personal baggage' as a researcher (Steven, 2002: 129) by outlining my background, worldview and expectations upon entering the field.

### **My Background, Influences and Worldview**

The following aspects of my background are considered to have played a key part in shaping the research interaction, process and outcomes:

- Personal profile including my age
- Lack of professional affiliation
- Volunteering experience with mental health service users and carers
- Psychology degree background and move to a qualitative, sociological approach

I am a white, British, 27 year old female, brought up in a working class family in the North East of England. I was initially drawn to apply for the PhD studentship as a psychology graduate with ambitions to follow a career in clinical psychology. After a year of non-response to lengthy job applications for assistant posts I was considering support work as an alternative route into mental health when I saw the studentship advertised. I decided to apply without any particular understanding of what a PhD was other than it being a research post, having found research the most enjoyable aspect of my undergraduate degree.

Essentially it was the research topic of the changing mental health workforce, specifically its impact on the user and carer community, that caught my interest.

I do not hold any professional affiliation; however I came into the studentship with experience as a volunteer within a local service user involvement organisation. This has continued, albeit to a lesser extent, throughout the course of my PhD study. As a voluntary sector, entirely user-run organisation (other

than myself as the 'token' non-service user), I feel this experience has socialised me considerably into the user and carer perspective of local services as well as wider issues around policy, stigma and recovery. My involvement as a research assistant on the user and carer aspects of the larger *New Roles in the Mental Health Workforce: Implementation and Experience* research project (Pearson et al., 2009) added to this viewpoint.

While I have experienced only limited direct contact with NPA workers as part of my volunteering experience, I hold an awareness of the value that many of them are attributed by users and carers locally as well as what are perceived to be funding and employment issues around many such roles. I am also aware of some contrasting unease towards the growth of brief interventions (such as those performed by IAPT and graduate mental health workers), which are perceived by some to symbolise a move *away* from the care of people with more enduring mental health needs. This prior understanding will certainly have influenced my initial motivation to undertake the study, choice of research topic and the way I subsequently approached the field and the gathered data.

I would consider my volunteering experience to sit predominantly within the social model of mental health care, however like many students' accounts reported in Silverman (2010) educationally I was socialised into a positivist research paradigm. While I have always assumed the side of 'nurture' over 'nature' and held a strong belief in social aspects of experience, my undergraduate research experience was entirely quantitative and experimental. Until the start of my PhD I held little awareness of other research paradigms, with my understanding of qualitative approaches limited to what I now consider to be extreme subjectivism (Crotty, 1998). Looking back to my undergraduate self I can see a major shift in beliefs and worldview across the course of this studentship. I now consider myself very much a qualitative researcher; it interests me more, suits my personality better and is able to tell me more of what

I want to know about the world. That said, the transition has been a challenge and my positivist socialisation certainly influenced my early research approach and the way I write.

### **Expectations upon Entering the Field**

In addition to my pre-existing personal beliefs and worldview I also took a number of additional preconceptions into the field based on the literature background overviewed in Chapter 2. Rather than the blank slate of grounded theory for example, I held a number of expectations. These were mainly around the likelihood of encountering conflict, misunderstanding and the potential for all-out war, or at least clear divisions, between professional and NPA workers. As we will see across the findings chapters, the picture encountered was somewhat different; more balanced and far more complex. Where battle lines did appear they were drawn somewhat differently to my expectations, thus challenging and contradicting my initial assumptions. An iterative shift in focus in response to this challenge is perhaps the key contribution of the current study and will be re-visited throughout the findings and in the discussion chapter.

This sub-section has provided a reflexive account to make explicit my position in the research process, assisting the reader to make their own judgements about the findings and interpretation of them offered in the forthcoming chapters. The beliefs and values that I hold have changed across the course of the study and will continue to do so. Of course, there will also be other influences at play of which I am unaware. Further reflections on the interview interaction itself can be found in Section 4.2.2 of Chapter 4.

### **Chapter Summary**

This chapter has outlined the broad theoretical underpinnings and subsequent design decisions which led to the choice of a qualitative, interview-based study supplemented by documentary analysis. The study has been situated within an

interpretivist paradigm informed by social constructionism and pragmatic influences. Section 3.2 then described how key ethical considerations were addressed including consent, confidentiality and study specific concerns around potential harm and service disruption. Attempts to enhance research quality by building credibility, transferability and authenticity into the study design have also been discussed. In keeping with a qualitative, social constructionist tradition this included the provision of a reflective account of my own subjective position in the research process.

The following chapter moves on to describe how the chosen study was carried out in practice, starting with an overview of the sampling and access strategy before moving on to consider details of data collection, analysis and writing. The separation of theoretical assumptions and the more concrete aspects of study design into more than one chapter is entirely practical; in reality the different aspects were interdependent and therefore closely aligned.

## **Chapter 4. Data Collection and Analysis**

### **Introduction**

Chapter 3 provided an overview of the broad theoretical underpinnings chosen as 'scaffolding' (Crotty, 1998) for an exploratory study of NPA working life. It highlighted a chosen commitment to an interpretivist approach, underpinned by social constructionism and pragmatic influences, and the final choice of a qualitative, interview-based study. This chapter provides a detailed account of how the chosen study was carried out in practice, including issues encountered and resulting developments. The three elements covered in this chapter are:

- Sampling and participant access strategy
- Data collection and reflections on the interview process
- Analysis and writing

An overview of the study's final design is illustrated in Figure 4.1.

**Fig. 4.1 Overview of Final Study Design**

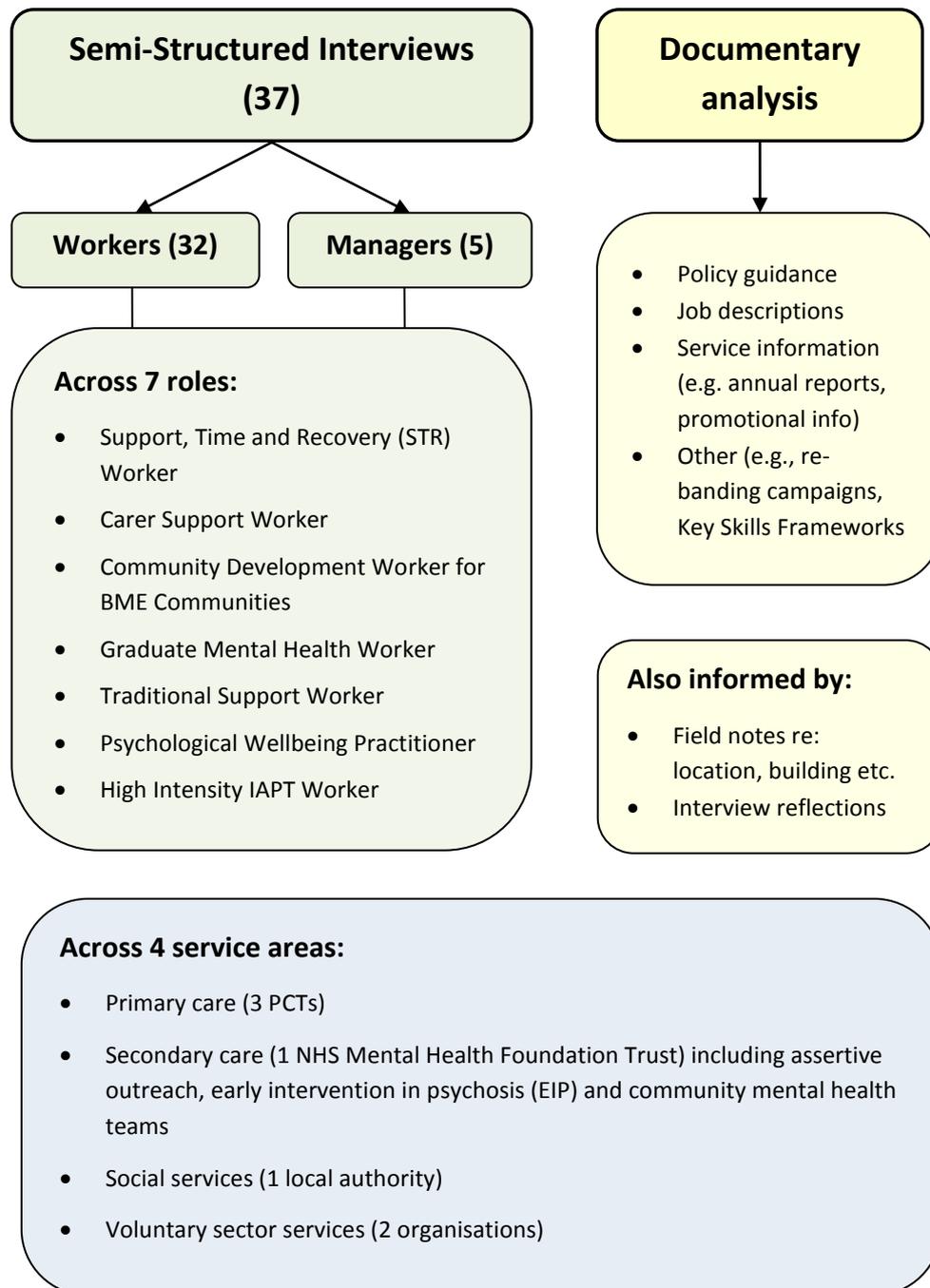


Figure 4.1 illustrates an overview of the final study design which comprised semi-structured interviews with NPA workers (32) as the primary data source. In addition, interviews with managers (5) and role-related documents including job descriptions and service promotion material provided supplementary sources of

data. Participants were employed across four service areas; namely primary care, secondary care, social services and voluntary sector services. Further details of the sampling and access strategy and research setting will now be considered.

## **4.1 Sampling and Participant Access Strategy**

### **4.1.1 Sampling Frame Development**

#### **Sampling Approaches in Qualitative Research**

Qualitative research aims to draw inferences about the nature of a studied phenomenon, rather than its prevalence or statistical distribution (Lewis and Ritchie, 2003). Given the emphasis on theoretical extrapolation and inferential - rather than statistical - generalisability, qualitative approaches tend to favour non-probability based purposive sampling rather than the statistical or random sampling techniques common to positivist approaches (Ritchie et al., 2003; Silverman, 2005). Purposive sampling creates a high level of correspondence between sampling and research questions because it involves choosing cases because they fulfil some form of criteria or have features in which we are interested (Silverman, 2005; Bryman, 2008). In essence, the researcher aims to seek out settings and people within those settings where 'the processes being studied are most likely to occur' (Denzin and Lincoln, 2000: 370).

The terms 'purposive sampling' and 'theoretical sampling' tend to be used interchangeably by researchers (Silverman, 2005), however methodology authors often distinguish between the two, suggesting theoretical sampling to be a particular *type* of purposive sampling (Patton, 2002; Ritchie, Lewis and Elam, 2003; Bryman, 2008). Patton (2002) identifies a number of purposive sampling techniques including deviant case sampling (seeking out unusual manifestations of a phenomenon such as extreme successes or failures), criterion sampling

(including all cases that meet specified inclusion criteria) and theoretical sampling (finding manifestations of a theoretical construct of particular interest).

The initial strategy utilised in the current study can be conceptualised as criterion sampling (Patton, 2002). The criterion for inclusion was current employment in a non-professionally affiliated (NPA) role within local community mental health services. As the study progressed however service developments, theoretical considerations and increasing complexity around the definition of the term 'non-professionally affiliated' (NPA) led to the use of an iterative, adaptive approach to case inclusion. Ritchie et al. (2003) suggest the key difference between theoretical and criterion sampling to be the *iterative* nature of theoretical sampling; the sampling frame is continually developed out of a relationship with the field and the emerging data. An approach commonly used by grounded theorists, it is also considered valuable to exploratory studies where inclusion criteria can be difficult to identify in advance (Ritchie et al., 2003). Although I did not anticipate the need for an iterative approach to case inclusion, the realities of the field resulted in a flexible sampling frame that developed over the course of the research.

### **Initial Sampling Frame**

Reflecting the funding origins of the PhD studentship, the original sampling frame involved only workers employed in *newly developed* mental health NPA roles; i.e. those implemented or expanded under the New Ways of Working initiative (DoH, 2005). This yielded four roles as the initial inclusion criteria:

- Support, Time and Recovery (STR) Workers
- Carer Support Workers
- Community Development Workers for BME Communities (CDWs)
- Graduate Mental Health Workers (GMHWs)

A brief overview of the tasks and policy intentions for each of these roles can be found in Appendix A. The choice to focus on local services was a logistical one, to facilitate ease of data collection within the available time and resources, and to enable the use of existing service knowledge. This is generally considered to be accepted practice in qualitative enquiry, with authors acknowledging that sampling choices are commonly influenced by pragmatic considerations around time and available resources, as well as issues linked to the nature and complexity of the intended study population (Ritchie et al., 2003; Patton, 2002; Silverman, 2010). 'Local' services were defined here using the geographical boundaries of the local NHS Foundation Trust (Northumberland, Tyne and Wear).<sup>10</sup>

Outside of the role and location-based criteria, no other characteristics were specified upon which to include or exclude cases. The sampling frame cut across different employing organisations, anticipated to primarily consist of the local NHS Trust and PCTs but to extend to other agencies (such as Local Authority and voluntary sector agencies) where necessary. Essentially the strategy was to go wherever workers were employed.

Due to the study's exploratory nature, the use of the term 'non-professionally affiliated' was deliberately kept broad. It was used to define those working in roles which were not articulated in official role guidance as forming part of a traditional profession such as nursing, psychiatry or clinical psychology.

### **Complexities in the Field and Criteria Development**

Two substantial changes to the inclusion criteria took place across the course of data collection. Firstly, a case of 'mistaken identity' early in the fieldwork resulted in a traditional support worker taking part in the study. Discussions

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<sup>10</sup> Within these geographical boundaries, three research sites - each of which held a different service set-up - were included in the study sample. Further details of local service set-up and demographic details related to each study site will be outlined in Section 4.1.3.

with this worker proved highly valuable, and as a result I later decided to concentrate recruitment efforts further towards the inclusion of traditional support workers<sup>11</sup>.

Secondly, the introduction of IAPT (Improving Access to Psychological Therapies) into one of the study sites led to the inclusion of two additional job roles. As the vast majority of GMHWs began moving over to the Psychological Wellbeing Practitioner (low intensity IAPT) role, the almost identical nature of the two remits led to an extension of the study sample to include these new workers. In practice, this led to the addition of a seventh role, the High Intensity IAPT Worker. As Band 6 workers the high intensity role may well be more appropriately described as 'paraprofessional', or even professional if pay and training are taken into account, however the blurring distinction and apparent lack of clarity over the professional status of workers<sup>12</sup> arose as a point of theoretical interest in itself.

As a result, the final sampling frame consisted of seven roles ranging from strictly non-professional to more paraprofessional in nature. This continuum can be seen most clearly when the roles are positioned alongside their NHS pay band (or equivalent for non-NHS workers), as illustrated in Figure 4.2. The numbers of workers interviewed are provided in brackets alongside each role title.

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<sup>11</sup> Unfortunately the recruitment attempt gained only one further participant; a much lower uptake rate than for other roles. Possible reasons for this will be explored further in section 4.1.2.

<sup>12</sup> At the time of writing (May 2011) it is still under discussion whether the High Intensity training course will be accredited by the BABCP (British Association of Behavioural and Cognitive Psychotherapies).

**Fig. 4.2 Overview of Final Sampling Frame**

Pay Banding	Role Title	
Band 3	• Traditional Support Workers	(2)
	• Carer Support Workers	(4)
Band 3-4	• Support, Time and Recovery (STR) workers	(8)
Band 4-5	• Graduate Mental Health Workers (GMHWs)	(6)
	• Psychological Wellbeing Practitioners (PWPs)	(5)
Band 5-6	• Community Development Workers for BME Communities (CDWs)	(5)
Band 6-7	• High Intensity Workers	(2)
	Total interviews	32

As can be seen in Figure 4.2 above, the final study sample consisted of workers from NHS Pay Band 3 to Band 6. Although the higher bandings may be considered paraprofessional or 'semi-professional' rather than strictly NPA, the roles' emergent nature within services and lack of clear affiliation to any pre-existing, traditional mental health profession meant that they can be considered within the broad definition of 'non-professionally affiliated' utilised in the current study.

### A Consideration of Sample Size

**'There are no rules for sample size in qualitative inquiry.** Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources.' (Patton, 2002: 244; emphasis in original)

Sample size *per se* is not a specific concern to qualitative researchers, as the iterative nature of qualitative enquiry emphasises the goal of reaching data

saturation rather than fulfilling a predetermined quota of participants (Patton, 2002, Silverman, 2005; 2010). Patton (2002) describes sample size in qualitative research as a trade-off between breadth and depth in the face of limited time and resources; a negotiation which should be judged based on study purpose. In the current study I aimed to fall somewhere in the middle but edged towards the breadth side of the trade-off. While in-depth data was deemed important, larger sample sizes are considered valuable to exploratory studies or in situations where the researcher is attempting to examine variation or diversity (Patton, 2002). In addition, the logistical issues already described in Chapter 3 placed limits on the maximum available investment from each individual participant.

Demographic information about the study sample will be briefly outlined in Section 4.1.4.

#### **4.1.2 *Gaining Access***

Bryman (2008) describes gaining access to study participants as a complex bargaining process, mediated by gatekeepers whose main concerns are researcher motives and a weighing up of prospective organisational gains against potential losses, in terms of worker time and potential risk to the organisation's image:

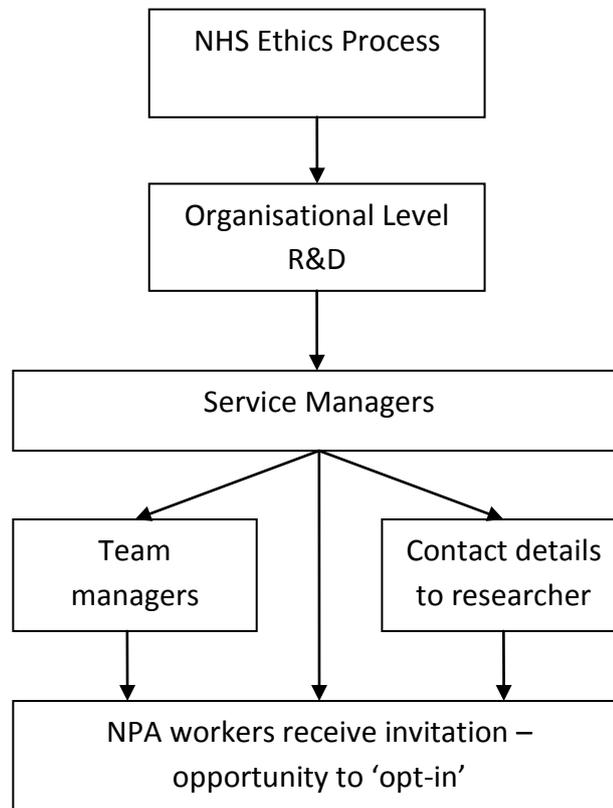
‘Consequently, gaining access is almost always a matter of negotiation, and as such inevitably turns into a political process. The results of this negotiation are often referred to as the ‘research bargain’ (Bryman, 2008: 131)

#### **Initial Access Strategy**

The current study involved several layers of gatekeeping including the NHS Research Ethics process, organisational level Research and Development (R&D), service management and team management. The ‘research bargain’ came at a price, with the loss of participants at each level of access. The various stages of

negotiation are identified in Figure 4.3 which provides an overview of the access strategy used in the current study.

**Fig. 4.3 Overview of Gatekeeping and Access Strategy**



As can be seen in Figure 4.3, gaining access to potential participants involved negotiations at a number of different levels. Following the NHS Research Ethics process described in Chapter 3, further clearance was then sought at an organisational level. Two PCTs withdrew from participation at this point, citing service re-structures and in one case being over-researched.

As illustrated in Figure 4.3, the transition of information from service managers to individual workers took a number of different forms dependent on manager preferences. In many cases the information was passed on to team managers with whom I then liaised separately. In others the study information was forwarded

directly to NPA workers within the service, or I was provided with worker details in order to make direct contact.

### **Gaining Access in Practice: Complexity, Visibility and Restrictions**

Given the narrowing pool of potential participants following the withdrawal of access by two key employers, the subsequently fairly small population of workers meant that in theory it was feasible to invite all workers fitting the inclusion criteria (and for whom access was granted by gatekeepers) to participate in the study. This shares similarities with 'whole population' sampling, favoured by critical enquiry and feminist approaches as it allows maximum variation and encourages the inclusion of atypical or unusual perspectives (Pawson, 1997). A number of strategies were employed to maximise the possibility of this, for example by stressing to managers the importance of all workers receiving information about the study and requesting it to be raised during team meetings. It was often possible to check the effectiveness of this approach as participants usually mentioned how they had received the invitation to participate. A group email to all NPA workers in the team/service and/or discussion during a team meeting were the most commonly reported methods.

In practice however the reality of gaining access in the way summarised in Figure 4.3 was a hugely complex process, resulting in a number of extensions to the fieldwork timeframe. Originally anticipated to take place over 5 months, the fieldwork actually lasted 16 months from the point of REC approval to the final interview. Key issues encountered in the field that led to access complexity included:

- Changing gatekeepers
- Lack of worker visibility
- Differences in service set-up and complexities at the sub-sector interface
- Inaccurate or incomplete information provided by some gatekeepers

### **Changing Gatekeepers**

The time lapse between initial consultation with managers and the commencement of fieldwork, as a result of the various approval processes required, meant the loss of a number of key gatekeepers through retirement, long term sickness leave or service re-structuring; elements which continued to create a fluid and constantly changing situation across the course of the study. As a result it became necessary to renegotiate previously held access in a number of cases, for example when a carer support team moved host organisation from statutory services to the voluntary sector. Elsewhere, originally agreed access to one STR team was withdrawn upon replacement of the team and service managers.

### **Visibility**

Worker visibility created a major challenge to identifying potential participants, particularly in rural Site 1 and instances where workers did not have an immediate team manager. On these occasions worker contact details tended to be provided directly by service managers, however a high prevalence of bounced emails and failed attempts at telephone contact created a long, complex and sometimes unsuccessful process of trying to track workers down. This is likely to have been exacerbated by the community-based and often part-time nature of the roles studied, and proved a particular issue for the recruitment of traditional support workers. Lack of email usage may also have contributed; the two support workers I did interview reported infrequent access to email, as did a number of carer support workers. A subsequent attempt to invite workers to participate by sending postal information was unsuccessful.

The visibility of workers at an organisational level was made more complex by marked contrasts in service set-up and employing organisation between localities, which created substantial variation in the positioning of workers and

numbers employed. Particular difficulties were encountered at the interface between different sub-sectors, as service managers from one organisation were not always aware of provisions elsewhere. In practice the identification of potential participants often relied on informal signposting from the local user and carer network who stepped in with advice when trails had 'gone cold', or interviewees mentioning colleagues or teams elsewhere that I had previously been unaware of.

Key details of service and team set-up encountered at the different study sites will now be briefly outlined.

#### **4.1.3 Research Sites and Service Set-Up**

'Context becomes the framework, the reference point, the map, the ecological sphere; it is used to place people and action in time and space and as a resource for understanding what they say and do... We have no idea how to decipher or decode an action, a gesture, a conversation, or an exclamation unless we see it embedded in context.' (Lawrence-Lightfoot, 1997: 41)

A consideration of the relevant service setting is central both to enhancing research quality and transferability (Guba and Lincoln, 1994) and to the current study aim of exploring how contextual and workplace factors may shape worker experience. This section briefly outlines key details of the service context, study sites and team set-up that will be drawn upon across the findings chapters.

#### **The Mental Health Service Context**

Community mental health care can be positioned within a three-tier service system that spans health and social care. Using slightly different terminology to other areas of health, in which hospital-based services are usually referred to as secondary care, in the mental health context inpatient treatment is described as *tertiary* care and is reserved for acute need and/or times of crisis. Secondary care forms the largest service component and is community based, made up of

multidisciplinary community mental health teams (CMHTs) which hold a general focus (i.e. cover a range of diagnoses) as well as specialist teams such as Early Intervention in Psychosis (EIP), assertive outreach and crisis resolution.

The three levels of primary, secondary and tertiary mental health provision are summarised in Figure 4.4, highlighting in italics the position of NPA roles within each.

**Fig. 4.4 Overview of Mental Health Service Provision**

<p><b>Primary Care</b></p> <p>Mild to moderate</p> <p><b>GP-based</b></p>	<p>GPs and multidisciplinary primary care mental health teams</p> <p>Primary care team members include community psychiatric nurses (CPNs), advanced practitioners (including counsellors, family therapists), <i>graduate mental health workers (GMHWs), IAPT workers</i></p>
<p><b>Secondary Care</b></p> <p>Moderate to severe</p> <p><b>Community-based</b></p>	<p>Multidisciplinary Community Mental Health Teams (CMHTs) and specialist teams</p> <p>Team members include psychiatrists, clinical psychologists, CPNs, occupational therapists, social workers, <i>support workers (including carer support workers, STR workers)</i></p>
<p><b>Tertiary Care</b></p> <p>Severe/crisis</p> <p><b>Hospital-based</b></p>	<p>Inpatient care</p> <p>Includes psychiatrists, psychiatric nurses, clinical psychologists, occupational therapists, <i>healthcare assistants (HCAs)</i></p>

### **North East Service Set-Up**

North East England has one of the highest rates of mental ill health in the UK based on responses to the General Health Questionnaire, when taking into account significant mental health problems, hospital admissions and suicide

rates. Paradoxically, the North East also holds one of lowest regional expenditures per person on mental health care (Pearson et al., 2009; Public Health Observatory, 2009). Compared to the national picture the region has a relatively low socio-economic status, with high levels of deprivation and unemployment combined with below average economic activity and educational attainment. Unemployment has risen dramatically with the recent loss of manufacturing and public sector jobs, upon which the region is 'disproportionately dependent' compared to other areas of the UK (Tomaney, 2006: 10; Government regional office, 2009; IPPR, 2009).

Geographical boundaries of the current sampling frame were drawn around the area served by the Northumberland, Tyne and Wear (NTW) Mental Health Foundation Trust. One of the largest Foundation Trusts in the UK following the merging of a number of smaller Trusts, it employs over 7000 staff, serves a population of around 1.5 million people and is responsible for a large amount of community-based health care (Pearson et al., 2009). Within the geographical boundaries of the NTW Trust, mental health provision is also undertaken by a number of additional providers including Primary Care Trusts (PCTs), local authority social services and the voluntary sector.

### **Overview of Study Sites**

At the time of study, the NTW area was served by six PCTs (three of which agreed to take part), grouped into two Primary Care Organisations (PCOs). As the main employers for the majority of roles examined in the study, these primary care boundaries were used to articulate two distinct study sites which held separate service configurations and geographical landscapes. Initially the PCO boundaries were used, yielding Sites 1 and 2, however as the fieldwork progressed structural differences observed *within* Site 2 led to a further split in order to facilitate ease of analysis and discussion. As such, the final study sites

were labelled Sites 1, 2a and 2b. Key demographics of each are briefly summarised in Figure 4.5 below.

**Fig. 4.5 Overview of Study Sites**

Site	Size	Population	Landscape
<b>Site 1</b>	5,013 km <sup>2</sup> (1,936 sq mi)	317,000 (1,578 using mental health services)	Rural with a few small market towns. No large population centres
<b>Site 2a</b>	142 km <sup>2</sup> (55 sq mi)	190,000 (5,668 using mental health services)	Roughly half rural, half urban; a number of medium sized population centres
<b>Site 2b</b>	64 km <sup>2</sup> (24.9 sq mi)	151,000 (3,767 using mental health services)	Mostly urban; large population centre

(Sources: Neighbourhood Statistics, 2011; PCT websites; local government websites, 2009-2010)

As can be seen in the demographic information provided in Figure 4.5, the three study sites varied in size, population and landscape with a particular distinction between rural Site 1 and urban Sites 2a and 2b. Sites 2a and 2b were geographically much smaller and more densely populated than Site 1, with a smaller total population but much larger numbers accessing mental health services. The numbers of NPA workers employed in the study sites generally reflected the level of service access, with Site 2b being the largest employer. In contrast, Site 1 workers tended to be fewer in number, more spread out and served a less densely populated but much larger geographical area.

Figure 4.6 provides a breakdown of the final sample numbers across the three study sites. The majority of roles examined in this study were employed at each of the study sites, with two exceptions that no mental health carer support

workers were employed in Site 2a and that IAPT implementation had not yet begun in Site 1. These are reflected as gaps in the breakdown provided. In addition, access was not granted to the local authority employed STR team in Site 2a.

**Fig. 4.6 Final Sample Distribution by Role and Study Site**

	Site 1	Site 2a	Site 2b	Total
Support, Time and Recovery (STR) Workers	3	0	5	8
Carer Support Workers	2	-	2	4
Graduate Mental Health Workers (GMHWs)	3	3	0	6
Community Development Workers (CDWs)	1	2	2	5
Psychological Wellbeing Practitioners (PWPs)	-	1	4	5
High Intensity Workers	-	0	2	2
Traditional Support Workers	2	0	0	2
Managers	2	1	2	5
<b>Total</b>	<b>11 workers</b> <b>2 managers</b>	<b>6 workers</b> <b>1 manager</b>	<b>15 workers</b> <b>2 managers</b>	<b>32 workers</b> <b>5 managers</b>

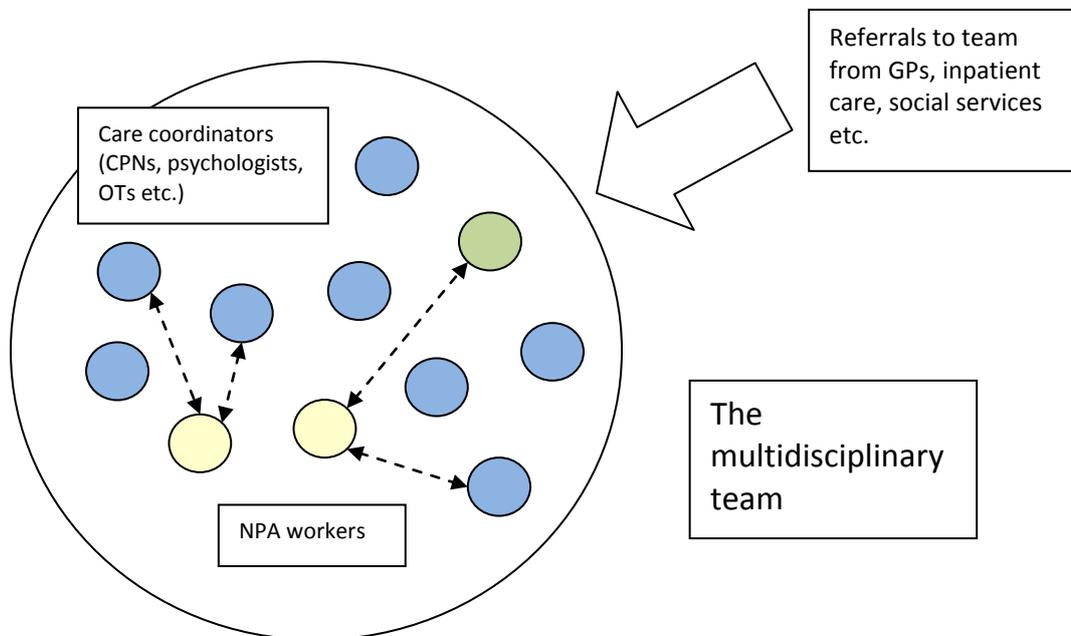
With the exception of the two IAPT roles (PWPs and high intensity workers), the final sample distribution illustrated in Figure 4.6 above roughly corresponded to the prevalence of a particular role in services. For example STR workers were the most prevalent role in services and also the role with the highest number of participants, while traditional support workers and carer support workers were

found to be the least prevalent. In most instances the number of workers who took part equated to roughly half the number employed in a particular role or site; for example there were a total of 11 STR workers and 4 carer support workers employed in Site 2b at the time of study, 6 GMHWs employed in Site 2a etc.

### Team Set-Up and Referral Routes

Wide variation was observed across the study in terms of team set-up and NPA worker positioning. The most common set-up encountered was the employment of NPAs as part of a multi-disciplinary team such as a CMHT, specialist team, or primary care mental health team. Figure 4.7 below provides a visual illustration of this type of team set-up. The yellow markers represent the position of NPA workers while blue represents professionals and green represents the team manager.

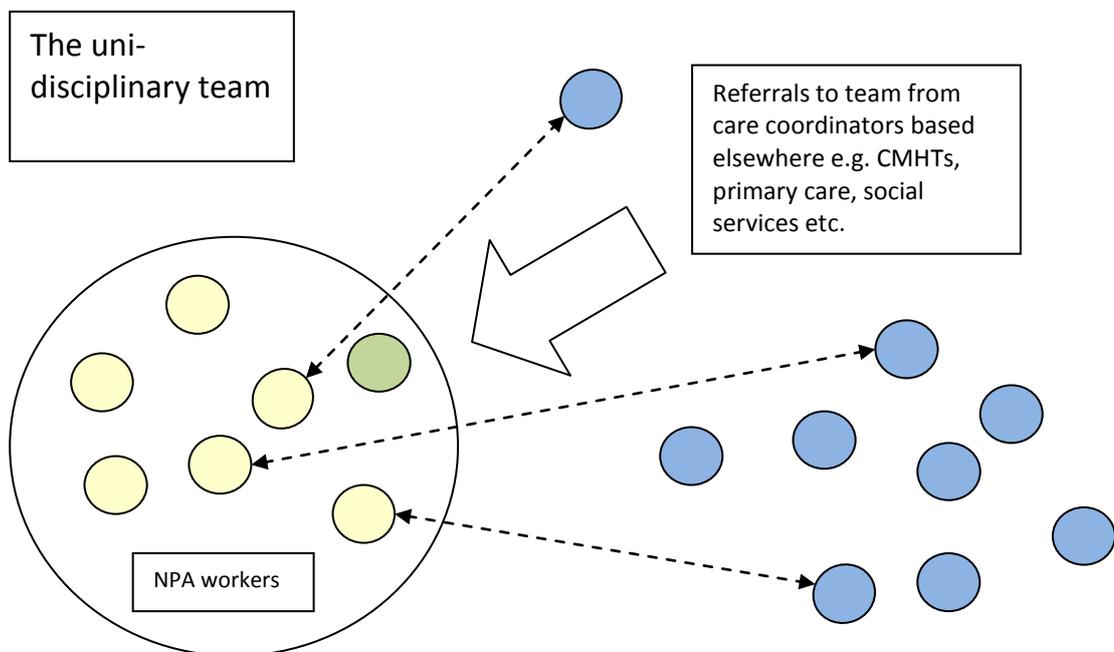
**Fig. 4.7 NPA Worker Position within a Multidisciplinary Team**



The employment set-up visualised in Figure 4.7 above was typical of NPA workers employed in multidisciplinary team settings, including graduate mental health workers and Site 1 STR workers, CDWs and carer support workers. In this set-up, one or two NPA workers (an STR worker and a carer support worker for example) were positioned alongside a range of professional team members. The dashed lines depict the *within-team* delegation and feedback system, whereby NPA workers would receive referrals directly from care coordinators and feedback relating to those referrals would occur within-team with the relevant care coordinator.

The second type of team set-up which was exclusively found in Sites 2a and 2b, presumably due to the larger number of NPA workers employed, took the form of uni-disciplinary NPA teams. Figure B.5 below provides a visual illustration of this type of team set-up.

**Fig. 4.8 NPA Worker Position with a Uni-Disciplinary Team**



The employment set-up visualised in Figure 4.8 above was typical of unidisciplinary NPA teams including the STR and carer support teams in Site 2b and the CDW team in Site 2a. As can be seen in the diagram, in this situation the immediate team is made up entirely of NPA workers and the team manager (where applicable). Referrals come from care coordinators in a variety of settings outside the immediate team. While referrals come to the team as a whole, feedback takes place with individual care coordinators as shown by the dashed lines. The difference in this context is that the care coordinators are situated elsewhere, illustrating a clear difference in proximity between NPA worker and delegating professional.

This variation in how client-related tasks are delegated to NPA workers illustrates a clear distinction from other settings, where the worker's primary point of contact would generally be the immediate professional(s) whom they assist and who are predominantly based in the same physical working space such as the hospital ward or school classroom. This difference between *within-team* and *distance* referral systems will be revisited in Chapter 5 when we consider variation in the nature of communication, contact and professional proximity.

The majority of teams included in the current study took one of the two aforementioned forms outlined in Figures 4.7 and 4.8. Some workers reported a blend of the two types of referral system; GMHWs for example received a mixture of within-team and distance referrals. A second key point to note which will be revisited in forthcoming chapters is the difference in proximity to other NPA workers as a result of the employment set-up. For the majority of teams examined here this can essentially be viewed as opposite to the level of professional contact. NPA workers in multi-disciplinary teams held relatively high levels of face-to-face contact with professionals but generally low levels of contact with other NPA workers, while workers in unidisciplinary NPA teams

experienced high levels of contact with their NPA co-workers but relatively low levels of face-to-face contact with professionals.

A final point to note is that despite the team boundary drawn in the above illustrations of employment set-up, this did not necessarily equate to workers sharing one team base. Instead the geographically dispersed nature of the community service context meant that a large number of workers reported working across a number of community buildings.

#### **4.1.4 *Sample Demographics***

Chapter 2 suggested that existing knowledge about the individuals that make up the non-professionally affiliated (NPA) health care workforce is limited, in terms of demographic information or educational and career background (Baldwin et al., 2003; Nancarrow and Shuttleworth, 2005). This sub-section briefly outlines demographic characteristics and career background of the current study sample.

##### **Sex and Age Distribution**

The current NPA study sample consisted of 21 females and 11 males, illustrating a roughly 2:1 ratio, with an age range from mid twenties to late fifties<sup>13</sup>. The female:male ratio was fairly even across all roles, with the exception of traditional support workers who were both male and GMHWs for whom 5 out of 6 were female. The five managers interviewed were all male, aged between early forties to late fifties.

Worker demographics in the current study were somewhat different to the picture painted in other settings. A recent survey of almost 750 HCAs carried out by Kessler et al. (2010) for example found the vast majority to be mature women with partners and children, suggesting a wider variation in post-holder background in the current study context.

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<sup>13</sup> Participant age was not directly asked but was estimated from discussions of worker background. As such, figures referred to here are approximate.

The wide age range observed here was not evenly spread however; almost half of NPA workers interviewed were over 45 and a large number mentioned being close to retirement. Age distribution varied greatly across job roles with those employed in lower paid support roles being on average much older than their brief interventions counterparts in graduate roles such as GMHW and PWP. This can be seen for example in Figure 4.9 below, which compares age distribution for support, carer support and STR workers to that of GMHWs and psychological wellbeing practitioners.

**Fig. 4.9 Age Distribution for Support, Carer Support and STR Workers, compared to GMHWs and Psychological Wellbeing Practitioners**

Support workers, CSWs and STRs		GMHWs and Psychological Wellbeing Practitioners	
Age Range	Number of participants	Age Range	Number of participants
<30	0	<30	7
30-45	3	30-45	3
>45	11	>45	0
Total	14	Total	10

Figure 4.9 above shows an opposite age distribution between lower paid support roles (support, carer support and STR) and graduate, brief interventions roles (GMHWs and PWPs). The pattern was different again for CDWs and high intensity workers; as the two highest paid roles, the age distribution fell towards the middle of the scale with the majority of workers fitting the 30-45 age range.

Worker reports suggested the difference in age distribution to be related to contrasting pay and career progression opportunities across the different roles studied. These differences were perceived to significantly impact on who was

able to work in each role, and the feasibility of each as a long term career option. This area of discussion will be revisited in the findings chapters.

### **Worker Background and Experience**

The NPA workers involved in the current study also demonstrated a diverse range of educational, career and life experience. Mirroring the difference in age distribution, worker background and experience varied across the different roles studied, with brief interventions workers possessing higher educational attainment (by nature of the role requirements) but less career and life experience than participants employed in other posts.

Participants fell roughly into one of three distinct groups based on their personal and educational background: *long term caring career*, *role as a life change* and *role as a stepping stone*. These groupings will be re-visited in forthcoming chapters and are useful to understand observed differences in terms of:

- What workers bring to the role in terms of skills, experience and expectations
- Motivation for doing the job
- What key issues workers see as important
- Future plans

Key characteristics of the different groups are summarised in Figure 4.10.

**Fig. 4.10 Categorisation of Worker Background: Caring Career, Life Change and Role as a Stepping Stone**

	<b>Long Term Caring Career</b>	<b>Role as a Life Change</b>	<b>Role as a Stepping Stone</b>
<b>Key characteristics</b>	<p><i>Career experience</i></p> <p>Long term experience in mental health support work or a related area e.g. youth work, learning disabilities</p> <p>Often moved to community care following long term career (up to 25 years) in inpatient services, motivated by practical advantages (e.g. more sociable hours) or desire for a new challenge</p>	<p><i>Life experience</i></p> <p>Part of a mid-life career change rather than initial career choice. Either successful career elsewhere (e.g. marketing, management) or varied, 'nomadic' background, followed by a 'calling' to mental health work, change in circumstances or values</p> <p>Most likely group to have personal experience of mental ill health or caring</p>	<p><i>Educational experience</i></p> <p>Youngest group with highest educational attainment, usually psychology graduates within last 5 years. Role as planned first step towards a career in mental health therapy or clinical psychology</p> <p>Least amount of prior experience in caring roles</p> <p>Most likely to hold plans to move on within next few years</p>
<b>Key issues reported by workers</b>	<p><b>Pay</b> and its link to status, <b>progression</b></p> <p>Least likely group to raise issues around risk, boundaries etc.</p>	<p><b>Interpersonal</b> aspects of client work e.g. risk, <b>boundaries</b>, mental health specific training</p>	<p><b>Confidence</b> in abilities, <b>supervision</b> and training, <b>career progression</b></p>
<b>Job roles most commonly displaying this background type</b>	<p>Traditional support worker, carer support worker, STR worker</p>	<p>Community development worker, carer support worker, STR worker, traditional support worker</p>	<p>Graduate mental health worker, psychological wellbeing practitioner, high intensity</p>
<b>R numbers displaying this background type</b>	<p>R1 (SS), R2, R7, R10, R11, R13, R17, R19, R20, R23, R26, R29,R30, R32</p>	<p>R6, R8, R9, R12, R14, R15, R18, R27(CC), R24, R34</p>	<p>R3, R4, R5, R16, R28 (CC), R33, R35, R36, R37</p>

As can be seen in Figure 4.10, participants in the current study held a diverse range of career, life and educational experience which could be roughly separated into three 'types' of background. These groupings were not entirely distinct, with a small number of workers spanning more than one (shown in bracketed letters next to the respondent number).

