The Interface between a Crisis Resolution and Home Treatment Team and Community Mental Health Teams: an exploration of experiences and expectations of the working relationship

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Abstract

Background: This research study focuses upon the relationship between a Crisis Resolution and Home Treatment Team (CRHT) and Community Mental Health Teams (CMHTs) in the local Trust. Analyses of the literature on inter-team/inter-agency collaboration indicate that problems do emerge when multidisciplinary teams attempt to work collaboratively. Others report that where protocols such as the use of integrated care pathways exist to guide the collaborating teams, the problems that emerge as a result of collaboration can be negotiated and sometimes avoided.

Aims & Objectives: A theoretical perspective was taken as a rationale for investigating whether or not problems do exist between the CRHT and the CMHTs in the Trust, because the care offered by these teams crosses team boundaries. This study aimed to elicit the types of problems, and the nature and impact of these problems (if any) on service-users, staff and the teams.

Method: To investigate this, two focus groups were conducted, each consisting of 8 participants who were purposively selected from the CRHT and Community Mental Health Teams respectively. The groups discussed semi-structured, open-ended questions to generate data. Audio-recorded tapes from the focus group discussions were transcribed verbatim, following which thematic content analysis was conducted.

Results: The major themes to emerge from the transcript analysis were problems with roles, responsibility (for teams and individual staff), information, communication and interdependence. The findings of this research study are consistent with some previous studies (Rummery 1998, Turnbull 1999) in which problems / conflicts were associated with inter-agency working, though not with others (Freeman & Peck 2006).
Conclusions: It is concluded that problems do exist between multidisciplinary teams which engage in collaborative working, especially where there are no protocols to guide the collaborative interaction. These findings have implications for practice and policy and program implementers. It is proposed that a comparative study of teams which have protocols to guide their collaborative relationships with others without such guidelines would confirm the findings in this and previous studies.

Introduction
In the Partnership Trust, a CRHT Crisis Resolution and Home Treatment Team (CRHT) works alongside well-established Community Mental Health Teams, providing a service to the same population. At a team building day in 2006 that involved members of both teams, a number of significant outcomes were highlighted:

- Things that were not going well and required action: lack of interface / joint working, joint planning and shared care; lack of respect of professional opinion between teams; a large number of referrals by CMHTs to the CRHT at the last hour on Fridays; and the members of different teams viewing their respective colleagues as unhelpful.
- Things to continue: working in partnership with the other teams; working to ensure that service users and their families are satisfied with the service.

The rationale for undertaking this research study was therefore two-fold: members of the two service teams recognised the need for and had requested an exploration of the interface between the two service teams, recognising the importance of collaboration and joint working; and, as the available evidence suggests that collaboration between teams can lead to conflicts and problems, this study would provide a direct test of collaboration and conflict between CMHTs and a CRHT within the Trust. A review of the relevant literature was provided in a previous paper (Sesay 2008).

Aims
The aims of this research study therefore were to:
- investigate whether problems do exist between the CMHTs and the CRHT;
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- identify the main problems that both service teams experience in their working relationship;
- investigate how these problems impact on the teams’ aspirations to succeed in the achievement of their goals; and,
- to clarify the reasons for these problems, and begin to generate potentially helpful solutions.

Methodology
A qualitative approach was adopted as the methodology, being most likely to elicit the subjective experiences of participants (Burns and Groves 2001). The significance of adopting this approach is that inter-agency / inter-team conflicts occur where inter-team collaboration is expected in the whole system of community care, and such conflicts are likely to affect service-users in their journeys to recovery between the CRHT and CMHTs (Rees et al 2004). It was hoped that this method would create a forum for participants to explore their teams’ relationship with the other, with a view to highlighting any problems / issues which may impede collaborative working, which is suggested to benefit individual staff, teams, service users and their carers (Sim 1998).