While all participants interviewed in the current study reported a strong, shared caring motivation based on a desire to help people or see people move forward, as illustrated in Figure 4.10 workers' short-term motivations varied. For stepping stone workers - usually those employed in brief interventions roles - the job was perceived as a first step towards a professional career, while for life change workers it often constituted a step *down* from a professional career elsewhere following a desire for something more people-focused or 'meaningful' (R19). For those who had spent a long-term career in support work, the autonomy, responsibility and 9-5 working hours of community-based services were often considered advantageous over previous ward-based posts.

The three types of worker background introduced here are important to the upcoming findings chapters because they offer some insight into what issues workers considered to be most important. These differences in background therefore play a key part in the subjective experience of working life. Worker background becomes particularly important in Chapter 7, where we consider preparation and support for the complexities of client work.

### ***Section Summary***

This section has outlined details of the sampling and access strategy employed in the current study, drawing attention to how it developed in response to changes in the field, service developments and differences across locality. This resulted in a fluid, changeable and often complex recruitment process. Sections 4.1.3 and 4.1.4 highlighted key demographic details of the research setting and study

sample, which will be drawn upon in later chapters and are useful to enhance the transferability of the study findings (Guba and Lincoln, 1994).

Sections 4.2 and 4.3 will now provide an overview of the data collection and analysis process, before moving on to explore the findings in Chapters 5-7.

## **4.2 Data Collection**

### ***4.2.1 Developing the Interview Topic Guide***

The use of an interview topic guide is a central aspect of semi-structured interviewing. It brings a flexible structure to the interaction and acts as a reminder to the researcher of key points of interest (Kvale, 1996; Patton, 2002; Rapley, 2004; Silverman, 2010). The initial content of the topic guide usually originates from the background literature alongside any 'thoughts and hunches' about areas of potential importance; however it is subject to adaptation as the field work progresses (Rapley, 2004: 17).

Based on the literature overviewed in Chapter 2, the key areas of interest identified in the current study were:

- Worker background and future plans
- Role performed (including component tasks; overlap with or impact on other workers; how it is viewed by others)
- Position and relationships within the team
- Preparation, supervision and support
- Any other aspects raised as important by the workers

Both the worker and manager topic guides covered these areas of interest and can be found in their final versions in Appendix D. Their development involved an extensive process of drafting and revising in order to ensure that there were no leading questions and that the discussion would flow as far as possible like a 'normal' conversation. This included adapting questions to ask about specific

experiences rather than abstract concepts and revising the order of questions several times. As can be seen in Appendix D, the final version included a fairly conversational opening question about worker background, leading in to more complex questions as the interview progressed.

The interview topic guides were not formally piloted, however the proposed topics had been sent to NPA workers and managers during earlier consultation in order to ensure their relevance. In addition, the guides were revisited during supervision after the first two interviews and then regularly throughout the fieldwork. During this time the question order was further revised and the manager topic guide altered to become more concise in light of the limited time often available for these interviews. In contrast to the common approach in exploratory studies, the content itself was not considered to require adaptation or a change of focus as the study progressed. Attempts were made however to probe the discussion of professional relations in more depth, as this aspect of worker experience did not appear to be coming out of the conversations to the extent expected based on the background literature<sup>14</sup>.

Although the interview topic guides were written as specific questions they were rarely spoken verbatim. Following the opening question, the order varied depending on the direction taken by each particular interview. As seems to be the recommended practice in semi-structured interviewing, and central to the method's value, the guide acted as checklist to ensure that the key areas of interest were covered rather than as a 'predetermined agenda' (Rapley, 2004: 18). Other than the opening question about worker background, the only other aspect of uniformity tended to be an emphasis on the final question which asked workers whether they had any additional points or issues to raise that had not been covered.

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<sup>14</sup> This will be revisited in the first results Chapter 5 when we consider professional proximity in the current study context.

### **4.2.2 The Interview Process**

A total of 37 semi-structured interviews were conducted over a period of 14 months. The majority lasted around one hour but ranged in duration from 32 minutes to over two and a half hours, often dictated by the amount of time available in between appointments with clients. Manager interviews tended to be shorter, ranging from 24 to 49 minutes in length.

#### **Before the Interview**

The date, time and location of each interview was arranged individually when participants 'opted in' to the study, by telephone or email depending on worker preference. The majority of participants chose to be interviewed at work, although as they often worked across a number of different bases the interviews usually took place away from the shared team building. Travelling to the workers enabled some limited observation of the practice setting and workspace as well as the surrounding locality. Upon arrival at the participant's workplace, generally there was time available for informal conversation while making tea or showing me round the building, which provided additional valuable context. The majority of interviews took place in a private meeting room or office, although they were sometimes subject to interruptions from colleagues or in order to take phone calls etc.

Five workers requested an interview away from work and chose to visit me at the university. Four expressed pragmatic reasons such as living nearby and one did not want colleagues to be made aware of participation in the study. My interview reflections noted an interesting change in dynamic for the interviews conducted in my own office as opposed to that of the worker, with me acting as tea maker and sharing my workspace with them seeming to create a more evenly balanced and less formal interaction.

Following a verbal discussion of the study's aims and obtaining written consent as described in the previous chapter, the official interview took place.

### **The 'Official' Interview**

'When we talk with someone else about the world, we take into account who the other is, what the other person could be presumed to know, 'where' the other is in relation to our self in the world we talk about.'  
(Baker, 1982: 109, in Silverman, 2001: 86)

Rapley (2004: 19) provides a useful discussion of two 'ideals' often referred to in relation to qualitative interview practice: *rappport* and *neutrality*. The latter, neutrality, is a somewhat contested notion with the perspective taken on it dependent on a researcher's particular epistemological stance (Rapley, 2004). Some authors, such as those holding a post-positivist perspective, consider neutrality to be a feasible and essential research practice, while others claim that attempts at neutrality, for example by the researcher asking questions but not offering their own thoughts, serve to create an interaction which is hierarchical and in which the participant is objectified (Rapley, 2004). Common to critical enquiry and feminist research, the latter standpoint argues for such attempts at neutrality to be actively discouraged in favour of mutual disclosure and joint learning (Fontana and Frey, 2000; Legard, Keegan and Ward, 2003).

The stance taken in the current study fell towards the midway point discussed by authors elsewhere (Holstein and Gubrium, 1995; Rapley, 2004). 'Interactional' neutrality (Rapley, 2004) was attempted through the use of non-leading questions and not offering my own opinions too heavily, yet any wider inference of *being* 'neutral' in its commonly used, objective sense was not considered possible given the central role played by the researcher in the interview process. The avoidance of leading questions was worked on personally and during supervision sessions by examining transcripts and reflecting on question wording, as well as potential missed cues or aspects that should have been followed up. This formed part of a

development and improvement process that took place across the course of the study.

The approach taken in the current study can be conceptualised as 'cooperative interviewing' Rapley (2004: 25). Cooperative interviewing involves introducing an initial discussion topic, listening to responses and:

- Asking follow-up questions
- Asking the interviewee to 'unpack' specific key words/phrases
- Providing personal opinions or ideas, or those of other people
- Using expressions including 'yeahs', 'mmms', nodding, laughing etc. (Rapley, 2004: 25-6)

Although my chosen approach was not heavily based on mutual disclosure, I nevertheless attempted to keep the interaction as informal and 'conversational' as possible, by sharing my own thoughts and answering participants' questions fully and honestly when addressed. I also began to dress according to how I expected the worker to be dressed; casual for social-focused support roles, slightly smarter for brief interventions workers, smarter for managers. While this type of detail seemed useful, as Dingwall (1997) points out it is important to remember that even with efforts to create a casual interaction, an interview can never be considered a genuinely mutual balance of power:

'The sequence may be flexible; the question wording may be flexible; it may be dressed up like a conversation between friends. But it is not a conversation between friends. It is a deliberately created opportunity to talk about something which the interviewer is interested in and which may not be of interest to the respondent.' (Dingwall, 1997: 58)

### **Building Rapport**

The second, less contested 'ideal' discussed in relation to qualitative interview practice is rapport, which is concerned with the relationship built between researcher and researched (Patton, 2002; Rapley, 2004; Silverman, 2010). The

ability to create an environment in which the participant feels safe and comfortable enough to talk openly and honestly is considered to rely heavily on personal characteristics but also something that can be developed and improved with practice (Kvale, 1996; Rapley, 2004).

I left the majority of interviews feeling happy with the level of rapport that had seemingly been gained. There were however variations across the course of the study. My interview reflections notes pointed to some key potential sources of this variation:

- Practical aspects of the interaction including the use of an audio recorder, nearby presence of or interruptions by colleagues, and the level of time available prior to the interview for informal conversation
- Individual aspects, particularly similarity of background, shared experience, my lack of professional affiliation and participant perceptions of my status as 'just a student'

Professional status of the researcher has been shown to influence the interview interaction (Richards and Emslie, 2000). While the absence of a professional affiliation may have played a part in the gatekeeping and access difficulties encountered in the current study, my lack of professional status seemed helpful during the interviews themselves. Largely immune from the ethical dilemmas associated with the 'double identity' of being a practitioner-researcher in one's own profession (Taylor, 1999; Young-Murphy, 2006), I was also able to draw upon my position as 'just a student' to help build an informal atmosphere. As a research student with a personal interest in working in mental health, the explanation of my research motivation at the start of each interview seemed to be well received and rarely treated with any suggestion of an underlying agenda.

That said, my status as a student may have held different connotations for different interviewees depending on their own educational or career background.

Looking back to my reflections notes, the two participants with whom I felt I held the least rapport did appear to retain some uncertainty as to why I wanted to talk to them, including a suggestion from one that any audio recording might 'end up on Ebay'. In hindsight, I shared the least similar background with these two workers in terms of sex, age and educational/career background; both were male, middle aged and had worked in caring roles since leaving secondary education. They also both reported high levels of isolation from other workers, particularly other NPA workers. In contrast, graduate workers in brief interventions roles may have been more familiar both with research practice and with audio recording discussions, as both formed an aspect of their current role and/or educational background. I also shared the most similar background with these workers, often having undertaken the same degree at the same university, which allowed an easy flow of initial conversation.

A key aspect of my individual profile that may have influenced the interview interaction was my age. A number of participants commented that I looked younger than they had expected, including an exclamation of, 'My god you look young!' from across the room as I entered one team's shared office. In hindsight I am still unsure as to whether this helped or hindered the interaction, although my reflections noted an interesting shift in dynamic between a more maternalistic type of interaction with some older workers - many of whom talked about having children around my age - and a more acquaintance-like interaction with younger workers. In all instances, common experience seemed a valuable foundation to building rapport, whether it was direct shared experience of a specific university course, empathy with workers being seen as 'too young' by some clients (R4), or discussions about a worker's son or daughter who was currently at university.

### **After the Interview**

At the end of the interview I thanked workers for their time and asked if they had any questions or reflections on the interview. Informal conversations after the 'official' interview ended often provided a rich source of insight. If considered useful data I asked the participant if I could switch the recorder back on or write it down to be included in the study. In each case the participant agreed.

As soon as possible upon leaving the interview situation I made initial reflections notes on how the interview had progressed, including level of rapport, major discussion points and anything that had surprised me or that linked to findings from other interviews. This often led to jottings on more abstract thoughts and ideas, many of which informed the discussions found throughout this thesis. I also took down field notes on the team building, interviewee's workspace and local area.

After the interview I emailed each participant to thank them for their participation, unless they had requested not to be contacted. All workers except one requested a summary of the research findings, which were sent out at the end of the study by email or post depending on indicated preference.

#### ***4.2.3 Collection of Documents***

In addition to policy-level guidance which had been collected during the study's design phase, role related documents were requested in advance of the interview and collected from participants during the interaction. An overview of the documents collected across the study can be found in Figure 4.11 below.

**Fig. 4.11 Overview of Collected Documents**

Type of Document	Number Collected						Total
	STR	CDW	CSW	GMHW	IAPT	SW	
Policy guidance	3	2	1	1	3	-	10
Job descriptions	3	2	-	2	2	-	9
Promotional information, leaflets etc.	2	3	1	-	2	-	8
Team or service reports/updates	1	-	3	-	-	-	4
Other (including KSFs, re-banding campaign information, NHS careers information, national job description)	4	1	2	3	1	5	16
<b>Total</b>	<b>13</b>	<b>8</b>	<b>7</b>	<b>6</b>	<b>8</b>	<b>5</b>	<b>47</b>

As can be seen in Figure 4.11, a total of 47 documents were collected across the course of the study including policy guidance, job descriptions, promotional information and service reports/updates. A number of workers did not have job descriptions available, particularly support workers, carer support workers or those who had been employed in their role for a number of years. A notable gap in the documentary data overviewed in Figure 4.6 is the lack of available policy guidance, job descriptions or promotional material in relation to traditional support workers. This created a reliance on documents that fell into the 'other' category, including a student information booklet related to R27's service, employment particulars provided by an ex-support worker R19 and three job descriptions for community mental health support posts elsewhere in the UK that were found through an online search (one based in a mental health trust in South UK, one based in the Scottish health service and one based in a UK charity).

The analysis of these documents provided supplementary information to the interview data and will be outlined in Section 4.3.4.

### **4.3 Analysis and Writing**

‘Analysis finally makes clear what would have been most important to study, if only we had known beforehand.’ (Halcolm, in Patton, 2002: 431)

This section describes how I made sense of the data collected during the study’s fieldwork phase. Although the nature of the thesis encourages a chronological presentation, in practice this took place as a cyclical process, moving iteratively between data collection, analysis and writing. The practice of writing as an integral part of the analysis, rather than a sequential second step, will be considered in Section 4.3.4.

#### **4.3.1 Overview of Analysis Approach**

Patton (2002: 432) describes the challenge of qualitative analysis to lie in making sense of ‘massive amounts of data’, through a process of reduction, sifting, identifying relationships and then finding an effective way to communicate what the data tells us. While guidelines exist as to how qualitative analysis *can* be undertaken, authors suggest that each researcher’s approach will be unique depending on the skills, insights and particular style of the individual researcher (Patton, 2002; Spencer, Ritchie and O’Conner, 2003; Bryman, 2008; Silverman, 2010). This ‘human factor’ (Patton, 2002: 433) provides both the strength of individuality and the subsequent weakness of non-uniform terminology and lack of clear articulation of the analysis process (Patton, 2002; Smith and Osborn, 2008; Silverman, 2010)<sup>15</sup>. This section provides an account of my own individual approach, which was thematic in nature and drew upon techniques and styles

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<sup>15</sup> Thematic analysis in particular has been criticised for authors’ lack of articulation of the process of theme construction (Boyatzis, 1998; Spencer, Ritchie and O’Connor, 2003; Braun and Clarke, 2006; Smith and Osborn, 2008). Use of the term ‘emerge’ in relation to this is argued to be particularly unhelpful as it implies the researcher’s role to be passive rather than active (Braun and Clarke, 2006).

from across a number of different authors' work; again forming a 'toolkit' style approach (Snape and Spencer, 2003: 15).

### **Choosing a Thematic Approach to Analysis**

Research texts describe a number of different data analysis strategies including those relating to pattern, theme or content analysis, those which are more explicitly based on the creation of theory such as grounded theory analysis, and those which are more cyclical and action-driven such as participatory analysis (Patton, 2002; Braun and Clarke, 2006; Bryman, 2008).

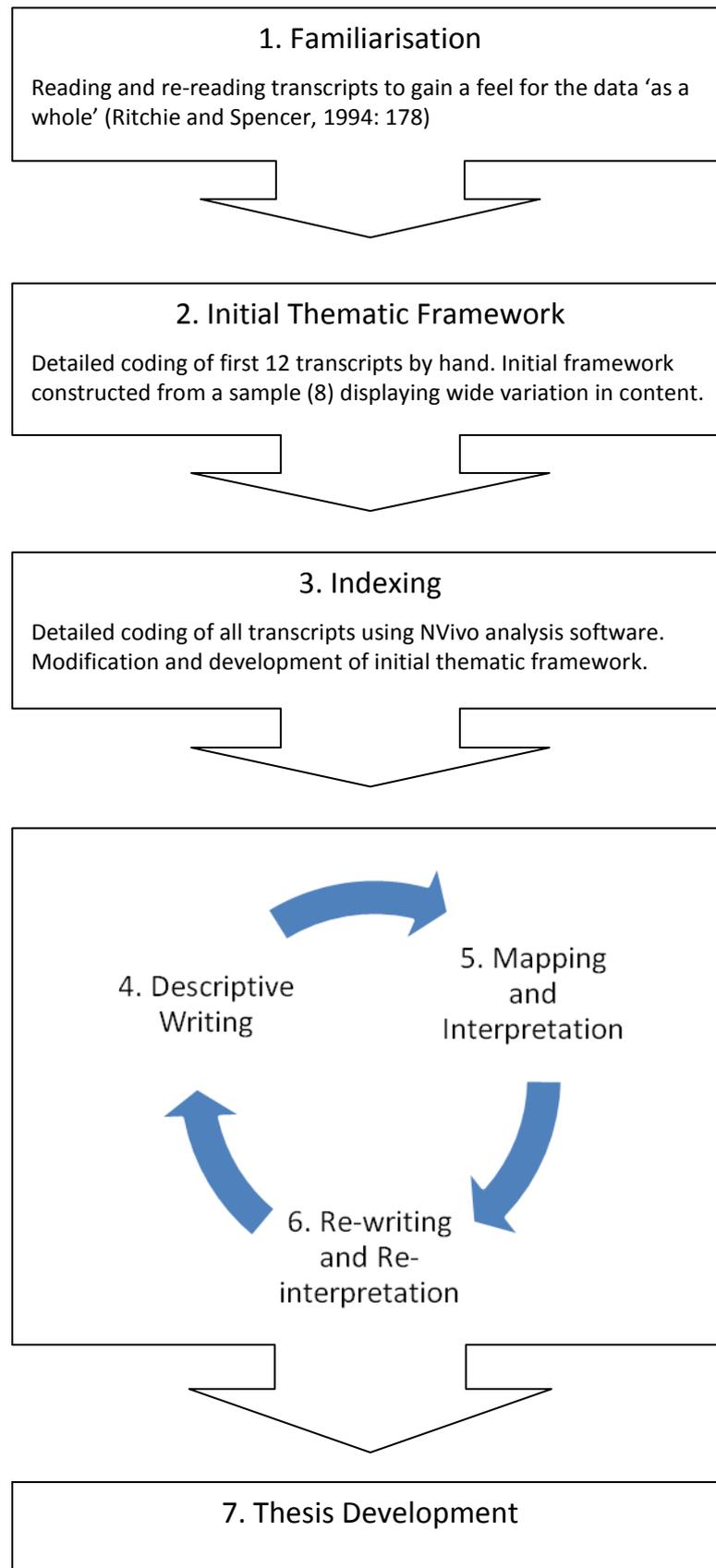
Taking a thematic approach to data analysis seemed the most logical option in the current study given its exploratory nature and pragmatic focus. Thematic analysis is described as a predominantly inductive technique driven by the data and involving the identification of patterns, categories and themes. Thus it emphasises the researcher's ability of 'pattern recognition' as a central principle (Boyatzis, 1998: 7; Patton, 2002; Braun and Clarke, 2006). In addition, latter stages are often deductive and consist of testing and confirming the authenticity of the findings, for example by examining deviant cases or data that does not easily fit into the identified themes and categories (Patton, 2002). Thematic analysis was considered to provide a useful balance between the 'descriptive' work most commonly associated with ethnographic and phenomenological research, and a more 'explanatory' approach (Spencer, Ritchie and O'Conner, 2003: 212).

After consulting a number of texts and guided by advice that step-by-step guides are best used as inspiration rather than concrete rules of analysis (Patton, 2002; Braun and Clarke, 2006; Smith and Osborn, 2008; Silverman, 2010), I undertook a hybrid approach which is illustrated in Figure 4.12. The key difference between my individual style and the majority of those found articulated elsewhere (e.g. Smith and Osborn, 2008) was a heavier use of writing as an iterative part of the analysis process. The headings and key concepts in Figure 4.12 are taken from

Ritchie and Spencer (1994: 177-85) and Spencer, Ritchie, and O'Conner (2003), with additional elements borrowed from Braun and Clarke (2006) and Smith and Osborn (2008).

As can be seen in Figure 4.12, following the first three steps of familiarisation, initial framework identification and indexing, data analysis became a cyclical process moving between writing, mapping and interpretation. Key elements of the analysis process visualised in Figure 4.12 will now be described in more detail.

**Fig. 4.12 Overview of Data Analysis Approach**



### 4.3.2 *Initial Steps*

#### **Transcription and Familiarisation**

Each recorded interview was transcribed verbatim, including any audible emotion such as laughing, any lengthy pauses and any interruptions. I transcribed the first 8 interviews myself and found it extremely valuable to becoming 'immersed' in the data. Very initial steps of analysis began at this early stage in the form of scribbled notes or 'memos', which often echoed and added extra reflection to the thoughts contained within my field diaries.

As the study progressed, limited time and resources resulted in a number of research secretaries helping with transcription. Each was familiar with transcribing for research purposes and was reminded of the ethical principles around data protection and confidentiality, including instructions for the removal of names and locations. I listened back through each audio file upon completion in order to check the transcript for accuracy and to re-familiarise myself with each interaction. For the three unrecorded interviews I typed up the interview notes exactly as written, including punctuation and anything emphasised, to prevent any alterations in hindsight<sup>16</sup>.

Across the course of the transcription process I familiarised myself with the data by reading and re-reading the transcripts in order to gain a feel for the data 'as a whole' (Ritchie and Spencer, 1994: 178). This also involved engaging with my field and reflections notes and writing initial thoughts and key points on each transcript.

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<sup>16</sup> Note that when quoting unrecorded interviews in the findings chapters, these notes have been converted into full sentences in order to improve the flow of the narrative.

### 4.3.3 Constructing a Thematic Framework

#### Identifying an Initial Thematic Framework

Following transcription and familiarisation, the first twelve transcripts were coded in detail by separating the data into small, manageable chunks (or *codes*). This was done by hand and involved writing codes in one margin and notes to self in the opposite. An example of a coded transcript section from graduate mental health worker R4's interview is shown in Figure 4.13 below.

**Fig. 4.13 Example of a Coded Transcript Section**

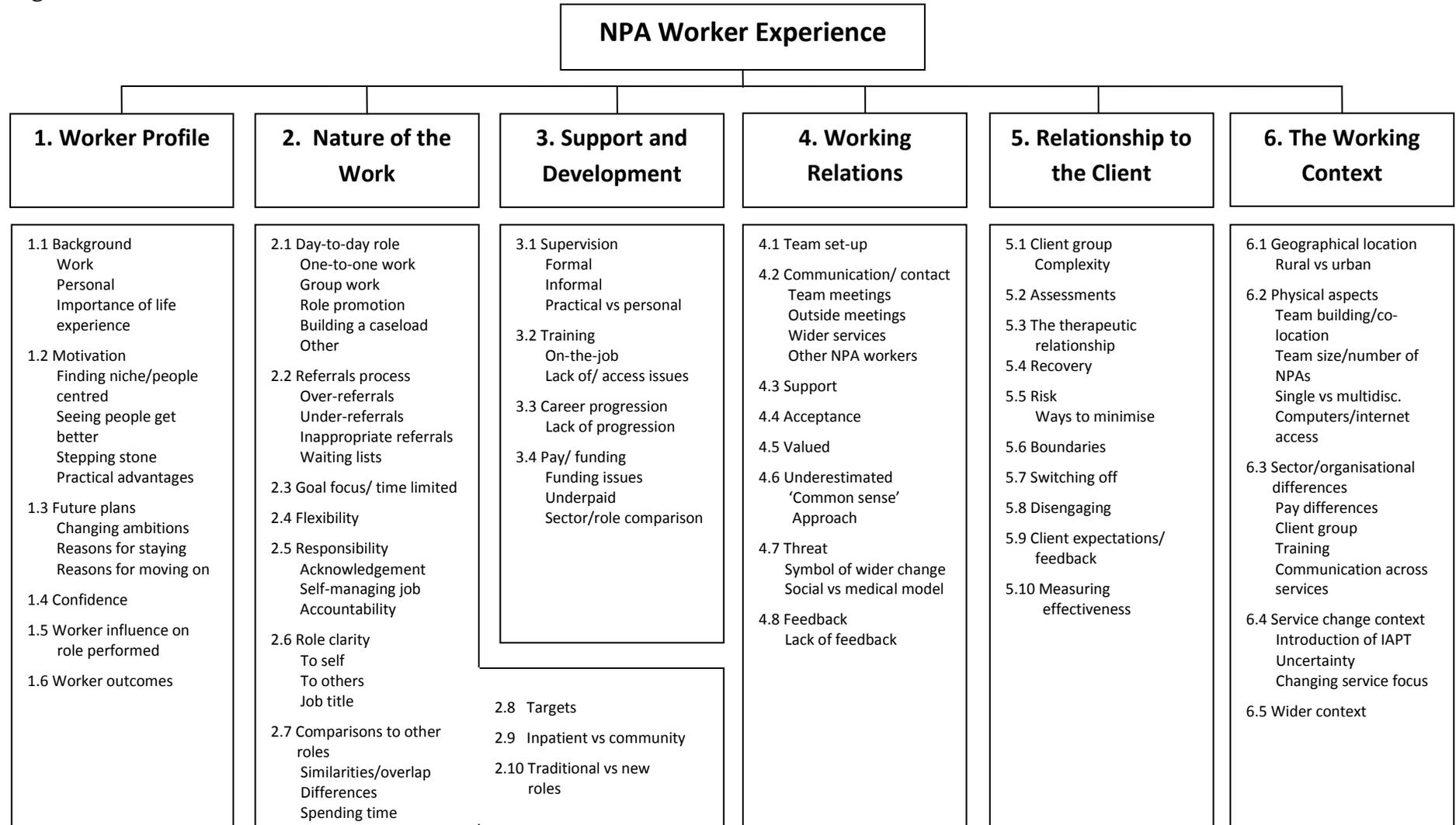
Coding		Notes
Confidence	<p>I've had sort of a, a couple of people who I've sort of thought, mmm I'm not really sure, and especially not having the sort of full, clear picture in my head of what I'm fully supposed to be doing, obviously I haven't had all the training and everything - I've just took that to supervision, I've just brought the case to supervision and said you know this is the situation what, you know and getting feedback from people to sort of decide on what to do but there's, you know there has been two or three especially in the supported self-help where I've said to the patient I've said you know I'm not sure if this is right for you especially when you only get forty minutes for an assessment and then 15 to twenty minutes for a follow-up, people aren't coming in with that expectation usually so, you know it's quite a new - not a new thing cos its been going for a while but to them, you know what their traditional view of what going in for a therapy session's gonna be like it's quite different from that so.</p>	Link between training and confidence
Role clarity to self		Reliance on supervision/ feedback from colleagues - no training
Lack of training		Some clients too complex/ unsuitable for time limits of the intervention?
Formal supervision		Difference between client expectations and what intervention looks like. Traditional views. Potential problem for new, novel roles?
Feedback from colleagues		
Client complexity/ service suitability		
Time limited		
Client expectations/ Role clarity to client		
New role		

As can be seen in Figure 4.13, coding involved separating the text into manageable chunks according to the topic of discussion. Codes included for example confidence, formal supervision, role clarity to self and client

expectations, which can be seen in the left-hand margin. Notes to self, questions and potential relationships were noted in the right-hand margin. In the featured extract for example the notes identified a potential link between training and worker confidence, highlighted the importance of formal supervision for worker support and raised questions around the suitability of some clients for the time limited nature of brief interventions. These notes formed initial thinking points which could then be developed and tested as analysis progressed.

Eight transcripts were then chosen which exhibited wide variation in content and from these an initial thematic framework was drawn up (Ritchie and Spencer, 1994). This involved listing on one piece of paper all of the codes from each transcript. After removing any repetitions, the codes were grouped together into 'families' of words which seemed to share a connection under a broad category heading. Similar codes were collapsed and alternative groupings considered. Ideas, recurrent themes and potential relationships were also noted down. The resulting initial thematic framework is illustrated in Figure 4.14.

**Fig. 4.14 Initial Thematic Framework**



As can be seen in Figure 4.14, the initial thematic framework was made up of six major over-arching themes referring to different aspects of worker experience: Worker profile/background, the nature of the work, support and development, working relations, relationship to the client and the working context. Within these major themes, two further levels of sub-theme were created. A number of early links were also identified, for example between training/life experience and confidence, between worker background and working relations/client relationship, and between threat and the wider change context. This early framework formed the initial, malleable building blocks upon which analysis of subsequent transcripts could be constructed.

### **Indexing and the Use of Data Management Software**

The next stage of data analysis was undertaken using the computer software package NVivo. 'Indexing' is the broad term used to describe the process of systematically applying the initial thematic framework to the entire set of raw data (Ritchie and Spencer, 1994). With most of my initial thought process having taken place on paper, NVivo was considered the most useful way to then organise and manage the huge amounts of generated data, as it allowed easier movement between texts than coding on paper. This led to a more efficient indexing process.

The initial thematic framework was set up in NVivo as a series of tree nodes, upon which both the initial twelve and remaining twenty five transcripts were coded. The use of computer software facilitated a malleable, flexible approach allowing new nodes to be created and existing nodes re-named, merged together or cut-and-pasted into different 'parent nodes' as the thematic framework developed. Memos and notes were created to record ideas or potential relationships, mirroring the process used in the earlier paper analysis.

In addition to the computer-based indexing, this stage of analysis also involved a considerable amount of ideas generation on paper through the use of a series of large, multi-coloured mind maps of various aspects of worker experience such as the client relationship or team working. These mind maps included links, potential relationships and unanswered questions and were re-visited and altered as the computer indexing progressed.

Following this stage of analysis all of the major over-arching themes remained the same as the initial thematic framework, although a number of smaller changes took place further down the 'branches' of the tree nodes through merging similar nodes or moving to a new parent node. Many additional links were also created, for example between inappropriate referrals and risk, between the therapeutic relationship and future plans and between the working context and a number of aspects of experience including supervision, future plans and role clarity.

#### ***4.3.4 Writing as a Method of Analysis***

In light of the overwhelming amount of data generated by the coded transcripts I was encouraged by my supervisors to start writing early. Although I initially found this a confusing prospect given my quantitative background, as time progressed writing became a central tool in my analysis approach. Richardson (2000: 924) asserts the value of writing as a 'dynamic, creative process' which is often underplayed by authors in favour of the more traditional method of 'writing up':

'I write because I want to find something out. I write in order to learn something that I didn't know before I wrote it. I was taught however, perhaps as you were too, not to write until I knew what I wanted to say, until my points were organised and outlined...' (Richardson, 2000: 924)

Richardson (2000) argues that by ignoring writing as a creative method of discovery the confidence of novice qualitative researchers can be undermined, as

it creates an inconsistency between perceived expectations and experience in practice. In the current study writing formed a key part of the iterative, cyclical process of interpretation and re-interpretation featured as stages 4-6 in earlier Figure 4.12.

### **Initial Thick Description**

‘Description forms the bedrock of all qualitative reporting... It is tempting to rush into the creative work of interpreting the data before doing the detailed, hard work of putting together coherent answers to major descriptive questions. But description comes first.’ (Patton, 2002: 438)

Writing began with the thick description of worker experience. The ‘major descriptive questions’ referred to in the above quote which formed the basis of initial writing were:

- What types of tasks do workers perform across the different roles studied?
- What does the working context look like, and what does the NPA worker position within it look like?
- How do workers describe communication, contact and working relationships?
- How do workers describe practical aspects such as pay, training and career progression?
- Are there any unexpected issues raised as important?

Initial descriptive headings such as ‘Day-to-day tasks’, ‘Supervision’ and ‘Overlap with other workers’ were formed from the tree nodes and grouped roughly into potential chapters. Field notes, memos and reflections were sorted under these headings and, alongside the ongoing process of indexing, I began to write. The resulting first draft of my findings were long and descriptive, paying attention to minute detail and focusing heavily on practical issues such as pay, training and career progression. Following this, and drawing on a number of helpful supervision discussions, I began to recognise wider themes and emerging patterns which were less role-specific and less practicalities-focused.

This formed the start of a gradual process of abstraction, re-grouping and reinterpretation. Many of the practical elements described as distinct concepts upon reconsideration appeared closely linked to wider issues. The concept of 'pay' for example had formed a self-contained section of the descriptive first draft. Upon further attention however it seemed related to two more abstract concepts. Firstly, pay was often discussed in relation to workers' perceived status within the employing organisation, with 'underpaid and undervalued' (R2) often appearing together. This formed part of a wider discussion around worker responsibility and its acknowledgement at an organisational and policy level. Secondly, the discussion of low pay was often described in terms of the constraints it placed on who was able to work in a particular role, requiring a perceived sacrifice as part of a trade-off between salary and valued client time. In turn this was linked to wider discussions around career progression and retention.

It was at this early stage of thick description and exploration of wider themes that the majority of documentary analysis took place. Documents collected during the fieldwork including job descriptions, service reports and promotional information were analysed thematically on paper in the same way as the coding of transcripts already described. Key points were then drawn iteratively into the writing process wherever useful to clarify particular points or raise questions, for example around career progression or discrepancies between intended role and that reported by workers. Field notes relating to locality and workplace were also drawn upon to aid the consideration of contextual factors.

### **Re-Interpretation, Comparisons and Theoretical Abstraction**

The new patterns, emerging relationships and unanswered questions observed as a result of the descriptive writing and engagement with role-related documents led back to the data in order to consider alternative, more useful ways of fitting the puzzle pieces together (Taylor, 1999). By looking for further associations, re-

drawing earlier mind maps and running 'queries' in NVivo, the findings began to refocus at a more abstract level. In addition, data summaries based on both interview and documentary data were created for each job role to facilitate effective comparisons.

This process led to categorisations of worker role and background and the identification of 'shaping factors' of key aspects of worker experience. As they took shape the data was revisited to look for concrete examples and deviant cases in order to verify and 'push' the boundaries of emerging categorisations. This illustrates the more deductive elements of the latter stages of thematic analysis described by Patton (2002). Where deviant cases were encountered they were examined in depth for what they took away or could add to the wider themes that were being created. As a result new ideas arose, drafts were re-written and themes developed further.

Authors suggest that it can be difficult to articulate the arrival at abstract themes from raw qualitative data, given the subjective and internal nature of the process (Spencer, Ritchie and O'Connor, 2003). Figure 4.15 on the following page attempts to visualise the process of theme development using working relations as an illustrative example.

**Fig. 4.15 Example of Thematic Development: Working Relations**

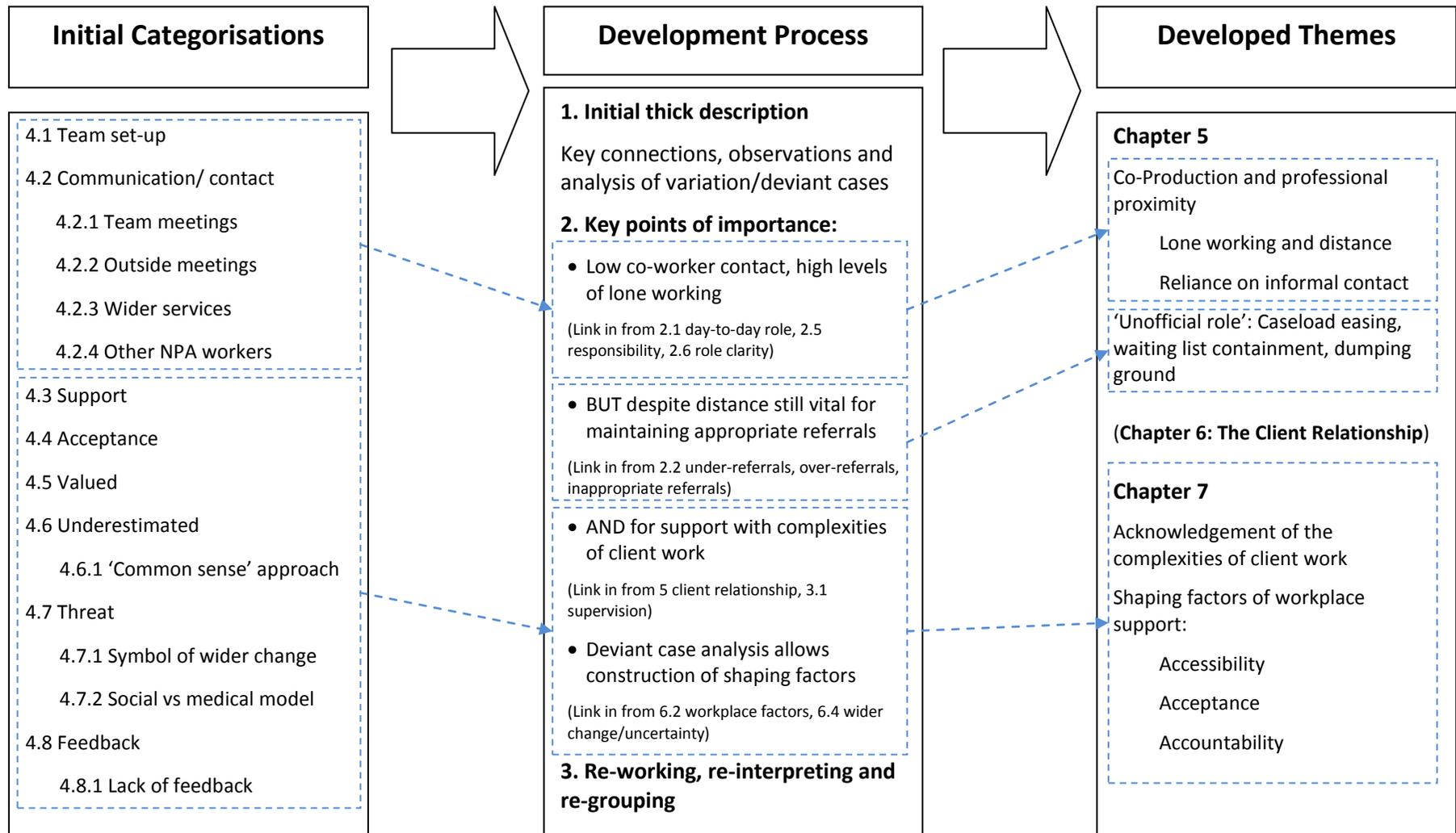


Figure 4.15 illustrates the process of development from initial categories to the final abstract themes that form the basis of the results chapters, using working relations as an example. As can be seen in the diagram, initial categories relating to communication/contact and worker perceptions of support, acceptance and resistance from co-workers were developed through a process of thick description, engagement with data from other themes and reinterpretation through further writing and further analysis. The final developments contributed firstly to the exploration of day-to-day worker role found in Chapter 5 through the consideration of lone working, responsibility and official/unofficial use of workers. Secondly it contributed to the development of three key *shaping factors* of worker support - accessibility, acceptance and accountability - which form the focus of results Chapter 7.

#### **4.3.5 Reaching Data Saturation**

Data saturation is described as the number of interviews required 'to get a reliable sense of thematic exhaustion and variability within [the] data set' (Guest, Bunce and Johnson, 2006: 65). Authors acknowledge that the notion of data saturation can be difficult to articulate even by experienced researchers and is rarely detailed in any depth in research reports (Taylor, 1999; Lincoln and Guba, 2000; Patton, 2002; Bryman, 2008).

Taylor (1999: 277) recommends the use of a puzzle as a metaphor. As the fieldwork progresses and the 'pieces of the puzzle' come together, new major pieces (i.e. themes or patterns) often cease to emerge after around twelve interviews. After this, additional data serves to provide clearer examples and to highlight where the researcher may have 'misinterpreted' some of the pieces. Prolonged fieldwork allows the themes - or pieces of the puzzle - to start forming a coherent picture. It is this understanding of *how the pieces fit together* that indicates when saturation has been reached. Taylor (1999) parallels this with the

concept of 'theoretical saturation' asserted by Glaser and Strauss (1967) in grounded theory and asserts:

'The question to ask is not "When is the study finished?" but "When does the fieldwork yield diminishing returns?" Nearly all studies reach a point at which the additional understanding and insights gained through fieldwork do not justify the hours spent collecting and recording data.' (Taylor, 1999: 277)

Upon entering the field I held concerns that data saturation may not have been possible without extension to additional study sites, given the fairly small sample pool for each role included in the study. In practice however despite large variation across the study sample, particularly between job roles, they nonetheless formed pieces of the same puzzle. The contrasts across role and workplace provided valuable variation under the same major themes, thus adding to rather than detracting from thematic exhaustion. Echoing the discussion by Taylor (1999), in practice the major themes were largely identified following the initial on-paper coding of the first twelve interviews. Even the introduction of two entirely new roles towards the end of the fieldwork phase did not elicit any major new themes. They did however influence how the themes were framed and provided clarity and coherence relating to their relationships and interconnections. This facilitated movement from a practicalities-based to a more abstract, *relationships*-based conceptualisation of working life, which forms the basis of the forthcoming results chapters.

## **Chapter Summary**

This chapter has provided a detailed account of how the chosen methods of data collection and analysis were carried out in practice. Section 4.1 described the sampling and access strategy employed in the current study - including issues encountered and subsequent developments - and provided key information relating to the study sample and service context that will be drawn upon in

forthcoming chapters. The second section provided details of data collection, including instrument design and reflections on the nature of the interview interaction. The final section then described the iterative process of analysis and writing, articulating how the findings were constructed from the raw data using a thematic, 'toolkit' approach which involved a cyclical process of analysis, writing and reinterpretation.

The product of the analytical process described here will now be presented in Chapters 5-7. Figure 4.16 provides an overview of the findings chapters.

**Fig. 4.16 Overview of Results Chapters**

### **Chapter 5. Redefining Worker Role: An Exploration of Professional Proximity and Client-Centred Tasks**

Key Question: What does NPA worker role look like in this context?

#### *5.1. Defining Workers in Terms of Professional Proximity*

- Community co-production
- Key features of working life: lone working, autonomy and responsibility

#### *5.2. Redefining Workers in Terms of Client Work*

- A Client-Centred Categorisation: *Supporter, Facilitator and Ambassador*
- Contextual influences on role function

### **Chapter 6. Exploring Variation in the Worker-Client Relationship**

Key Question: How is the worker-client relationship shaped in this context?

#### **Shaping Factors of the Worker-Client Interaction:**

- *6.1 Individual factors: Building rapport*
- *6.2 Role-level factors: Time, flexibility, accessibility and formality*
- *6.3 Team-level factors: Professional pressures*
- *6.4 Wider policy and political influences*

### **Chapter 7. Managing the Complexities of Client Work: Preparation and Workplace Support**

Key Question: How are workers prepared and supported for the complexities of client work?

#### *7.1. Emotional responsibility and worker preparation:*

Training, life and career experience

#### *7.2. Shaping factors of workplace support:*

- Accountability
- Accessibility
- Acceptance

## **Chapter 5. Redefining Worker Role: An Exploration of Professional Proximity and Client-Centred Tasks**

### **Introduction**

The literature review chapter of this thesis highlighted a lack of current understanding of the role performed by non-professionally affiliated (NPA) workers. Knowledge advancement has been hindered by a sociological preoccupation with the NPA-professional relationship (Kessler et al., 2007) and a lack of application to non-traditional service settings. The novel study context of community mental health care allows a useful extension to the existing knowledge base. This first findings chapter aims to answer an initial key question: What does the role of NPA workers look like in this context?

The chapter is separated into two sections. The first positions workers as 'co-producers' of mental health care within the existing categorisation provided by Kessler et al. (2007). It then explores key reported features of co-production in the community context including lone working, autonomy and responsibility. Section 6.2 moves on to propose an alternative way of categorising worker role argued to be more useful in the current study setting, by defining workers in terms of their position relative to the *client* rather than relative to the professional. By providing information about underlying role motivation and component tasks, this alternative categorisation provides a useful platform to consider contextual influences on role function, as well as variation in the nature of the worker-client interaction which will form the focus of the following findings chapter.

## 5.1 Defining Worker Role in Terms of Professional Proximity

### 5.1.1 Defining NPA Workers as 'Co-Producers' of Mental Health Care

The analysis of assistant roles in health, education and social care provided by Kessler et al. (2006; 2007; Bach et al., 2008) suggested four possible roles that the assistant worker may perform: relief, substitute, co-producer or apprentice. A reminder of this categorisation is provided in Figure 5.1 below. As already noted in Chapter 2, the confinement of existing research to the professional viewpoint has led to a preoccupation with the first two categories, *relief* and *substitute* (Kessler et al., 2007). As a result the *co-producer* category, which describes a distinct, complementary NPA contribution, remains underdeveloped even in Kessler et al.'s (2007) own work.

**Fig. 5.1 Assistant Role Categorisation Provided by Kessler et al. (2007)**

<b>Role</b>	<b>Key Features</b>
<b>Relief</b>	Performs non-core tasks previously undertaken by the professional. Skill mix as promoted in health care policy.
<b>Substitute</b>	Performs core, professionally 'owned' tasks, driven by financial considerations and staff shortages. The 'economic reality of skill mix'.
<b>Co-Producer</b>	Contributes alongside the professional in a distinctive, complementary way. Policy directed, with emphasis on provision to the service user.
<b>Apprentice</b>	Role forms start of a pathway into professional training/registration.

Despite the lack of co-production observed in Bach et al.'s (2008) analysis of the hospital-based HCA, all community mental health roles examined in this study

fulfilled the criteria of co-production. The novel study setting can therefore be used to shed light on this under-developed 'type' of worker, by examining the nature of NPA co-production in the current service context.

### **Co-Production in Day-to-Day Tasks: A Deconstruction of Worker Role**

The summary of policy intentions provided in Appendix A present a clear initial suggestion of NPA co-production. While *New Ways of Working* (DoH, 2005; 2007) was motivated in part by a need to reduce the burden on psychiatrists, the introduction of new NPA roles primarily aimed to fill perceived service gaps or engage under-represented client groups, rather than to directly assist the professional workforce. The STR worker for example was introduced in response to 'an identified need for a totally new role' (DoH, 2007: 82) in order to enhance social inclusion and service user independence; a type of support considered to be only inconsistently provided by the existing NPA workforce (DoH, 2003). The community development worker (CDW) role aimed to facilitate service change in order to accommodate the needs of BME community groups, while also working at a community level to raise awareness and improve service access (DoH, 2005). The graduate mental health worker (GMHW) and subsequent IAPT roles were designed to focus on milder mental health needs than were previously offered a targeted intervention (DoH, 2011b). In essence, each role can be seen to contribute a different aspect of the care process to that performed by professionals.

Evidence of co-production was also found in an in-depth deconstruction of day-to-day tasks, based on both worker reports and role-related documents. The separation of core tasks into their various foci (client, professional/team, service, individual worker) can be found detailed in Figure 5.2.

**Fig. 5.2 Overview of Tasks Performed by Study Participants**

<b>Client-Focus</b>	<b>Professional/ Team-Focus</b>	<b>Service-Focus</b>	<b>Individual/ Other- Focus</b>
Practical one-to-one support (SWs, CSWs, STRs, CDWs)  Emotional one-to-one support (All roles)  Facilitation/ motivation work e.g. graded exposure (STRs, GMHWs)  One-to-one supported self-help/brief interventions therapy (GMHW, IAPT)  Assessing client need (IAPT)  Signposting to other services (All roles)  Facilitate group support sessions (CDWs, SWs, CSWs, some STRs)  Health promotion/education work with community groups (CDWs, CSWs, GMHWs, IAPT)  Organise group/social events (SWs, CSWs, CDWs, some STRs)	Monitor early relapse signs (SWs, STRs)  Attend team meetings (All roles)  Take part in review meetings with care coordinator (STRs, SWs)  Medication monitoring* (STRs)	Service development (CDWs, STRs, GMHWs, CSWs, SWs)  Advising/ delivering training (CSWs, CDWs)  Organising/attending events/conferences (CDWs, CSWs, IAPT)  Role promotion (GMHWs, IAPT, STRs, CDWs, CSWs)  Audit, research, report writing (GMHWs)	Admin –including time/diary management*  Training/personal development

In Figure 5.2 above, the bracketed letters alongside each task refer to the job roles to which it applied. All tasks were present in both worker reports and

documentary analysis, other than the two featuring an asterisk\* - medication management for some STR workers and administrative duties - which highlight a discrepancy between the two data sources and are discussed in Sections 5.2.2 and 5.1.2 respectively.

Key points to note from the deconstruction of worker role are:

- A high prevalence of client-focused duties and delegation based on client need rather than professional assistance
- Independently performed tasks with a notable lack of joint working or requirement for professional input
- A *distinct* role, observed through a lack of professional-NPA role overlap or boundary blurring

Regardless of specific job title, worker role in the current study was predominantly made up of independently performed, *client* assistance tasks combined with a relative absence of professional assistance duties. Client-focused tasks reported by workers included a breadth of duties, from practical support (paying bills, shopping or doing DIY for example) to the brief psychological therapies provided by graduate mental health workers (GMHWs) and IAPT workers. Despite the variation in detail, the majority of daily tasks were reported to take place on a self-directed, one-to-one basis with the client.

In contrast, the professional-focused tasks detailed in Figure 5.2 were relatively small in number and predominantly related to attending team meetings or taking part in review meetings with the client, rather than being relief or assistance-based. The referral of clients into an NPA worker's service was reported to be largely directed by client need rather than professional requirements, with a primary aim to improve an aspect of the client experience such as service access, social inclusion or emotional wellbeing. While these goals were likely to have been in line with professional care aims, the relief of professionals from

peripheral aspects of their *own* role was not generally seen as a direct driver of referral decisions.

Evidence of the centrality of client-focused tasks to worker role was visible in interview discussions where workers described a 'typical' working week. As can be seen in the following transcript extracts, aside from team meetings and administrative work, the majority of worker time was spent in direct client interaction:

'Most of it involves face to face contact with carers - I mean I do run a support group which is once a month... and the rest of the time... most of it's one-to-one support, signposting them to any other agencies that might be helpful and kind of listening to them.' (R13, carer support worker)

'With clients we use supported self-help materials so booklets, worksheets based on CBT techniques... I do initial assessments so... having a chat about what kind of therapy they want... either face-to-face or over the phone... I also go to the cardiac rehab groups... and just talk to... clients in the group every six weeks... tell them about mental health and depression and... let them know that we are here... ' (R35, PWP)

While high levels of client contact in itself does not necessarily set workers apart from those performing a relief or substitute role in other NPA contexts, the *nature* of tasks described in the above extracts depict a distinct role made up of complementary duties that would not otherwise be performed by professional workers. These tasks were reported to take place independently and with a demonstrable lack of requirement for professional input, other than during the referral and feedback process or for advice in cases of unexpected risk or complexity.

The monitoring of early relapse signs reported by STR and support workers shares perhaps the most similarities with existing concepts of professional assistance. As illustrated by the following quote from STR manager R25M

however, this feedback mechanism took place as a by-product of the client intervention rather than forming its underlying motivation:

‘It’s part of what they do... but it’s not set up as the primary function, the primary function would be to... get somebody healthy, get somebody some different coping strategies or busy or whatever, so monitoring would just be a part of it... [to] feed back when something’s not quite right.’ (R25M, STR manager)

The lack of requirement for regular professional input into day-to-day role was reported alongside a notable absence of perceived overlap or boundary blurring between professional and NPA remits. While most obvious for roles that worked with a specialist client group such as carers or BME communities, those who shared a client base with professional workers (such as STR workers or support workers) also reported a notable lack of role blurring. This can be seen in the examples below:

‘Nothing I do overlaps with anything anybody else does in the team.’ (R10, STR worker)

‘There is no direct [joint] work... we are doing our bit and they are doing theirs.’ (R26, CDW)

‘Maybe slightly with other support workers it can overlap, but apart from that... it’s kind of on its own.’ (R13, carer support worker)

The data therefore suggests NPA workers in the current study to be positioned as ‘co-producers’ of community mental health care within the existing categorisation provided by Kessler et al. (2007). As illustrated, co-production is characterised here as a distinct, complementary service that would otherwise not be provided, driven primarily by client rather than professional need<sup>17</sup>. A definition of NPA workers as co-producers of care naturally calls for an

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<sup>17</sup> A small number of ‘unofficial’ exceptions to this will be explored in the following chapter when we consider how professional workload pressures can shape the worker-client interaction. See section 6.3 for full discussion of this.

exploration of how co-production is experienced, in order to advance existing knowledge related to this under-developed role category. In particular the lack of role blurring or requirement for professional input into day-to-day role raises the possibility of a different kind of working relationship to that described elsewhere.

The remainder of this section will explore key features of working life in the community co-production context.

### ***5.1.2 Co-Production in the Community: Key Features of Working Life***

Co-production can be seen to create a novel set of worker circumstances, given the independently performed task set and lack of professional attachment. In addition, the community working context was observed to add a further distinctive set of circumstances in the form of physical separation and geographical distance, heightening the autonomous nature of co-production and bringing additional considerations around time management, risk and lone working. Six major defining features of 'community co-production' were constructed through a thematic analysis of the interview data:

- Lone working and professional distance
- Autonomy
- Role responsibility
- Personal responsibility (i.e. risk management)
- Reliance on informal support structures
- Centrality of the client interaction

Figure 5.3 visually represents these key features of working life at the combined interface of community co-production, as the autonomous nature of co-production met the logistics of community working.

**Fig. 5.3 Key Features of Community Co-Production**

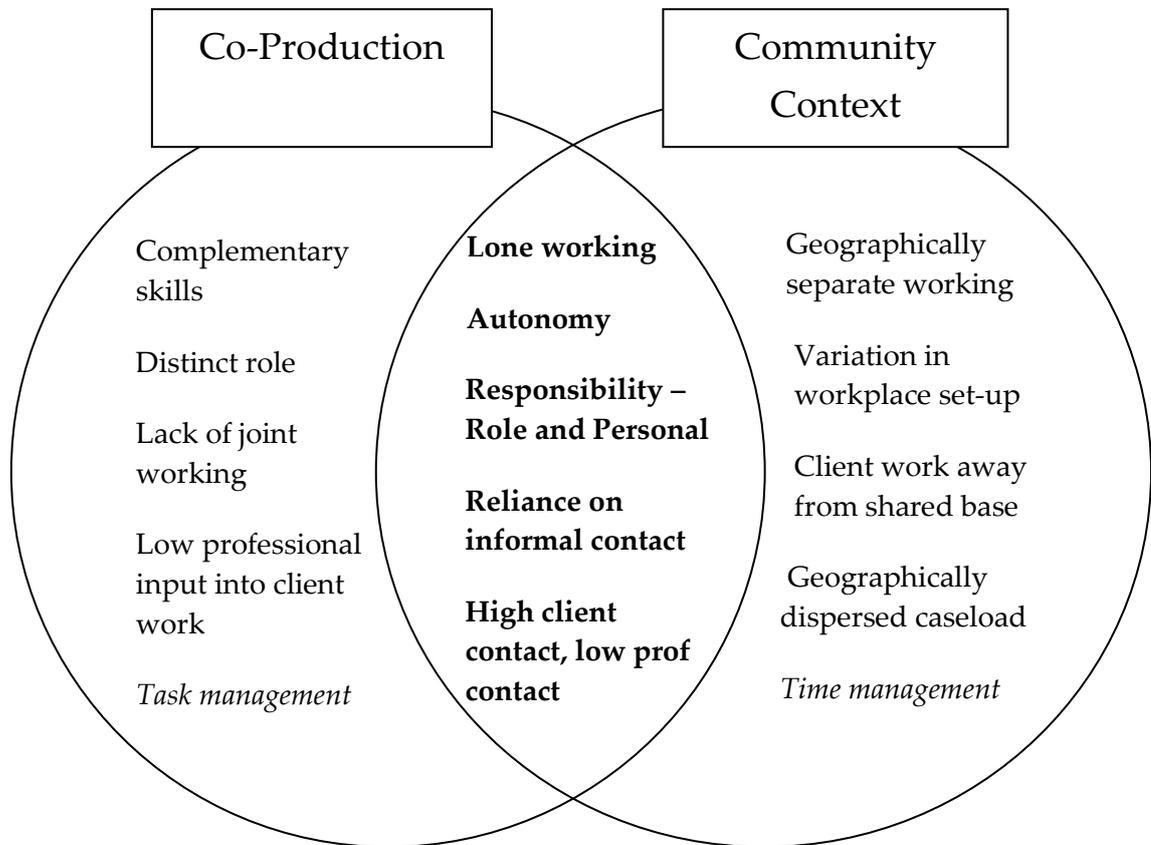


Figure 5.3 above illustrates how the combination of co-production and the community context were interpreted to come together to create the key characteristics of working life observed in the current study. While each central aspect (in bold type) is likely to be experienced to an extent through either co-production or community working, the combination of both was seen to create the unique set of circumstances reported here. For example, lone working could occur as a product of co-production’s distinct task set, lack of requirement for joint working or absence of a shared client group. It could also arise from the geographically dispersed nature of community care and the provision of interventions in community settings or across a number of bases rather than one shared workplace. Thus for the majority of community co-producers lone

working could be seen to arise two-fold, from the provision of autonomous, one-to-one client work *and* geographical separation from colleagues.

As a second example, a high level of *role responsibility* (referring to diary management, administrative and organisational tasks etc.) is featured at the interface of Figure 5.3. This can be conceptualised as a merging of co-production's emphasis on intervention-level *task management* - management of the specific tasks that make up day-to-day role - together with community working's requirement for time and resource management, given the geographically dispersed client base and necessity to travel often large distances.

The core shared features of worker experience summarised in Figure 5.3 will now be outlined using interview data for evidence and insight.

### **5.1.3 Lone Working and Professional Distance**

Kessler et al.'s (2007) observation of co-production in the education sub-sector saw teachers and teaching assistants carrying out largely autonomous roles within the same physical space (the classroom) and with the same broad client group (the pupils in the class). The community mental health context provides a sharp contrast, with professional and NPA co-workers rarely sharing the same physical space during day-to-day working life. Even when teams are co-located, both professional and non-professional workers spend the majority of their working day geographically separated from co-workers, as client-focused duties are usually undertaken in the community, away from the shared team building.

Lone working is described as:

'Any situation or location in which someone works without a colleague nearby; or when someone is working out of sight or earshot of another colleague.' (DoH, 2009: 4)

'Those who work by themselves without close or direct supervision.'  
(Health and Safety Executive, 2009: 1)

Lone working was acknowledged as a central part of day-to-day role both in job specifications and interview discussions. Interviewees described working 'literally' (R10) on their own, with all workers reporting the client-focused bulk of their remit to be performed on a one-to-one basis alone with the client. Formal communication with colleagues was limited to weekly or fortnightly team meetings, supervision sessions and the referral process itself<sup>18</sup>. In light of this, the discussion of day-to-day role commonly went alongside a reported distance from co-workers which can be seen in the examples below:

'People tend to feel that they work in isolation... You can end up not seeing people for days on end cos you always sort of, pass each other by...' (R4, GMHW)

'I work independently, on my own.' (R7, STR worker)

'You see people in passing really... generally you can go weeks without seeing other members of the team.' (R28, PWP)

At the more extreme end of worker reports, graduate mental health worker R16 raised questions around the nature of team membership itself:

'I say team, but... I don't know, 'team' is a very, very loose sense you know. Basically I'm a lone worker.' (R16, GMHW)

This self-conceptualisation as lone or distant workers raises two key issues that will be further explored as the thesis progresses. Firstly, it suggests a potentially precarious nature of working relationships and raises questions around the availability of support to workers. The only interviewees who did not directly mention lone working were those situated in co-located, uni-disciplinary NPA teams. There, despite physical separation from professional referrers, a level of proximity to NPA colleagues and their supervisor/manager appeared to reduce

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<sup>18</sup> The usefulness of these different aspects in supporting workers with the complexities of client work will be considered in Chapter 7, where we explore variation across role and a shared reliance on informal support structures.

this self-appraisal of co-worker distance. Shaping factors of workplace support, including contextual and workplace factors, will be considered in depth in Chapter 7 following Chapter 6's exploration of the complexities involved in client work.

Secondly, the discussion of lone working raises the possibility of another relationship as central to working life; the relationship to the client. The perceived level of distance from other workers was summed up by high intensity worker R33, following a discussion around the lack of face-to-face contact involved in the IAPT referral process. When I asked who she felt she had the most contact with, she replied:

'To be truthful, just the client...' (R33 IAPT high intensity worker)

A possible redefinition of worker role in terms of their position relative to the client, rather than relative to the professional, forms the focus of the following Section 5.2. For now we move on to consider a second key defining feature of community co-production, linked to the practice of lone working and reported professional distance: high levels of responsibility. Across the interview discussions a number of different elements of responsibility emerged as central features of worker role. They can be grouped into two key concepts of *role responsibility*, which refers to the logistical and organisational management of day-to-day tasks, and *personal responsibility* which refers to the management of risk, both to self and client.

#### **5.1.4 *Autonomy and Role Responsibility***

Three different aspects of role responsibility were identified during data analysis and will be briefly described:

- Time and resource management
- Role creation

- Role promotion

### **Time and Resource Management**

The requirement for extensive time and resource management was described as both a positive and negative aspect of working life. On the positive side, high levels of autonomy were consistently reported as a key role benefit, providing the opportunity for workers to manage their own caseloads and structure their own day according to personal preferences. For those who had previously worked in hospital or residential settings this was seen as a key advantage over past positions, as illustrated in the following extract from support worker R2's interview notes:

Enjoys being own boss and managing his own day. On the wards things are very structured but with this role there's that freedom to arrange his caseload however he likes... that doesn't happen on the wards, it's like a "conveyor belt". (R2, support worker – unrecorded interview notes)

The benefits of autonomy were balanced however against the high levels of organisational and caseload management skills reported to arise from the work's 'self-managing' nature (R2), including time and diary management, administration and finances. The importance of effective time and diary management was particularly salient for rural workers, with a widely dispersed client base creating a heightened emphasis on careful, strategic caseload planning in order to get the most out of the large distances travelled each day.

Whether the level of time and resource management inherent in the work was appropriately acknowledged at a policy level was called into question by STR workers R6 and R7 during their interviews, with R6 commenting that student nurses were often 'amazed' by the level of responsibility that they held for aspects such as finances and involvement in student nurse training. At a documentary level, a 'realistic' job specification developed by the workers as part of pay re-banding campaign highlighted a number of additional organisational

skills when compared to their official job description, including a higher emphasis on the planning, monitoring and adjustment of client-focused tasks. This supports perceptions raised that the extent of role management skills required of workers may have been underestimated at a policy or organisational level.

In further support of this, a lack of administrative assistance for uni-disciplinary NPA teams was raised as a concern and appeared to significantly increase the burden on individual workers and team management. A lack of administrative support was described as a 'key threat' to the Site 2b STR service in the team's 2009 outcomes report. The team manager and senior STR worker reported significant amounts of their working day engaged in administrative duties rather than hands-on work or NPA support, as well as holding responsibility for workers calling in to confirm their safety between appointments, at the end of the working day and on rare occasions of out-of-hours working.

'All I can describe it as is organised chaos really...' (R20, STR worker)

The lack of administrative support appeared to be predominantly confined to socially orientated roles of STR, CDW and support workers and can be linked to perceived funding issues that will be considered in more depth in Chapter 7. In comparison, psychological wellbeing practitioners (PWPs), high intensity workers and the large GMHW team in Site 2a reported team administration support to deal with aspects such as appointments, diary management and discharge letters. Despite this assistance however, tensions were nevertheless raised by PWPs and high intensity workers around the amount of case-level administrative time available, with one worker describing the 10-15 minutes between appointments to record client progress as 'impossible' (R36).

## **Role Creation and Service Development**

Further to the high levels of day-to-day role management reported by workers, additional elements of role responsibility took the form of role creation and service development, as well as an ongoing need for role promotion in many cases. Both of these role aspects provide a point of contrast to the tasks described for existing NPA roles such as the health care assistant (HCA). Interviews with workers and managers who had been involved in initial implementation provided a useful insight into the often 'intense' (R21M) period of role introduction.

A high prevalence of service development-related tasks across all job roles included in the study can be observed in the deconstruction of worker role provided in earlier Figure 5.2, which identifies promotional tasks such as presentations to professionals and attending events as well as the development of materials and refinement of service aims as core aspects of worker role. While the requirement for service development was generally acknowledged in official role-related documents, the extent of the challenges involved in initial implementation were often reported as an unanticipated and demanding aspect of working life. References to individual workers starting 'from scratch' (R23) or creating a role from nothing were fairly common among workers who had been involved in initial service set-up, as can be seen in the following examples:

'I had to learn a new set of skills in terms of creating a job that wasn't there.'  
(R16, GMHW)

'It has been left to... individual people really to make it up themselves.'  
(R26, CDW)

The requirement for role creation was reported to result from either a perceived inadequacy of policy guidance to relate to the local context (for CDWs) or a lack of preparation at an organisational level (for some GMHWs). For PWP and high

intensity workers, while the IAPT initiative training programme and electronic referral system appeared to have been set-up in advance, the rapid nature of the initiative's introduction was reported to have created significant upheaval to the existing workforce, including the requirement for a large-scale office move and a new assessment system. This speed of implementation will be revisited in Chapter 6 when we consider political influences on worker role and service priorities.

Interestingly, the challenges associated with initial service set-up were not only limited to newly designed roles. The necessity for role creation was also reported by carer support workers and by support worker R2 upon initial employment. In these cases however the requirement for role creation arose from employment gaps or a shift in client group between the interviewee entering employment and their predecessor leaving. This led to the new worker being required to build a new caseload or set up a new service from scratch. As can be seen in the example below from carer support worker R13, an employment gap of eight months due to HR issues left her unable to pick up the previous worker's caseload:

'I am working with one or two that she saw, but... there was such a long period in between that... it didn't really work that way.' (R13, carer support worker)

### **Role Promotion**

'We have to remind them that we are there.' (R14, CDW)

In addition to role creation for some workers, a common aspect of initial service set-up took the form of promotional activities in order to get the new role known, accepted and understood by the existing workforce. This was reported to have involved substantial effort on the part of individual workers, particularly as the success of all newly implemented roles examined here relied upon some form of change to existing professional practice. For STR workers this involved

combating 'resistance' (R21M) from professionals, service users and their families to the movement away from the traditional model of support work towards something more facilitative and time-limited. For carer support workers and CDWs it required increased provision to - or a change of practice to accommodate - the needs of an under-represented group. For GMHWs and IAPT workers the challenge lay in encouraging GPs to refer a client group into the system who once would have been 'turned away' (R1). Difficulties involved in encouraging professionals to change their working practice and implications for worker referrals can be seen in the quotes below:

'The CPNs have spent years and years training their GPs not to send them self-help clients... they've given them this baseline of 'nobody below that' ... and they've trained these GPs so well that they just don't have the self-help referrals...' (R1, GMHW)

'GPs can sometimes be quite difficult... they're very set in their ways, they'll not change how they do things... we tend to find there's a very small group of GPs who do refer and a lot of GPs who don't...' (R3, GMHW)

'If teams... are very well established and... they've been doing the same routine for many years it's hard to... offer something new because they have their own way of doing things... I have met some professionals who are very happy with it... others don't have BME clients so they... don't see the need for the role... it can be frustrating.' (R14, CDW)

As illustrated in the first two quotes, workers that relied heavily on GP referrals - namely GMHW, PWP and high intensity workers - often reported difficulties building and maintaining a caseload. Role clarity problems associated with ambiguous role titles were reported to add to the hurdle of gaining referrals. In contrast to support workers and carer supporter workers for whom the role 'does what it says on tin' (R18), STR workers and CDWs both reported problems around being mistaken for these more traditional roles by professionals. GMHWs reported role clarity issues to arrive two-fold, from a job title that implied that they were 'fresh out of uni' (R5, GMHW) combined with their higher-level, Band

4/5 status but lack of professional training. This was perceived to affect both referral rate and referral appropriateness and was linked to seemingly ambiguous working relationships. In the following extract, graduate mental health worker R16 described the response from CPNs to the role's introduction:

'A lot of confusion, they weren't entirely sure what we were meant to be doing, they weren't sure on the appropriateness of referrals... that and just the ambiguity within the role meant, "Well you're not trained therapists, well what kind of stuff could you do?" ... to start with it was like getting blood out of a stone getting referrals...' (R16, GMHW)

'We're the only people who really understand our roles. Even the managers don't really understand what we do on a day-to-day basis.' (R17, GMHW - unrecorded interview notes)

For many workers, particularly CDWs, carer support workers and STR workers, professional awareness was generally reported to have improved over time alongside improvements in workers' own understanding of the role and familiarity with the system. In addition to promotional work in the form of presentations and attending events, time was considered central to building trust with professionals. Time to adjust was perceived to make professionals more open to the new role and more aware of its purpose and scope, as well as providing reassurance that workers understood issues such as client confidentiality. That said, there was also a notably common area of discussion around the requirement for ongoing role promotion activities such as presentations and awareness raising exercises. Continuing promotional work held two key aims:

- To improve service uptake (i.e. to increase the rate of referrals)
- To improve role clarity (i.e. to increase the appropriateness of referrals)

The visibility of workers emerged as central to continuing caseload problems where they existed; as such they tended to be reported for distance referrers<sup>19</sup> rather than those with whom workers were co-located or had regular face-to-face contact. Persistent issues tended to be raised by workers that relied heavily on distance referrals from GPs, namely GMHWs and the two IAPT roles. The required change of practice for GPs appeared to have had inconsistent results, with a small number of 'the same names' (R35) always coming up on the referral system. Ongoing problems can be seen in the following quote from GMHW R1, who described GPs as having only a 'vague awareness' of the role, despite a substantial time in post:

'If you go into [name of location] and talk to the doctors surgeries... they still wouldn't know what a graduate mental health worker was, which is just ridiculous when I've been in the post for three years... I go to a lot of action groups and... I say who I am and you can see everybody thinking, "What the -?" ...' (R1, GMHW)

Interviews with workers who had been employed in both roles suggested that, despite the recent nature of implementation, in general IAPT workers suffered fewer role clarity issues than their GMHW predecessors. This was suggested to be due to their larger number, more visible location, higher profile implementation and more clearly articulated training background. PWP R28 did however report the level of GP referrals to have dropped following the workers' relocation out of GP surgeries into a separate building elsewhere, further highlighting the importance of worker visibility to achieving an effective referral system.

Worker reports pointed to two potential outcomes of the caseload and referral issues raised here. Workers either reported taking on more complex referrals than their intervention was designed for, in the case of PWPs and some GMHWs, or being faced with having few clients to work with. The former scenario will be

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<sup>19</sup> See Section 4.1.3 in Chapter 4 for details of the distinction between within-team and distance referrals.

considered in more depth in Chapter 6 when we explore shaping factors of the worker-client relationship. For the latter workers, inability to build an adequate caseload led to frustration and workers having to seek out tasks such as report writing or administrative tasks in order to fill their time, as can be seen in the quotes below:

‘For the first month or so I was like, ah it’ll just pick up... another six months of banging on people’s doors was a little bit dispiriting, and demotivating...’ (R16, GMHW)

‘I just, I feel like I could do more and I’m not... It’s almost like I’m like, right ok now what’s next... I should be doing something else I shouldn’t just be sitting on a computer...’ (R4, GMHW)

For R4 the lack of a caseload was reported to impact on perceived value and future plans, resulting in a decision to move on in light of feeling under-utilised and that her skills might be better used elsewhere.

This sub-section has illustrated a number of aspects of role responsibility made up of time and resource management, role creation and role promotion. Reported to form an often central part of worker role, these elements set the current NPA context apart from worker experience described elsewhere in the literature. Three key issues have been shown here to influence the creation of an effective referral system: visibility, role clarity and the requirement to change professional practice<sup>20</sup>. The reported role clarity issues and difficulties building a caseload for some workers are likely to be linked to the co-productive nature and lack of professional attachment of the roles examined here, creating a lack of existing knowledge of the role or clear articulation of its nature and position within the workforce.

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<sup>20</sup> An additional potential reason behind ongoing inappropriate referrals will be examined further in Chapter 6, when we consider the impact of professional caseload pressures on the worker-client relationship.

We will now consider the final defining feature of community co-production observed in the current study: *personal responsibility*.

### **5.1.5 Personal Responsibility**

‘Some of the referrals when you read them... can look pretty horrific, but I always say... it is about a person, there is a person here... you have got to try and put it in perspective.’ (R21M, STR manager)

The second key type of responsibility raised by workers, this time clearly visible in job descriptions, is conceptualised here as *personal responsibility* and refers to the management of risk to both worker and client during day-to-day working life. Significant levels of personal responsibility were reported in the current study, arising from the practice of lone working in the community combined with the potentially unpredictable nature of mental health work.

The majority of interviewees reported working regularly with clients who held highly complex needs. The most obvious examples were reported by secondary care workers and included clients with histories of aggression or assault charges (R6, R7, R12), alcohol or drug problems (R8, R12, R10) or those with severe and enduring mental health problems such as psychosis and personality disorders (R27, R6, R7, R10). While primary care interventions were aimed at milder mental health issues, the ‘raw’(R12), untouched nature of people’s problems meant that additional issues would often ‘open out’ (R28, PWP) during therapy, with client complexity increasing as the intervention progressed. In addition to the lack of role-appropriate cases created by the referral problems already described, the vast majority of GMHWs and PWPs reported working with clients beyond the level officially considered suitable for their particular service.

‘The people I tend to see have been fairly complex and have... had risk attached and things, I mean obviously the idea is that part of my role shouldn’t really be involving risk...’ (R1, graduate mental health worker)

'...but there aren't less complex people coming through that's the problem.'  
(R28, PWP)

Workers expressed a high level of awareness of the need to regularly monitor risk to both themselves and the client. Systems in place to monitor this included regular risk assessments in relation to both the client and the working environment, as well as adherence to lone working policies such as phoning in after appointments for workers based in the community or undertaking joint visits in light of any safety concerns. Despite the procedures in place however, the nature of the work created a heavy reliance on the worker's own awareness of the situation, as can be seen in the quotes below from STR workers R6 and R20:

'I was out with a trainee psychologist and one of our clients was sort of threatening violence and had weapons... available... I suggested on the way back that we [do] a risk assessment, should we really be in that flat alone... should we be doing joint visits or should we avoid that flat altogether you know... you need to get access to the client to be able to help them, but you don't want to put yourself in... any danger if you can avoid it.' (R6, STR worker)

'It only takes one incident... we can't be complacent, you have to always have it in the back of your mind... without you know obviously walking round being frightened all the time but it's still got to be in the back of your mind... what could possibly happen...' (R20, senior STR worker)

The reliance on worker awareness and intuition was intensified by the requirement for *hindsight* support inherent in the community working set-up, rather than having direct, immediate access to colleagues. This can be seen for example in the following quote from team manager R25 who described the STR role as 'a *lot* harder' (R25M) than inpatient support work; while inpatient workers deal with higher levels of acuity, the support network was considered much stronger:

'Unfortunately... it's with the nature of their roles is that they actually spend a large proportion of their time in direct face-to-face contact with clients away from base. You can see it's a much more difficult role than say a

support worker on a ward who are constantly surrounded by qualified colleagues... even though they may want that kind of support, often they have to deal with a situation then come back and assess it, rather than actually having direct supervision at the time.' (R25M, STR manager)

The comparison to inpatient support work was also made by a number of workers who had previously held a hospital-based post and proved an area of tension particularly around pay. STR and community support workers described being paid the same, or sometimes less, than their ward-based counterparts, despite there being 'no safety net' for community workers (R2, support worker).

Issues around risk were seen to be further complicated by the difficult nature of mental health referrals, with risk not always being immediately visible. As can be seen in the following situation described by STR worker R8, sometimes issues did not emerge until after a few sessions, either because the client had not told the care coordinator everything or because information had not been effectively passed on:

'I found out not from the care coordinator but from the client when I was out with her one day, that she suffers panic attacks and sometimes passes out. Now that should be on the referral form but she hadn't put it down so... perhaps [the care coordinator] didn't know. But it's something they should know, because it's very important if people have panic attacks.' (R8, STR worker)

Even the concept of risk itself appeared to be a complex issue in the current study context, with other less obvious types of risk arising from the supportive nature of the work. STR worker R12 raised questions over whether less 'stereotypical' forms of risk, such as inappropriate advances from clients or verbal rather than physical aggression, were taken as seriously as physical risk by the team:

'I have worked with a person who was... very manipulative and dishonest... and I was in this very tricky situation where I wasn't going to be stabbed by a psychotic killer or a schizophrenic or anything of that stereotype but there was risk there... it had been suggested that I work at her home with her one-to-one... I didn't want to be on my own with this

person and it took a lot of courage really... it was left to me to be assertive...I wonder about the freedom to walk away from the situation in reality... whether people feel that they can...' (R12, STR worker)

Other less obvious aspects of risk to both worker and client, for example the risk posed by blurred boundaries between worker and friend, will be considered further in Chapter 6. How prepared and comfortable workers reportedly felt with the levels of responsibility placed upon them was largely dependent on worker characteristics and prior experience, as well as the perceived availability of support structures. Each of these aspects will be explored in Chapter 7, after we have examined the complexities of client work in more depth in Chapter 6.

### ***Section Summary***

This opening section has positioned NPA workers as 'co-producers' of community mental health care within the existing categorisation provided by Kessler et al. (2007). Defining workers in this way has provided a useful framework to explore how their position relative to the professional differs from research in more traditional settings, and to consider the nature of co-production in a community context. Nevertheless we are faced with an interesting observation, as a definition of workers as 'community co-producers' has enabled only limited knowledge advancement around what NPA workers actually do. The broad label of co-production has failed to take into account the diversity of tasks undertaken by workers in the current study, other than informing us that they are complementary, client-focused and distinct from the professional remit. The co-produced tasks themselves require further consideration if we are to understand the complexities and variation observed across the current study *within* the broad label of co-production.

In response to this, the next section moves forward by exploring in more depth the client-focused tasks that make up day-to-day worker role. In doing so it argues that in the current study context it may be more useful to define workers

in terms of what they do for the service user rather than what they do, or don't do, for the professional.

## 5.2 Re-Defining Worker Role in Terms of Client Work

### 5.2.1 A Client-Focused Categorisation

As illustrated in Section 5.1, in the current study setting workers reported spending the majority of their working day alone with the client. Across the course of the study the most substantial variation in day-to-day tasks was observed not in terms of the position relative to the professional, as discussed by researchers elsewhere and the focus of the opening section of the chapter, but in terms of how the worker's position to the *client* varied across different job roles and teams. Within the broad umbrella of co-production arose a number of different functions carried out by workers. The range of client-focused tasks outlined in the deconstruction of worker role found in earlier Figure 5.2 can be seen to fall into three distinct client-centred functions: *supporter*, *facilitator* and *ambassador*. Categorising worker role in this way provides useful information about the underlying motivation of the intervention, as well as the target client group and subsequent nature of its component tasks. Examples of core component tasks and the role titles displaying each function are provided in Figure 5.4.

The three core functions constructed from the analysis of interview data and role-related documents are defined as follows:

- **Supporter** – The intervention focuses on **maintenance** and **support** with aspects of daily life, including a wide breadth of practical support tasks (e.g. shopping, paying bills, DIY etc), emotional support tasks (e.g. one-to-one and telephone support) and community participation/social inclusion tasks such as accompanying the client on social outings.

The most common client group are those who require long-term support, for example carers or service users with 'severe and enduring' conditions

such as psychosis or personality disorders. This is the most client-led role; support is shaped by client preferences and is often long-term and relatively unconditional<sup>21</sup>.

- **Facilitator** – Rather than providing ‘unconditional’ support, the intervention is **goal-focused** and emphasises service user **independence** through the provision of skills, encouragement and/or education to facilitate the client to do things *for themselves*. The intervention is time-limited in that it has a conceptualised endpoint once a specific goal has been reached. While emotional support is often a key aspect, it exists as part of a wider facilitative aim.

The target client group are those who would benefit from a time-limited intervention and where visible progress is likely to be seen, for example conditions such as anxiety, phobias and panic disorder. The facilitator function can also be seen at a community level, for example by workers facilitating access to services or information, or by creating support networks which are then maintained without requirement for the worker’s long-term input.

- **Ambassador** – A worker fulfilling this function acts as a **spokesperson** for the under-represented group with whom their work specialises, for example carers or BME communities. Tasks involve organising, attending and speaking at conferences, advising/training professionals, anti-stigma work, leading on service change initiatives or otherwise providing a voice for the particular community. **Service development** is often a key desired outcome.

Figure 5.4 provides an overview of core tasks that make up each of the three client-focused functions observed in the current study, based on interview discussions and documentary analysis. The right-hand column identifies which job roles were seen to perform each function. As illustrated, the three identified functions varied in prevalence across the job titles included in the study, and thus within the broad label of co-production.

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<sup>21</sup> The term ‘unconditional’ is used here to describe a role that has relatively few constraints (other than funding) on intervention length, content or expectations/requirements of the client.

**Fig. 5.4 Overview of Tasks Performed by Supporter, Facilitator and Ambassador Role Functions**

<b>Function</b>	<b>Examples of Tasks Performed</b>	<b>NPA roles displaying function</b>
<b>Supporter</b>	<p>Practical - paying bills, taking shopping, driving to appointments, help with filling forms, decorating/DIY, exercise groups, teaching cookery skills, accompany to the gym</p> <p>Emotional - running support groups and social activities, visiting clients at home, telephone support, one-to-one visits, 'going for coffee', support to attend doctors appointments/court hearings etc.</p>	Support workers, carer support workers, <i>some</i> STRs
<b>Facilitator</b>	<p>Goal-focused STR work and GMHW project work e.g. graded exposure to overcome phobias/anxiety, access training courses etc.</p> <p>Supported self-help and 'homework' set by GMHWs/PWPs/high intensity workers</p> <p>Stress control and depression management classes delivered by GMHWs</p> <p>Creation of support networks e.g. Peer support groups set up and then handed over to volunteers</p> <p>Signposting to other services, information provision</p>	<p>STR workers, CDWs <b>Long term</b></p> <p>GMHWs, PWP, high intensity workers <b>Short term</b></p>
<b>Ambassador</b>	<p>Organising, attending and speaking at conferences.</p> <p>Attending meetings, providing one-to-one advice and/or training to raise awareness e.g. carers' issues, cultural awareness, or relating to the needs of an individual client.</p> <p>Strategic work e.g. CDWs changing inpatient hospital menu.</p>	CDWs, CSWs (to a lesser extent)

As illustrated in Figure 5.4, the tasks carried out by workers can be seen to fit broadly within three client-focused functions: supporter, facilitator and ambassador. The prevalence of each will be briefly explained below, drawing on interview data and using Figure 5.4 for reference.

### **Supporter**

The *supporter* function describes perhaps the most common, 'traditional' understanding of a support worker and embodies the traditional support work role examined here as well as the core role of carer support workers. The support function, which emphasises long-term practical and emotional support without a specified endpoint, can be seen in the following examples of workers describing their day-to-day role:

'Some people I take them out for coffee and we just have a chat... it's just a chance to get things off their chest, some people I'll go to their houses... any problems that come up we'll deal with them... benefits and all that... helping people go to the doctors or just whatever comes up really... (R19, carer support worker)

'Taking people to appointments... helping people in the house... social interaction, helping them with their shopping and helping them with various things day-to-day that we sort of take for granted really.' (R22M, support worker manager describing the role)

In the above quotes a broad, client-led remit is clearly visible, designed to support clients in both practical and emotional aspects of day-to-day life.

### **Facilitator**

The *facilitator* was the most commonly observed function in the current study<sup>22</sup>, making up the core role of STR workers and CDWs and providing the sole function of all brief interventions focused roles (GMHWs, PWP's and high

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<sup>22</sup> This is likely to be a product of the sampling strategy focusing on newly implemented NWW roles than necessarily a reflection of prevalence in the workforce and will be considered further in the discussion chapter under Section 8.5.1 Considerations and Directions for Future Research.

intensity workers). Characterised by a goal-focus and defined endpoint to the intervention, this function aims to promote independence and enable clients to do things for themselves. As will become clear in the following chapter, it is useful to differentiate between *long-term* facilitator roles (STR workers and CDWs) which hold a more social focus and *short-term* facilitator roles (GMHWs, PWP and high intensity workers) which hold more clinical, therapy-based aims.