Study Design
For the purpose of collecting data, it was decided to use focus groups as: the two service teams may have perspectives of each other that can best be explored through this method; group discussion is a familiar feature to both teams, wherein practice and management issues are often deliberated; this would allow participants’ views and interactions to be observed, probed and clarified in a relaxed group atmosphere (Krueger 1994); and, the group process would help participants to explore their views and even generate questions in ways that may be difficult in individual interviews (Kitzinger 1995). Kitzinger (1994) defines the focus group approach as ‘group discussions organised to explore a specific set of issues’ (Kitzinger 1994), within ‘a social setting, moderated by a facilitator, and sometimes co-moderator, so as to generate descriptive or explanatory information’. The use of focus group interviews to collect research has received considerable attention in the literature as a result of increased interest in qualitative research methods (Morgan 1988, Kreuger 1994, Robinson 1999).
Research Participants and Sampling

Participants were recruited from four CMHTs and one CRHT in the Trust. For participation within the study, team-members needed to be qualified practitioners who had been working within the team between Jan 2005 & Jan 2007. Those eligible to take part were invited to do so via e-mail / letter. For the CMHTs, 24 of 28 team-members who were approached agreed to participate (response rate of 85%). For the CRHT, 16 of 22 team-members agreed (response rate of 73%).

Sample Generation

Purposive sampling was used to recruit participants to form two focus groups from those who had agreed to participate. Though not necessarily representative of the entire organisation which is being studied (Morgan 1998, Reed & Roskell-Payton 1997), the sample is naturally occurring as the selected groups work in the same teams and may therefore share similar experiences (Mansell et al 2004). Two focus groups were generated: a CMHT group with team-members from different CMHTs; a CRHT group. The CRHT group ranged in age from 25-45 years old, and was balanced for gender and ethnic background (Black, White and Asian). For the CMHT group, participants ranged in age from 25-55 years old, included mainly female staff, though was balanced for ethnic background.

Adopting the concept of smaller focus groups, 8 participants were recruited from each service team, yielding a total of 16 participants for the entire study. There are strong arguments favouring smaller focus groups (Krueger 1994, Fern 2001). Information on the study was provided to participants in the form of a ‘participant information sheet’ and written consent was obtained from each participant.

The Role & Recruitment of a Moderator

It is recommended for focus groups to be facilitated by a moderator, often assisted by a co-moderator or co-researcher (Sim 1998). The skills and role of the moderator are to facilitate and guide the discussion (Krueger 1998), while the co-moderator welcomes participants, sets up the room, records the discussions, observes and takes notes on the interactions among and between the participants (Mansell et al 2004). Trained group facilitators from a neutral department were therefore approached to fulfill the role of moderator, and especially as the researcher was a CRHT-member.
Data Collection Tools and Pilot Study

Semi-structured open-ended questions were prepared for use within the focus groups, to gain more specific information about selected topics (Bowling 2002: 378). The tool was prepared in consultation with staff from both service teams to determine the relevance and appropriateness of topics for discussion.

The semi-structured interview tool was piloted with a CMHT and another CRHT in June 2007, following which a number of refinements were made.

Data Collection

Two days prior to the planned focus groups, the semi-structured open-ended questions were distributed to participants to allow them the opportunity to consider their thoughts and the range of topics included for discussion (Bowling 2002). The two focus groups were conducted during July 2007, being facilitated by a moderator and a co-moderator. The moderator assured all participants of the confidential nature of the discussions and emphasised the need for honesty in their responses. Participants were reminded that their identities would remain anonymous, and that the findings would be presented to the service and team managers of both service teams which may have the potential to improve the quality of relationships. As recommended by Reiskin (1992) the moderator set the mood of the groups by creating a non-threatening, warm, accepting, enthusiastic, and objective environment, which encouraged all group participants to share their views honestly. Two methods of recording took place: audio-recording; and, detailed note-taking by the co-moderator.

Data Analysis

The audio-recorded focus group sessions were transcribed using a method suggested by Sandelowski (1991). Manual data analysis, using the ‘Framework’ method was conducted, being guided by an analytic approach (Ritchie and Spencer 1994). This method highlights key stages in the data analysis process, fulfills the principle of auditability in following a well-defined procedure, and has been cited as highly transparent (Barbour 2002, Lane et al 2001, Matthews et al 2006). This method involved five stages of qualitative data analysis: familiarization; identifying a thematic framework; indexing; charting; and, mapping and interpretation (Ritchie and Spencer 1994).
In order that the emergent themes were reliable and consistent, an independent second reader with expert knowledge and skills confirmed such by reading the transcripts against a summary of the findings presented (for inter-rater reliability). The data was validated by performing checks with focus groups members at two stages (Sandelowski 1993, Lane et al 2001): at the end of the interview either through a session summary using a flipchart or through a moderator facilitated summary of discussion; and, emergent themes were subsequently presented to members of each group, resulting in favourable comments about the interpretation of the sessions.