The facilitator function can be seen in the following descriptions of daily tasks:

‘It varies depending on the goals... for one person it might be being able to get to the garden gate... for somebody else it could be getting a job... it’s all about re-integrating into society... when we step back to be able to just be involved and contribute and be able to move on just as everybody else does, and have access to what everybody else does.’ (R20, STR worker)

‘I will... get a call from a doctor referring somebody... who wants support in the community... I would call the person and ask what needs they have... it would probably be joining a community group with people from his own community... to integrate and socialise with them... We work with the groups to help people who need to access them.’ (R24, CDW)

‘I am just like a facilitator if you like... half the time they can problem solve themselves if you just give them enough time.’ (R32, PWP)

On the surface supporter and long-term facilitator roles could often look alike and STR workers reported often being mistaken for traditional support workers. However the quotes above highlight a clear difference between the ‘doing for’ (R25M) supporter role and the facilitator’s emphasis on enabling clients to do things for themselves. Worker perceptions of this distinction formed a key tension in the data and will be explored further in the following chapter when we explore shaping factors of the worker-client interaction.

### **Ambassador**

The *ambassador* function was performed by those who worked with an under-represented or disadvantaged group; in this case carers and BME communities.

Although this spokesperson-type role appeared as a separate function in the data due to its distinct task set, in both cases ambassadorial tasks sat alongside another function (facilitator for CDWs and supporter for carer support workers) and as such was the least common function observed in the study<sup>23</sup>. Nevertheless it played a central part in the CDW remit, blended with facilitation as part of the policy intention to improve services for BME communities. CDW co-ordinator R26 described the role as a 'solution finder' and a 'fixer', containing around fifty per cent facilitative community work and fifty per cent strategic work. The strategic, ambassadorial component was described to take information from the 'grass roots' (R26), related to service shortfalls or needs of the community for example, and use it to influence decision makers and frontline staff. The blend between facilitation and ambassador functions is visible in the following quote from CDW R24 who described the role as a 'marriage' between BME communities and service providers:

'To... help and support the [BME] community to access mental health services and try to highlight some of the needs that the community have in accessing mental health... Looking at this role as a marriage, you bring the community together with the services and you make them closer together, understand each other more so that they can work together...' (R24, CDW)

To a lesser extent some carer support workers also reported intermittent ambassadorial aspects blended with their predominantly supporter role, for example through attending conferences and taking part in awareness raising exercises.

The categorisation of NPA role according to its client-focused function rather than professional proximity holds a number of benefits. Firstly it provides a useful lens through which to examine how contextual factors can shape worker role; a key limitation of the existing NPA literature reviewed in Chapter 2 and the

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<sup>23</sup> The ambassador function does however form the sole function of some user-held voluntary positions in local mental health services, such as a regional BME Ambassador post or users/carers who are involved in service planning or evaluation for example.

focus of the following sub-section 5.2.2. Secondly, it provides a platform upon which to consider variation in the nature of the worker-client relationship, including perceived outcomes and observed tensions. This will form the basis of our exploration in Chapter 6.

### **5.2.2 Contextual Influences on Role Function**

As highlighted in earlier Figure 5.4, the three client-focused role functions identified in the current study were primarily attached to the remit of each specific job title, for example support workers fulfilled the supporter function while STR workers fulfilled one of long-term facilitation. There were however also a number of contextual influences on function performed that are useful to draw attention to how wider factors can be seen to shape worker role. Key influences on role function observed in the data were:

- Employing organisation
- Team specialism/client group
- Geographical location
- Role funding and worker numbers

#### **Employing Organisation**

For community development workers (CDWs), the ratio of ambassador to facilitator tasks that made up their blended role function was heavily influenced by employing organisation. This resulted in notably different roles performed by voluntary and statutory sector workers. The strategic influence and professional advisory role performed as part of the ambassador function was considered easier to fulfil for those in NHS employment due to shared management and stronger access links to health care professionals. In contrast, voluntary sector workers reported some logistical barriers to strategic access to professionals but a reported benefit of being closer to the BME community and being treated with less 'suspicion' (R26) than their statutory employed counterparts. As a result,

voluntary sector CDWs reported the use of a primarily bottom-up, 'grassroots' style approach, featuring a high proportion of facilitation activities such as setting up community groups and using them as a platform to assess the community's needs. Statutory workers reported heavier use of a top-down, strategic approach for example by delivering training and attending meetings with health care professionals to raise awareness of BME issues, albeit within the same overall aims of the CDW initiative<sup>24</sup>.

### **Team Specialism/Client Group**

Team specialism was observed to impact on the function performed by STR workers, by altering the target client group for worker interventions. As described earlier in the section, by definition the facilitator role is intended for clients where progress is expected to be seen; however the employment of STR workers in specialist teams such as Early Intervention in Psychosis (EIP) or Assertive Outreach was seen to require an adaptation of the role to meet the requirements of those with more enduring mental health problems. A subsequent reduction in the role's goal-focused, time limited nature in favour of more long-term and less conditional methods of support created a blended supporter and facilitator role which in practice looked like a hybrid of STR and traditional support worker. While less policy-accurate than STR workers interviewed elsewhere, this appeared to be effective in addressing the complex needs of the target client group.

The hybrid role largely retained its facilitative aims and contained strong elements of facilitation work, for example graded exposure with clients who were unable to leave the house or helping clients to access training opportunities. These were combined however with supportive elements such as arranging

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<sup>24</sup> A similar area of discussion was raised by users and carers in Pearson et al.'s (2009) evaluation of mental health workforce change, whereby the benefits of neutrality perceived to be held by voluntary sector carer support workers were balanced against their statutory counterparts who were considered to be more 'plugged in' to services.

social events and ongoing, long-term group activities. This blended role function performed by STR workers in specialist MDTs can be compared for example to the Site 2b STR team, where the intended client group held more moderate mental health issues such as anxiety and phobias and were therefore more suited to goal-focused support. This made possible a remit that stuck more rigidly to facilitative policy intentions, for example by not running group projects or visiting clients in their homes.

The complex needs associated with the target client group for specialist team STR workers were also shown to lead to a further blend involving some tasks from the professional domain. Highlighted by an asterisk\* next to the task of medication management in earlier Figure 5.2, this provided the one exception to the predominance of co-production seen across the study. Here, STR workers R6 and R7 reported a blended role primarily of co-production but with additional tasks more akin to professional relief or substitution. This blended role can be seen in the team manager R25M's discussion of how team functioning had changed following the introduction of two STR workers:

'You can see two big effects, one is about... helping our service engage with people who are a bit reluctant... and [secondly] to kind of get people back into whatever it is they used to like doing... it's not natural for nursing staff and qualified staff to do things like that, so that's been good... the third bit that you notice is that it just kind of helps with *stuff*, so like taking people to clozaril<sup>25</sup> clinics and things like that, so there is... an element of them doing things that need to be done but don't need to be done by qualified staff who are more expensive so there is that kind of effectiveness, efficiency bit of their job too.' (R25M, STR manager)

The 'third bit' described by manager R25M did not form part of the official policy intentions of STR, however the working set-up in Early Intervention in Psychosis (EIP), described as 'a little bit more flexible or unusual' (R25M) than other teams,

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<sup>25</sup> Clozaril is the brand name for clozapine, an atypical antipsychotic used to treat schizophrenia. It is restricted to service users who are intolerant to other antipsychotics as it can cause serious side effects and so users are required to undertake regular blood tests as part of a patient monitoring service.

was reported to create an uncommon amount of overlap between qualified staff and NPAs in order to meet the specialist needs of the client base. Although only one aspect of a broad, varied remit, the performance of tasks such as monitoring medication compliance and taking urine samples for drug screening appeared as a source of tension for STR workers R6 and R7. While the performance of such duties by workers who were well known and trusted was considered to be in the clients' best interests, medication management fell strictly outside the official STR remit. This created an apparent conflict between perceived client interests, team interests and official acknowledgement of worker responsibilities:

'There's a lot of things where we could turn round and say, 'I don't get paid to do that', you know but - you're letting the team down then... a lot of the time it's in the client's best interest as well.' (R6, STR worker)

Frustration was expressed by both workers that such responsibility was not acknowledged in pay or at a policy level. Complicating matters further, R7 reported that the responsibility for medication management *had* been officially acknowledged when the role was a traditional support post prior to the introduction of STR. However the movement to STR involved a narrowing of the workers' official remit while in practice the role remained unchanged.

'I keep saying to [team manager], just call us a support worker go on change the title back to support worker, I'd be a lot happier...' (R7, STR worker)

### **Geographical Location**

Team specialism has been shown to create different functions within the same job title. In addition, geographical location was also suggested to play a part in the development of the hybrid facilitator/supporter role for some STR workers. The substantial travel requirement between individual clients for rural workers was observed to result in more planned social activities and group work, such as walking groups or the creation of an allotment project. This was reported to stem from both a worker motivation towards time efficiency as well as an attempt to

address some of the key barriers to social inclusion for clients living in rural areas, such as social isolation and a less accessible public transport system. As such, rural workers also reported it being commonplace to transport service users in their cars; something that workers in the more strictly facilitative Site 2b team were strongly opposed to:

‘We’ve got a policy we don’t drive people around in cars... all we look at is when we disengage, what you going to do then?’ (R9, STR worker)

### **Funding and Worker Numbers**

Interestingly, an *opposite* trend whereby a supporter function had developed elements of facilitation arose in instances where funding or employment problems were observed to have created challenges to the intended worker remit. Most commonly reported by carer support workers, a combination of low worker numbers, part-time working hours and often large geographical distances to be covered created a necessity for a more novel use of the role in order to provide the most effective support. This can be seen for example in the following quote from R10 as she discussed the facilitation of a carer-led support group that would be able to ‘run itself’ during her previous position as a carer support worker. Again the influence of geographical dispersion on worker function is also visible here:

‘It’s not a full time job and it’s very rural... a lot of time was spent driving to and from [carers]... that’s how I first started the group thing up to get a load of people... to get together... and meet between themselves.’ (R10, STR worker talking about previous CSW post)

Similarly, R13 described trying to match up carers who shared similar interests or issues so that they could provide mutual support to each other, due to the limited time available for one-to-one support sessions. The perceived compromises made in the face of funding and employment issues were generally reported in negative terms by workers, as a key barrier to effective role functioning. For

workers who had maintained a supporter role function, high caseloads were often reported to have reduced the opportunity for intensive work at times of crisis or upon hospital discharge, or the loss of one-to-one sessions in favour of group activities as the only feasible option to support their entire caseload. This can be seen for example in the following extract from support worker R2's unrecorded interview notes, where he described how he would like to see the role develop:

Would like a reduction in his caseload, to allow more scope to give short-term acute care, e.g. for first referrals or times of crisis. Timing is vital in cases like this, can stop someone from becoming acutely ill if support gets to them at the right time. The size of his current caseload and covering such a huge area 'goes against the grain of what you need to do.' (R2, unrecorded interview notes)

## Chapter Summary

This opening results chapter aimed to explore an initial key question: what does NPA worker role look like in the current working context? By exploring core features of NPA working life in the community mental health setting it has drawn attention to how the findings presented here differ to those based in more traditional service contexts. The first section began by defining NPA workers as 'co-producers' of care within the existing categorisation provided by Kessler et al. (2007). A de-construction of day-to-day role illustrated a distinct, complementary service in which tasks were directly focused on service user need and recovery rather than on professional assistance. The concept of 'community co-production' was then used to explore key features of worker experience. In doing so a picture of working life has been created which is defined more by professional *distance* than professional proximity. The freedom of autonomy has been balanced against high levels of lone working, responsibility for day-to-day role management and the management of high levels of risk to both worker and client, as a result of spending the majority of the working day engaged in one-to-one client work.

Section 5.2 moved on to explore in further depth the diverse range of tasks undertaken during day-to-day client work. A definition of worker role in terms of the position relative to the *client* (supporter, facilitator or ambassador) rather than relative to the professional was proposed as a potentially more useful way to categorise workers in the current study context. Providing information about underlying role motivation, component tasks and target client group, this alternative categorisation was then used to illustrate how the wider working context was observed to shape worker role in the current study.

A categorisation of worker role in terms of client work rather than professional proximity is not only important to extend our understanding of what workers do. Given the variation in intended remit, policy expectations and target client group, workers holding different functions were seen to experience different *versions* of the worker-client relationship, with reported implications for both worker and client outcomes. An in-depth exploration of this variation led to the development of a number of 'shaping factors' of the worker-client interaction, which form the focus of the following results Chapter 6.

## Chapter 6. Exploring Variation in the Worker-Client Relationship

### Introduction

‘One of the things that is undervalued generally I think is the ability of some people to make relationships...’ (R31M, service manger)

The opening results chapter provided an initial exploration of the day-to-day role of workers. In light of the observed distance from professional co-workers compared to high levels of client contact, Section 5.2 argued that it may be more useful to define workers in terms of their position relative to the client rather than relative to the professional. Three distinct client-focused functions were put forward: *supporter*, *facilitator* and *ambassador*.

This chapter builds on the alternative categorisation by using it to examine how the nature of the worker-client interaction varied across the study sample. A number of shaping factors of the relationship between worker and client are put forward including individual characteristics, role and team-level influences and the wider policy and political context. Through this exploration the client relationship is illustrated to go far beyond its usefulness in defining the role of workers, by exerting considerable influence over perceptions of role value, fulfilment and future plans. The chapter is split into four sections which correspond to the various levels of influence overviewed in Figure 6.1: individual, role, team and the wider context.

### 6.1 Individual-Level Shaping Factors

#### 6.1.1 *The Centrality of Client Relations: Worker Motivation*

The client-worker interaction formed one of two major emergent themes (the other being the working context) about which no specific questions were asked on the interview topic guide. Not only central to the day-to-day tasks overviewed

in Chapter 5, the client also appeared central to worker motivation. When asked about their reasons for doing the job, worker responses related to seeing people move forward or making a difference to people's lives. As outlined in the summary of worker background provided in Chapter 4 (Section 4.1.4), for some workers this had formed the basis for a long term career in support work, while for others it had involved some form of life change following personal experience of mental health, caring or the desire to undertake a more people-centred occupation. For a third group it formed a 'stepping stone' as part of longer term professional ambitions. Despite variation in short-term motivation underlying their current post, for all workers this was underpinned by a strong, shared caring motivation that can be seen in the following examples:

'When I worked as a nursing assistant that was the first time that you really see yourself making a positive impact on someone's life and how you can help... that's what motivates me really... being able to make a difference.'  
(R3, GMHW)

'I care about how people are and I like to see them... getting better, encouraging them to move forward... I've had mental health problems myself so I understand what it's like.' (R8, STR worker)

'I understand very well from my own experience how difficult it is to arrive to a new country, not able to speak the language, have barriers to accessing information and how that affects your life... so I'm happy that I can contribute to... breaking these barriers for people... it's very rewarding for me to be able to help people... in accessing information, services, support...'  
(R14, CDW)

Despite the client relationship appearing central to worker motivation across all roles, the nature and apparent *strength* of the therapeutic relationship was seen to vary greatly across the study sample, impacting on the level of satisfaction that could be drawn from it. The worker-client interaction - and worker appraisal of it - appeared to be strongly shaped by role boundaries, policy expectations and adherence to targets for some workers. The observed variation prompted a

deeper exploration that resulted in the construction of a number of *shaping factors* of the worker-client interaction, which are represented visually in Figure 6.1. As can be seen in the diagram, these can be grouped into four levels of influence: individual, role, team and the wider policy/political context.

**Fig. 6.1 Overview of Shaping Factors of the Worker-Client Interaction**

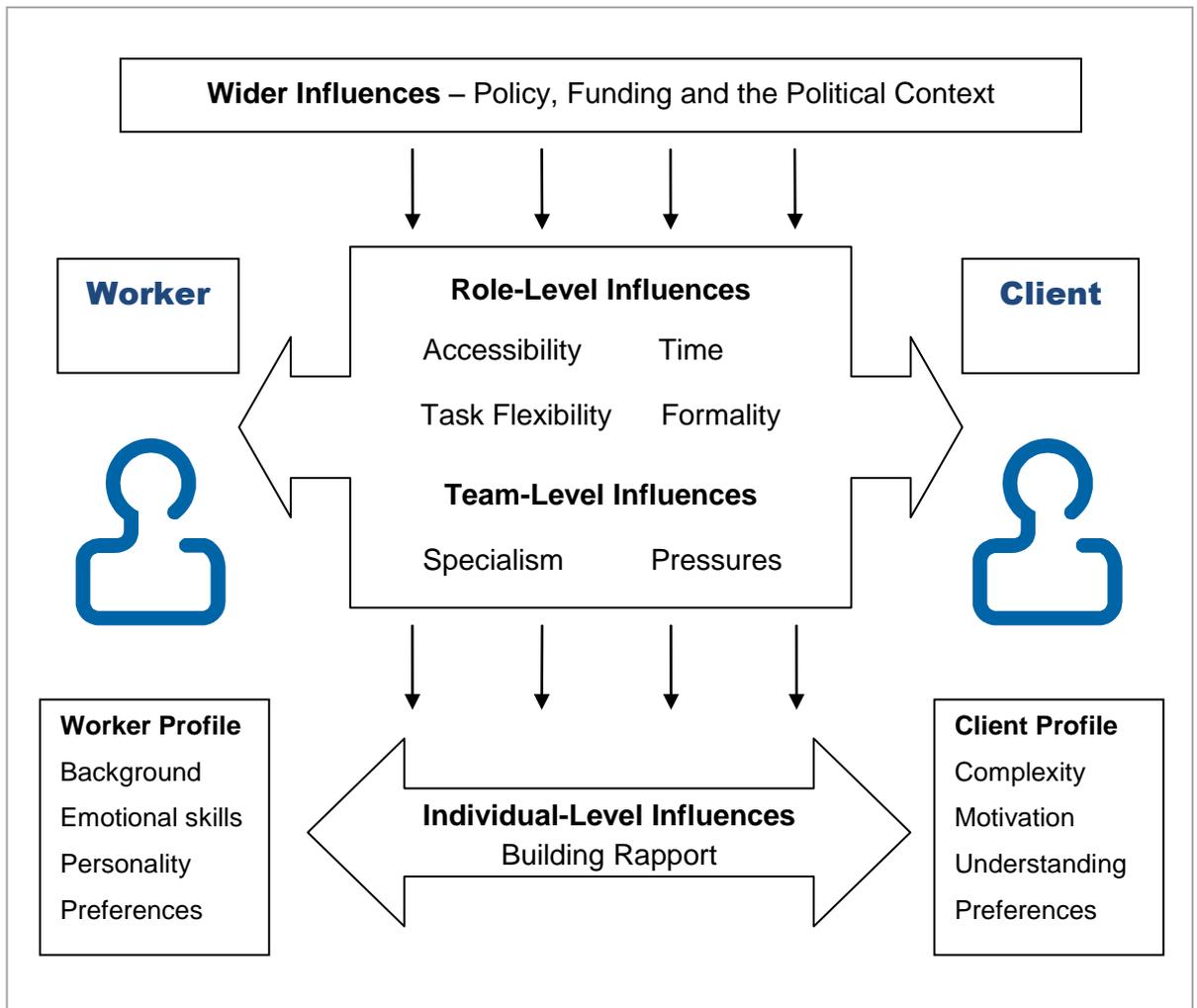


Figure 6.1 provides an overview of shaping factors of the worker-client interaction, grouped into four 'levels' of influence. As illustrated, the different levels can be considered to influence the client-worker interaction in an inter-related way. Individual factors (related to characteristics such as motivation and personality traits) emerged as a direct mediator of the relationship. Role-level influences (related to the task-level remit of a particular job role) were seen to

directly influence the ability of workers to build rapport and trust with the client, by creating the boundaries within which the therapeutic relationship could be built. Team-level influences were also seen to directly influence the level of rapport, by impacting upon client complexity and service suitability. Both role and team-level influences were shaped in turn by the wider policy and political context, through the provision - or lack - of policy guidance, outcome measures and perceived funding priorities.

The remainder of this section will explore individual influences on the client-worker relationship, before moving on to consider role, team and wider influences.

### **6.1.2 *Shared Experience and Worker Personality***

Individual compatibility between worker and client emerged as central to creating an effective therapeutic relationship, with workers expressing the importance of 'who meshes well' (R5) to positive interactions and successful client outcomes:

'At the end of the day a lot of what we do I think crystallises down into what vibes you are getting off me and I'm getting off you... it will stand or fall based on that...' (R12, STR worker)

'You have to click, you've got to be able to develop trust very quickly... adapt yourself very quickly to different people and get to know their circumstances, their triggers, how their mental health affects them... it keeps you on your toes that's why I find it so interesting.' (R20, STR worker)

As can be seen in the second quote from STR worker R20, worker reports linked individual-level rapport not just to client outcomes but also to worker satisfaction. Figure 6.1 outlined a number of personal aspects suggested to directly influence the level of rapport between the two parties, including background, motivation and personal preferences. Interview discussions drew particular attention to the perceived value of shared experience and workers

being on the same 'level' as the client, for example by being locally embedded or having personal experience of mental health upon which to draw. This was seen as key to effective communication and the client being able to 'relate' (R20) to the worker. In addition, specific personality traits such as the ability to empathise and motivate others were also seen as crucial to the working relationship and were considered to be very difficult to learn. STR manager R21M described personality and 'people skills' as the predominant consideration when recruiting new workers, given their importance to successful outcomes:

'The dialogue between support worker and service user is crucial to outcomes so if you've got that personality where you can empathise, where you can listen, where you can motivate, if you've got that... then it should be a success.' (R21M, STR manager)

For long term facilitator and supporter roles, background and interests were often described as central to within-team delegation decisions, with clients and workers being matched based on common interests in order to increase the likelihood of effective rapport being built. While this was only possible for teams with more than one worker, it can be compared to the system for short-term facilitator roles whereby available workers took the next client on the waiting list. This fixed allocation system received mixed reviews; while it avoided clients having to repeat information to different workers, GMHW R5 for example raised a potential downside due to its lack of attention to interpersonal factors:

'If you're a patient... if your style doesn't meet their style then... you're kind of stuck because that's the only scope...' (R5, GMHW)

### **6.1.3 Client Motivation and Existing Beliefs**

Three interrelated client characteristics arose as key influences on the worker-client interaction: *motivation*, *complexity* and *role clarity/existing beliefs*. The motivation of the client to engage with the intervention was suggested by

workers in all goal-focused roles as vital to making good progress. Its centrality can be inferred from the following quotes from STR workers R8 and R20:

‘This one lady I’ve got... I’ve had her seven months... she’s trying really hard, even though it’s so hard, difficult for her... it’s going against how she feels, but she’s determined to do it, she wants to do it, and I know she’s going to get there.’ (R8, STR worker)

‘You can get a referral which looks very very complex on paper and it’s actually... great to work with... I had one guy came to us with psychosis he had you know auditory hallucinations, noises and all the rest of it, but he was a pleasure to work with. He knew what he wanted and he was willing to work and was very committed and it was great.’ (R20, senior STR worker)

While some seemingly complex clients could therefore be highly motivated, in general examples of clients lacking motivation were linked to cases of low client-intervention suitability, which in turn tended to be influenced by case complexity. As already mentioned in Chapter 5, client complexity arose from a number of sources, including it being inherent in a particular worker’s target client group or issues ‘opening out’ over the course of an intervention. A third source - unofficial use by professionals - will be considered in Section 6.3 as a team-level influence in the worker-client interaction.

Client motivation was also perceived to be influenced by individual preferences, understanding and beliefs. The role clarity issues related to newly implemented roles described in Chapter 5 extended not just to professional referrers but also to service users and their families, with similar difficulties raised in differentiating between traditional types of support and the more goal-focused nature of newly implemented roles. As such, traditional support workers and carer support workers did not report any problems around client understanding of the role’s function, while those employed in long-term facilitation roles (STR and CDW) expressed issues around role clarity and often being mistaken for traditional support workers. For those employed in the hybrid STR role found in specialist

teams this did not seem to cause problems for workers, however for those performing a more policy-accurate, strictly facilitative function a tension was visible between the goal-focused remit and client expectations. A potentially inconsistent situation for the client can be seen in the following quote from STR worker R20, as she described cases where the client already accessed traditional support:

‘If they already had a support worker, it wasn’t conflict but things weren’t working properly... “Oh, I’m not going out with you today, I can go out with her instead she’ll ferry me around in the car...” (R20, STR worker)

A potential discrepancy between expectations and practice for some clients was also raised by short-term facilitators, due to the disparity between their novel, brief interventions approach compared to ‘traditional’ understanding of what a therapy session should look like (R4, GMHW). Community Development Workers (CDWs) reported a particular set of challenges, with a lack of pre-existing understanding of the role’s function combined with significant stigma and fear surrounding open discussion of mental health issues. While this was in part what the intervention was aiming to reduce, it was reported to create potential avoidance of the workers altogether by members of BME communities:

‘When you start talking about mental health the first time you meet somebody then they will... try to avoid you. Back at home if you have a mental health problem you hide it, you even hide yourself it is like a shame to the community.’ (R24, CDW)

The challenges posed by this led to workers using novel solutions to allow mental health to be addressed in a less overt way, for example by setting up exercise groups or social groups in the community, where mental health could be gradually introduced as part of a wider wellbeing focus. By initially concentrating on physical or social wellbeing, workers reported being able to build trust over time before raising more direct issues. The availability of time to workers to enable this gradual process was seen as key to the initiative’s success:

'It's the same as working with professionals, it's a matter of time... you build up trust and people get to know you...' (R14, CDW)

### ***Section Summary***

This section has raised the importance of individual-level rapport and worker-client compatibility in achieving a positive therapeutic relationship; achieved through a combination of personal characteristics, motivation and client understanding. In some roles attempts were made to enhance the opportunity for rapport to be built, for example by matching clients and workers based on background or shared interests or by gradually challenging pre-existing beliefs.

The level of rapport between worker and client was not constructed in isolation. It was moulded within role-level remit boundaries and further shaped by team-level and wider influences. Given the variation in remit from the brief interventions of short-term facilitators to the almost unconditional support of those performing a supporter function, the strongest contrast seen in the data was in relation to role-level shaping factors. These will now be explored.

## **6.2 Role-Level Shaping Factors**

The level of rapport that could be built between worker and client was seen to be heavily influenced by role-level boundaries and constraints. These role-level shaping factors were observed to impact on the quality of the worker-client interaction, by setting limits within which the relationship had to be built and influencing the level to which workers felt able to tailor the intervention to individual client need. Just as individual-level factors were seen to shape the level of 'fit' or congruency between the client and the worker or intervention, role-level factors were seen to manipulate the level of congruency that it was possible to achieve.

Earlier Figure 6.1 illustrated four role-level characteristics that emerged as central to negotiating the client-worker interaction:

- Time
- Task Flexibility<sup>26</sup>
- Accessibility
- Formality

The roles studied here displayed high levels of variation on each of these aspects, with a particular contrast between short-term facilitators which held a more clinical, brief interventions-focus (GMHW and IAPT workers) and those with a longer term facilitation or supporter function (STR, CDW, CSW and support workers). By comparing across the different roles it is possible to shed light on how these role-level aspects shape the interaction, including perceived outcomes for both client and worker.

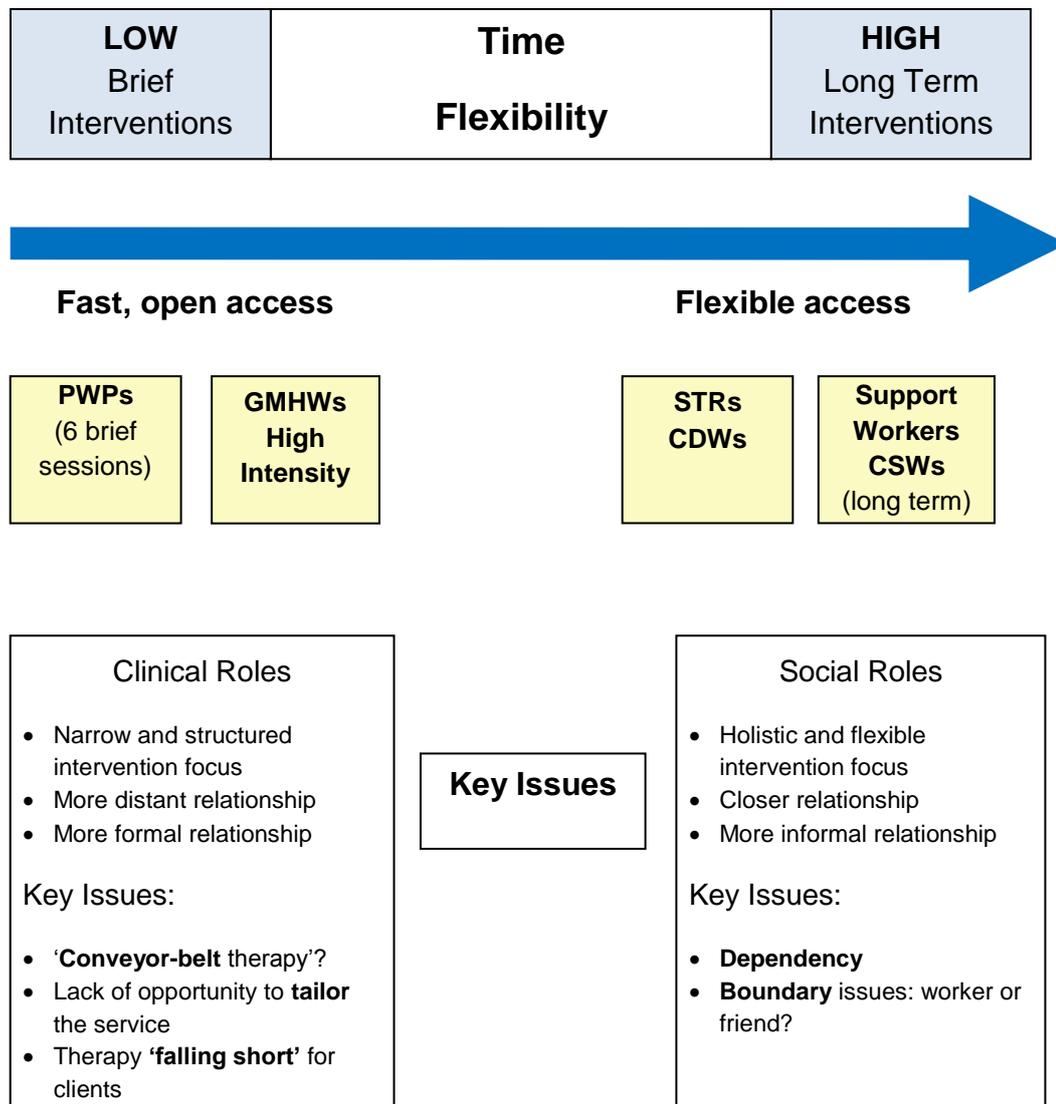
### ***6.2.1 Overview of Role-Level Shaping Factors and Key Issues***

In line with the different functions and target client groups overviewed in Chapter 5, the seven roles studied here can be conceptualised on a continuum from flexible, unconditional and non-time limited support, to interventions that were narrower in focus and held more structured time limits and permitted task remit. Visualised in Figure 6.2, at each end of the scale the nature of the client relationship looked different and raised a different set of perceived issues for workers.

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<sup>26</sup> 'Task flexibility' is defined here as the level of flexibility held by the worker over the content of the intervention itself; a combination of the breadth of permitted role remit and level of worker control/discretion held over it.

Fig. 6.2 Overview of Role Level Influences and Key Associated Issues



As illustrated in Figure 6.2, the four role-level shaping factors identified in the current study - time, task-level flexibility, accessibility and formality - were reported to vary substantially across roles included in the study sample. A number of salient issues were raised by and for workers relating to the different versions of the worker-client relationship experienced. These issues can be broadly framed within a distinction between long-term and short-term roles, however they were suggested to become more prominent at the extremes of the

scale. For example, PWPs were the workers most likely to report concerns around 'conveyor-belt therapy' (R37) and lack of opportunities to tailor the service, while concerns around dependency and boundary maintenance were most closely linked to the unconditional support of traditional support workers.

Key issues and points of comparison for each role-level shaping factor will now be considered.

### **6.2.2 The Availability of Time**

'You can't be a hardnosed deadlines person, you have got to work to their rate, at their pace... if you don't then you are the one that is left frustrated.'  
(R26, CDW)

When exploring the interview data in relation to the worker-client interaction, the most commonly recurring theme was around time. Largely dictated by role purpose and intended client group, the level of time available to workers ranged on a continuum from the six brief sessions of the shortest-term facilitator, the psychological wellbeing practitioner (PWP), to the often unlimited interventions of the long-term supporter.

For workers at the long-term end of the continuum, extensive time was acknowledged as the foundation of service value, setting it apart from the professional remit due to the perceived strength of relationship which could be built as a result. As illustrated in the following quotes, high levels of 'one-to-one time' (R2) were also linked to both worker satisfaction and perceived value to the service user. STR worker R11 for example described how the role compared to previous HCA and supported housing worker posts:

'The time, you've got as much time as you want to spend with somebody. That's the best part about the job... the *time*.' (R11, STR worker)

'I could probably say it's the best job I've ever had... even me wife says, I mean she's a CPN but she says, "I'd love to do your job" ... because you can spend quality time with people...' (R9, STR worker)

'The longest we have worked with somebody is about eighteen months ... a young lad couldn't cross the door, but now we know he takes his dog on the beach, goes to his family and all sorts so... for that person that was time really well spent.' (R21M, STR manager)

The notions of *time* and *trust* often appeared as inter-related concepts in interview discussions. As already mentioned when considering the CDW approach to tackling stigma in BME communities, a relationship based on high levels of trust was seen as key to progress, while this in turn was developed gradually over time. R7 advocated the importance of building trust to get to the source of clients' problems:

'You've got to build that trust with people to find out what's going on... you're never going to [find out] if somebody just comes along and says, "So what is it then?" ... it's about building up trust.' (R7, STR worker)

Perceived issues were raised for both client and worker at each extreme of the continuum of time availability. At the long-term end, while time was generally considered central to role value, concerns were expressed about the use of long-term interventions *without* a conceptualised endpoint; the approach common to traditional supporter roles. Long-term, non-time limited support was perceived to hold the potential to create client dependency and invited criticism from those undertaking a more finite approach. This view can be seen for example in the following quote from STR worker R11 as she compared the two types of support:

'Support workers sometimes the clients get dependent on them, whereas they tend not to with us, because we're not in that long – I mean I have been over a year with a person which is quite a long time [but] it's still to a set finishing time... Support workers can work for years with people -that's not always a good thing.' (R11, STR worker)

While client dependency was not self-reported as an issue by any support workers, it nevertheless appeared as a tension in the data. A number of STR workers - many of whom had worked in traditional support roles prior to their current post - raised concerns that high involvement in the client's day-to-day life

combined with a lack of conceptual end-point could prevent the fostering of independence and encouragement of clients to do things for themselves; a sentiment which in contrast was a cornerstone of both STR and CDW roles. A second, related issue around boundary maintenance will be discussed later in Section 6.2.5 Formality.

At the opposite end of the time continuum, psychological wellbeing practitioners (PWPs) consistently reported the low number and brief nature of therapy sessions to be a key limitation of the role. Concerns were raised about the potential danger of strictly time-limited therapies to both the client and to the workers themselves:

‘If people are assessed appropriately then really according to NICE guidelines that [six sessions] is all they should really need... but obviously everybody’s different... You could actually do more harm than good if people kind of get somewhere but then it all falls short... they can internalise that as, “I think I was doing really well and I’ll never get over it, because I’ve obviously slipped now,” and... enter them into a much more vicious cycle if you don’t progress that work...’ (R5, GMHW)

‘It is a little bit like conveyor belt therapy, we are expected to have forty-five clients on our caseload, giving however many thirty minute sessions a week... it’s going to be a high burn-out rate for anyone who is trying to do that. It’s what you’re actually getting out of the job as well when you are working like that.’ (R37, PWP)

Challenges associated with working to short session numbers, high caseloads and fast turnaround times were visible in other interviews, with PWPs describing the amount of admin time allowed between sessions as ‘impossible’ (R35) and expressing difficulty attempting to ‘get back on track’ (R36) if a client became upset during a therapy session. Graduate mental health worker R17 described these pressures - and their impact on perceived role value - as central to her reasons for leaving the post. This is visible in the following extract from her unrecorded interview notes:

‘Doesn’t feel confident that she is giving people the best service they can get. Not enough time to prepare, to feel confident in what she is doing... 30 minute appointments weren’t working.’ (R17, GMHW unrecorded interview notes)

When comparing short-term and long-term roles in this way it is important to remember the different intended client groups outlined in Chapter 6. As pointed out in R5’s earlier quote, a short number of sessions should be adequate for the majority of clients accessing brief interventions and is in accordance with NICE (2004; 2009) guidelines. Worker reports suggested that it was not necessarily the level of time *per se*, but the level of flexibility over that time - for example, over the number of sessions offered to a client - that was key to perceived outcomes.

Workers in longer term, more socially-focused roles consistently reported high levels of discretion over the provision of time to the client, centred on the requirements of each individual case and sensitive to fluctuations in need across the course of the intervention such as relapses or unanticipated progress. High flexibility was evident in appointment frequency and the overall number of sessions available to clients, as well as the time committed to each individual session. Carer support worker R18 commented for example that her team did not put a time limit on one-to-one sessions unless they ‘really have to be somewhere’. When I asked STR worker R8 whether there was a ‘typical’ length of time a client accessed the STR service she responded:

‘It depends on the client, it’s how long they need... some people take longer than others.’ (R8, STR worker)

Similarly, carer support worker R13 described how often she would tend to see her clients:

‘Depending on their need there’s some people I see once a week, others I maybe see once a month... and maybe have telephone contact in between... it depends what’s happening in their lives really, what the problems are...’ (R13, carer support worker)

'We don't like to get sucked into, "We only work with people for this amount of time"... they might struggle, they might relapse... but if they are committed to it then... we would negotiate... we'll go through it to see whether we can make some adjustments to make it work.' (R21, STR manager)

The above examples illustrate a notable lack of pressure to discharge clients or remain within specified time boundaries. The level of time flexibility available to short-term facilitators was reported to be relatively limited and highly variable across role, team and over time. Initially framed within policy guidelines around appropriate numbers of sessions and recommended caseload sizes, the ability of workers to then adjust the limits for individual clients can be conceptualised as a 'trade-off' between waiting lists and flexibility. This was reported to result in inconsistent levels of worker discretion, as it fluctuated in reaction to the shifting constraints created by waiting lists and policy-level targets.

In instances where service demand was fairly low, or where fewer policy-level targets were required to be met (i.e. for the majority of GMHWs interviewed, or IAPT teams as described in the early days of implementation), workers reported some discretion over the time available to each client, with team management supportive of additional sessions if considered to be within the client's best interests. At times of high demand or in busier teams however the situation was reported to change. Given the difficulties in building a steady flow of referrals already raised in Chapter 5, and subsequent requirement for role promotion, demand fluctuation appeared considerable and occurred alongside role promotion initiatives which created a sharp, but not usually sustained, increase in referrals. At this point, the discretion experienced by workers was cut short in order to reduce waiting list pressures.

The IAPT initiative's policy commitment to reduce waiting times for psychological therapy appeared central to this trade-off. At the time of interview PWP R35 commented that the need to reduce waiting lists had been raised

during the last two team meetings, resulting in a management request for workers to stay within 6 sessions. By the final interview PWP R37 mentioned that in further efforts to meet demand the guideline for high intensity workers had been reduced to six sessions for milder cases rather than the originally recommended 16-20, although this was under review.

The reported fluctuations in time flexibility were perceived to create an inconsistent service for clients whereby one week they would be able to access additional sessions if needed, while another week it would require being stepped up to a different therapist. Concerns were raised over the impact of this on the patient journey, in light of a seeming inability to prevent therapy falling short for some clients:

‘Obviously... improving access goes against the idea that we have got waiting lists, so there is pressure to reduce that but, you’ve still got a duty to do what you do as a therapist...’ (R33, high intensity worker)

This in turn was reported to create frustration for some workers at being unable to extend intervention length when progress could be seen and a level of rapport had been built. In addition, PWP R36 predicted difficulties for newly employed workers as a result of the team ‘feeling the waiting list pressure’. In the early days of service set-up it was reported to have been possible for new starters to allow extra administration time or slightly longer sessions while getting used to the role, however R36 predicted that new workers would no longer be afforded such luxury.

Thus, the considerable discussion around the availability of time in the current study suggested it to be both crucial to the therapeutic relationship and also a major source of tension, both for those working with restricted time and for those undertaking long-term, non-time limited interventions. Time as a product of the wider policy, political and funding context will be considered further in Section 6.4.

### 6.2.3 *Task Flexibility: Creating a Tailored Service*

‘You have to be really adaptable in the role because different clients require different things...’ (R6, STR worker)

Just as supporter and long-term facilitator roles held a higher degree of flexibility over the time provided to each client, they also reported a large degree of flexibility relating to the content of the intervention itself. This can be evidenced both in terms of the breadth of intervention focus as well as the extent of tailoring to the needs of individual clients or client groups. The tailoring of intervention-level tasks to client need can be seen in the following transcript extracts whereby workers described the content of their one-to-one client work:

‘It varies really... whatever the person wants to do, because we try and fit it round them obviously or it wouldn’t work.’ (R19, carer support worker)

‘It depends on what’s happening in the carer’s life... if they’re feeling really low, if they’re having problems with the person they care for... then they need to just sit and really talk and you just need to listen. Sometimes they’re okay and you can go out for a coffee... or go to a park or something, sometimes you need to signpost them to other places if they’re having problems...’ (R18, carer support worker)

As is visible in the above quotes, workers employed in supporter roles described high levels of task discretion, with each intervention centred around current client need. The extensive, almost unconditional breadth of remit was suggested to contribute to a holistic service by addressing a combination of practical, social and emotional needs and being able to cross care boundaries - for example by bridging the gap between primary and secondary care<sup>27</sup>.

For STR workers and CDWs, while the facilitative, goal focus of their work was seen to create some remit boundaries, such as not transporting clients in cars or undertaking group activities for some workers, a high level of tailoring to client

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<sup>27</sup> Issues around continuity of care at the primary-secondary interface, described as the ‘abyss of discharge’, were a key area of discussion in the user and carer elements of Pearson et al.’s (2009) evaluation of mental health workforce change.

need was still apparent in interview discussions. In the following quote for example, STR worker R9 described having the discretion to 'waver' from goals set at the start of the intervention if considered to be within the client's best interests:

'Sometimes you can waver from them goals, like I'm working with a young lad now... he's having a terrible time where he lives. Single person, he's being picked on [by] the kids round there... even though he's got to identify goals, there's no way you can work with that lad until you get him out of that house. So straight away at the [referral] meeting I identified that I says, "Well we need you out of there straight away, and then you can maybe start thinking about them things." So you can waver a little bit like that.' (R9, STR worker)

A second clear example of task flexibility was the way in which CDW tasks were tailored to the specific needs of a particular BME group or local community. Different approaches were described for example when working with asylum seekers or first generation BME people, compared to third or fourth generation families who tended to have fewer language barriers and greater local knowledge. As such, very different ways of working were described between rural and urban areas. Rural communities tended to be less culturally diverse, more isolated and with a higher proportion of first generation BME inhabitants, thus requiring comparatively more ground-work to create social networks and raise service awareness. Having worked in two demographically contrasting localities, R14 commented:

'The philosophy of the job is the same... what changes are the needs of the people and also the... profile of the BME groups... so the approach to the work needs to be different...' (R14, CDW)

While creating a non-uniform way of working, this lack of uniformity was reported to be central to the role's value and success. In contrast, workers employed in short-term facilitation roles reported fewer opportunities to exercise intervention-level flexibility and discretion. While interview discussions

illustrated workers to have patient choice high on their agenda, opportunities for flexibility were limited within the parameters of the role remit and time available. Despite this, many examples were given of ways in which workers attempted to be flexible, for example by giving the client choice over which booklet to use or which issue to focus on should they present with more than one. In the following quote, R35 described attempts to tailor her approach to individual clients:

‘I try to gage with each client whether they are able to do a lot of reading... if they are quite low I don’t want to completely overwhelm them so I might just give them a diary to do so that they can bring it back and kind of look for patterns... the majority of it’s supposed to be giving them booklets but I just try and give them what they can use...’ (R35, PWP)

While attempts to be flexible to client need were clearly visible, the extent to which worker discretion over tasks could be exercised was clearly lower than that held by workers in support and long-term facilitation roles. For those who had previously undertaken a more socially-focused role this created a visible tension in the data. PWP R36 for example described a difficult transition from her previous role as an STR worker, due to the restrictive nature of IAPT when compared to the flexibility and ‘freedom’ of the STR role.

Central to the observed tension for some workers was IAPT’s requirement to address only one issue within a given intervention (i.e. anxiety *or* low mood). This created a rigidly upheld remit boundary for both PWPs and high intensity workers whereby they were required to ‘stick to one thing’ (R28, PWP), even if they were aware of a number of different issues. This single-issue approach was criticised by some PWPs for its lack of attention to the complexity of mental health and to the client’s social context, creating a sharp contrast to supporter and long-term facilitator roles that reportedly held a strong social orientation.

Highlighting the importance of worker background and prior experience, PWP R37 had decided to leave her role due to frustration at perceived constraints of

the role. After training as an occupational therapist and being taught to take a 'holistic' view of people's problems, she reported feeling that treating someone for one issue while ignoring other aspects of their lives was 'just skimming the surface' (R37). This had led to R37 adapting the role by seeking out a 'niche of services' into which she could signpost clients for further support. The situation appeared to be exacerbated when working with those on waiting lists for more complex therapy, which will be revisited in Section 6.3 when we consider the impact of team pressures:

'It's somebody's life and if they are waiting for a complex therapy they have got loads of things wrong, it is not just that they have got mental health problems it is social issues... dealing with all of that... is very hard to do giving somebody one session a week for thirty minutes. That is what I struggle with.' (R37, psychological wellbeing practitioner)

PWP R32 suggested that it was not just the time-limited nature of the interventions but the CBT model itself that was confining compared the more 'hands-on' content of occupational therapy training. While she reported enjoying the PWP post, R32 also commented that constraints of the CBT model prevented the use of many of her existing skills. One high intensity worker reported that the role was generally perceived as less restrictive by those who had been 'brainwashed into using CBT' (R33), for example by taking up the role immediately after university without any experience of more socially oriented mental health work. However even workers who reported to be happy in their current post and within the CBT model suggested that their preferred next career step would be to move on to the broader focus of the CBT diploma rather than remaining within IAPT's narrower focus on anxiety and depression.

#### **6.2.4 Accessibility**

The third role level shaping factor of the worker-client interaction, *accessibility*, can be conceptualised as a further form of flexibility, at the initial point of access rather than being task or time-related. As noted in the overview of role purpose

featured in Appendix A, accessibility formed the key selling point of short-term facilitator roles through their provision of fast, open access interventions at the primary care level. The commitment to prevention and catching people early was considered central to the IAPT initiative's value, as can be seen in R32's comparison to the pre-IAPT mental health service in which she had trained as an occupational therapist:

'I've definitely helped keep some people out of secondary services by the job I'm in, and I get a lot of satisfaction from that, getting them early on... I have worked in secondary services where... they've waited on the waiting list for about three or four weeks to be assessed, then another three or four weeks, they can reach crisis point and then end up being admitted to hospital. Whereas at the minute because they are coming so early on, they are not at that stage with their depression... They are getting a much better service through IAPT.' (R32, PWP)

This quote illustrates a clearly articulated positive impact on client outcomes through the fast access approach, by providing therapy before issues required secondary care intervention. Interviews suggested however that the open referral system was a double-edged sword, cutting both ways by delivering the benefits of rapid, open access alongside substantial constraints on physical accessibility.

Both R32 and other PWPs described issues around the lack of physical access options available to those wishing to make use of the service, with clients being required to travel to the worker at a practice-based setting during the 9-5 working day. Some interviewees identified this as going *against* the idea of improving access, due to the difficulties it created for those in full-time employment or for whom, by the nature of the target mental health issues (anxiety, panic disorder and depression), may not feel comfortable travelling to an unfamiliar environment:

'I have had so many people come in here who can't stand the clinical-ness of the building... they want to sit outside and we are not allowed to, it's the rules... the whole purpose of IAPT is that we're more accessible to people

and I... think that is a barrier... the effort you have got to make to get here, people just don't want to come... If you have got depression you can't be bothered to do your own hobbies, what the hell are you gonna want to come and see me for? So, I'd like to change it... it is just about giving people a choice... because it is about being accessible isn't it?' (R32, psychological wellbeing practitioner)

The above quote suggests a lack of flexibility available to the worker to tailor physical aspects of service access to the needs of the target client group; something which R32 suggested to be enough to 'keep people away' from therapy rather than facilitate their admission. Although interviewees did not directly link the two issues, this could be a reason behind the high level of 'DNAs' (i.e. clients who Did Not Attend) reported in Site 2b. R35 commented that while those who attended their first appointment would usually continue through to the final therapy session, the team experienced high levels of DNAs for first appointments, with R35 reporting 4-5 in the previous week. This had resulted in the introduction of a 'three strikes then out' rule for clients who did not attend appointments.

Central to concerns around physical accessibility were the lack of out-of-hours working and exclusion of community work from the IAPT worker remit. This can be compared to long-term facilitator and supporter roles, for whom both aspects often formed a key component of perceived role value:

'Sometimes evenings are better for seeing people, or sort of early mornings so I do it flexibly... I have one or two clients who work and I'll maybe meet them in their lunch break or after work.' (R13, carer support worker)

'People are different in the community, and they're different in their own environments to what they are when they come into hospitals or even when they come into day centres... so you see the true people... that's not always good like (laughs) but yeah, you do get to see the true people...' (R11, STR worker)

The data points therefore to another trade-off between open, fast access and flexible physical accessibility. While IAPT was open access and even accepted self-referrals, the vast majority of other workers held some form of exclusion criteria as part of the referral process, usually by being limited to clients who were care managed (or those who cared for someone who was care managed for the majority of carer support workers) and could also be subject to waiting lists. This created its own challenges to accessibility and required a flexible approach to individual cases as can be seen in the quote below:

*'If a priority [referral] comes through where somebody is due to come out of hospital and they need help straight away... it's not that they're queue jumping, but [name of manager] will prioritise somebody if they're desperate.'* (R11, STR worker)

A similar level of access-related flexibility was evident in the way carer support workers tended to describe cases as 'active' or 'dormant' rather than ever being closed. This was designed to allow carers to re-access the service quickly at times of need and reflected the nature of mental health where issues 'don't just go away' (R15), while also addressing the challenge of an otherwise overburdening caseload. In the following illustration, R18 described the way carers were transferred onto telephone support when their circumstances were relatively stable, where a worker would make regular telephone contact to confirm their wellbeing:

*'Most of the time they're okay, some of the time they're not and they come back into the service, the files come out. We have what we call an archive, we don't do a closed case file we call it an archive because they're never closed.'* (R18, carer support worker)

Accessibility can therefore be conceptualised as a difficult negotiation between accessibility in terms of numbers and speed, and the provision of flexible access to clients; a tension particularly visible for IAPT workers for whom fast access

and being *accessible* to clients appeared as two distinct elements at odds with each other.

### **6.2.5 Formality**

Aspects of each of the three shaping factors already considered in this section were seen to culminate in a fourth, by impacting on the formality of the relationship between worker and client. There has been a visible contrast for example between the more formal relationship of short term facilitation roles, based within structured time boundaries and taking place in a statutory building, and the community based remit of supporter and long-term facilitators which enabled them to become embedded in the client's own environment.

In addition, the formality of the interaction was influenced directly by aspects of role specification. One of the most immediately obvious differences between short-term facilitation roles and those undertaking longer-term, more socially focused interventions was the difference in language used to describe the service user. Brief interventions workers were more likely to discuss the 'client' or the 'patient', often using the two terms interchangeably:

'Again I said patient, client it's hard to sort of say one or the other.' (R33, high intensity worker)

This suggests a clearer demarcation between worker and client for short-term facilitation roles and a potentially more medicalised approach to mental health when compared to STR and support workers, who never used the term 'patient'. Instead they were more likely to make use of affectionate terms such as 'young lad', 'gentleman' or 'lady' when describing members of their caseload. For supporter and long term facilitators, an informal client relationship appeared to be cultivated at a role specification level, for example by workers being encouraged not to wear ID badges and to dress casually:

'I've got an ID badge... but we don't wear those because you don't wanna be taking people out and advertising the fact that...they're mentally unwell so, and this is why we dress casual...you don't want to be dressed differently cos you stand out and... they don't feel comfortable with that.' (R6, STR worker)

Client progress was suggested to develop often as a direct result of the relationship's informality. This can be seen for example in STR worker R7's description of a client with whom professionals had been unable to make progress and who had requested not to be visited at home by members of the multidisciplinary team. While seemingly wary of mental health professionals, he had accepted social support from R7 who was then able to keep track of his wellbeing through a highly informal relationship:

'[He] isn't well at the moment, but... we're able to sit and have a coffee and a chat... just superficial stuff like you know films, music but from that I'm picking up about how he is thinking... he'll feel relaxed and he'll let things slip about what's going on.' (R7, STR worker)

This suggests the informal nature of the STR worker-client relationship to allow a unique contribution to feedback mechanisms within the team, based on information the worker was able to gather through informal social interaction; information that would potentially have been unavailable to professional members of the team.

Another technique used to maintain relationship informality at a community level described by STR worker R20 was to be introduced as a friend rather than a worker. This was suggested to help the client's re-integration back into mainstream society; a situation in which considerable public stigma was still perceived to exist. This introduces a key issue around the maintenance of 'professional' boundaries, raised as a potential danger of this informal type of relationship. The consideration of boundary issues was notably absent in short-term facilitator interviews, however for STR and support workers it formed a key

area of discussion and a clear challenge to workers during day-to-day working life. The tension between worker and friend came up often in conversations with STR and support workers, as can be seen in the following examples:

‘It’s difficult you know, in a way you are acting as a friend for some people.’  
(R6, STR worker)

‘It is a fine line between being an STR worker and being someone’s friend because you have to build that sort of close relationship for them to trust you...’ (R8, STR worker)

‘Especially if people have got no family or friends... you might be the only person they actually see.’ (R11, STR worker).

Support worker R2 suggested boundary maintenance to be particularly challenging for locally embedded workers; while aiding rapport it could also involve bumping into clients outside of work in more social circumstances. STR workers described a number of tactics used to maintain professionalism, such as making clear the worker’s status as a member of the care team prior to the start of the intervention and discussing aspects such as the use of the term ‘friend’ at regular intervals. The role’s goal focus and use of regular tripartite meetings with the care coordinator appeared to aid boundary maintenance, as it allowed workers to regularly revisit the ‘structure’ (R20) of the work and keep it at the forefront of the intervention.

Nevertheless, boundary setting and maintenance often appeared to be an ongoing learning curve, with a number of examples raised by workers of detrimental outcomes for both client and worker as a result of unsuccessful attempts to maintain appropriate boundaries. In the following extract, R8 described such an experience and highlights a potential tension around matching worker and client *too* closely:

‘We had common interests... and I think she felt because of that she had more claim on me as a friend than a worker and at one point I had to... be

specific and say, “Look, we can’t be friends as best friends... I’m here to support you to become independent and that means... when my role finishes, that’s it”... she got very upset and her daughter was so annoyed with me about it... what have I done and why am I so horrible to her - I said, “I’m not being horrible... it’s not that sort of relationship, it’s a job...” So that was difficult and I had to apologise in case I had given any... appearance that I was going to be her friend... forever, kind of thing...’ (R8, STR worker)

While R8’s example reported above suggested role clarity on behalf of the client to be a key issue in boundary maintenance, other interview discussions suggested that attachment on the part of the worker may also in some cases have played an active part in the blurring of boundaries. This can be seen in the following example from STR worker R9:

‘I would be a liar to say that I haven’t gotten on with somebody better than all the rest, I mean the young lad I got back to work you know, I really felt for him, because he had nobody... I probably carried on working with [him] a little bit longer than what I should, but that was me wanting to see it all... come together. He probably didn’t really need me in the end... [but] I would pop to see him and nobody knew I was an STR worker they just thought I was his mate... just to see if he had any problems or he was managing alright financially you know.’ (R9, STR worker)

‘You do get terribly attached...’ (R10, STR worker)

STR worker R6 provided a poignant example of the potentially negative impact of blurred boundaries on worker wellbeing. Describing boundary issues as ‘extremely difficult’, particularly when he had been new to the role, R6 described how he had encountered a steep learning curve while working with a client to enable him to leave the house:

‘[It] became very intense... I was crossing boundaries which I set you know and it was becoming – well, it did become – very much like a friendship... I was kind of bending the rules too much really... he would text us [me] in the middle of the night just wanting reassurance about different things...’

Sadly, during the course of the STR intervention R6's client had died suddenly. This was described as a 'massive shock', which required extensive reflection on the nature of their working relationship:

'I actually took that really bad... it wasn't until after that happened that I sort of recognised the fact that I was crossing those boundaries... it probably wasn't good for me and it probably wasn't good for the client... he probably was getting to the stage where he was becoming quite reliant... That's something I've had to do a lot of work on.' (R6, STR worker)

As a result, R6 reported spending a large amount of time working on boundary setting techniques through supervision, internet research and reading. Echoing this, STR manager R25M described boundary challenges as a potential source of confusion for both client and worker that required 'a lot of managing':

'There are very occasional things that say this is not an ordinary friendship, this is a professional relationship, but actually an awful lot of the day-to-day of what happens probably looks an awful lot like a friendship to people... there's a tension in the role shall we say.' (R25M, service manager)

This tension was observed perhaps even greater for the most unconditional types of support. Support worker R27 reported having lost a number of clients, one of whom he had been working with for ten years, and supporting some through serious medical diagnoses including stroke and cancer. He described this part of his role as:

'...really, really hard... probably the worst aspect of my job.' (R27, support worker)

Boundary maintenance therefore appears as one of a number of complexities involved in negotiating the worker-client relationship, embedded in the informal nature of long-term roles and holding clear potential implications for worker wellbeing.

### ***Section Summary***

This section has examined the key source of variation in the nature of the worker-client interaction observed in the current study, in the form of role-level shaping factors. It has illustrated how variations in the availability of time, task-level flexibility, accessibility and formality of the intervention were seen to create different versions of the worker-client relationship by constructing the boundaries within which it could be built. Contrasting perceived outcomes for both worker and client have been highlighted as a result of varying role-level constraints, and as a result of the complex negotiations involved in maintaining this relationship. The importance of training, supervision and personal experience in managing the complexities of client work, as well as perceived adequacy of existing support mechanisms, will form the focus of the final results Chapter 7.

The remainder of this chapter will outline two further levels of influence on the nature of the worker-client interaction: team-level influence in the form of professional pressures and their impact on client-intervention compatibility, and the influence of wider policy and political factors on perceptions of authenticity.

### **6.3 Team-Level Shaping Factors**

Chapter 5 illustrated how team specialism could impact on the role function performed by workers, for example by creating a blended supporter-facilitator role for STR workers in order to tailor to the needs of a specialist client group. A further level of professional/team influence, in the form of perceived professional workload pressures, was seen to impact directly on the individual relationship and level of rapport between worker and client, by influencing client complexity and service suitability.

The task-level analysis undertaken in Chapter 5 illustrated clearly defined, separate NPA and professional remits. This was supported by a deconstruction

of worker role which illustrated notably few discrepancies between job specifications and worker reports. Co-production could therefore be theorised to elicit a lesser likelihood of NPA worker role being moulded to professional or organisational need in the way that has been illustrated elsewhere (e.g. Spilsbury and Meyer, 2004a; Kessler et al., 2007; Bach et al., 2008). Based on a task-level analysis worker role appears undiluted and closely matched to policy intentions.

In contrast to this assumption, an in-depth analysis of the interview data highlighted numerous instances of 'unofficial' use by professionals, yet it was rarely visible at the task level because it was reported to affect client complexity and service suitability, rather than the actual interventions themselves. Elements of unofficial or inappropriate use can therefore be seen to occur *within* the co-produced remit, with appropriate and inappropriate referrals sitting alongside each other and varying in nature according to employing role and referring professional.

For the purpose of the following analysis, an inappropriate referral was defined as one reported to involve a client considered to be unsuitable for the service, driven by professional or organisational pressures rather than official policy intention. Examples of unofficial use reported by workers fell into three main categories:

- Monitoring and maintenance
- Waiting list containment
- 'Dumping' of complex clients

The nature, prevalence and perceived outcomes for the worker-client relationship of these forms of unofficial use will now be considered.

### **6.3.1 Monitoring and Maintenance**

As identified in Section 5.1, the monitoring of client progress and early relapse signs formed an officially recognised part of the role of STR and traditional support workers, as a by-product of their co-produced client work. In some cases however this was reported to go beyond the role of information sharing, driven by professional caseloads pressures and limited contact time with individual clients. The specific nature of this type of use varied across role and team.

#### **Observation and ‘Spying’**

The first example was reported by workers in the Site 2b uni-disciplinary STR team, where in some cases workers described being required to perform an observational role motivated by a care coordinator’s desire to ‘check up’ on a client or verify a particular aspect of their reported problems:

‘A service user or client may be telling them certain things [but] they are not so sure and they bring us in... We do end up being - sounds awful saying eyes and ears because it sounds like you’re reporting back and that’s not the purpose of the work we do...’ (R20, senior STR worker)

Primarily linked to social work referrals, this ‘spying’ (R9) role was attributed to the extensive time available to STR workers and their ability to observe clients in their own environment. Although workers tended to express understanding towards the professional pressures underpinning such referrals, they also acknowledged a discrepancy between this type of use and official role purpose. Discussions also hinted that the resulting outcomes may not as articulated in policy guidance, with worker feedback being used to judge a client’s entitlement to support elsewhere, or the type of support they receive, rather than a focus on improving social inclusion or client independence.

### **Caseload Easing and Client Maintenance**

The most common example of ‘unofficial’ monitoring and maintenance in response to professional pressures was reported when referrals were perceived to be primarily motivated by a need to maintain clients in the community, rather than being driven by client preferences or a desire for improved social inclusion *per se*. Reported by workers employed in STR and traditional support roles, the tension created by this can be seen in the following transcript extract from support worker R27:

‘Sometimes care management will refer people, this might sound a bit strange, for their reasons and not the client’s reasons... they are wanting a cheaper way... It is a difficult situation because obviously the client might not want to see anybody, but... the care manager will go out and try to convince them that they would benefit from the session.’ (R27, support worker)

A potential disparity between professional need and client preference is clearly visible here, with such instances perceived to result in the receipt of referrals where support was not always welcomed by the service user. Referrals against client preferences appeared common for STR and support workers and were reported as a key influence on client motivation, identified in Section 6.1 as central to the likelihood of positive outcomes. In the following quotes, STR workers R8 and R11 described the likely outcome if a client had been ‘persuaded’ (R8) by their care coordinator to undertake an STR intervention:

‘You were arranging meetings and the client wouldn’t turn up... you’d go to the house and they wouldn’t answer the door and you would waste quite a bit of time and then you would find out that they didn’t want you anyway. It was just the social worker, they must’ve thought, “Oh that’s a good idea, give them an STR worker then maybe they won’t have to see us quite as often.”’ (R11, STR worker)

‘Not everyone’s going to get better, cos not everyone keeps going... They make excuses, they cancel... and then you ask them, “Do you really want an

STR worker?" ... if they don't there's no point, it's wasting our time and there could be someone else who could benefit.' (R8, STR worker)

Linked to social work and CPN referrals, such cases were described as a 'difficult part of the job'(R8) and a clear waste of resources. A perceived professional motivation of caseload easing is visible in R11's transcript extract, although it is important to note the past tense of her discussion. It was generally reported that while caseload easing was still an issue, the introduction of a specific service referral form around a year before the study took place had greatly reduced its frequency. The requirement for care coordinators to discuss the STR service with clients and agree on initial goals prior to the referral being accepted was perceived to have resulted in a greater level of 'respect' for the service and a reduction in professionals using it to 'free up some time' for themselves (R21M).

The reduction of inappropriate referrals in this instance can therefore be considered intertwined with a refinement of the STR referral process and introduction of a structured gatekeeping system. Where no such structured referral system existed, it seemed more difficult to protect the remit against unofficial maintenance work. The manager of Site 1 STR workers R6 and R7 described a necessity to keep 'reinventing' the role in order to stop it slipping back into being used as a 'doing for and getting people out' (R25M) type of role. Expressed views on this were mixed, with an acknowledgement of the benefits of hospital avoidance to both professionals and clients pitted against disappointment that the role was not always used to its full potential as a 'creative force for social inclusion' (R25M). Outreach worker R27's interview also suggested the potential for a stagnant caseload and lack of observable client progress, arising from the long-term, non-goal focused provision. This can be inferred from the following quote when R27 described what happened at the end of an agreed piece of work:

‘Usually you have a review with the care manager and then... nine times out of ten they would rather have it continue because the guy hadn’t relapsed or he is not in hospital... he is maintained in the community which is a lot less money... even though I would like some new referrals.’ (R27, outreach worker)

### **6.3.2 *Waiting List Containment***

The use of NPA workers in a monitoring or maintenance capacity was confined to roles with a high supportive component, namely STR and traditional support workers. A second and perhaps more concerning type of unofficial use, given its clear alignment with professional substitution (Kessler et al., 2007), took the form of waiting list containment. Waiting list containment refers here to workers receiving referrals for clients whose needs had already been assessed as requiring a more complex service than they were able to offer. The reported motivation for such referrals was either to ‘keep a lid on’ (R37) clients’ problems while they awaited an intervention from a more highly qualified worker, or as an experiment to see if their problems may be responsive to a lower level intervention before placing them on a professional waiting list.

Reported as a common experience by the majority of workers in roles that received referrals from primary care mental health (some STR workers, GMHWs and both IAPT roles), this type of unofficial use was underpinned by substantial waiting lists, often of many months, reported for higher level therapies such as counselling, CBT and family therapy. In contrast to the mixed views reported on the relative value and burden of maintenance and monitoring practices, waiting list containment was discussed in persistently negative terms by those who experienced it.

After describing the way in which the STR service could complement the receipt of psychological therapy by reinforcing learned techniques in the client’s natural environment, STR worker R8 mentioned that the system did not always work ‘properly’ in this way:

'Sometimes... they're not having therapy, they're on the waiting list. We're working with them before they've had the therapy, which in some ways is backwards because we're not allowed to teach them CBT, we can just reinforce positive things but if they're not getting the therapy they've got no theory behind it.' (R8, STR worker)

Waiting list containment was suggested to impact on the suitability between client and intervention, heavily influencing referral complexity due to the 'raw' (R12) nature of the mental health issues experienced by these clients. This was perceived by R12 to render them unsuitable for the intervention they were being offered:

'Very often those people are quite complicated and they're quite fragile... we're having to contain their emotions, and that is the strain in the work I would say... I help keep people's hope alive basically, that's what I'm doing keeping their hope alive for when the therapy comes...' (R12, STR worker)

A similar situation was reported by psychological wellbeing practitioners (PWPs), where the low referral rate of clients with 'mild' problems was reported to have resulted in workers taking on those who were perceived to have more complex needs than could be addressed by supported self-help. The team was described to have adopted a tiered system whereby all new referrals would be initially offered self-help regardless of their assessed suitability, to be then stepped up after the first session should they be deemed too complex. Reporting around half of her clients to require being stepped up to a higher level therapy, R37 expressed strong reservations about this management 'vision' being promoted as the most positive way forward for clients. Concerns were raised about the potentially detrimental impact of an ill-fitting service, tempering the success of therapy by setting clients up for failure:

'I just think if I was a client... if I had come into somewhere expecting to get help and was assessed as not suitable... I would feel that I have failed before I even started and I just think you'd lose a lot of people at that point, whereas if people were coming in and getting the therapy that [is] more

suitable for them we probably wouldn't find that the drop-out rate would be so much.' (R37, PWP)

Given the time and flexibility constraints already described in Section 6.2, psychological wellbeing practitioners in particular reported difficulties in catering for additional levels of complexity. Alongside the perceived impact on client progress described in the quote above, discussions also pointed to implications for worker morale in the form of de-motivation and finding such cases 'frustrating' (R28, PWP) and 'soul destroying' (R37, PWP), due to the lack of progress that could be made. These clients were reported to vary in their willingness to engage with self-help and often required a risk assessment at the start of each half hour session, making it 'difficult to do any therapy' (R35, PWP).

### **6.3.3 A 'Dumping Ground' for Difficult Clients?**

A final, less common issue but one nevertheless related to professional caseload pressures was reported as a form of 'dumping' (R17) of difficult clients onto NPA workers. Three of the six graduate mental health workers (GMHWs) interviewed reported CPNs to have referred clients with whom they were unable to make progress; perceived either as a way to 'play the system' (R17) in order to have a break from a difficult client, or to pass on cases that they were struggling with:

'The way they justify it is that we have more time... but sometimes you do feel like, well actually it's because you're stuck with this person that you're giving them to me... is that really our role?' (R3, GMHW)

Echoing outcomes of the previous form of misuse, waiting list containment, this type of referral was perceived to impact on client-service suitability by resulting in cases too complex for the intervention's capacity. It is important to note the visible assumption of intentionality here, suggesting that the GMHWs felt they were intentionally given overly complex referrals by CPNs. As the current data did not draw upon the professional viewpoint, intentionality behind

inappropriate referrals is a difficult concept to examine and refers here to NPA perceptions of professional motivation.

Elsewhere, suggestions were made of NPA workers being referred clients whom the referrer may not have known where to send, or for whom no suitable service seemed to be available. PWP R28 for example raised concerns around the number of IAPT referrals related to people being bullied at work, estimated at around twenty per cent, and suggested it to result from the GP not knowing where else to send them. In a similar tone, STR manager R21M described increasing numbers of referrals from drug and alcohol services; a trend which was expected to continue in light of a current policy spotlight on dual diagnosis. While clients were supposed to be recovered from addiction problems before being referred into the STR service, worker reports suggested that this was not always the case, with ongoing alcohol issues sometimes having been 'skirted around' in client assessments:

'We'll get an assessment and it'll say, 'there may have been some alcohol problems in the past but we don't know' ... and then it turns out that it is a bigger problem than we all thought, therefore they are not actually going to get to see an advanced therapist because they won't work with them, so *well what do I do with them then?* I work with her for a while and then... eventually it's almost like you let the person – it's dreadful to say this but – you let the person eventually become de-motivated and then not turn up.'  
(R12, STR worker, emphasis added)

The concept of dumping is clearly visible here, with R12 reportedly being left with clients upon the discovery that they were no longer eligible for the therapy for which they were waiting. Referring to the 'very, very many clients' with long term alcohol problems, for whom the STR service was considered unable to address the underlying problem, R12 went on to describe the potentially devastating perceived impact of this:

'So then on paper she doesn't attend twice and we kick her off the waiting list. She is off, she's gone. So she is now left in her world and she actually

hasn't benefited from the service at all in my mind. There has been admin, there has been my time, there has been her hope that has been dashed and she has found nowhere and that is the result of how the system works... All we've learnt from it is, isn't it awful when you don't find out at the beginning what is really the matter?' (R12, STR worker)

The reference to dashed hopes and the client being left in her world creates a vivid picture of the potential impact of this type of unofficial use on service user wellbeing, as well as wasted resources in terms of worker time and administration. In addition it raises significant questions around the impact on the workers themselves of this type of unsuccessful outcome.

#### **6.3.4 Immunity from Misuse and 'Box Ticking'**

Discussion so far in this section has suggested that types of unofficial use varied according to NPA role. There has been a notable absence of CDWs and carer support workers from the considerations provided, and perceived professional misuse did not appear as an issue for the majority of these workers. A possible reason for this may be the lack of shared client group which presumably would limit the extent to which professionals could use the workers' service to relieve their own caseload pressures. Interestingly, one exception raised by CDW R23 pointed to a method of potential misuse faced by those working with marginalised groups in the form of 'box ticking'; whereby workers were asked to attend meetings or provide service input in order to 'tick the BME box' (R23, CDW) and meet targets rather than a genuine desire for service development.

#### **Section Summary**

This section has suggested that, despite the status of NPA workers as co-producers and their seemingly distinct, client-focused remit, professional and team-level pressures could still be seen to exert influence in response to their own needs and caseload pressures. Rather than impacting on the actual tasks performed by workers, in the current study this was manifested at the level of the worker-client relationship, by impacting on client complexity and service

suitability. Linking back to the importance of worker-client compatibility and motivation outlined in Section 6.1, this has been shown to have significant implications both for client outcomes and worker satisfaction.

Given the impact on client suitability rather than tasks performed, the appraisal of a referral as appropriate or inappropriate appeared difficult to articulate in the current study, inviting questions around the capacity of workers to raise concerns. Labelling certain referrals as inappropriate was often based on my own subjective interpretation, following a consideration of policy guidance, job specifications and worker discussions. It was not always considered as such by workers, and where it was it remained unclear whether an appraisal as misuse would be shared by the referring professional. This tension can be seen in the following quote when I asked STR worker R20 whether the 'spying' role performed for some social work referrals would be classed as inappropriate:

'It's never put across that way so no it wouldn't be identified as inappropriate, that's just how I've felt at times afterwards.' (R20, STR worker)

The final section of this chapter will briefly consider one final level of influence on the worker-client interaction: the wider policy and political context.

## **6.4 The Wider Policy and Political Context**

Sections 6.2 and 6.3 have illustrated how the nature of the worker-client relationship varied according to a number of role and team-related shaping factors. Role-level freedoms and constraints as well as the reported pressures facing professional team members were seen to be forged within existing policy and the current political climate. Two key elements of the wider context were seen to impact on how workers construed the client relationship, role value and subsequent satisfaction. These were the perceived political motivation behind newly implemented brief interventions roles, and the contrasting lack of

perceived political priority for other roles. In both instances, but for different reasons, observed issues were seen to impact on perceived authenticity of the worker-client interaction.

#### **6.4.1 Politics and the Economy: IAPT's 'Hidden Agenda'?**

The influence of policy and wider politics on the worker-client relationship was observed most strongly for those employed by the IAPT initiative. References to targets and 'the rules' (R32) passed down by policy makers have already been illustrated in Section 6.2 to place perceived constraints on worker time and remit. Perceptions of authenticity and value to clients were also heavily influenced by worker opinion of the IAPT initiative's underlying motives. The data pointed to cynicism amongst workers over perceived political undertones driving the targets and outcome measures to which they were required to adhere. A sense of disillusionment and distrust of government motives could be inferred from worker reports and can be seen in the following quotes. The first comment for example was made by high intensity worker R33 when describing the pressure to take on high numbers of cases:

'...it's not what I signed up for... you were led to believe it was going to be something different.' (R33, high intensity worker)

'IAPT was a political decision. It worked well for me but it was a political decision.' (R34, high intensity worker)

Particular tension arose from the existence of annual team targets for the number of clients who had returned to work following IAPT intervention. The focus on getting people back to work and keeping people in work was described as an 'unfortunate' (R33) product of IAPT's introduction coinciding with the economic recession. Graduate mental health worker R3, who had recently applied for a high intensity position, suggested cynicism around this to be the primary reason why only a small number of applications had been received for the advertised posts:

‘Some people really don’t like the idea of IAPT... they don’t like the idea of it all being about work and getting people off benefits... they don’t agree with that...’ (R3, GMHW)

Questions were raised around the underlying motive for employment-based outcome measures, in light of the lack of attention they paid to those who had accessed volunteering opportunities or were actively looking for work. PWP R28 described that the service manager had written to policy makers to express the need for more holistic outcome measures, commenting:

‘I know some people have got into volunteering, that isn’t measured and it should be measured, if the government were interested in people they would be measuring that but it sounds to me like their interest is in the economy.’ (R28, PWP)

Given the high numbers of referrals reported for workplace bullying and work-related stress, R28 raised further questions around the extent to which efforts to keep people in work could always be considered in the clients’ best interests. These work-related targets can be compared for example to the employment aims of long-term facilitator roles STR and community development workers. While STR workers and CDWs did report encouraging people into employment or training, attempts were reported to be driven by client desire to move forward rather than external targets. In the following example, STR worker R9 expressed helping clients back into work as one of the most enjoyable parts of his job. He described recently helping a client towards taking up a volunteer position with the befriending service of a local hospital:

‘I like working with people with employment. Not that I want to get everybody back to work but... at least courses and doing something, giving back. Like the lad I’m working with with the befriending service, he might never move on from that - he might just be happy doing that, but... he’s giving something back and I think that’s a big thing... he gets satisfaction out of helping somebody else.’ (R9, STR worker)

The impact of wider policy on brief interventions workers was also visible at the task level. GMHW R1 for example predicted the removal of computerised cognitive behavioural therapy (CCBT) from the brief interventions remit following its disappearance from NICE (2004; 2009) guidelines, despite positive feedback from the clients who had undertaken it. This prediction was confirmed in later interviews, with CCBT having been removed from the remit of both GMHWs and IAPT workers. A potential loss of role variation was further expressed by PWP's in concerns over the erosion of health promotion activities and delivery of group sessions - despite their seeming value to clients - because they held less relevance to team targets than one-to-one therapy sessions.

Concerns raised were linked to wider reported cynicism around the short-termist, target driven nature of the modernised NHS and echoed disappointment raised by CDWs that the Delivering Race Equality programme (DoH, 2005b) had been a five-year rather than a ten-year plan. Team manager R22M, who had worked in the health service for over thirty years, compared current services to the system in the seventies where the 'patient came first':

'It's a business now the NHS, it's not a caring profession it's a business and it's orchestrated by money... and I think people suffer unfortunately.'  
(R22M, CMHT manager)

'I suppose that is progress but... it just seems that everything has gone very corporate and we are losing sight.' (R21M, STR manager)

#### **6.4.2 Funding and Policy Priorities**

The outcome measures and perceived political orientation of the IAPT initiative drew a contrast with supporter and long-term facilitator roles. As already described in Section 6.2, workers in these roles reported higher levels of flexibility and worker discretion over the client interaction, allowing interventions to be tailored to individual client need. This undiluted, client-centred role motivation - seemingly linked to the roles' apparent immunity from political pressures -

elicited strong assertions of role value and role commitment from workers. With workers rarely reporting plans to move on, high perceptions of role value can be seen in the examples below:

‘It sounds corny but it’s the feeling like you can and are making a difference. You’re seeing things through... working to get somebody into a position where they’re on the road to recovery.’ (R2, support worker)

‘When you see someone who was frightened to go out of the house... to see them being able to walk to the post office and back on their own and to choose to do it on their own one day without being prompted... that’s really fulfilling... you’ve done your job if you see that happening.’ (R8, STR worker)

‘It is a really lovely job... a worthwhile job, I go home on a night and I feel fulfilled... I have done jobs over the years, where I’ve gone home on a night thinking, “Oh dear”, you know... but this one I think, well I’ve earned my money I think I’ve made a difference.’ (R18, carer support worker)

While brief interventions workers did report instances of positive client outcomes and worker fulfilment, in general they were less clearly articulated and balanced against the concerns and cynicism already described. For socially focused workers, high levels of fulfilment and perceived value to the client were however pitted against *low* perceived status in the priorities of commissioners and policy makers. As already raised in Chapter 5 (Section 5.2.2), this was suggested to result in substantial funding and employment issues reported by workers in more socially focused roles. Perhaps reflective of the policy movement towards facilitation seen under *New Ways of Working* (DoH, 2005a; 2007), supporters in particular reported being constrained not by targets and outcome measures but by a lack of resources. High caseloads and small worker numbers were argued to go ‘against the grain’ (R2) of what the roles were supposed to do, by preventing workers from offering intensive support in times of crisis or to vulnerable groups such as young carers, or service users negotiating the hospital-community interface. Financial resources and access to role-related expenses also appeared

sparse, with carer support workers for example reporting paying for their own stamps to send letters to carers, and support worker R2 reporting that he could only take a client for a coffee if they could afford to pay for it themselves. A reported lack of internet or computer access for some workers added further symbols of perceived underlying low status, described by carer support worker R15 to 'devalue' the job:

'When we're told that... there's no budget for anything, which is really what we've been told not to spend any money at all, it limits what you can do... although people say they value the service you sometimes wonder... I think there is a hierarchy and we are very, very low... it does devalue the job... each time we ask for something and each time we're knocked back.'  
(R15, carer support worker)

For workers in long-term roles the relationship can therefore still be considered to be constrained at a wider level; not by the role itself but by a lack of resources.

### ***Section Summary***

This section has highlighted the perceived impact of the wider policy and political context on the worker-client relationship. For brief interventions roles it has been depicted as instrumental in creating the role constraints outlined in Section 6.2, through the existence of politically-embedded, intervention-level targets. For longer-term interventions, particularly supporter roles, a perceived lack of policy and political interest was illustrated to have had an opposite impact, creating perceived funding and resource issues. Thus, the wider policy and political context can be considered to hold potential constraints in both directions, with implications of both for workers and the worker-client relationship.

### **Chapter Summary**

Despite all workers in the current study holding a strong, shared caring motivation, the nature and perceived quality of the worker-client interaction

varied across job roles included in the study sample. This chapter explored shaping factors of the worker-client interaction at a number of levels including individual, role, team and the wider policy/political context. The biggest contrast observed in the current study related to role-level influences. Wide variation in the availability of time, accessibility and intervention-level flexibility was seen to shape the boundaries within which the therapeutic relationship could be built. These in turn were shown to be influenced by the constraints and freedoms generated by the wider policy and political context. Attention has also been drawn to the impact of professional pressures on the worker-client relationship, seen to occur *within* the workers' distinct, co-produced remit by impacting on client complexity and service suitability rather than tasks performed. Of significant importance throughout this chapter has been the degree of flexibility or discretion available to workers in order to tailor interventions to perceived client need.

In exploring the worker-client relationship, this chapter has illustrated it to be critical to understanding worker wellbeing, future plans and perceived client outcomes. A number of tensions have been highlighted related to the negotiation of this complex relationship, for example boundary maintenance for long-term roles or fitting a therapeutic service into thirty minute appointments for short-term facilitators. This has demonstrated a third key type of responsibility held by workers in addition to the role and personal responsibility introduced in Chapter 5. Described here as *inter-personal* responsibility, this refers to management of the emotional and interpersonal aspects of client work. In light of the highly complex negotiations presented here, the next and final results chapter examines worker preparation and support for the complexities of client work.

## **Chapter 7. Managing the Complexities of Client Work: Preparation and Workplace Support**

### **Introduction**

The opening results chapter illustrated high levels of lone working, professional distance and a reliance on communication outside of day-to-day client work. When combined with the tensions and challenges inherent in the worker-client interaction explored in Chapter 6, this raises questions around how workers are prepared and supported for the complexities and client work. This final results chapter explores variation in worker perceptions of preparation and support observed across the current study. The first section focuses on formal and informal worker preparation in the form of training, life and career experience and in doing so considers the extent to which emotional aspects of work are acknowledged at a management and policy level. Section 7.2 then examines workplace support structures, in light of wide observed variation across role, team and locality. Comparisons between positive and negative accounts are used to develop a conceptual model of factors illustrated to shape worker support.