Findings

About the Participants
The CRHT focus group was comprised of six team-members, with an average age of 40 (range = 25-55), of whom three were female (two White and one Black) and three were male (all Asian). This group included one Social Worker, three Mental Health Nurses and two Psychiatric Doctors, all of whom were educated to university level.

The CMHT focus group was comprised of seven team-members, with an average age of 42 (range = 26-58), of whom four were female (two White and one Afro-Caribbean) and three were male (one White, one Black and one of Asian origin). This group included two Social Workers, one Psychiatric Doctor and four Mental Health Nurses, all being educated to university level.

Summary of Key Findings
The main findings which emerged related to the following themes: roles, responsibilities, information, communication and, joint working / interdependence / collaboration.

1. Roles
The role or purpose of each team could be differentiated from the functions performed by individual professionals. Participants from one team seemed to know the main purpose of the other team. The following statements were used to describe the role of the CRHT as presented by the CMHT focus group: “The purpose of the crisis team is to assist service users to remain in their own homes and be treated in times of crisis”; “to
facilitate early discharge of service users from acute wards”; “to work in conjunction with other community mental health teams”; “to act at a point of crisis”; “to gate keep acute psychiatric beds”. Conversely participants from CRHT focus group discussed the following as the purpose of CMHTs: “Their role is looking after clients that have reached a point where they are quite settled, the clients that have chronic mental health problems”; “to treat and maintain patients to a level of functioning”; “I disagree with the maintenance role alone, as CMHTs can carry extremes of complex and a lot of crisis work”.

Whilst participants from one team seem to acknowledge the purpose / role of the other team, it also emerged that there was an overlap of roles between the CMHTs and CRHT in some of the functions they perform. For example, a description of what constitutes a crisis became a focal point in both groups: “There are disagreements about the definition of ‘crisis’ and we tend to care for patients who are in crisis as well as those who are well settled” (CMHT); as a CRHT participant put it, “this is where there is the overlap and the CMHTs are not too clear when to refer patients who are in crisis to the CRHT, and likewise the CRHT are not too sure when to discharge patients back to CMHT’s” (CRHT). From the above dialogue, there seems to be lack of role clarity for each team.

With regard to the role of individuals within the teams, other sub-themes emerged which in their totality may be constructed as problematic in the teams’ working relationship. For example: role confusion, where individuals from CMHTs and CRHT do not seem to understand each other’s roles. As a result there is confusion over who does what. For example: “If we take somebody who is on depot and with the CMHT, sometimes we are not sure who should administer it – that’s where we have the conflict” (CRHT); “When my patient was discharged into the care of the crisis team and needed medication management, that was not done. The crisis worker said that was not his job – it required long- term work by the CMHT care coordinator” (CMHT); “Someone... from crisis team said... oh no! Health promotion is not for crisis workers, its long-term work that could be done by CMHT Care Coordination” (CMHT).

Participants in both groups agreed that there needs to be some form of clarification to ensure that roles and functions are not duplicated or left undone.
2. Responsibility

Accountability and the capability of the teams and employees within them emerged as another theme which proved to be particularly salient to participants. From a team standpoint it emerged that whilst the CRHT adopts a team approach to patient care (where any team member can provide care to the same patients), CMHTs adopt an individual case management approach wherein a number of service-users are assigned to a team-member who is responsible for meeting the care needs of those service-users on his/ her caseload. In the midst of these differing approaches to patient care it emerged that conflicts do arise because the teams are not sure about their responsibilities, as illustrated: “When it comes to taking some responsibility, as a team they will say... well it’s not our responsibility: I think that’s because they are not sure of how we work, and they say it’s not their responsibility” (CRHT); “In my experience with the CRHT, they never give us an up-to-date risk assessment as we would do when referring patients to that team” (CMHT). It thus emerged that each team believes that the other is neglecting their responsibilities to their service-users and to the sister community team.