### **7.1 Interpersonal Responsibility and Worker Preparation**

#### **7.1.1 *The Emotional Demands of Client Work***

The portrayal of the worker-client interaction presented in the previous results chapter illustrated it to be a complex process, often requiring the negotiation of issues such as dependency, boundary maintenance and the management of 'raw emotion' (R12, R15) within prescribed remit boundaries. Particularly for those delivering long-term interventions, worker fulfilment was described alongside high levels of emotional intensity. The psychologically demanding nature of the job was clearly visible in worker reports, with carer support workers R15 and R18 for example describing a team decision to limit the number of one-to-one sessions to a maximum of four per day, in order to prevent workers being 'soaked up'

(R18) by the work's intensity. While exacerbated by 'unofficial' levels of complexity described in Chapter 6, even appropriate referrals were described as highly demanding given the mental health issues and emotion with which they dealt. This was reported by a number of workers to lead to issues 'switching off' at the end of the working day; an element that can be conceptualised as another type of boundary maintenance between work life and home life. As can be seen in the following examples, workers across all role functions reported such difficulties:

'People can go to their nine-to-five job... and then close down the computer and go home again and not actually think about the clients that you've left but... [in this job] sometimes you've left somebody who's just taken an overdose... You learn how to cope... I don't think that I would ever not take work home with me in my head, but you have to learn not to – I mean you've got to go home to your own family and not sit worrying.' (R10, STR worker)

'There's... been days where I've went home and just my head's just been... completely overloaded... not having that opportunity to sort of talk about it... ' (R4, GMHW)

'You can't not take work home with you in this job.' (R27, support worker)

The data suggested the management of the emotional intensity and interpersonal negotiations involved in the worker-client relationship to rely on a host of complex skills. A number of long-term workers described a need for extensive preparation in order to 'switch character' (R2) between clients, as the type of interaction could vary greatly in terms of language used, acceptable behaviour and most effective way of working dependent on the triggers, behaviour and individual circumstances of each case. The time required for putting a case to one side and getting into role for the next was informally negotiated, usually taking place during the travel time from one appointment to the next. As demonstrated further in the following quotes, acknowledgement of the complex skills involved in the worker-client interaction at a policy and management level

was called into question by the data. In the first example, STR worker R12 articulated the skills required in negotiating the tension between personal protection and the need to build an authentic therapeutic relationship:

‘To have to always be weighing the person up in terms of, ‘What’s the worst that could happen here?’ ... to have to do that when actually you need to be empathic with people... I think that is our skill that we bring... to have that going on as the main plot but to have this sub-plot underneath it... now that is a thing that I think we are underpaid for, for those of us who are good at it.’ (R12, STR worker)

‘I don’t think people realise the complexity of the cases that we get in, or how hard it is to provide a therapeutic service with a forty minute assessment and twenty minute follow ups.’ (R5, graduate mental health worker)

The examples described here raise questions around the visibility and acknowledgement of the skills involved in the interpersonal negotiations that make up day-to-day client work, in time as well as pay for longer term roles. While the level of personal responsibility (i.e. risk management) was well acknowledged in job specifications, emotional aspects of responsibility appeared barely visible other than citing ‘emotional effort’ as a requirement (Site 1 STR worker job description). In comparison, the ‘realistic’ job specification developed by R6 and R7 as part of a pay re-banding campaign provided much more detail on the complexities involved in communication and relationship work. Skills specified included being able to deal with ‘complex and sensitive information’, being the first point of contact in times of service user crisis, making fast judgements about risk and the mental state of clients, and being able to modify interventions according to the degree of illness, motivation and level of understanding held by the service user. In addition, it stated that STR workers are ‘often exposed to intense, highly distressing and emotionally demanding situations’ (‘Realistic’ STR job description, Site 1).

The appraisal of interpersonal skills as a specific skills-set by the workers themselves also varied, with the data illustrating an interesting spectrum from the conceptualisation of support work as a 'common sense' approach, as seen in the quote below from support worker R27, through to more reflective considerations such as the earlier example from STR worker R12:

'I am not a clinician... I have come from a mining background and... a lot of it is just common sense, that's all it is common sense... obviously I have got the way that I speak to people and you know my approach to things... like I say you just need to listen to people sometimes.' (R27, outreach worker)

When discussing the process of switching character in order to remain 'on the same level' with different clients, STR worker R20 commented:

'You don't realise you're doing it at the time I mean you're just doing it, but I suppose it is a skill.' (R20, STR worker)

Variation in the appraisal of emotional role aspects as either common sense or as a specific skills-set was further seen in the level of preparation and support available to workers. The response to working with the complex issues presented during client work varied from enthusiasm to concern depending on perceived team 'back-up' (R1) and the level of confidence held by the worker that the specific level of complexity fell within their capabilities. The analysis of interview data suggested four key elements of worker preparation and support as protective factors for the complexities of day-to-day client work:

- Training
- Life/career experience
- Formal supervision structures
- Informal workplace support

The remainder of this chapter will explore observed variation across these different elements, by first examining variation in worker preparation and then outlining observed shaping factors of workplace support in Section 7.2.

### **7.1.2 Worker Preparation: Training and Life Experience**

#### **Formal Training Opportunities**

Worker preparation for day-to-day client work was made up of a combination of formal training, life experience and career experience. There were notable differences in the reported availability of formal training opportunities across the job roles included in the study sample, with a particular distinction between short-term facilitators and those employed in more socially-oriented roles. The two IAPT roles of psychological wellbeing practitioner (PWP) and high intensity worker featured intensive, university-based training courses which, despite some reported teething problems given the first year of implementation, were generally highly regarded. The use of role play scenarios and practitioner feedback to allow extensive practice of delivering therapeutic interventions were well received and considered a key advantage over the postgraduate certificate undertaken by the roles' GMHW predecessor.

Workers in all other roles however appeared to have less ready access to formal training opportunities. This was reported to be a major issue by stepping stone workers employed as graduate mental health workers (GMHWs), who tended to hold the least prior experience of caring roles<sup>28</sup>. For GMHWs, issues accessing the required postgraduate certificate were exacerbated by its disbandment following the planned introduction of the IAPT initiative, resulting in workers undertaking one-to-one interventions without any official preparation. Left to rely on an undergraduate psychology degree as their primary experience of mental health

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<sup>28</sup> See Section 4.1.4, page 115 for an overview of worker background and experience.

work, the concern this created for some workers was substantial and can be seen in the following transcript extracts:

‘I’ve... worked in post nearly a year... without the training... I’m just doing things and hoping that they work.’ (R4, GMHW)

‘Since I’ve come into the post I’ve had no training whatsoever, so that’s quite interesting because you’re basically reading text books and using your own ideas about how to treat someone... you’ve got supervision but at the end of the day... you’re delving into people’s minds and people’s problems and pasts... it’s not really good enough to say, well... you’ve got a degree you’re a competent individual just get on and do it... it needs specialist training and that’s been completely lacking... [a degree] is not training on how to unpack someone’s thoughts...’ (R16, GMHW)

In addition to the disappearance of the postgraduate certificate, GMHW R1 reported the access to ongoing development opportunities to be hindered by professional attitudes that ‘a monkey could do self-help’ (R1), which prevented the team from allowing her to access self-help training. This sentiment was echoed elsewhere by support and STR workers, with R2 reporting being at the ‘bottom of the pile’ (R2) as a support worker for training and development. STR worker R10 described that it had taken four years of ‘nagging’ (R10) before she was afforded the opportunity to undertake an NVQ (National Vocational Qualification) and that she had been refused access to training designed for professional workers. STR worker R8 described finding it ‘scary’ and ‘difficult’ upon starting the role without any mental health specific training, commenting:

‘I’m wondering if it’s... that it’s just common sense so they don’t think you need it...’ (R8, STR worker)

The lack of formal training opportunities were not shared by all workers; some - particularly carer support workers - reported more extensive access to courses such as family therapy and counselling skills. Key to the wide observed variation appeared to be management and team opinions towards the role and its requirement for training, with some managers reported to be enthusiastic and

others more ambivalent or negative. Service manager R25M suggested that professional staff often do not understand the extent to which their own boundaries have been shaped by the extensive experience and mentoring involved in professional training programmes, leaving them with an unrealistic outlook towards the abilities, needs and difficulties faced by NPA workers. The importance of professional attitudes to the availability of support will be considered further in Section 7.2.4 - Acceptance.

Feelings towards the importance of formal training also differed among the workers themselves and were linked to background and prior experience. Workers who had held a long term caring career and often had experience of ward-based mental health work tended to express some cynicism over the relevance of qualifications such as NVQs to day-to-day practice, questioning the extent to which the skills involved in motivational and supportive work could be formally taught. In comparison, life change and stepping stone workers tended to place more value on formal qualifications and were more likely to raise concerns where a lack of training opportunities were reported to exist.

The discussion of training for supporters and long-term facilitators was underpinned by a key area of tension around the link between training and career progression. As can be seen in the following quote from STR worker R7, for caring career workers in particular training was seen to hold limited value when it could not enhance career progression or increase the role's pay scale. When R7 discussed his decision not to undertake an NVQ he commented:

'We come in as a [Band] 3 and that's it, no matter what I do, no matter what training I do.' (R7, STR worker)

A large number of workers in long term roles described feeling stuck or having 'nowhere to go' (R12). For workers who were supported to undertake training for personal development reasons, a further tension appeared when they became

over-qualified for the job as a result and were then 'ripe' to move on (R21M). Particularly an issue for younger workers, this tension was intertwined with issues around low pay and can be seen in the following transcript extract:

'[Name STR worker] has come in... and she is fantastic at her job, and for her to progress she is doing a management qualification which I think is good, [but] it's not going to make any difference to her banding and with the experience that she has got she is primed for moving on to a better salary... it would be such a blow to the service if she does... but there are financial issues around, "I want to be able to get a mortgage... I don't really want to leave but I have to"... and that is what they do.' (R21M, STR manager)

### **Personal Experience**

For all roles outside the newly implemented IAPT programme, inconsistent training opportunities went alongside a high perceived reliance on past career or life experience as worker preparation for the complexities of client work. The importance of life experience can be seen in the following extract from STR worker R12's interview:

'We do motivational work with people but no one's ever sat down and taught us... any of the theories of how to do that, I mean... I've been a service user so I know what it's like to actually think, "How am I gonna make myself get up and face day one of the rest of my life and still take care of these children's needs?"... so I'll look round in my personal toolbox for what I can do... and I think everybody is doing that but we're not formally trained and maybe we don't necessarily give ourselves credit for that.' (R12, STR worker)

Worker use of their 'personal toolbox' of skills, whether created through life experience or a long term caring career, was clearly visible elsewhere. Workers asserted the importance of extensive practice and experience in being able to get into role for different clients, maintain professional boundaries and 'draw a line' (R2) at the end of the working day. Concerns were expressed by caring career interviewees for those coming in without prior experience of mental health work,

given that so many crucial skills were learned 'as you went along' (R8, STR worker). Linking to a much wider discussion over the relative merits of formal qualifications and past experience, some workers suggested that a minimum requirement for life experience, rather than educational attainment, should be written in to role specifications.

### ***Section Summary***

This section has provided an overview of the variation in worker preparation observed across the current study. In light of training opportunities that appeared inconsistent and largely dependent on team and management attitudes towards the need for NPA skills development, workers reported a heavy reliance on skills drawn from prior life or career experience. As outlined in the overview of worker background provided in Chapter 4 (Section 4.1.4), the extent and type of experience held by workers varied across the study sample. As such, stepping stone workers in particular appeared vulnerable in the face of unsuccessful attempts to access training, leading to a lack of confidence in their abilities to provide an effective service to clients.

In addition to initial preparation and prior experience, ongoing support for the complexities of client work took place both formally and informally as part of within-team support structures. The following section examines variation in the availability of support to workers.

## **7.2 Shaping Factors of Workplace Support**

Despite the autonomous nature of NPA co-production and high levels of professional distance illustrated in Chapter 6, co-worker relations emerged as a crucial aspect of working life; relied upon for supervision, informal guidance and support and the maintenance of an effective referral system. The following quote from GMHW R1 illustrates the importance of wider support networks, particularly for those without extensive career preparation:

'If you haven't done it before you don't know your own limitations, you don't know how much you have to put into each one... there aren't any simple cases... if you haven't done that before or haven't got a very supportive team around you it's very difficult to recognise the impact it's having on you.' (R1, GMHW)

One of the key observations that stood out in early interviews was that immediate team relations were expressed far more positively than I had anticipated based on the background literature, with workers commonly reporting feeling welcomed and supported by other team members. As data collection continued however the picture became increasingly complex, with a majority positive view sitting alongside a small number of exceptions and an increasing number of more mixed responses. Suggesting a strong influence of individual and contextual factors, the availability of support to workers appeared intertwined with personal relationships, co-worker attitudes and physical aspects of the working context. Initial field notes paid attention to the way in which a number of interviewees who reported positive working relations referred to themselves as feeling 'lucky' and had stories to tell of less fortunate NPA colleagues, or previous teams that were not perceived to have worked together so successfully. This can be seen in the following quotes from participants:

'I was really lucky I just happened to get [name of team/location]...and my team have been really good... very supportive...that's not been the experience elsewhere I mean my team's been quite unusual like that...' (R1, graduate mental health worker)

'We're lucky because it's a good team.' (R10, STR worker)

'We do tend –in this community mental health team anyway –to work quite closely together.' (R13, carer support worker)

Against a backdrop of mostly positive reports, a small number of cases stood out as illustrations of the negative side to the workers' story. Highlighting the potentially damaging effect of poor working relations on the availability of

support and subsequent worker outcomes, these cases resulted in workers seeking alternative employment, or in one case undergoing a period of long-term absence related to stress. Although these situations describe what may be termed 'exceptional' circumstances, by comparing them to positive and more mixed perspectives of team relations it became possible to explore key influences on the experience of working relations and workplace support.

### **7.2.1 Overview of Shaping Factors**

A comparative analysis across all workers at the individual, role, team and site level facilitated the identification of a number of influences on the overall level of support available to workers. They can be grouped into three key shaping factors:

- Accountability
- Accessibility
- Acceptance

Details of how these themes were constructed from the raw data can be found in Chapter 4: Data Collection and Analysis (Section 4.3.4, page 140), where they appear as an illustrative example of thematic development. Figure 7.1 provides a visual overview of the three shaping factors.

**Fig. 7.1 Overview of Shaping Factors of Worker Support**



As can be seen in Figure 7.1, a number of different aspects acted as potential facilitators or barriers to workers accessing effective support. *Accountability* refers to the level of formal accountability for worker wellbeing, for example in the existence of a workload moderator and official supervision structures. The theme of *accessibility* refers to how accessible informal support structures were perceived to be and is made up of both physical and individual factors. Individual aspects of accessibility were linked to the final theme of *acceptance*, which refers to co-worker perceptions and attitudes towards the NPA role and worker.

In general, positive worker experiences were associated with feeling supported, valued and accepted by co-workers (including colleagues, management and wider referrers), both on an individual level and in terms of the job role occupied, while negative experiences pointed to the absence of these things. Each key theme will now be examined in turn, considering the impact of the various factors on worker outcomes.

### **7.2.2 Accountability**

The first shaping factor of workplace support refers to the level of formal accountability for the NPA worker's workload and wellbeing, held at a management or supervisory level. In other words it refers to the extent to which workers reported having somebody 'looking out for them'. Given the lack of professional attachment and autonomous nature of co-production described in Chapter 5, accountability links were not always clearly defined in the current study. Two key, interrelated elements of accountability were visible in the data: caseload moderation and accountability for worker wellbeing.

#### **Existence of a Caseload Moderator**

The different team set-ups outlined in Chapter 4 (Section 4.1.3) highlighted variation in the referral process across role, team and site. Contact involved in the referral process ranged from face-to-face tripartite meetings between the worker, client and care coordinator followed by regular review meetings, shared electronic notes and a tripartite discharge meeting at the end of the intervention for the Site 2b uni-disciplinary STR team, through a more informal approach using verbal or telephone discussions for the majority of workers based in MDTs, to an entirely internet-based system for PWP's and high intensity workers. As such, psychological wellbeing practitioners and high intensity workers reported the most minimal amount of face-to-face or verbal contact during the referral process, due to the entire system from initial referral, referring onto other

workers and final discharge of the client being carried out within the IAPTUS computer database.

As a result, large differences were observed in the way NPA caseloads were moderated. The existence of a caseload moderator to protect and negotiate the NPA worker remit was most clearly defined for IAPT workers and those based in uni-disciplinary teams, where referrals and waiting lists were monitored by an administrative worker or by the team manager, thus acting as a gatekeeper for workers' caseloads.

For those based in multidisciplinary teams, the delegation process was often less formalised. As can be seen in the following examples, caseload moderation was more likely to take place on an individual, informal basis with the referring professional:

'Notionally there is a referral system to help people be allocated and prioritised which has *kind of* happened but a lot of the time it's just, "Oh, [name STR worker] I've got this bloke and he'd be interested in going down to the allotment," ... routinely it works more informally.' (R25M, service manager)

'Not a system... that's like official, there's bound to be some policy or other somewhere but it's basically just sort of common sense, they will say have you got time to spend and then I would check my diary for that week....' (R10, STR worker)

Whether formally structured or negotiated more casually between NPA worker and the rest of the team, the existence of a workload moderator arose as a central aspect of perceptions of effective support. For the majority of workers, caseload management also formed part of formal supervision structures whereby caseload size and worker capacity were formally discussed. These tactics emerged as central not just to prevent over-burdening in terms of numbers but also to reduce the rate of inappropriate referrals, which were exacerbated by the role clarity issues and aspects of unofficial use already discussed in Chapters 5 and 6.

The more informal methods of caseload moderation experienced by workers in multidisciplinary teams were often reported positively, however it is important to note that they relied heavily on the existence of effective communication channels between the worker and referring professionals. As such, they depended on workers feeling comfortable in discussing any concerns and being able to 'hand someone back', for example if they were considered too complex. The following quotes from GMHWs R1 and R3 depict situations where this was reported to work well:

'We always have a bit of a chat about it and if it sounded like... something that we weren't confident about we would... just say it then and there really before I met with the person...' (R3)

'I knew quite quickly that if I did have a problem, and I mean I have... referred people back and said, "Look I'm sorry... this has come up they're much more risky than it first appeared," or whatever, and either we've done something together... or I've just handed them back and said, "Right okay, they're going back to you for therapy," and it's never been a problem.' (R1, GMHW)

Amongst the majority picture of effective caseload moderation, a small number of exceptions highlighted its importance to worker wellbeing. When describing his situation leading up to a period of long-term absence related to stress, graduate mental health worker R16 reported an overwhelmingly high caseload resulting from perceived inefficiencies at a role management level. R16 reported holding a caseload of 35 clients with a further 35 people waiting, creating a 'pressured situation' that was not properly managed:

'The major problem was the lack of structure within management tied to the role... I had like two psychologists and six CPNs who I was answerable to and also two line managers... in a sense there was like ten bosses but no one was really taking care of us... there was no interface between me and the referrers... I went in one time and there was like eleven new referrals waiting for me.' (R16, GMHW)

As can be seen in the above quote, a lack of 'interface' between R16 and professional referrers was described as a result of the receipt of referrals from a number of different sources, without a single point of moderation. R16 described that although caseload management was a regular part of supervision, because he discussed different cases with different supervisors no one person was responsible for overseeing his entire workload. When talking about supervision he added:

'It was *there*, it just wasn't enough or wasn't structured properly, I don't know.' (R16, GMHW)

In this situation it seemed to fall to fellow graduate mental health workers to monitor the pressures faced by R16, however this was made difficult by workplace factors that will be considered further in the following Section 7.2.3. With GMHW colleague R1 described as R16's main point of contact, seeing her approximately once a week, a sense of personal responsibility for the situation was inferred during her own interview:

'We weren't seeing him enough to be able to... recognise the signs... I think if I'd seen his diary or something I would've known it was that bad... I think somebody did eventually sit down with him over there and just literally went through his diary and said, "For God's sake, you can't see this many people in a day" ...' (R1, GMHW)

A second key example of unsuccessful caseload moderation was reported by graduate mental health worker R3, as the reason behind her leaving a previous GMHW position in a neighbouring team. In this case, the *loss* of an effective caseload moderator arose when her immediate supervisor left and was not 'properly replaced', creating a largely unsupervised and rapidly increasing caseload. Although a supportive relationship was reported when her supervisor had been in place, upon his leaving R3 reported her caseload to increase to over 30 one-to-one clients and high numbers of inappropriate referrals:

'I started having to take on a lot more referrals than I should have... I pretty much ended up doing his job really at the end... I'd only been there like six months when that happened so I didn't really feel that confident then all of a sudden I'm getting all these patients...' (R3, GMHW)

In both exceptional cases described, a clear overarching issue was the lack of a clearly defined moderator for the worker's caseload. For R3, when her immediate supervisor left nobody else assumed accountability, while for R16 multiple referrers and line managers led to no one particular person holding responsibility for his role. This links back to the lack of professional attachment considered in Chapter 5 as a key element of co-production in the current context, and may also have been exacerbated by the personal characteristics of individual workers. As can be seen in the following quote, R16 suggested that his personal approach to the role may have had an influence on his resulting negative outcomes, by not making the team aware of him being unable to cope. Describing himself as a 'yes man', R16 referred to his enthusiasm for the job as his 'own undoing'. This highlights an issue that may be shared by other stepping stone workers hoping to follow a psychology career:

'I had a mentality of like, "I should be able to deal with this," ... especially when you want to get onto a clinical psychology course the field's so fiercely competitive that you're not going to be like, "Oh, I can't handle this," you want to get as much experience and put yourself out there as much as possible... a reputation of being able to work hard, being able to cope...' (R16, GMHW)

### **Accountability for Worker Wellbeing**

While the majority of workers in the current study reported caseload management to be an integral part of formal supervision structures, accountability for more emotional aspects of worker wellbeing appeared more varied and were often informally negotiated. Given the requirement for hindsight support as a key feature of community co-production, outside of the

referral system formal contact opportunities with co-workers were limited to team meetings and formal supervision structures.

Team meetings were generally described as an information session, with a number of regular 'formalities' including child protection, infection control and health and safety, alongside factual content relating to any organisational or service changes relevant to the team. Perceived relevance to a worker's day-to-day practice was linked to both team size and meeting focus. Smaller teams and those with a uni-disciplinary focus were suggested to provide a source of peer support whereas larger meetings, or those which bridged primary and secondary care, were reported to take a more strictly informative approach. As such they were associated with fewer opportunities to raise any personal or role-specific issues. This contrast can be seen in the quotes below, which compare how STR worker R11 (part of a uni-disciplinary STR team) and R33 (part of the 35-strong primary care team in Site 2b) described the content of team meetings:

'Anything that's got to be discussed gets put on the agenda and at the very end if anybody's got any issues, cos... sometimes you get a client where you've gone down every avenue and you're struggling to think of something else to try... if anybody's got anything like that to bring up we do... because one person could think of something that you haven't so.'  
(R11, STR worker)

In comparison, R33 described a more strictly informative approach:

'It's more a factual kind of setting so, "This is what's going on, this is what we need to change," things like that... a bit of scope for people to put other views across but. I think because we're such a big team... it's hard to keep it quite structured if we have all got a view, an opinion on something... so it is much more an informative kind of session than anything.'  
(R33, high intensity worker)

In some larger teams this was combated by introducing separate role or sector specific meetings, reported to be held monthly in addition to the main team meeting to provide smaller forums for information sharing.

The level and nature of formal supervision structures also varied widely across role, team and site with a marked difference between the type of provision for long term roles and those with a more clinical, short-term facilitation focus. The majority of the study sample conveyed satisfaction with the amount of supervision available, reporting formal supervision with at least one professional team member (or senior NPA worker in uni-disciplinary teams) taking place on an approximately monthly basis. The exceptions to this were four rural Site 1 workers; STR worker R10, carer support worker R19, support worker R2 and GMHW R17 who explained that regular supervision existed 'in theory' (R10) but that in reality team pressures were such that it was often replaced by more informal, ad hoc arrangements:

'We normally try (laughs) and meet up every six weeks, or something like that. It doesn't always happen... but to be honest if anything comes up, I just ask people anyway, do you know what I mean?' (R19, carer support worker)

While STR and support workers were more likely to report inconsistent access to formal supervision structures, the content of supervision itself was positively appraised. Workers tended to report an informal, person-centred focus with attention paid for example to any difficulties with clients and emotional aspects of worker wellbeing. A holistic approach can be seen in the following description of supervision from STR worker R10:

'We talk about my case load, me, my job if I've got any problems... goals, objectives and stuff like that.' (R10, STR worker)

In contrast to the picture for long-term roles, while short-term facilitators reported the largest amount of supervision, being pleasantly surprised for example by the level of attention to career development and training needs (R32), opinions of the *content* of supervision itself showed a more mixed picture. Despite workers reporting extensive attention to therapy techniques, personal

development and caseload management, some interviewees raised concerns about a perceived lack of consideration of the emotional aspects of client work. The observed tension primarily surrounded the use of case management as the primary, most regular form of worker supervision; a structured approach that involved overviewing progress and outcomes on a case-by-case basis, spending a few minutes on each. As can be seen in the following quote from R28, this elicited strong feelings from some workers due to its lack of accountability for wider aspects of worker wellbeing:

‘It’s a vile, vile way of supervising... there’s nothing about what’s going on for you and how you’re managing, how you’re coping or if you’ve got any problems. It’s very, very mechanical... But that is what this job is meant to be so.’ (R28, psychological wellbeing practitioner)

A point of contrast can therefore be drawn between longer-term, more socially-focused roles where formal supervision was often less consistent but more person-centred in approach, compared to short-term facilitator roles for whom supervision was more frequent and more formally recognised but perceived by some to lack attention to the more emotional aspects of work. Shared by workers across all roles were reports that a large proportion of support to address the complexities of client work was *informally* negotiated, outside of client work and formal communication structures. As such it depended heavily on individual and contextual factors such as workplace set-up, personality and co-worker perceptions of the role. The following section considers variation in the perceived accessibility of informal support networks.

### **7.2.3 Accessibility**

The theme of *accessibility* refers to the degree to which NPA workers felt able to access co-workers for support, advice or knowledge. The available data pointed to a high reliance on informally negotiated interactions as a key source of advice and peer support. Some opportunities were created at a team level, such as

meeting for lunch once a week for some rural teams, however the majority of informal contact points were reported to either have occurred naturally through chance meetings and 'bumping into' people, or to have been engineered by the workers themselves. Worker created opportunities included telephoning co-workers for advice, 'hanging around' (R1) outside their office or meeting socially outside of work in the case of peer support from NPA colleagues.

The reliance on informal communication mirrors Spilsbury and Meyer's (2004a) observation of the informal negotiations that take place between hospital-based HCAs and registered nurses. In the current working context it resulted in a highly variable situation for workers, with opportunities for informal contact less likely to occur naturally and heavily dependent on physical workplace factors and the presence of strong personal relationships with co-workers.

### **Physical Accessibility**

The importance of physical workplace factors to the accessibility of support is visible in the following quote from graduate mental health worker R4, as she described when she would tend to see other team members:

'It'll just be sort of whenever people float in and out between their sessions in the surgeries... so if you happen to be around when people are floating...'  
(R4, GMHW)

The reference to accessing contact 'if you happen to be around' sums up its potentially variable nature, suggesting that being in the right place at the right time to be vital in gaining support from co-workers. Practical, workplace aspects were observed as both facilitators and major potential barriers to this, with team dispersion interpreted as particularly important. Co-located teams with one shared base were associated with high co-worker accessibility, as can be inferred from the following positive accounts of team working from co-located NPA workers:

'I'm lucky in the fact that our team door's always open, the manager's there and you can just go knock on his door and say, "Can you help me out with this?"' (R6, STR worker)

'We're all knocking about all the time so... everybody's approachable and really helpful...' (R19, carer support worker)

'They will come and knock on the door and say, "I am not sure about this what do you think?" It might be a risk issue or it might be a client who is being difficult to engage with or whatever...' (R21, STR manager)

In general, workers based in co-located teams reported their position within that team more positively, reported easier communication and a generally more supportive working environment. Co-location was also expressed to help reduce issues around role clarity and worker visibility considered in Chapter 5. Those who had experienced both co-location and dispersion from referring professionals tended to describe difficulties associated with the latter set-up. High intensity worker R33 for example had moved from a role whereby she was co-located within a GP surgery to her current post where she was located separately to referrers. The referral relationship was now described to be 'at a distance':

'I'm not used to working like this, you can't just phone a GP up and say, "Well I have seen this client that you referred... what do you think if we were to do this?" ... I personally miss those links because it makes the job easier I think to have them.' (R33, high intensity worker)

STR manager R25M suggested co-location to be crucial to the informal 'mentoring and modelling' networks upon which the team's NPA workers relied for support, particularly in dealing with interpersonal issues such as boundary maintenance. Workers who were not co-located alongside other team members, or shared a number of bases rather than just one, were more likely to report difficulties integrating into the team and were less likely to talk positively about aspects such as team cohesion or relations. GMHW R16 described physical

barriers as a key reason behind reported isolation from both professional and non-professional workers, leading up to his period of long-term absence. Given the geographically large, rural locality, the team was dispersed across three different bases. The team building in which R16 was based was described as 'transient' and a 'stopping point', with the team manager visiting once a fortnight while other workers popped in occasionally between community-based appointments:

'You just don't see people... which was basically it you know, no one's in the same place for any given length of time which means you can't really build up a team atmosphere or anything...' (R16, GMHW)

This can be compared for example to neighbouring graduate worker R1's physical team set-up. While R16's team relied on meeting for lunch once a week as a key point of contact, R1 reported more ready-made opportunities due to the use of one shared base. This was perceived to allow 'much more' face to face contact and the ability to 'pop next door' to her supervisor's office when she needed advice:

'It makes such a difference working as a team as opposed to individually...'  
(R1, GMHW)

Other examples illustrated the way that perceived isolation could arise from a lack of shared focus between NPA worker and the rest of the team. When describing the motivation behind leaving her previous GMHW role, R3 described similar feelings of isolation to R16. It was created however not through absolute separation from co-workers but from the majority of interactions taking place with secondary care workers, while her only primary care colleague was out at surgeries all day. R3 compared this to her current, large primary care team where she perceived high levels of support and positive team relations:

'It's much better... you feel part of the team, whereas I didn't really before I just felt like a tag on.' (R3, GMHW)

Similarly, carer support worker R13 reported isolation as a result of working with a different client group to professional team members, which was suggested to impact on the availability of support:

‘It can be quite isolating because you’re the only person here that does that job... if you want to kind of check something out with somebody, you’re not on the opposite side to the care manager but sometimes there can be a conflict between what the carer wants and what the care manager perceives that the client needs.’ (R13, carer support worker)

Those located at a distance from professionals often reported a reliance on NPA colleagues for peer support, however such opportunities were subject to the same dependency on physical workplace factors. Co-location in one base, as seen for uni-disciplinary NPA teams, increased levels of informal contact at the start and end of the working day as well as between client appointments, allowing workers to ‘get help from each other’ (R11, STR worker). When NPA co-workers were dispersed across a number of bases however, informal contact became heavily dictated by logistical aspects such as room bookings, worker numbers and working hours for part-time workers. PWPs and high intensity workers benefited from some engineered contact opportunities including peer supervision sessions and the shared training course, which were reported to facilitate forming bonds and friendships with other workers both within and outside the immediate team.

The importance of NPA worker numbers to the accessibility of peer support can be seen in the following quote from graduate mental health worker R5:

‘I suppose the supportive capacity... it’s good that there are six of us and I think it’s going to be quite challenging when the other four move on [to IAPT posts].’ (R5, GMHW)

In general, those who did not work directly alongside other NPA workers reported notably few contact opportunities. For carer support and CDW roles attempts had been made to set up monthly regional networks to facilitate

information sharing and mutual support, and were described as 'very positive' (R14) by workers. For STR workers, a national conference had been held shortly after the role's introduction and was expressed to have provided a valuable opportunity for networking and sharing best practice, however manager R21M reported that no external funding existed to repeat such meetings. At the more extreme end of worker reports, support worker R2 described that he had not come into contact with another support worker in the two years he had been in post, citing the 'sheer volume of work' as a barrier to seeking out opportunities to meet other workers:

'I would like to have the time...' (R2, support worker - unrecorded interview notes)

### **Individual Aspects of Accessibility**

Physical workplace aspects have been illustrated to significantly impact upon the perceived ability of workers to access co-workers for advice and support. It is important to note however that workplace factors were not the only influence on perceptions of accessibility. Many interviewees expressed co-worker accessibility in terms of individual characteristics, personality traits and attitudes such as 'approachable', 'accessible', 'open' and 'welcoming'. Individual accessibility can be seen for example in STR worker R10's interpretation of her team situation following the retirement of her immediate supervisor:

'I did feel very much that I was working on my own, but the support of the team was fantastic. I just had to make a phone call or grab somebody... I've never felt that I'm out there with nobody...' (R10, STR worker)

Similarly, GMHW R5 described her integration into the primary care team:

'Everyone's been... welcoming and open so if you've got questions or you're not sure it's been quite an easy team to ask and say, "Well actually I'm not quite sure what that means" ... to be honest I've been really surprised at how quickly and easily I've settled here...' (R5, graduate mental health worker)

Despite the lack of formal contact during day-to-day tasks, most interviewees reported feeling well supported and able to ask professional team members for advice through open, accessible lines of communication. In the majority of worker reports, this was accompanied by a notable lack of suggestion of the kind of professional-NPA hierarchy that has been illustrated in other research contexts, as can be inferred for example from the following quotes:

‘Superb team’, gets on well with all of them... Two of the care managers are newly qualified consultant psychiatrists –gets on well with both, fully supportive of his role, feels that they take his opinions on board. (R2, support worker - unrecorded interview notes)

‘If I was concerned about a particular client and the client’s care coordinator wasn’t there... the psychiatrist’s quite happy for me to go along and see her.’ (R6, STR worker)

Accessibility therefore can be construed both in physical and individual terms. Co-location was suggested to facilitate physical access and strength of team atmosphere, while an accessible, open attitude on behalf of co-workers also appeared crucial to workers feeling able to access support structures. Individual aspects of accessibility were largely contingent on perceived levels of *acceptance* by colleagues, which leads to discussion of the final shaping factor of workplace support.

#### **7.2.4 Acceptance**

Acceptance refers to the degree to which the NPA worker felt accepted as a valued member of the team, both on an individual level and in terms of the role occupied. The analysis of worker reports suggested acceptance to be influenced by three key aspects:

- Co-worker perceptions of role value/usefulness
- Wider inferences/connotations attached to the role
- Individual/personality characteristics

### **Co-Worker Perceptions of Role Value**

Enthusiasm towards the specific NPA roles and perceptions of their value, both at a management level and from professional co-workers, arose as central to NPA perceptions of acceptance and varied across the study sample. For long term roles that shared a client group with professional colleagues (support and STR workers), workers reported a clear positive impact on professional practice. This can be seen in the following interview responses:

‘If they lost the STR worker... it would cause a lot of anxieties because... they wouldn’t be able to do what I do. They just haven’t got the time... So they do value it very much.’ (R10, STR worker)

‘When there’s a possible relapse, it’s very much up to the STR worker because we’re having so much contact... somebody might start avoiding us, not answering the door... [other team members] very much value our opinion because we get to know them so well... we have such a good relationship with the clients they tend to trust us...’ (R6, STR worker)

Alongside widespread reports of positive feedback from care coordinators, high levels of perceived value were also supported during manager interviews. STR manager R25M for example commented that he had found the time to take part, despite being incredibly busy, because he considered the roles to be such an important service component. Echoing the worker quotes above, this value was reported to stem from the time available to workers and their ‘good judgement’ in reading subtle signs and changes in behaviour. Similarly, CMHT manager R22M commented that the interview had been useful to reflect on just how valuable the teams’ carer support worker and support worker were to the service.

For other roles however, where workers held a distinct client group or a highly bounded remit, co-worker perceptions of role value were less clearly asserted. Instead the data pointed to a blend of positive and negative outcomes for colleagues. This can be seen for example in the following quote from carer

support worker R13, which suggests the benefits of information sharing to be balanced against the additional paperwork created by the role:

‘The information I can give the care manager can give a fuller picture of the situation... which in theory should benefit the clients as well... [but] care managers have quite a high workload anyway and it can be extra work for them really... it’s the paperwork side of it... so it is a two way thing but I think there is a bit of a negative impact there as well.’ (R13, carer support worker)

This links back to the requirement for professionals to change their working practice, which was illustrated in Chapter 5 (Section 5.1.4) to be more salient for roles that worked with a specialist client group. Across the study sample, Site 1 GMHWs reported the lowest co-worker value perceptions. A lack of professional enthusiasm for the role is clearly visible in the following extract from manager R22M’s interview, which weighs the role’s Band 5 salary against their remit constraints. This was suggested as the reason behind the seven original posts having reduced to three:

‘They gradually just weaned it all off... there wasn’t the need I think... they were operating as Band 5s but there were limits to what they could do... this is a *personal* opinion, I don’t think that they were operationally as successful as what they were supposed to be... and I thought that they were an expensive resource as such... and I think the expectations of the primary care nurses were a little bit higher than maybes what they could do... It was never really clear what their functions were... I just think it was very confusing for everybody... there were such a lot of changes going on within [name of NHS Trust].’ (R22M, CMHT manager)

The above quote highlights a number of intertwined influences on perceived role value, including perceived demand, cost-efficiency and role clarity in the face of extensive service change. R22M described that as the posts became vacant, the funding was diverted into other parts of the service. This can be compared for example to the Site 2a GMHW team. Although the team manager was unavailable for interview, at the time of study additional GMHWs were

continuing to be recruited despite the recent introduction of the IAPT initiative, which may provide an anecdotal indication of higher value placed on the role at a management level.

In contrast to the positive views of working relations expressed by Site 2a GMHWs (R3, R4 and R5), the outlook was less positive for the three remaining Site 1 workers (R1, R16 and R17). Previous workers were described to have left because they had 'completely had it' (R17) with a lack of support and resistance from professional workers. The three remaining workers expressed a fairly ambiguous appraisal of their own role value. Although R1 did express supportive working relationships within her team, she also commented that they didn't 'see the point' of her. As can be seen in the following extract from R16's interview, this may have been linked to the role's minimal impact on professional caseload pressures:

'I don't think it's made a massive impact... if you think about it logically it couldn't really do because... the resource is just so little, even when I was working 5 days a week... if you've got referrals from six CPNs you're only going to ease the burden slightly on each one.' (R16, GMHW)

The situation appeared to have been made more complex by the introduction of targets for CPN levels of face-to-face client time, reported to have made professional team members 'self-conscious' (R1) about their own caseloads. In addition, a lack of long-term value perceptions may have arisen from the high number of GMHWs who had left their posts. This was reported to have made professional team members reluctant to supervise or mentor graduate workers, as the level of work involved was not rewarded:

'They've seen graduates come and go so they're reticent to... sink anything into it or believe that you will be around for any length of time cos no, you'll be sodding off to clinical psychology course or something, like the last bunch of graduates did... "We can't rely on you, we don't know how long you're going to be around"...' (R16, GMHW)

### **Wider Connotations Attached to the NPA Roles**

The acceptance of NPA workers into existing teams was also linked in some cases to wider connotations attached to their role. The lack of boundary blurring and distinct NPA and professional remits illustrated in Chapter 5 could be predicted to result in lower perceived threat or professional resistance than has been illustrated in other contexts. While interviews with workers in the vast majority of roles supported this assumption, noted in the absence of tensions raised in relation to this topic, a key exception was seen in the perceived relationship between graduate mental health workers (GMHW) and community psychiatric nurses (CPNs).

Tensions around professional team members, particularly CPNs, feeling threatened by the GMHW role were reported to varying extents by five of the six GMHWs interviewed, although it was considerably more prominent in interviews with workers in rural Site 1. Interestingly, in all cases it was attributed not to remit overlap or immediate boundary blurring - as seen in the wider literature - but to *wider* connotations attached to the workers' psychology degree background. A perceived tension between psychology and nursing can be seen in the following examples:

'They have quite a paranoid view of psychology, which has been proven to be right really that psychology is trying to take over the world... I don't think it is necessarily a bad thing but... I suppose their point of view is that they feel like nursing is being marginalised...' (R1, GMHW)

'There's a bit of a divide between us and the primary care workers... people sometimes even refer to us as 'The Band 5s' and they're 'The Band 6s'... You sometimes get the impression that... they might be threatened by our role...' (R3, GMHW)

This situation, described as a 'medieval us-and-them attitude' (R16) rather than team working, provided a key exception to the lack of perceived hierarchy inferred elsewhere. Perceived threat seemed to be mediated by individual

characteristics of both the worker and professional team members. R1, who reported more positive team relations than the other Site 1 GMHWs, described herself as having 'a foot in both camps' between psychology and nursing, due to a long background as a hospital-based support worker. This can be compared for example to R16 and R17 who held previous experience primarily in psychology assistant or clinical roles, and highlights the importance of worker background in negotiating tensions with co-workers:

'I remember one girl who worked in [name of location] was introduced as, "This is the girl with all the psychology degrees," ... they came across as very intimidated, whereas I think because I worked, for so long as well, as a support worker... I knew a bit more about how wards worked and how nurses worked...' (R1, GMHW)

In addition to her support work background, R1 also attributed her more positive experience to differences in the confidence of professional team members, which in turn was perceived to be linked to geography and turnover. R1 suggested that because the CPNs in her team were highly confident in their own practice, they were more open to supporting her development. In contrast, she described other teams in Site 1 as far less confident in their abilities, partly because their rural location meant that they were not used to supporting student nurses or other trainees. This lack of experience was considered to have left teams feeling 'like people were checking up on them' (R1) through the introduction of the GMHW role, which in turn created resistance and a 'blank' attitude towards the idea of providing help or support. GMHW R17 described the impact to have gone further, reporting professional team members to have made a 'show' of giving her inappropriately complex clients only to say the work was easy when she sought advice. Reporting very poor working relations in general, and a loss of self-confidence in her own abilities following the experience, she commented:

'I don't know if it was about me, or about the role, or about making themselves look superior... Given a choice I wouldn't go back to it.' (R17, GMHW - unrecorded interview notes)

In contrast, for R1 CPN confidence in their own role was perceived to have prevented them from attributing wider concerns to her as an individual:

'They knew that these new roles brought in other things, you know that things were gonna change... the difference was my team were quite apprehensive about what the new roles might mean but they didn't attribute any of it to me... I was lucky like that whereas the rest of them were seen as... part of the threat really.' (R1, GMHW)

Despite R1 reporting a positive, supportive relationship with professional members of her team, she nevertheless suggested that they saw her as a 'cut-price CPN', a 'cheap way of pushing CPNs out the door' and a 'CPN secret', kept in the back room. The conceptualisation of NPA workers as a symbol of wider, unwanted change was hinted at - albeit to a lesser extent - in interview discussions with other roles. Early tensions upon role implementation described by IAPT workers and carer support worker R19 linked teething problems to the 'unsettled' and 'insecure' (R19) teams into which they were being introduced, as the existing workforce dealt with the repercussions of rapid, widespread and continuous change.

The data appears to suggest therefore that despite workers performing a distinct, co-produced remit, in a small number of cases the availability of support was perceived to have been negatively impacted by professional resistance; not to immediate threat of boundary encroachment but to wider, unwanted change of which the NPA workers were a symbol.

### **Individual Differences and Acceptance**

In addition to team confidence, perceived acceptance was reported to vary between individual co-workers according to personal attitudes and personality

factors. Thus it is important to note that even amongst the potential tensions and worries already described, not all professionals were perceived to hold a negative view of the GMHW role. This can be seen for example in R3's comment when discussing primary care workers being threatened by the role:

'I mean not everybody, some people are really, really positive about us and see us as a really good resource...' (R3, GMHW)

A more positive professional perspective seemed to be linked to those who were considered to be creative, forward-thinking and not heavily influenced by structured, ward-based ideas around professional and NPA roles. Site 1's STR manager R25M for example described a particularly strong, supportive relationship between one CPN and the team's STR workers due to her own 'creative' outlook. Described as an 'outside-the-box thinker' which allowed the role to be used to its full potential, this CPN was compared to the 'what can you do for me' (R25M) ward mentality of what a support worker should do.

Graduate mental health worker R17 reported a similar situation. While she described team relationships in predominantly negative terms, one CPN stood out as reportedly viewing the GMHW role very positively, leading to appropriate referrals and a supportive working relationship. She was also reported to 'stick up' for R17 in team meetings, before she left the post due to retirement. R17 reported strong feelings that all teams worked 'completely differently', even within a fairly small geographical area, and that the outcomes for team working relied heavily on individual staff personalities and attitudes. This was supported by more positive examples of team working which were often attributed to the individual personalities of team members.

Personality traits of the workers themselves also appeared to be important in building supportive working relationships. This can be seen for example in the

following transcript extract, where R16 described personality as a key reason behind colleague R1's closer relationship with her team:

'I can't be arsed... just putting all that effort in and not getting anything back... she's [R1] people warm to her and she's a great lass... It's kind of effortless for her... whereas for me... it felt a bit authoritarian and I don't really, I don't take to that... so I think probably personality issues within the team were as much a fact as the fact that we weren't in the same place at the same time...' (R16, GMHW)

As already raised in Section 7.2.2, R16's personal approach to the job as a 'yes man' may also have played a part in his perceived lack of support structure. The combined importance of personal characteristics of both professional team members and the individual NPA worker were summed up in responses from R1 and R17 when describing the negative outcomes experienced by their GMHW colleague. Highlighting the importance of NPA worker assertiveness and team understanding, they commented on his long-term absence:

'I would've been the same [as R16] except that my lot were so sympathetic...' (R1, GMHW)

Would have been the same as R16 except that she refused to take so much on. (R17, GMHW - unrecorded interview notes)

As can be seen in the above quotes, personal characteristics of both team members and the individual NPA worker can be seen to impact on worker outcomes. Role acceptance, illustrated here as central to the availability of effective support, can be considered as a trade-off between what professionals are perceived to gain from the role (i.e. role value) and what they are perceived to lose in terms of workload or threat to identity, mediated by personal characteristics of both stakeholders.

## Chapter Summary

Results Chapter 6 placed the worker-client relationship as a missing piece of the jigsaw in relation to much of the academic discussion surrounding NPA roles in healthcare. This final results chapter examined the perceived level of preparation and support available to workers, particularly in relation to the complexities of client work. Section 7.1 began by examining variation in the acknowledgement of interpersonal responsibility, both at a management and policy level and by the workers themselves. In doing so, worker-client relations have been suggested to require a social and emotional 'toolkit' of specialist skills which many workers perceive are not fully acknowledged and can not be directly taught. A subsequent consideration of formal and informal worker preparation highlighted a reliance on life and career experience for many workers, alongside workplace support structures that were largely informally negotiated.

Given their informal nature, workplace support structures were seen to be heavily influenced by individual and workplace factors and as such varied widely across the study sample. In light of this high variation, Section 7.2 provided an in-depth exploration of factors observed to shape worker support in the current study. While working relations were generally reported far more positively than I had expected to find, a small number of negative cases allowed an examination of key influences on workplace support. The three central factors presented highlighted the importance of formal *accountability* for worker wellbeing, physical and individual forms of co-worker *accessibility*, and *acceptance* of the NPA worker as a valued team member, both on a personal and a role-based level. While worker acceptance was influenced in some cases by traditional sociological concepts of threat and resistance, it was limited to specific circumstances and, where it did occur, was attributed to wider connotations attached to the roles rather than immediate fear of boundary encroachment. Providing a point of departure from studies elsewhere, the current findings will

be positioned within existing sociological literature as the starting point for discussion in Chapter 8, which explores implications of the current study for researchers and policy makers.

## Chapter 8. Discussion and Conclusions

### Introduction

The literature review chapter illustrated a dearth of existing knowledge related to the non-professionally affiliated (NPA) healthcare workforce. A particular knowledge gap was highlighted in relation to those positioned outside of clinical settings and specific to mental health care. Academic considerations have historically focused on the NPA-professional relationship and while recent developments have called for a more subjective approach, the discussion has remained rooted in a professionally oriented discourse and confined to settings where a recognisably traditional relationship exists (e.g. Spilsbury and Meyer, 2004a, 2004b; Kessler et al., 2006, 2007; Bach et al., 2007, 2008). In response to these limitations the aim of the current study was to undertake a holistic exploration of the subjective NPA worker experience, within the novel research context of community mental health care.

In contrast to the picture painted elsewhere, the findings presented here have depicted a working life characterised by professional distance rather than professional proximity and in which other relationships - particularly the relationship to the client - and other aspects of working life emerge as central to worker experience. The key contributions of the current study are as follows:

- Situating the NPA-professional relationship, and sociological concepts underlying it, firmly within the wider NPA worker experience alongside other relationships, individual and contextual factors.
- Advancing recent theoretical developments by expanding the knowledge base on NPA 'co-production' (Kessler et al., 2007) and using the community service setting to extend our understanding of contextual influences on worker experience.

- Positioning the worker-client relationship as central to worker experience and advancing the literature on emotional labour by providing an in-depth exploration of how the relationship is shaped, its importance to workers and the complex negotiations it requires.
- Providing a detailed consideration of how less visible aspects of NPA worker role - particularly the emotional and personal aspects described here as *interpersonal responsibility* - are acknowledged and supported through training, supervision and informal peer support.
- Advancing our understanding of how NPA worker wellbeing and effective working relationships can be nurtured at a management and policy level.

This final chapter reflects on the findings and considers implications for both researchers and policy makers. The first three sections position the findings within the relevant academic literature overviewed in Chapter 2, starting with traditional NPA theory and moving on to highlight its contribution to recent definitional approaches and finally to considerations of the client relationship. Section 8.4 then briefly summarises the study's implications for policy and the management of NPA workers in the community mental health context, before the final section outlines limitations, conclusions and directions for future research.

## **8.1 Implications for Traditional Theory: Sociology of the Professions**

Chapter 2 highlighted a number of criticisms of the sociology of the professions' consideration of the NPA workforce. In particular, its confinement to hospital wards and lack of attention to contextual factors has been argued to leave it outdated in the face of the modernised health care system (Davies, 2003; Kessler et al., 2007; Bach et al., 2008). Recent theoretical developments have moved away from sociological approaches in favour of organisational theory such as Braverman's (1974) Labour Process Theory, albeit retaining the NPA-professional

relationship as the central focus (e.g. Kessler et al., 2006; 2007; Bach et al., 2007; 2008).

Concepts of threat, resistance and NPA-professional conflict, while commonplace in traditional NPA discussion, have been illustrated in the current study as one relatively small component of the overall worker experience. That said, while such conflict rarely materialised in discussions with workers, when it was reported it appeared to hold significant implications for worker support and the maintenance of an appropriate referral system. As such it may be more useful to consider how concepts of threat may be changing and developing within the wider context, rather than moving away from traditional theory altogether.

### **8.1.1 *Threat, Resistance and Wider Change***

‘They knew that these roles brought in other things... that things were gonna change.’ (R1, GMHW)

The lack of reported conflict by the majority of workers in the current study does not necessarily support the call to move away from traditional NPA theory. The co-productive nature of client work and lack of boundary blurring observed here would be predicted to create less NPA-professional conflict than relationships based on encroachment, if we consider the findings in relation to the jurisdictional disputes involved in protecting the professional project (Larson, 1977; Abbott, 1988). Professionals could be argued to have much less to fear from NPA co-producers than those performing a relief or substitute role.

Interestingly, where resistance was reported in the current study, it was attributed not to immediate fear of encroachment on professionally ‘owned’ tasks or role boundaries but to much wider uncertainties about shifting policies and service change. Worker perceptions of professionals feeling threatened were limited to one specific role, the graduate mental health worker (GMHW), and to one key professional group - mental health nursing. Tensions were attributed to

fears about the growing dominance of psychology and what this could mean for the long-term future of mental health nursing, with the newly introduced workers serving as a symbol of wider, unwanted change. As illustrated in Sections 2.1.3 and 2.3.2 of the literature review chapter, tensions between psychology and existing professions - particularly nursing and psychiatry - have been described elsewhere (Pilgrim and Rogers, 2001; Craddock et al., 2008; McCrae et al., 2008).

It was too early to tell in the current study whether IAPT workers will experience similar levels of resistance to that reported by their GMHW predecessors; at the time of fieldwork workers had recently completed their training and had so far encountered only limited contact with professional team members. Whether the recent government investment of £400 million into the IAPT initiative (DoH, 2011b) will increase these tensions also remains to be seen. Interestingly, the 'shifting discourse' towards detection and treatment of mild mental health problems was identified by Rogers and Pilgrim as early as 2001, who described it as a potential jurisdictional tactic:

'It is not clear at the time of writing how far this psychiatrisation of hitherto everyday distress will be taken. Policy questions are raised by this enthusiasm for detection, which may, in part, be seen as an attempt to find a new role for professionals such as psychiatrists whose traditional roles are changing and being challenged by other stakeholders.' (2001: 172-3)

While it appears to have been psychology, not psychiatry that has benefited from the recent movement towards wellbeing, the surge in brief psychological interventions can therefore be conceptualised as part of psychology's bid to 'take over the world' (R1). Extensive funding and employment problems reported by workers in socially focused NPA roles may lend further support to the suggestion that policy priorities are becoming increasingly orientated towards psychological rather than social interventions. What this means for existing occupations, both professional and NPA, remains to be seen.

‘You can kind of see where they’re coming from... we’ll see what happens with all these changes coming in, if all these worries come true.’ (R1, GMHW)

### **8.1.2 Teamworking and Workforce-NHS Conflict**

The theme of wider change uncertainty arose strongly in the current study. While conflict between NPA workers and professional colleagues did not emerge to the extent anticipated, perceptions of a major source of shared conflict appeared between the workforce as a whole and the bureaucratic, target-driven nature of the modernised NHS. A shared loss of faith in the mental health system and distrust of ‘managerial solutions’ to interprofessional challenges has been discussed elsewhere (Norman and Peck, 1999: 221), yet considerations of teamworking in mental health seem to have remained strongly rooted in the examination of inequalities and disagreements between occupations.

The current study adds to the emerging literature which suggests a more positive picture of teamworking itself in community mental health. Many cases of high team cohesion and positive, supportive working relationships were reported from the NPA perspective, albeit alongside a small number of negative experiences. The importance of team members feeling confident in their own role and having a clear understanding of the role of others, and the importance of time and preparation in building such a working environment, have all been illustrated here and support other authors (e.g. Molyneux, 2001; Nancarrow, 2004; Hudson, 2007). Co-location and face-to-face-contact in particular have been illustrated as a crucial component of building a positive team atmosphere and effective communication networks, supporting long-standing discussions elsewhere (e.g. Pearson and Spencer, 1995; Hudson, 2007).

Whether support for the more positive model of teamworking coincides with a more optimistic view of the future of mental health care *per se* is less clearly apparent. While interprofessional conflict was less visible than predicted, shared

struggles against overwhelming caseloads, a stark lack of client contact time for professionals and a common distrust of the target-driven nature of the NHS came across strongly in worker perceptions. This supports the small number of recent qualitative studies of mental health care overviewed in Section 2.1.3 in their suggestion that issues around excessive workloads and managing demand are often reported to be more important to workers than professional identity or occupational differences (Lankshear, 2003; Donnison et al., 2009). In the current study the major source of threat to team members appeared to originate not from each other but from workload pressures, targets and the threat of continuous, rapid workforce change. Where threat or resistance was reported it was often sympathised with, set against strong imagery of the entire frontline workforce, both professional and NPA, situated as pawns in a wider political process:

‘The government does what it does and we deal with it.’ (R34, high intensity worker)

Perceptions of a shared distrust in the motives underlying the modernised NHS, alongside positive accounts of team working contrasted against low perceived status within ‘upper management structures’ (R2), created a major shift in where I had placed the ‘us’ and ‘them’ divides upon entering the field. This is perhaps where an over-reliance on survey studies of teamworking in mental health, as identified by Onyett (2011), is particularly salient, as surveys are generally too rigid to accommodate or identify changes in direction of interest. The findings here support Onyett’s (2011) call for further qualitative study of how mental health work is experienced, in order to re-assert what is most important to workers and examine whether sources of conflict other than inter-occupational divides may be emerging as central influences on working life.

### **8.1.3 NPA Terminology and Emerging Tensions**

As one final point on the consideration of traditional theory, the findings presented in this thesis have highlighted the diverse nature of the roles that make

up the NPA health care workforce. This creates difficulties in discussing the NPA workforce as one homogenous group and in seeing the professional-NPA demarcation as a clear-cut distinction. The seven roles included in this study sample were all initially considered to fall within the broad definition of 'non-professionally affiliated' asserted in the introduction chapter, however the findings have highlighted difficulties in grouping roles together in a meaningful way. A particular distinction between long-term, socially focused roles and short-term, brief interventions roles has been visible throughout the findings, with a seemingly distinct set of issues experienced by each. The findings suggest firstly that the clinical-social distinction may be more important than the professional-NPA distinction, and secondly that professionalism may be more appropriately conceptualised as a continuum rather than a clear demarcation.

The identification of tensions *within* the NPA workforce between different types of NPA function adds further weight to the latter point and is an area of discussion barely visible in the existing literature, probably as a result of the homogenous samples that form the most common focus of NPA studies. In particular, tensions have been observed between supporter and facilitator roles over the most effective type of support to clients, and also between short-term and long term facilitation roles. Interestingly, the differences highlighted by workers and described in Chapter 6 went alongside a striking number of task-level similarities; for example the longer-term pieces of 'project work' described by GMHWs appeared identical to the role of STR workers. Likewise, the graded exposure interventions of STR workers and their role in supporting clients to carry out IAPT 'homework' or reinforce CBT techniques learned during therapy appeared to hold notable similarities to the techniques taught during the brief interventions themselves. From my own subjective viewpoint the differences between roles seemed to be given more emphasis by the workers themselves than they appeared to hold in practice, perhaps as a way to justify higher rewards

than the tier below (for PWP, GMHWs and high intensity workers) or to support initiatives to gain higher reward (for STR workers). This holds similarities with some 'boundary work' tactics described in the professional literature, whereby occupations emphasise their differences from other groups in order to assert their own unique contribution (Abbott, 1988; Leonard, 2003; Nancarrow and Borthwick, 2005; Sanders and Harrison, 2008).

As the NPA workforce increases in diversity and higher-level support roles become more commonplace, it is likely that the consideration of workers as one homogenous group will become progressively more difficult. In addition, it may become increasingly likely that divisions will appear between NPA roles rather than disputes being confined to negotiations between the professions. Initial findings relating to the introduction of the higher-level assistant practitioner role in general nursing have also hinted at the possibility of emerging tensions between HCA and the assistant practitioner (Spilsbury et al., 2010). Relations between these different levels may provide a key area for future discussion.

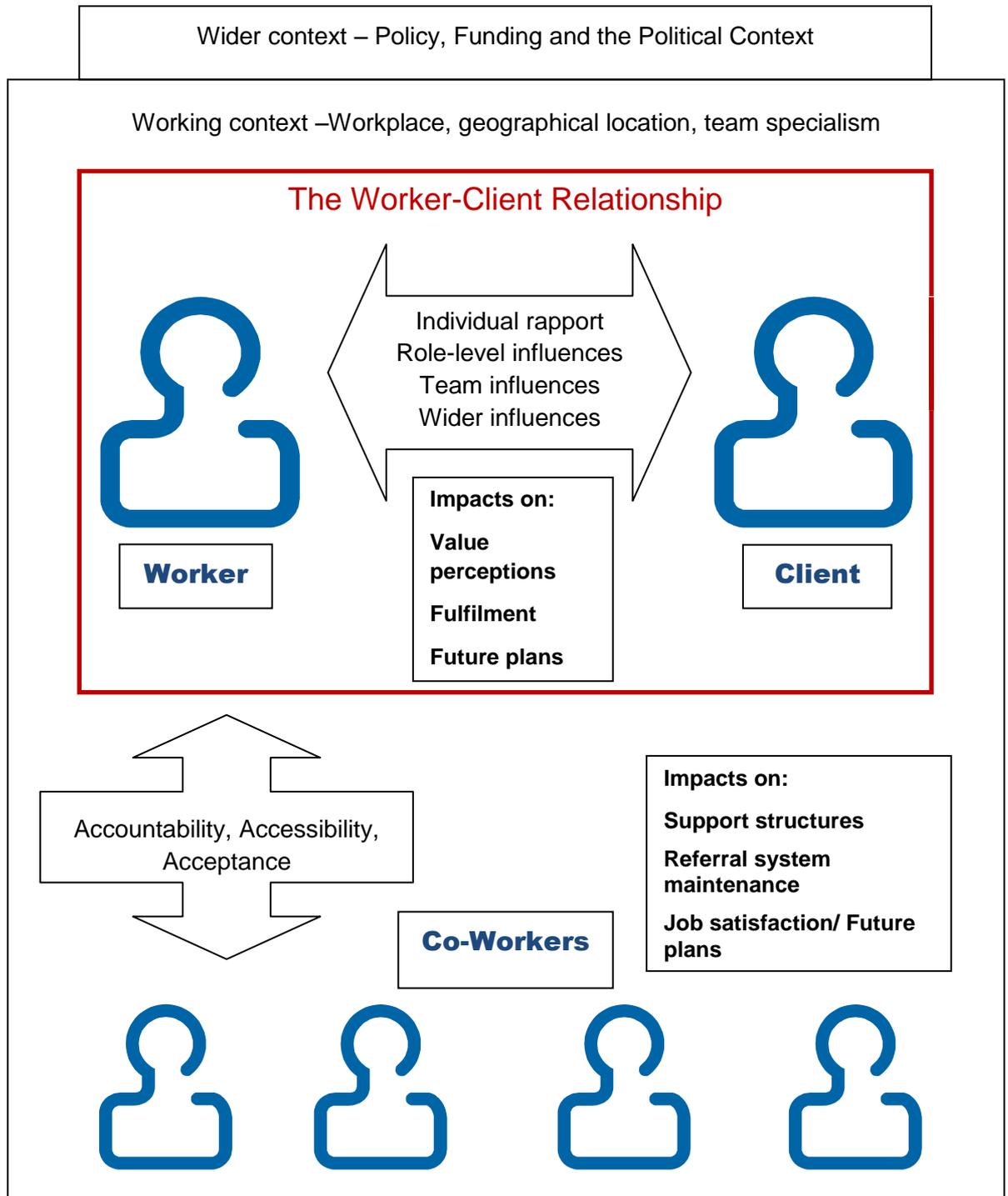
#### ***8.1.4 Putting Threat and Resistance into Context: An Overview of Key Aspects of Worker Experience***

So far the discussion has suggested that rather than moving away from the sociology of the professions completely in favour of more organisational approaches as undertaken elsewhere (Kessler et al., 2006; 2007; Bach et al., 2007; 2008), it may be useful to move forward by considering wider sources of threat than inter-occupational disputes, and to examine the possibility of emerging divisions *within* the NPA workforce. While the findings presented in this thesis have supported traditional theory to an extent, importantly they have also served to position traditional concepts of NPA-professional conflict and resistance within a much more holistic interpretation of worker experience.

Rather than the NPA-professional relationship embodying worker experience, the findings here have argued the worker-client relationship to be the most central aspect of working life. While effective NPA-professional relations are necessary to worker wellbeing, their importance seems to lie primarily in the support they provide for the complexities of client work and to maintaining an appropriate system of referrals, rather than forming the central defining feature of worker experience. Furthermore, the experience of resistance and conflict between NPA and professional forms only *one* aspect of a complex set of influences on working relations, including individual, role and physical workplace factors.

Figure 8.1 provides a visual representation of key aspects of working life from the subjective NPA viewpoint.

**Fig. 8.1 Overview of Key Aspects of NPA Worker Experience**



As can be seen in Figure 8.1 above, the worker-client relationship was observed to take centre stage in the current study. The NPA-professional relationship can be considered as a key influence on the level of available support and perceived effectiveness of the worker-client interaction, alongside other influences in the

form of individual, team, workplace and wider political factors. The consideration of sociological aspects of threat and resistance form part of the 'acceptance' element of co-worker relations; one of a number of influences on working relationships and, in general, a relatively small part of the overall worker experience.

This interpretation is different to that commonly found elsewhere, given the separation of discussion illustrated in the literature review between sociological and organisational fields (Davies et al., 2003; Bach et al., 2008) and between discussion of the professional relationship and the client relationship. This has tended to result in the consideration of one or the other as crucial, rather than placing them in context alongside each other. Having already explored the study's contribution to traditional NPA theory, we will now consider its relevance firstly to recent theoretical developments in defining worker role and then to current considerations of the worker-client relationship.

## **8.2 Definitional and Organisational Contribution**

### **8.2.1 *Adding to Knowledge on Role: Community Co-Production***

'Basic knowledge about the content of occupations remains rooted in an industrial past, undermining our appreciation of the occupational distribution of tasks at the modern workplace.' (Kessler et al, 2006: 682)

The literature review chapter argued that the call to define NPA worker role in more concrete terms, led predominantly by Kessler, Bach and Heron (2007; 2008), has provided a valuable advancement of existing theory but remains under-developed. Application of the role categorisation provided by these authors has been confined to working contexts where a notably traditional NPA-professional relationship exists. Because of this, the possibility for NPA 'co-production' remains largely unconsidered even in Kessler et al.'s (2007) own work. This study has increased the NPA knowledge base by examining an altogether

different type of working environment, stepping outside of the hospital ward and traditional NPA-professional hierarchy. In doing so it has allowed us to provide clarification and advance our understanding of how NPA co-production can be created at a policy level in order to fulfil perceived service gaps and, importantly, what nature it can take in practice.

Chapter 5 provided an exploration of key features of working life for NPA co-producers in the community mental health context. It depicted a working environment based on professional *distance* rather than assistance and proximity, with workers performing a distinct, complementary service usually on a one-to-one basis alone with the service user. While bringing the benefits of autonomy, community co-production has also been illustrated to hold implications for workers in terms of the extensive responsibility it brings, both on a personal level and in terms of day-to-day task and time management. The distinct contribution to services and often geographically separated way of working has been shown to create a considerable reliance on indirect, *hindsight* support from co-workers in dealing with the complexities of client work. These hindsight support structures were often informally negotiated and as such were heavily shaped by physical workplace factors, individual personalities and by professional perceptions and understanding of the roles. Given the nature of community co-production, where support structures were reported to have failed through geographical isolation, personality clashes or lack of professional acceptance, workers became 'literally' (R10) lone workers.

In addition, the distinct nature of co-production, lack of professional attachment and often ambiguous job titles have been shown to create a strong requirement for role development and promotional work in order to build and maintain an effective referral system. The picture of working life depicted here can therefore be considered a somewhat different environment to that reported in more traditional settings such as the hospital ward or classroom. While some elements

of responsibility, for example the management of physical risk, may be heightened by the mental health setting, high levels of risk have also been noted elsewhere for community-based home care workers (Stacey, 2005; Taylor and Donnelly, 2006). Given that health services are continuing to move away from the hospital in favour of more cost-effective community alternatives (Davies, 2003), many of the considerations raised here - such as those around worker responsibility and the existence of support structures - may well become more salient as service modernisation continues.

### **8.2.2 *Advancing Knowledge of Contextual and Workplace Influences***

As raised in the literature review chapter, the key criticism levelled at the sociology of the professions' treatment of NPA workers has been its lack of attention to organisational and workplace context; an oversight argued to have prevented knowledge advancement on the NPA workforce (Kessler et al., 2006, 2007; Bach et al., 2008). Kessler et al.'s subsequent commentary emphasised the importance of sub-sector variation - specifically regulation - and organisational ethos in shaping the role performed by workers. The diversity of roles, teams and employing organisations involved in the current study provided a useful backdrop to undertake a comprehensive examination of workplace influences on worker role. As such it was possible to both support Kessler et al.'s (2007) assertion of the importance of context and also advance our understanding of the various different levels of influence. In addition, the analysis of contextual factors in the current study went beyond consideration of how they shape the tasks performed by workers, to illustrate how they can alter the experience of working relationships, availability of support and perceived outcomes for both worker and client.

The overview of key aspects of worker experience provided in earlier Figure 8.1 highlighted a number of different contextual influences on worker experience that have been threaded through the findings chapters. These include individual

characteristics of both the worker and client base (including background, personality, complexity and motivation), team and workplace factors, employing organisation/sector and the wider policy and political context. In support of earlier work (Kessler et al., 2007; Bach et al., 2008), sub-sector and organisational influences on worker role were visible in the current study. Sub-sector for example has been shown in Section 5.2.2 to influence the client-focused function performed by workers and how the workers are perceived by clients.

### **Micro-Level Workplace Factors**

While supporting previous work, the key contribution of the current study to the consideration of contextual influences on NPA experience lies in its analysis of micro-level variation in terms of team set-up, specialism and physical workplace factors. Geographical location and team specialism emerged as key influences on worker role, often creating malleable remit boundaries in order to tailor the intervention to meet specific requirements. Team specialism for example was shown in Section 5.2.2 to influence the needs of the target client group and subsequent tasks performed by workers, while geographical location was also shown to influence worker remit by requiring rural workers to weigh desired interventions against logistical considerations of travel time and client isolation. This resulted in NPA remits that often varied widely across teams and localities within the same broad policy aims. This lack of uniformity was largely considered a valuable and necessary tool in tailoring the role to client need.

Given the reliance on informal support structures already mentioned, team and workplace factors were observed to be crucial not just to the role performed by workers in the current study but also to their wellbeing. In particular, co-location with team members, both professional and non-professional, arose as crucial to enhancing role clarity and the accessibility of informal support. Team set-up was further illustrated in Section 7.2.3 to create variation in worker experience, with uni-disciplinary NPA teams generating fewer reports of isolation, a higher level

of NPA peer support and clearer caseload moderation, yet with a notable distance from professional referrers. In contrast, workers situated in multi-disciplinary teams in general reported closer professional relationships and a more blurred remit but far less contact with other NPAs. Where professional relations were perceived to work well this appeared as a highly effective way of working, however where it failed workers reported being left isolated by the lack of opportunities for peer support.

### **Wider Political Influences**

The current findings have also highlighted a further level of influence barely visible in other NPA studies: the wider political context. Political factors have been illustrated here to impact on an intervention's underlying motivation and the desirability of component tasks, if for example we consider the loss of computerised CBT from the brief interventions remit following its disappearance from NICE guidelines, or the perceived motivation of IAPT to 'get people back to work' (R33). Also reported to influence the availability of funding and existence of target outcomes, the wider political climate came across as a strong influence on worker role and experience. In addition to influencing worker remit, political undertones appeared central to perceptions of role value and authenticity which in turn influenced job satisfaction and future plans. This links back to the earlier point made in Section 8.1.2 that alternative, wider sources of conflict may be emerging - between workers and wider circumstances rather than between occupational groups. Perceived outcomes for both worker and client will be discussed further in Section 8.3.

### **8.2.3 Unofficial Use and Professional Pressures**

The existing literature overviewed in Chapter 2 suggested the misuse of NPA workers to primarily occur when they are unofficially utilised as a substitute for the professional by undertaking professionally 'owned', core tasks rather than

their official remit (Spilsbury and Meyer, 2004b; Kessler et al., 2006). While it could be predicted that the distinct remit of the NPA co-producer would be less susceptible to undertaking unofficial, professionally-led tasks, the data presented here strongly argues that unofficial use can occur even within a distinct, co-produced remit. The nature of unofficial use took a notably different form however, more likely to impact on client complexity and subsequent service suitability than actual tasks performed. Largely invisible at the task level, this perhaps echoes the 'hidden', unspoken work of the ward-based HCA reported elsewhere, as the workers plug gaps in professional care (Spilsbury and Meyer, 2004a).

In contribution to the organisational literature, the findings here emphasise the strength of the link between professionals' own caseload pressures and how NPA workers are subsequently used. Kessler et al.'s (2006) commentary on the role of social work assistants suggested each team to be 'affected unevenly by similar pressures, encouraging a differential use of the support worker' (2006: 680). In the current multidisciplinary context, the data illustrated a differential use of the NPA worker to occur between *individual* referrers, dictated by their own needs and personal understanding of what a support role should entail. The result appears to be an inconsistent role similar to that described in McCrae et al.'s (2008) study of four community support workers and Brown et al.'s (2008) study of mental health assistant practitioners (Section 2.3.2), whereby worker remit varied according to the requirements and beliefs of professional team members. Here this variation was illustrated to contain a blend of appropriate and inappropriate referrals depending on the source of each, as professionals responded to their own work pressures, and with a subsequent impact on client complexity rather than actual tasks performed.

The multidisciplinary context is therefore a useful backdrop to examine the impact of professional pressures on NPA worker experience and one which has

rarely appeared in the NPA literature to date. Perceived outcomes of unofficial use for both clients and workers will be further considered in the following section.

### **8.3 The Worker-Client Relationship: Contribution to the Literature on Emotional Aspects of Work**

The literature review chapter argued that discussion of the worker-client relationship has been notably quiet in existing NPA research. The few recent studies overviewed in Section 2.3 have appeared somewhat in isolation, citing no connection to each other or to a shared literature base (e.g. Warne and Stark, 2004; Huxley et al., 2009; Gensichen et al., 2009; Schneider, 2010). Elsewhere the growing body of literature on emotional aspects of care work (e.g. Bolton, 2000; Stacey, 2005; Lopez, 2006) has evolved separately, creating a fragmentation of discussion whereby NPA roles that work alongside professionals are considered almost entirely in professional terms, while those who work alone are discussed entirely in terms of the emotional aspects of client work.

Workers in the current study can be conceptualised as falling somewhere between the two interpretations of worker experience, being required to manage both the complex negotiations involved in autonomous client work *and* those involved in professional relations. As illustrated in earlier Figure 8.1, the two relationships are perhaps most usefully considered alongside each other in an interrelated way. In the current study the two relationships appeared as co-dependent aspects of worker experience. The advice, skills and support gained from co-workers provided scaffolding for positive client interactions, while the strength and informal nature of the NPA-client relationship often appeared central to its perceived value to professionals. In more negative cases, where the value of the NPA-client interaction was considered minimal - or detrimental - to professional co-workers, this could be harmful to communication structures,

availability of support and the maintenance of an effective referral system. In turn the availability of support, and professional use of the NPA roles, influenced workers' perceived ability to deal with the emotional responsibility involved in client work.<sup>29</sup>

The findings presented in this thesis advance our understanding of the emotional aspects of work in a number of ways:

- By illustrating the worker-client relationship as a source of both fulfilment *and* burden. This supports emerging criticism within the emotional labour literature that authors' preoccupation with demonstrating one outcome or the other has created a barrier to theoretical advancement (Lopez, 2006; Stacey, 2005). The current findings provide a more detailed consideration of both outcomes, alongside each other, including the identification of specific types of burden such as boundary maintenance and client dependency.
- By identifying different *versions* of the worker-client relationship (*supporter, facilitator and ambassador*) and considering how this variation can impact on worker wellbeing, job satisfaction and perceived client outcomes. Findings illustrate how this variation is created at a role, team and wider policy level; thus helping to address the observed separation between emotional labour and organisational theory.
- By highlighting the *co-dependent* nature of co-worker and client relationships, rather than discussing them as separate concepts as is commonplace in the background literature. In particular, the impact of 'unofficial use' by professionals is shown to be crucial to the ability of workers to carry out effective relationship work, by influencing client complexity and worker confidence.

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<sup>29</sup> See Section 7.2.4 for the link between role value to professionals and the availability of support, and Section 6.3 for the impact of professional use on client complexity.

- By strengthening the call for managers and policy makers to acknowledge interpersonal responsibility as an essential, crucial part of the care process; an aspect which should be embraced and supported rather than ignored or constrained within role boundaries.

This section will now consider in more detail the study's specific contributions to the field of emotional labour and emotional aspects of care work, highlighting how it builds on other authors' work to advance existing theory.

### **8.3.1 Centrality of the Client Relationship: Weighing up Fulfilment and Burden**

The current findings have asserted that the client relationship, rather than the professional relationship, forms the central defining feature of worker experience in the community mental health context. Section 5.2 of the opening findings chapter argued that it is perhaps more useful to define workers in terms of their part played in the client's care or recovery (*supporter, facilitator or ambassador*) rather than their position relative to the professional as tends to be the focus elsewhere (e.g. Kessler et al., 2007; Bach et al., 2008). Defining workers in terms of their client-focused function has allowed a clearer understanding of role performed, how it is shaped by contextual factors and emerging tensions between different types of NPA function.

Further to this, Chapter 5 illustrated the client interaction to go far beyond its usefulness in defining the role of workers; a relationship able to elicit unshaking role commitment even in the face of feeling 'underpaid and undervalued' (R2), or able to move workers to seek alternative employment should they feel unable to provide a valued, effective service. The power that the worker-client interaction holds over worker wellbeing, job satisfaction and future plans demands far more attention than it is currently afforded in the professional literature.

The findings presented in this thesis support the emerging argument, outlined in Section 2.4 of the literature review, of the client interaction as a source of both

fulfilment and burden. This was identified in Gensichen et al.'s (2009) HCA study and argued by Stacey (2005) and Lopez (2006) in the wider emotional labour literature, in criticism of authors who have created a fragmented debate by focusing on either one outcome or the other. The almost paradoxical nature of the relationship, whereby it can cause substantial burden yet also be considered a protective factor *against* that burden was clearly visible here. As is visible in the consideration of the worker-client interaction found in Chapter 6, the workers that described the most highly complex negotiations as part of the relationship - predominantly those working in support and long-term facilitator roles - also described the highest levels of fulfilment and job satisfaction, so long as they felt well-supported and confident in their abilities to deal with such complexity. On the other hand, workers for whom the relationship was confined within time and remit constraints - usually those in short-term facilitator roles - reported fewer tensions around issues such as boundary maintenance or dependency but also lower job satisfaction. They were also more likely to report intentions to leave the post, despite higher pay and opportunities for career progression when compared to their supporter counterparts.

Despite being a source of potential burden then, the client relationship - and the complex negotiations it brings - appear necessary to worker satisfaction. This supports the assertion raised by Scheid (2004) and Lopez (2006) in the emotional labour literature that employers should aim to nurture and support emotional aspects of work rather than constrain or suppress them. Here client complexity was embraced, even desired, by the majority of workers and provided a key source of fulfilment and role commitment, so long as it was perceived to be well supported, within the worker's capabilities and remit boundaries, and properly acknowledged at a management or policy level.

### **8.3.2 *Shaping Factors of the Emotional Aspects of Work***

The key contribution of this study to existing literature on the worker-client relationship is its exploration of shaping factors of the interaction. As mentioned in Section 2.4 of the literature review, Bury's (2004) critique of existing research on the professional-client interaction in health care called for attempts to consider how wider contextual factors, such as policy change or shifts in public trust, may influence interactions inside the clinical environment. Similarly, the emotional labour literature has been criticised for its lack of theoretical advancement, as researchers concentrate on illustrating value or burden rather than how the relationship is negotiated or shaped (Stacey, 2005; Wharton, 2009). The lack of consideration of wider influences may be reflective of the separation between organisational theory and emotional labour discussions.

The relatively heterogeneous sample of the current study when compared to more common ethnographic approaches allowed a comparison across roles and workplaces which elicited a number of shaping factors of the worker-client interaction. Overviewed in earlier Figure 8.1 and illustrated in more depth in Figure 6.1 at the start of Chapter 6, the current data identified shaping factors of the worker-client relationship at a number of different levels. These included individual characteristics such as personality traits and motivation which appeared crucial to building rapport; role-level influences including time, flexibility and formality which constructed the boundaries within which the relationship could be built; and team-level influences, particularly professional workload pressures, which influenced client complexity and service suitability.

Of particular importance in the current study was the over-arching level of influence in the form of wider policy and political factors. Section 6.4 illustrated the way in which the existence of targets and perceived service priorities were observed to impact on the nature of the client relationship. Policy guidance and the level of flexibility inherent in it was shown in Section 6.2 to influence role-

level remit boundaries, constraints and the level of control held by the worker to tailor the intervention to perceived client need. In turn this was influenced by the wider political climate, for example by creating targets for IAPT workers to get clients back into work or by influencing the perceived level of policy interest in - and subsequent funding to - more socially orientated roles.

Manifested at the intervention-level, these wider influences were seen to create different *versions* of the worker-client relationship, with clear perceived outcomes for both worker and client. Short-term, brief interventions roles were illustrated in Chapter 6 to be constrained by targets and remit boundaries, creating frustration for some workers as well as cynicism over the role's value and authenticity. In contrast workers in longer term roles often displayed high role flexibility and tailoring to client need alongside strongly held views of role value, pitted against the constraints of perceived funding issues and small worker numbers. This also created frustration for some workers by placing its own restrictions on role performed, for example by limiting worker ability to provide intensive one-to-one support at times of crisis or reach under-engaged groups such as young carers. In both cases, but for contrasting reasons, policy and political- level influences can be seen to impact upon worker role and value judgements.

The various constraints on worker role observed in the current study can be conceptualised within Biestek's (1957) framework for effective casework relationships, used by Huxley et al. (2009) to explore the therapeutic nature of the interaction between STR workers and their clients.<sup>30</sup> The roles examined here varied in the extent to which post-holders described themselves as able to fulfil Biestek's (1957) central principles of effective relationship work, for example the treatment of clients as individuals and the provision of opportunities for clients to express their feelings and make their own decisions. These principles can be

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<sup>30</sup> See Section 2.4.1, page 55-6 for earlier discussion of this work.

compared to the constraints described in Section 6.2 which left some brief interventions workers for example unable to 'get back on track' if a client became upset (R36), or provide for clients who just wanted to talk their problems through. Despite clear attempts by workers to tailor to individual clients, success was restricted within time and remit boundaries. Thus embracing client individuality and decision-making seemed to fall outside of intervention boundaries for some workers. In support of Biestek's (1957) work, this held negative perceived implications for both worker and client, in the form of 'conveyor-belt therapy' (R37) which could sometimes fall short of client need.

We can therefore see differing levels of the extent to which the human aspects of relationship work, or the 'soul of help' (Biestek, 1957), are cultivated at a policy level across the different roles included in the current study. This shares similarities with Lopez' (2006) ethnographic study of care assistants in three nursing homes which illustrated varying levels of encouragement or discouragement of the human aspects of care originating from how such interactions were perceived at a management level. Specifically, the opportunity for workers to develop meaningful relationships with clients depended on whether the worker-client interaction was considered by management as a 'means to an end' in day-to-day tasks, or as a central aspect of worker role and service to the client (Lopez, 2006). In the current study similar variation can be observed at a policy level, with the therapeutic interaction seen as a key - if not *the* key - aspect of worker role for longer term roles such as support workers and STR workers, while appearing as more of a 'means to an end' in the delivery of brief interventions. As already mentioned here and explored in depth in Chapter 6, this has been observed to hold significant perceived implications for both worker and client.

### **8.3.3 The Impact and Appraisal of Unofficial Use: Implications for Emotional Responsibility**

A second key influence on the worker-client relationship worthy of further discussion here is the impact of unofficial use by professionals, considered in Section 6.3 as a key team-level influence. Unanticipated client complexity was reported to originate from a number of sources in the current study; sometimes being inherent in the diagnoses of the target client group or emerging as issues 'open out' (R28) during therapy. A third source of complexity was reported to originate from the referring professional, as they responded to their own caseload pressures and perceptions of the NPA role. As already mentioned in Section 8.2.3, unofficial use in the current study impacted on client complexity rather than actual tasks performed. Providing a point of contrast to NPA misuse reported elsewhere (e.g. Spilsbury and Meyer, 2004b), this raises important questions about both the visibility and appraisal of such unofficial role aspects and about the potential impact on worker and client outcomes.

While the impact of misuse on client complexity, rather than tasks performed, seems to be less visible than the types of misuse reported elsewhere, it has been shown to hold major implications for client and worker outcomes. Key tensions presented in Chapter 6 strongly suggested each role to be effective with the client group *for whom it is designed*, unless workers are afforded the flexibility, preparation and support to accommodate additional client complexity. While clearly positive examples were given of beneficial outcomes when the right intervention was delivered to the right client, it was common for workers to report providing services to people considered unsuitable for their remit boundaries or individual capabilities. Chapter 6 provided examples of the perceived impact of this on motivation, satisfaction and wellbeing of both worker and client, for example by creating feelings of failure in the client while the worker finds the lack of progress 'soul destroying' (R37).

The findings illustrated here echo the exceptional case reported in Section 2.4.1 of Farrand et al.'s (2007) interview-based GMHW evaluation, in which one client reported both herself and the worker to have been used as a 'holding operation' while she awaited a more suitable therapy (2007: 491), creating feelings of anger and having been patronised. The key difference between the current study and Farrand et al.'s (2007) is that here, rather than being one exceptional case, the use of workers to contain waiting lists and relieve professionals of their own caseload pressures appeared to be more deeply embedded in the referral system. The outcomes of this for both worker and client should not be underestimated, and warrant further consideration at both an academic and policy level.

## **8.4 Implications for Managers and Policy Makers**

The discussion so far has positioned current findings within the academic literature overviewed in Chapter 2, including traditional professional theory, recent theoretical developments and considerations of the worker-client relationship. In doing so a number of implications for policy and management have been raised, for example relating to worker views of the modernised NHS and the impact of unofficial use on worker and client outcomes. In addition to the points already raised, a number of further considerations specific to the policy and management of NPA workers are summarised as follows.