Participants, in their description of staff responsibilities in the CRHT and CMHTs used words or phrases such as: “passing the buck”; “neglect of responsibilities”. Care Coordinator responsibilities stood out prominently in both focus groups. It emerged that Care Coordinators are designated staff, usually a nurse or social worker, who organises care arrangements for a number of service-users on his/ her caseload. This is equivalent to a crisis worker in the crisis team. This arrangement makes the care coordinator / crisis worker accountable for the care processes for his/ her assigned patients. The following sub-theme was identified: inconsistent approaches to Care Coordinator / crisis worker responsibility.

A theme of the perceived neglect of responsibility and passing it on to others emerged strongly in the data: “How can you possibly refer a patient to another team simply because the patient has missed his depot injection and is beginning to relapse?”; “Most of such referrals come in on Fridays or a Bank Holiday... and they may be saying, it’s up to them... it’s their responsibility now” (CRHT); “You sometimes go on a joint visit with a view to discharging a patient and the crisis worker is not the one who attends, and the one who attends does not know the patient. I’m sure if the crisis worker who made the care plan, did the risk assessment, you know, was
there it will help a lot. Now the patient is discharged and I have no clue what I am doing with her” (CMHT).

It emerged from the data that the timing and circumstances in which responsibility is shifted to others is predictable. For instance: “We spend a great amount of time on the phone talking to members of the other team in order to discharge their patient, but the response we get is that patient’s care coordinator is off sick or on leave, and I can’t accept that responsibility” (CRHT). On the other hand the CMHT focus group commented: “Of course staff in the crisis team are trained and can deliver special interventions such as medication management, but they would choose to refer patients to us” (CMHT).

Being proactive and accountable in taking personal responsibility as a care coordinator/ crisis worker also emerged from the data: “If only the care coordinators are a bit proactive to refer their patients to the crisis team before the patients become very unwell it will solve the conflict between us” (CRHT). In a similar manner, CMHT data revealed that CRHT crisis workers hardly ever knew the patients they are assigned to: “I once contacted the crisis worker about one of my patients in their care for update… and she could not tell me, saying ‘I do not know this patient’; “I asked for an up-to-date risk assessment and it took nearly two days before I got one” (CMHT).

3. Communication

The need for better channels, consistent means and appropriate methods of communication featured prominently in the data for both groups. A number of sub-themes emerged which included the need for a central point / person to direct communication: “You may have something urgent to discuss... say with someone who has assessed your patient, or made a referral to our team, but you are never lucky to get past the receptionist...” (CMHT); “That’s why I go straight to their manager... you know I have her number. That way I ask the question or request for the information and she directs me to the right person” (CMHT); “And I think they need to give us their mobile numbers like you were saying. They are not precious... you can liaise with them on their mobile because sometimes you have to wait for them to get back to you which they hardly do” (CRHT).
A further sub-theme concerned a lack of feedback between the two teams, which seems to lead to frustration between teams and individuals: “My experience is we never hear about the outcomes” (CRHT); “I think sometimes you do emails as a prompt to the CMHT and there is no response” (CRHT); “The main difficulty is with feedback after they have assessed the patient” (CMHT); “Getting feedback as soon as possible will reduce our anxiety... knowing that a suicidal patient is receiving care... is safe, but you need to call before anyone says anything” (CMHT).

Another sub-theme relates to the nature of the communication style, suggesting that those communicating do not negotiate, do not take ‘no’ for an answer, nor explore alternative solutions: “The ones that I’ve experienced... are the ones following an assessment and the patient did not meet the criteria for admission to hospital. The referrer was unhappy and said, ‘that person has got to be in hospital, or with your team; I’m not taking anything else’ ” (CRHT); “Sometimes, and very recently I sent a referral by fax and one hour later I was asked to justify why this patient was referred. The caller’s reason for the query was that this patient was discharged from their team not too long ago” (CMHT).