### **8.4.1 *Recognition and Preparation for the Emotional Aspects of Work***

This thesis has illustrated the client relationship to be the central defining feature of NPA worker experience; a source of fulfilment but also a highly complex interaction and major source of potential burden. Chapter 7 raised questions concerning the level of acknowledgement of the emotional aspects of work and the complexities faced by workers, such as boundary maintenance and tackling dependency for longer term roles, or attempting to fit a therapeutic service into 30 minutes for brief interventions workers. This echoes the argument raised

elsewhere that the complexities involved in relationship work often go unspecified in official documentation (Huxley et al., 2009). Whether worker responsibility is fully acknowledged in training opportunities or pay structures for longer term, socially orientated NPA roles formed a particular area of tension in the current study.

Questions have been raised regarding the extent to which the issues involved in client work are at the forefront of existing training and supervision structures, such as NVQs or 'case management' types of supervision. As raised by service manager R25M, the need for simultaneous engagement and detachment may not seem like a major challenge to professionals, however the years of training, mentoring and experience in preparing professional workers to deal with such issues should not be underestimated. In the current study workers reported relying heavily on past experience such as an inpatient caring career, particularly in relation to boundary maintenance, yet not all workers held such prior experience. In addition the impact of unofficial use - for example to contain professional waiting lists - on worker burden and required skills appeared largely unacknowledged in the level of support and preparation available to workers, despite it substantially increasing the complexity of cases with whom they were required to work.

As has been illustrated in Chapter 6, the issues created in client work hold major implications for both worker and client wellbeing. The findings presented here support Gensichen et al.'s (2009) call for training in aspects such as counselling techniques and strategies to prevent overburdening in order to help workers deal with interpersonal client work issues. Drawing on the previously discussed emotional labour literature, the ideal scenario would seem to be acknowledgement and support for workers in dealing with the emotional aspects of work, rather than attempting to prevent or constrain them, or simply failing to acknowledge their existence (Scheid, 2004; Gensichen et al., 2009). Boundary

issues in particular are likely to become more prominent with the introduction of direct payments, which are increasing the number of support workers employed who are already known to the service user (Stainton and Boyce, 2004).

#### **8.4.2 Accountability for Worker Wellbeing and Reliance on Informal Support**

Findings in the current study have illustrated a high reliance on informally negotiated support structures in dealing with the complexities of client work. A lack of formal communication opportunities has been illustrated in other contexts such as for ward-based HCAs (Spilsbury and Meyer, 2004a), however the community working context has been shown here to create a significant barrier to the accessibility of more informal types of support. As illustrated in Chapter 7, these have been shown to rely heavily on physical workplace aspects, particularly co-location and geographical dispersion, individual personalities and professional attitudes. Where it was perceived to work well the informal nature of support was often considered valuable, however in the small number of cases where these networks failed the negative implications for worker wellbeing were significant.

Perhaps the most important point to take from the current findings in relation to worker support is that, given the co-productive nature of many newly implemented roles and subsequent lack of attachment to any specific profession or member of the wider team, accountability for worker wellbeing can appear hazy and support networks are not always clearly defined. This is particularly an issue in settings where contact with other workers is less likely to occur naturally, for example in rural areas or for workers that rely on distance referrals. In these cases accountability relationships and communication opportunities may need to be actively created, whether formally or informally, rather than being assumed to exist. Opportunities for peer support with other NPA workers were also highly valued but rarely experienced unless actively created by policy, management or the workers themselves. This can be considered in light of Korczynski's (2003)

discussion within the emotional labour literature of 'communities of coping' built between service workers and the importance of this peer support in dealing with 'difficult customers' and the complexities involved in client interaction.

### **8.4.3 A Note on NPA Regulation**

Proposed regulation of the health care support workforce is considered a positive step towards improved patient safety and quality of care, by creating more 'defences' between the actions of HCAs and patient outcomes (Spilsbury and Meyer, 2004b: 417; Griffiths and Robinson, 2010). As plans for support worker regulation move forward, the findings presented in this thesis raise a number of points for consideration.

The argument for support worker regulation, along with the academic literature underpinning it, is heavily embedded in a professionally orientated discourse whereby the professions are required to 'resist attempts by assistants to encroach on their territory' (Kessler et al., 2006: 681). The findings presented here have directly challenged the assumption that NPA workers actively seek out ways to encroach on professional boundaries. Rather than innocent victims of role theft, professional workers have been illustrated here as active participants in the increasingly complex nature of NPA tasks as they respond to their own caseload pressures and perceptions. This is a process over which NPA workers appear to have little control.

Given that the undertaking of tasks previously owned by professionals is considered central to the risk posed to public safety (Griffiths and Robinson, 2010), this raises some important and perhaps uncomfortable questions. What part do the professions really play in all of this? If the public are to be protected, do the NPA workers themselves need protection from professional misuse? If the professionals themselves are reacting to crippling workload pressures then we may need to consider more carefully how regulation will alter the shape of both

professional and non-professional workplace roles. Regulation will serve to create clearer demarcation and less boundary blurring between professional and NPA official remits. While this seems to be regarded positively in the discourse surrounding proposed regulation, it seems over-simplistic to assume that the outcomes of greater demarcation would be unanimously positive for workers or for clients.

Instead there appear to be a number of potential outcomes each with complex implications. If for example regulation increases the likelihood of support workers refusing to undertake tasks outside their official remit, professional team members will be required to regain peripheral tasks that have been unofficially handed down (such as the drug screening and medication monitoring function of STR workers R6 and R7) into already overburdening caseloads, despite it being considered in the clients' best interests for them to be performed by NPA workers. This may well create tensions for working relationships; as in the case of GMHW R17 who reported a breakdown in support structures and personal relationships following refusals to take on referrals outside her official remit.

On the other hand, support workers may continue to carry out unofficial tasks or unofficial levels of complexity at the request of the delegating professional, but under an increased level of risk due to their increased legal accountability for client outcomes. This opens up a host of ethical and moral dilemmas and could leave workers caught in the middle between team pressures, patient interests and legal accountability. A parallel can be drawn here with Stacey's (2005) ethnographic study of US home care aides. In line with professional expectations aides were often seen to undertake minor medical procedures such as wound dressing, simply because there was nobody else to do it and despite it falling strictly outside their official remit. Those who refused through fear of losing their job if something went wrong faced significant emotional and moral burden, in the knowledge that the client would suffer as a result of their refusal and that

they were actively going against professional expectations. As Stacey (2005) points out:

*'Although nurses resent their shrinking jurisdictional boundaries in home care, it is the clients and home care workers who truly absorb the risk of this arrangement.'* (2005: 842, emphasis added)

The benefits of NPA regulation to professional bodies are clear, and it is within the professional domain that regulation decisions will no doubt be made. While it is beyond the scope of the current study to examine the pros and cons of NPA regulation, the findings presented here call for a more in-depth - and perhaps more balanced - discussion of how regulation may alter the shape of existing workplace roles, including potential outcomes for both clients and workers.

## **8.5 Conclusions and Directions for Future Research**

### **8.5.1 Study Considerations and Directions for Future Research**

*'No study can ever be considered finished. There are always deeper levels of understanding to be achieved. Yet if we did not withdraw from the field every once in a while to try to make sense out of what we have seen, heard, and experienced, we would be left with piles of data with no understanding of the social world at all.'* (Taylor, 1999: 277)

By providing a qualitative, in-depth examination of a relatively novel service setting, the findings presented in this thesis provide a useful, theoretically relevant jigsaw piece to be considered alongside other studies and contexts. Rather than striving for statistical generalisability as is common in quantitative approaches, the focus here has been to maximise the potential for inferential and theoretical extrapolation (Bryman, 1988; Lewis and Ritchie, 2003; Silverman, 2005)<sup>31</sup>. This has been enhanced through the various techniques described in

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<sup>31</sup> This refers to the 'generalizability of cases to theoretical positions rather than to populations or universes.' (Bryman, 1988: 90). It has also been referred to as 'analytical generalisation' (Yin, 1994; Gray, 2004), however other authors argue that it may be more useful to step away from the highly quantitative term *generalisation* in favour of *extrapolation*, as this better captures the process in qualitative research (Alasuutari, 1995; Silverman, 2005).

Chapter 3 (Section 3.2.3, page 86) which were undertaken to increase the study's *credibility* and *transferability*, for example by paying attention to deviant cases and providing a detailed description of the study context (Guba and Lincoln, 1994). The provision of a comprehensive literature review in order to position the data comparatively to other settings is also crucial to theoretical extrapolation (Silverman, 2005).

The mental health context itself has provided both an advantage and a limitation of the current study. While the lack of research in this field is a clear shortfall of existing knowledge on the NPA workforce, the findings may benefit from application to other contexts, particularly other community services. This would enable researchers to tease out for example which aspects of worker experience are linked to mental health work and which are likely to be shared by other areas of community care. Similarly, the examination across a number of NPA roles rather than one in depth has held both limitations and advantages. This approach was undertaken deliberately as sample diversity was considered a valuable way to explore role and workplace variation, however it involved sacrificing some of the depth that would have been permitted by an ethnographic approach for example. Given the lack of existing research in mental health, each of the roles examined here would be worthy of further in-depth attention.

Perhaps the most obvious limitation of the current study is its sole focus on the NPA worker perspective. While this has allowed an in-depth consideration of the viewpoint which corresponded to the greatest identified knowledge gap, the findings do not take into account other important perspectives, namely professional co-workers and clients. As already mentioned in Section 2.2.3 of the literature review, the perspectives of different stakeholders can vary greatly and positive NPA perceptions of team functioning may not equate to positive professional views. In Petrova et al.'s (2010) interview study of general practice

HCA's for example, both HCA's and GPs were demonstrated to be largely unaware of the concerns and feelings of devaluation reported by nurses.

As such it is important to consider the presented findings as a representation of NPA worker *perceptions* of the various working relationships addressed, rather than any observable 'reality' or shared perceptions. Nevertheless it is hoped that the proposed shaping factors of worker experience and issues raised here may provide a platform for further exploration. Two key directions for future research involving other stakeholder viewpoints would be to ascertain client reported outcomes in addition to NPA worker perceptions of them, and professionally reported motivation and decision-making behind the referral/delegation process. Research elsewhere has shown that perceptions of motivation can vary. In Farrand et al.'s (2007) evaluation of the GMHW role for example, managers and supervisors reported a lack of role clarity to be the primary reason behind inappropriate GP referrals. Interviews with the GPs themselves however suggested that they were aware of the inappropriate nature of referrals but made them anyway out of frustration that the role was not aimed at those with the greatest perceived need (Farrand et al., 2007).

As with any type of research study, questions are raised here around those who did not take part. Despite rigorous attempts to ensure that information reached as many workers as possible, the substantial procedures involved in gaining access from relevant gatekeepers meant that enthusiastic managers may have been more likely to help with the study. While the majority of workers who received information about the study opted to take part, a small number did not reply to the invitation. Workers with strongly held views that they wished to express, whether positive or negative, may have been more likely to agree to take part.

As a final consideration, this study has provided an insight into one snapshot in time, yet the discussions themselves have highlighted the importance both of time to adjust and the rapidly changing nature of health services. While a longitudinal study or follow-up interviews were not possible here due to time, resource and logistical considerations, future longitudinal research or a follow up study would be hugely valuable.

### **Directions for Future Research**

The findings presented in this thesis raise a number of key questions and directions for future research in addition to those already mentioned. In the interprofessional literature it appears timely to reassess existing concepts of conflict and resistance in order to take into account other, potentially wider sources of threat to teamworking. In relation to the NPA-professional discussion, we need to examine not just the impact of direct encroachment on professional boundaries, but also the impact on working relations of NPA roles being perceived as a symbol of wider, unwanted change even where no immediate encroachment threat exists. It may also be necessary to ask whether it is the NPA workers themselves, or the organisational structure imposing the changes, that is considered the biggest threat to the existing workforce. In the case of the latter, what does this mean for the changing relationship between NHS workers and the organisation within which they work? Secondly, what does an increasing link between political and health care agendas mean for occupations that are considered less of a political priority?

Alongside user and carer concerns over the seeming disappearance of social models of mental health (NTWSU&CN, 2011b), there is a need for further consideration of the impact of political processes on the delivery of mental health care. In the NPA literature there remains a dearth of understanding related to traditional support roles and how they might compare to the experiences found in the more 'novel' roles focused on here. Given the New Ways of Working

(DoH, 2005a; 2007) backdrop to the current study, this fell somewhat outside the scope of the sample examined here, yet the small number of support workers interviewed raised considerations around the level of support, supervision and communication available to these workers. The findings also raised the possibility of an even more intense client relationship for traditional workers, given the long term nature of support and lack of defined endpoint. As the research spotlight moves from one newly implemented role to the next, it appears to silently pass by those who hold less immediate implications for professional groups yet still play an important part in the delivery of care. As HCAs have risen to recent importance for both professionals and policy makers, countless other roles continue to form the 'invisible workers' (Thornley, 1997) of health and social care. As the NPA workforce continues to grow and increase in complexity, it seems increasingly inadequate to retain a focus solely on roles that hold professional implications.

Finally, the main argument arising from this study calls for the client relationship to be considered more intently as a key source of fulfilment and retention for both NPA and professional workers, as well as a source of burden. Specific to the emotional labour literature, further developments and wider application of the various shaping factors identified here would be hugely valuable, and may address recent criticism of the lack of theoretical development related to how worker-client relations are negotiated and maintained (Lopez, 2006; Stacey 2005). The three versions of worker-client relationship observed here (*supporter*, *facilitator* and *ambassador*) are unlikely to be exhaustive; application to alternative settings - including those more traditionally associated with the study of emotional labour such as home care and nursing homes - would provide a useful basis for theoretical advancement.

Useful areas of future study may involve, for example, symbolic interactionist examinations of the client-NPA worker interaction in community service settings,

or further qualitative study of community mental health teams in order to expand our understanding of how this relationship differs across occupational groups. In addition, the interdependence of client relations and co-worker relations appears to have received little interest in the academic literature, perhaps as a result of the separation of the two bodies of discussion. Further attempts to reconcile these literatures into a coherent whole would be hugely valuable to gaining a holistic understanding of worker experience.

### **8.5.2 *Personal Impact: Reflections upon Leaving the Field***

The latter of Pellat's (2003) reflexive questions introduced in Section 3.2.3 asks, "How has the research affected me?" and, "Where am I now?" This studentship has been - and continues to be - an intense personal journey alongside an academic one. It has challenged my perceptions, beliefs and required me to reconsider the way I look at the world and the social actors within it. It has resulted in changing ambitions and a changing worldview. I have found it a truly inspiring process, not least for the insights I have shared with participants and others I have met along the way. I leave the field with huge respect for both non-professional and professional workers as they negotiate what has appeared to me as almost impossible workloads, political agendas and the bureaucratic nature of a modernised health care system. Despite these burdens, I was touched by the enthusiasm and warmth with which I was so often greeted as a researcher. As I start my career as a qualitative researcher, I can only hope that the journey of each new study is as powerful as this one.

### **8.5.3 *Conclusion***

In response to identified gaps in our understanding of the non-professionally affiliated (NPA) workforce, this study has attempted to provide a holistic, subjective exploration of worker experience within the context of community mental health care. In doing so it has built a contrasting picture to that anticipated, in which the relationship to the client - not to the professional -

appears as the central defining feature of working life. The findings have called for a more substantial consideration of this under-discussed aspect of worker experience, including how the emotional aspects of work are acknowledged and supported, and the co-dependent nature of client and co-worker relationships. As the NPA health care workforce grows in number and complexity, it is time to move beyond thinking about workers in purely professional terms towards a broader exploration of worker wellbeing, including how it is shaped by other relationships and the wider working context. This study calls for a reconsideration of the nature of collaboration and conflict in the modernised healthcare system, and a re-positioning of the client in understanding the working lives of both NPA and professional workers.

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## Appendix A. Overview of NPA Roles Implemented Under New Ways of Working

Fig. A.1 Overview of Role Purpose

<p><b>Support, Time and Recovery (STR) Workers</b></p> <p>‘...someone who works as part of a team that provides mental health services and focuses directly on the needs of service users, working across boundaries of care, organisation and role. They will provide support, give time to the service user and thus promote their recovery.’ (DoH, 2003a: 16)</p>
<p><b>Carer Support Workers</b></p> <p>‘...health or social care professionals who provide specialised support to carers of people with mental health problems.’ (DoH, 2002: 7)</p>
<p><b>Community Development Workers for Black and Minority Ethnic (BME) Communities</b></p> <p>‘...work with and support communities including the black and minority ethnic (BME) voluntary sector, help build capacity within them, and ensure the views of the minority communities are taken into account by the statutory sector during planning and delivery of services.’ (DoH, 2006: 1)</p>
<p><b>Primary Care Graduate Mental Health Workers (GMHWs)</b></p> <p>‘...support the delivery of brief, evidence-based effective interventions and self-help for people with common mental disorders of all ages.’ (DoH, 2003b: 12)</p>
<p><b>Improving Access to Psychological Therapies (IAPT) Workers</b></p> <p><b>Psychological Wellbeing Practitioners (PWPs)</b> are ‘...trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression.’ (DoH, 2011c)</p> <p><b>High Intensity Workers</b> are ‘...trained in cognitive behavioural therapy for people with moderate and severe depression and anxiety disorders.’ (DoH, 2011c)</p>

### ***Support, Time and Recovery (STR) Workers***

The STR worker role focuses on enabling service users to live ordinary lives, by spending time with the service user, giving appropriate support and aiding their recovery as a result (DoH, 2007). The development of the STR Worker role was

recommended by the Workforce Action Team (WAT) set up in 2000 to look at the workforce, education and training implications of the National Service Framework for Mental Health (1999) and the NHS Plan (2001). The recommendation was based on consultation with service users as to what they regarded to be the most valuable type of support, alongside an acknowledgement of the increasing workload of professionally qualified staff (DoH, 2003a; James, Chadwick and Rushforth, 2006). The role was introduced into six pilot sites, followed by national implementation using an accelerated development programme (ADP) from 2002-2007 (DoH, 2007).

The role provides practical help and support, with a focus on promoting independence and integration into the community and improving access to employment and community resources. STR workers also work with service users to identify early signs of relapse and support them to take an active part in their care programme (DoH, 2007). Clear guidance exists relating to what STR Workers do *not* do, including providing clinical or medical treatment, monitoring or administering medication and undertaking counselling or other forms of therapy (DoH, 2003a, 2007).

STR workers work across traditional health and social care boundaries and in a variety of statutory and non-statutory settings. A third of STR workers are employed within CMHTs, with the remainder largely employed by assertive outreach teams, recovery/rehabilitation, crisis resolution and housing services (DoH, 2007; Dickinson et al., 2008). A 'specified education and training pathway' sets the role apart from more traditional support work roles, as well as guidance to encourage applications from those who would not traditionally apply for jobs in health and social care, such as service users and carers (DoH, 2003a; 2007).

According to the Department of Health (2007), the target of 3000 STR Workers in post by December 2006 was achieved, by creating new posts and converting existing roles such as community support workers. The STR Worker appeared to be the highest profile of all new roles introduced under New Ways of Working, having received the largest amount of public and research attention as well as the largest amount of official policy documentation (DoH, 2003a; 2007; Huxley et al., 2005; James, Chadwick and Rushforth, 2006; Dickinson et al., 2008) .

### ***Carer Support Workers***

Carer support workers provide support for the carers and families of people with mental illness (DoH, 2002). Aspects of the role include providing carers and

family members with information, support and breaks from caring, helping to identify carers, making links between services to ensure carer access, helping to resolve disagreements between carer and service user and encouraging carer involvement in developing and improving local mental health services (DoH, 2002). Carer Support Workers are usually located within community mental health teams (CMHTs) but are also employed to work in GP surgeries, carer centres and voluntary services (DoH, 2002).

Carer Support workers already existed within mental health services prior to New Ways of Working (NWW), with the voluntary sector as a key employer. The NHS Plan (2000) identified that while some services already provided good carer support, provision was inconsistent and standards in general needed to be raised. In response to this the Plan set out a commitment to provide 700 additional workers by 2005. No official figures were found relating to whether or not the target figure was reached, but results from the Durham Workforce Mapping Project suggest that it was narrowly missed with 621 WTE in post in March 2005 (Dickinson et al., 2008). Carer Support Workers are perhaps the lowest profile of the roles implemented under NWW, with the only documentation of the role existing in the original policy guidance (DoH, 2002).

### ***Community Development Workers for Black and Minority Ethnic (BME) Communities***

The Community Development Worker (CDW) for BME communities was developed as part of the Department of Health's Delivering Race Equality (DoH, 2005c) programme; a wider programme of work aimed at tackling the inequalities faced by BME mental health service users. The role focuses on enabling greater understanding and ownership of the issues facing people from BME communities in order to improve the commissioning and provision of mental health services for people from BME communities. CDWs are seen as a core part of increasing community engagement by supporting the development and exchange of information, knowledge and skills between mental health services and the communities they serve. There are four main aspects of the CDW role:

- Role as a **change agent** to identify community concerns and gaps in services, increase channels of communication between community and statutory services and to seek out capabilities for communities to develop innovative practices.

- Role as an **access facilitator** by helping people to find effective pathways across services, directing people to community resources and addressing language and other barriers.
- Role as a **service developer** by advising on the training and education of staff, highlighting the importance of culture in service systems and developing joint working between statutory and community services.
- Role as a **capacity builder** to develop socially inclusive BME communities, engage in the establishment of community leadership and assist in the development of community organisations (DoH, 2006)

CDWs are employed in PCTs, local authorities, NHS mental health trusts and in voluntary sector organisations (DoH, 2006; Dickinson et al., 2008). The Department of Health set a target of 500 CDWs to be in post by December 2006, which was reinforced by the publication of the Delivering Race Equality Action Plan (DoH, 2005c). Despite £16 million being released to Primary Care Trusts to support implementation, development was slower than expected and the target deadline was extended to December 2007 (DoH, 2006). No official figures were found relating to whether or not the target figure was reached but data from the Durham Workforce Mapping project suggested that the number of CDWs employed in mental health services dropped from 314 WTE posts in 2004 to 160 WTE by March 2006. Reasons behind this decrease were unclear (Dickinson et al., 2008). As with carer support workers, there is limited literature available relating to CDWs outside the role's original policy guidance (DoH, 2004; 2006).

### ***Graduate Mental Health Workers***

GMHWs formed part of the NHS Plan's (2000) proposal to strengthen primary care mental health provision by increasing the provision of 'psycho-bio-social' interventions for common mental health problems (DoH, 2003b: 5). Their role includes providing CBT-based brief interventions ('supported self-help') to clients with common mental health problems such as depression, anxiety and panic disorder, as well as mental health promotion work, strengthening the availability of information and community networking/liaison. GMHWs are employed in primary care settings such as GP surgeries and clinics (DoH, 2003b).

The NHS Plan (2000) set out a proposal to have 1000 GMHWs in place by 2004, with £2.5 million made available during 2002/3 to Primary Care Trusts (PCTs) in order to establish GMHW training and development programmes. Workers were required to hold an undergraduate degree in a relevant subject, usually

psychology and the subsequent training programme was made up of the 'Postgraduate Certificate in Primary Mental Health Care Practice' (DoH, 2003b). At a local level, at the time of writing the postgraduate certificate had been disbanded and it was expected that GMHWs would instead undertake the low intensity IAPT training programme.

Official policy documents relating to GMHWs were limited to the original guidance (DoH, 2003b), however a small number of early evaluations of the role were found in the academic literature and form part of the literature review undertaken in Chapter 2 (Bower, Jerrim and Gask, 2004; Gilbert and Russell, 2006; Farrand, Duncan and Byng, 2007). See section 2.3 for details.

### ***IAPT Workers (Psychological Wellbeing Practitioners and High Intensity Workers)***

The Improving Access to Psychological Therapies (IAPT) programme was introduced to enable PCTs to implement the NICE (2004; 2009) guidelines in providing services to people suffering from depression and anxiety disorders (DoH, 2008a). Initially funded under the previous Labour government as part of the New Horizons (DoH, 2009a) programme, the initial target was to create 3,600 newly trained therapists by 2010/11 in order to help 900,000 people access therapy. £33 million was committed for 2008/9, with a further £70 million pledged for 2009/10 and £70 million for 2010/11, bringing the total to £173 million (DoH, 2010). The coalition government's most recent mental health publication *Talking therapies: A four-year plan of action* (DoH, 2011b) announced a further investment of £400 million over the next four years, with planned savings of over £700 million to the public sector in healthcare, tax and welfare benefits.

The IAPT workforce comprises two newly implemented roles. The Psychological Wellbeing Practitioner (PWP, formerly the low intensity worker) is the rough equivalent to the GMHW role, with workers trained in cognitive behavioural approaches for mild to moderate anxiety and depression. These approaches include guided self-help, problem-solving, signposting and the delivery of psycho-educational groups (DoH, 2008b; 2011c). The high intensity worker - the next tier of the workforce - provides cognitive behavioural therapy (CBT) to people with moderate to severe anxiety and depression. The workers operate to guideline intervention lengths, of up to seven sessions for PWPs and up to twenty for high intensity workers (DoH, 2008a).

PWPs are required to hold a degree, usually in psychology, or relevant life/career experience plus the ability to demonstrate being able to study at a postgraduate level, in order to undertake the postgraduate low intensity training programme. High intensity workers are required to hold either three years experience as a GMHW or PWP, or be professionally qualified such as clinical psychologists, psychotherapists, counsellors or nurses. They undertake a 2 days per week high intensity training programme (DoH, 2008a; 2011c).

## **Appendix B. Participant Information and Consent**

*Participant Information Sheet*

*Participant Invitation Letter and Opt-in Form*

*Participant Consent Form*

# Support and Community Roles in Mental Health Care: Worker Perceptions and Experience

## Participant Information Sheet (Interviews)

### **An invitation to take part**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

### **What is the purpose of the study?**

Recent changes in government policy have led to a large increase in the number of support and community roles within the mental health workforce. There has been an introduction of new roles such as the Support, Time and Recovery (STR) Worker, the Graduate Mental Health Worker, the Community Development Worker for Black and Minority Ethnic (BME) communities and the IAPT (Improving Access to Psychological Therapies) Worker. There has also been an increase in the number of workers in existing roles such as the Carer Support Worker. The purpose of this study is to explore the experiences and perceptions of people who work in these roles relating to various aspects of working life, from the workers' own perspectives.

### **Why have I been chosen?**

You have been chosen because you work in one of the roles listed above (an STR Worker, a Carer Support Worker, a Graduate Mental Health Worker, a Community Development Worker or an IAPT worker), or in another mental health support work role.

### **Do I have to take part?**

It is up to you to decide whether or not to take part in the project. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work or any education or training you may be undertaking.

## **What will happen to me if I take part?**

If you decide you would like to take part and agree to be interviewed, I will contact you to arrange a mutually convenient time and place to meet. This could be at your workplace or at a different location, away from work, if you would prefer (such as a room at the university or a local café). The interview is likely to last around 45 minutes. If you have to travel for any part of the study then your travel expenses will be paid, although in most cases I will be happy to travel to you.

During the interview I would like to talk about topics such as: your role and what it entails, your experiences working in any teams you are part of, how you think others view your role and what impact you feel your role has had on other staff. I would also like to find out about any other issues which you feel are important to you, relating to your working life or role in mental health services.

Face-to-face interviews are the preferred method in this study, however if you would rather use a different method (such as speaking to you over the telephone or by email) then please contact me and I will be happy to arrange it.

## **Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the study will be confidential. Your contact details will only be kept if you express that you would like to receive written feedback about the study after it has ended. Any contact details will be stored securely on University premises.

Before the interview I will ask for your permission to audio tape the discussion. If you would prefer not to be audio taped then please let me know at the start of the interview, as other arrangements can be made. If the interview is audio taped, with your agreement, the audio files will be securely stored on university premises and wiped at the end of the study.

All transcription of the interviews will be done at the School of Medical Sciences Education Development, Newcastle University. No names of people, places or organisations will be transcribed. If you think there is any other way that it might be possible to identify you from the discussions then please let me know and we can talk about possible ways to keep your identity safe.

Please note that while interview discussions in this study are intended to be strictly confidential, this does not apply to any disclosure of criminal behaviour or malpractice, about which researchers are legally required to inform an appropriate person.

### **What will happen to the results of the research study?**

The results of this research study will form part of my PhD thesis. They may also be published in academic journals. Details of any publications will be obtainable from me on any of the contact details provided. *You will not be identified in any report or publication.*

### **Who is funding the research?**

This PhD study is part of a larger research project called *New Roles in the Mental Health Workforce: Implementation and Experience* which is led by Newcastle University. Both projects are funded by the Department of Health (National Institute for Health Research).

### **If you would like any further information please contact me:**

Deborah Harrison  
PhD Student  
School of Medical Sciences Education Development,  
The Medical School,  
Newcastle University,  
16-17 Framlington Place,  
Newcastle upon Tyne  
NE2 4HH

Tel: 0191 246 4527

Email: [deborah.harrison@ncl.ac.uk](mailto:deborah.harrison@ncl.ac.uk)

Thank you for taking the time to read this

[Space for university header]

2nd March 2010

Dear worker,

I would like to invite you to take part in a research project which is part of my PhD study, based at Newcastle University and funded by the Department of Health (National Institute for Health Research). The study is looking at the experiences of staff working in support and community roles within the mental health workforce, with particular focus on the following roles: Support, Time and Recovery (STR) Workers, Carer Support Workers, Graduate Mental Health Workers, IAPT Workers and Community Development Workers for BME communities.

I would like you to be involved in the research because of your experience working in one of the roles the study is focusing on. I hope to understand your experiences and the issues surrounding your role from your perspective.

If you agree to take part it will involve around 45 minutes of your time to talk to me about your experiences. I will visit you at a time and location which is convenient to you, either at work or away from your workplace depending on your preference.

It is up to you to decide whether or not you would like to take part in the project. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work or any education or training you may be undertaking.

Please find the enclosed information sheet to tell you more about my study. If you would like to take part or would like to find out more about the research please complete your details on the reply slip enclosed and return it to me in the stamped, addressed envelope provided. Alternatively please feel free to contact me directly by telephone, email or post to discuss the project in more depth.

Thank you for taking the time to read this letter.

Yours faithfully,

Deborah Harrison  
PhD student

Telephone 0191 246 4527  
Email [deborah.harrison@ncl.ac.uk](mailto:deborah.harrison@ncl.ac.uk)

**New Roles in Mental Health Reply Slip**

Please tick the most applicable of the following options:

- I **do** wish to be involved in the research
- I **do not** wish to be involved in the research
- I would like to find out more about the project

If you would like to be involved in the research, or would like to find out more about the project, please fill in your details below (please print clearly) and I will contact you:

Name:

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Contact address:

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---

---

---

Contact telephone number:

---

**Please return this slip in the stamped envelope provided to:**

Deborah Harrison  
PhD Student  
School of Medical Education Development  
The Medical School  
Newcastle University  
Framlington Place  
Newcastle upon Tyne  
NE2 4HH

Tel: 0191 246 4527

Participant Identification Number:

## CONSENT FORM

### Title of Project: Support and Community Roles in Mental Health Care

Name of Researcher: Deborah Harrison

**Please initial  
box**

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my work or legal rights being affected.

3. I agree to take part in the above study.

4. I agree to the interview being audio recorded and understand that the recordings will be securely stored in the research base and destroyed within 4 weeks of the completion of the study report.

If you would like to receive a written summary of the study's findings then please complete your details on the sheet overleaf.

Name of Participant

Date

Signature

Researcher

Date

Signature

1 copy for participant; 1 copy for researcher

### **CONTACT DETAILS FOR SUMMARY OF RESULTS**

Would you like to receive a written summary of the study's findings?

Yes

No

If you answered 'yes', please give your contact details below and indicate how you would prefer to be contacted:

**I would prefer to be contacted by:**

**Post**

**Email**

**Postal address:**

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**Email address:**

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**Thank you for taking part in the study**

## **Appendix C. Protocols for Distress, Malpractice and Lone Working**

*Management of Potential Distress Protocol*

*Protocol for the Disclosure of Malpractice, Criminal or Unethical Behaviour*

*Lone Working Protocol*

## **Management of Potential Distress Protocol**

### **Protocol for researchers conducting interviews**

While conducting interviews which discuss potentially sensitive topics, there is a possibility that participants may become upset or distressed.

In the context of the proposed study, discussion topics which may cause participants to become uncomfortable, upset or distressed may include:

- Experiences of working life
- Working relations between the interview participant and their colleagues
- How workers consider that the role is seen by others (including service users and carers, other workers and the general public)

#### **Before the interview starts**

Ensure that participants are aware that they do not have to answer any questions they feel uncomfortable with and that they can leave questions unanswered, ask to move on to a different topic or end the interview at any point, without any explanation being required or asked for. This will be discussed prior to obtaining written consent.

#### **During the interview**

If a participant appears to become upset or distressed at any point during the interview I will follow the protocol set out below:

Ask the participant if they would like to move on to a different question or to end the interview.

#### **If the participant would like to end the interview:**

1. Turn off the audio recorder
2. Give the participant as much time as they need.
3. Discuss possible support options with the participant:

Ask the participant if they know anybody they feel they might like to discuss the issue with, or if they have already talked to somebody about it. If appropriate, suggest some possible support options that the participant might like to consider. This will vary depending on context but may include a friend or colleague, the worker's line manager or supervisor (where appropriate, depending on the upsetting issue and who it involves) or their human resources department. It may be appropriate to suggest an external source of support (such as a trade union representative or a local counselling service).

Note that while the discussion will be based on recommending possible support channels, it is up to the participant to decide whether they wish to make use of any of the suggested options. Pressure will not be placed on a participant to take any action or to seek support from any sources suggested.

#### 4. Leaving the interview

Make every effort to ensure that the participant is no longer upset (or that this has been minimised as much as possible) before leaving the interview location. Make sure that the participant has my contact details in case they require any further advice.

Ask the participant whether they wish for their interview to be included in the study's findings or if they would prefer it to be excluded (allow participants to decide this later if they so wish –give contact details).

#### **If the participant does not wish to end the interview:**

1. Give the participant as much time as they need (turn off the recorder where appropriate).
2. After taking this break, ask the participant if they still wish to continue. (If they do not wish to continue, refer to the above protocol). If they would like to continue:
3. Re-emphasise that it is fine to end the discussion at any time, move on to a new topic or not answer any questions that the participant does not feel completely comfortable with. Offer to move on to a different question or discussion topic.
4. Continue with the interview.
5. At end of the interview refer to steps 3-4 above (discuss possible sources of support for the participant should they wish to use them, ensure that the participant is no longer upset or that the upset has been minimised as much as is possible, make sure that the participant has researcher contact details etc).

#### **After the interview:**

Record the incident in writing in my interview notes, along with any advice given to the participant.

## **Protocol for the Disclosure of Malpractice, Criminal or Unethical Behaviour**

### **Protocol for researchers conducting interviews**

While I am conducting research interviews with staff working in a health service setting, I may become aware of practice which could be considered dangerous, criminal, inappropriate or potentially harmful to staff, service users, carers or the general public.

- Practice which is dangerous, inappropriate or harmful may include:
- Criminal activity which either has been or is about to be committed
- Failure to comply with a legal obligation
- Improper conduct or unethical behaviour (including abuse, ill treatment, discriminatory practices such as bullying or harassment, or causing harm/distress to colleagues, service users, carers or the general public)

Concerns may be about behaviour which has already occurred, is currently occurring or is likely to occur. It could be actual or intended behaviour.

**If a member of staff discloses such practice during an interview I will act immediately following the protocol set out below:**

#### **1. During the interview:**

Inform the participant that the disclosed practice may be of concern and therefore I am required to inform an appropriate person within the organisation about my concerns.

If the concerned behaviour relates to another member of staff (e.g. a colleague or manager), ask the interview participant if they have brought the concerned behaviour to the attention of an appropriate person. If the matter has not already been adequately resolved then inform the participant that I am required to inform an appropriate person.

Direct the participant to the Trust's Whistleblowing Policy if they would like further information or contacts such as Public Concern at Work.

#### **2. After the interview:**

I will immediately bring my concerns to the attention of an appropriate senior member of staff, *as soon as possible or within one working day.*

The appropriate person in this study will vary depending on the context but is most likely to be the worker's line manager (if the disclosed behaviour relates to an interview participant or one of their immediate colleagues), or the service manager if it is not appropriate to approach the line manager. I will ensure that I have contact details for the relevant managers prior to visiting the interview location to conduct interviews.

If in any doubt about who is the most appropriate contact, or if I am unsure as to whether a disclosed behaviour is considered malpractice, I will immediately contact my lead supervisor Revd. Dr Pauline Pearson for advice. If still unsure then we will contact Dr Roger Paxton (within-Trust supervisor, Director of Research and Clinical Effectiveness and Director of Psychological Services for the Northumberland, Tyne and Wear NHS Trust) for advice.

Upon contacting the appropriate person I will expect to be informed of how my concerns will be investigated and how I will be kept informed of the investigation.

### **3. Record my concerns in writing**

I will record my concerns in writing as soon as possible after the incident.

I will notify my educational supervisors of my concerns and subsequent actions as soon as possible and supply them with a written copy of my concerns.

This protocol is based on the Trust's Whistleblowing Policy and Misconduct and Fraud Policy, as well as existing protocols from current research projects and discussions with my supervisors and other experienced researchers.

The following statement will be featured on participant information sheets so that potential participants are aware that the disclosure of malpractice or criminal behaviour will result in action being taken: 'Please note that while interview discussions are intended to be confidential, this does not apply to any disclosure of criminal behaviour or malpractice, about which researchers are legally required to inform an appropriate person'.

## Lone Working Protocol

A Lone Working Risk Assessment was undertaken for the proposed research using the local Trust's lone working checklist. The risk is considered to be fairly low for the following reasons:

- Interviews will not take place in people's homes
- Interviews will take place with staff rather than patients/ service users
- Interviews will take place during normal working hours and at a safe location (usually participants' work premises)

Outlined below are the procedures I will follow to maximise personal safety while conducting the research:

### **Before interviews take place**

- A daily itinerary will be left with the project's research secretary outlining time/s and location of interviews.
- I will contact the research secretary by telephone after each interview (or each block of interviews if they are taking place at the same location) so that they can be logged.
- Contact details for each interview location and researcher contact details (including address, vehicle details and emergency contacts) will be held by the research secretary.

### **Interviewing participants on their work premises**

I will make myself aware of local security/access procedures prior to visiting the interview site and ensure that I adopt any local protocols to maintain security of the building.

I will ensure that the appropriate manager is aware of my arrival and departure.

### **Interviewing participants away from work**

This is only expected to apply a very small number of interviews.

When choosing an interview location I will ensure that it is one which is familiar, safe and easy to travel to/from, for the participant and for myself.

I will make sure that myself and the participant are aware of any local security/access procedures and ensure that these are followed.

I will ensure that I inform the appropriate person of our arrival and departure (where relevant, for example on university or Launchpad premises).

**Travelling between interview locations**

When travelling between interview locations I will ensure that I follow usual safety procedures e.g. planning/booking trips in advance when using public transport or taking taxis, keeping to busy and well-lit roads and bus-stops and carrying a personal attack alarm.

This protocol is based on NHS and Newcastle University Lone Worker Policies.

## **Appendix D. Interview Topic Guides**

*Interview Topic Guide - NPA Workers*

*Interview Topic Guide - Managers*

## Interview Topic Guide

### Background and Role

Could you tell me a bit about your background and how you came to work as a (name of role)?

- How long have you worked as a (name of role)?
- What made you apply/ attracted you to it? (If applicable)
- What did you do before your current position?

Tell me a bit about what you do...

- Does it fit with what you were expecting when you applied for/ took on the job?
- How does it compare to your previous job? (If relevant)

Have you received any support or preparation for the job?

- What was it like?
- Ongoing training?
- Supervision?

### Working Relationships

Do you work as part of a multidisciplinary team (or more than one team)?

- (If yes) What team/s are you part of? Who are the other members of the team/s?
- (If more than one team) Do you have different roles in the different teams? Do you work more closely with one team than the others?
- (If no) Which other workers do you work closely with/ see on a regular basis?

If yes:

Tell me a bit about how the team works...

- What is your role?
- What is it like working in the team?
- Tell me a bit about how team meetings work... (If applicable)
- What about communication between meetings?
- How are decisions made?

Do you think your role has changed the way other staff are working?

## APPENDIX D

- (If yes) What do you think the changes are?

Do you think any parts of your role overlap with other types of worker?

- (If yes) Which ones?

How do you think other workers see your role?

### Identity

How would you describe to someone what it 'means' to be a (name of role)?

- How do you see your role?
- What do you see as being the essence/ most important part of your role?

Do you think other people share your view?

- Other (name of role)s
- Your manager, those you work alongside
- The general public

### Aspirations

Where do you see yourself in 5 years time?

- If you think you will have moved on, why do you think it will be?
- Have your career aspirations changed compared to what your ideas were when you first started the job?

Is there anything else you would like to discuss?

- Are there any issues that I have not asked you about, that you feel are important to you as a (name of role)?
- Is there anything we have discussed which you would like to go back to?

(NB. Bullet points refer to possible probe questions, not to specific questions to be asked)

## Interview Topic Guide

### Managers

#### *Role*

Could you tell me a bit about your role as manager?

- What do you do/who do you manage?
- Team/service set-up

Could you tell me about the role of (name of role) in the organisation?

- What do they do?
- What is their position in the team? (if applicable)
- Which other workers do they work closely with/ see on a regular basis?
- Any differences between the role they are performing and policy guidance/job descriptions?

Could you tell me about your experience managing (name of role)?

- Supervision
- Training/preparation
- Caseload management

#### *Working Relations*

Do you think other staff are clear about what the role is?

What impact do you think the role has had on other workers?

Is there any overlap between the role of (name of role) and other workers?

How do you think the role is seen by other workers?

#### *Future Plans*

Turnover –how often do (name of role) tend to stay in post?

What jobs do they tend to move on to?

Why do they tend to move on?

Is there anything else you would like to discuss?

- Any issues that I have not asked you about, that you feel are important to (name of role), those they work alongside or you as a manager?
- Anything we have discussed which you would like to go back to?