4. Information

The use of and sharing information within and between teams emerged strongly as being helpful to patient care and allaying staff anxiety. However, the data revealed that information is either used inappropriately or not used to good effect. A sub-theme about inadequate or a lack of information emerged, with participants reporting that service-users are often discharged without the relevant risk information and this places those who then take responsibility for their care at potential risk or places the discharged service-user at risk: “There is a need for the crisis team to fax a short discharge summary at the point of discharge to care coordinators and responsible medical officer. We have had incidents when patients are discharged without any background information relating to medication” (CMHT); “There was a referral we received a few weeks ago and two of us, females, went to assess this patient. We could not do it, because when we saw this patient, Oh!, he was so verbally abusive. It turned out later that even the care coordinator who referred this patient does not visit him at home, but this was not indicated on the referral form” (CRHT).
A further sub-theme that emerged concerned misleading or delayed information, particularly at the time of referral between teams: “Often you get a referral and when you go out to assess the patients it turns out the information given on the form is a bunch of lies and that’s not very good but you can’t complain” (CRHT); “What is even more traumatic is when they (CRHT) assess a patient and they tell them... ‘Oh we will not give you the outcome till we return to the office and discuss with the rest of the team. And minutes later a call comes to the patient to say sorry we did not find you appropriate for crisis intervention. Surely in that circumstance we will have no option but to ask the patient to go to the Accident and Emergency Department to be reassessed” (CMHT).

In view of past unfortunate experiences in how information has been withheld, distorted or delayed, the data revealed suggestions about how to move forward to combat such anomalies, even though these suggestions are practices which participants expected to have already been in operation: for team-members from both service teams making available photocopies of relevant documents; having face-to-face meetings; giving advice on the health status of service-users; having an active link-worker between the teams; arranging opportunities for cross team shadowing to raise awareness of team practices.

5. Inter-dependence / Joint-working / Collaboration

Used as interchangeable terms by participants, there was recognition that the absence of inter-dependence between the two teams could have an impact on service users, team task performance and individual staff. Participants’ evidence from previous experience indicates that variable responses have been encountered when staff from one team had attempted to initiate collaborative working, which has had a lasting and potentially unfavourable effect upon team-members: “Initially some CMHT managers attended our meetings, and that was useful. Relationship with those is fine” (CRHT); “My own experience is different – it’s about going to their meeting and not feeling welcome. Some of us have had bad experiences. I was told not to attend their (CMHT) meeting” (CRHT).

It was reported that due to the lack of close working relationships, with regard to care coordination, service-users are not easily discharged (because there is no one to continue care for them) leading to an increased caseload. This leads some individual staff to feel irritable and angry: “My
fury at times is that we plan a joint visit to see a patient with a view to discharging them and there is no one from the crisis team to handover the patient” (CMHT); “Sometimes you refer a patient for follow up and you are told ‘oh the care coordinator is on leave / off sick and I can’t take that responsibility“ (CRHT). Participants, upon discussing the impact on service users of the lack of collaboration between the two service teams, revealed that service-users are the ones who suffer as a result: “We can’t work in isolation; otherwise it’s not going to be good for the service users” (CRHT); “Sometimes when the patients’ care coordinator is on leave / off sick… no one takes responsibility and we discharge the patient to no one, which is unfortunate for the patient” (CRHT); “They (CRHT) hardly share information on what has been done with the patients and when we take over, the patient is left confused about our own role” (CMHT).

In view of the difficulties posed by a lack of collaborative working, the data revealed participants making proposals about ways of achieving joint working: “team building activities with the CMHT such as having joint away days.....” (CRHT); “mentorship”; “more active link workers with the CRHT”; “induction of new members about work in other teams in both teams”; “cross-team shadowing, or developing care pathways” (CMHT).

Limitations
There are a number of limitations which might have affected the findings of this study: the limitations of the focus group approach, in that some participants may feel inhibited in a group situation (Greenbaum 1998) or social pressures could cause over-claiming (Webb 2001); the presence of the researcher, as a CRHT team-member, at the focus group interviews may have inhibited some participants to actually air important issues, instead expressing what they thought was wanted; only two focus groups were conducted, limiting participation to 13 team-members from a total eligible group of 44; purposive sampling could be criticised in not being representative of the population being studied (Morgan 1998); in one of the focus groups, one of the participants attempted to dominate the proceedings and this may have inhibited others from making a generous contribution to the data. Nevertheless, the findings may be viewed as credible as the team had an opportunity to express views on the questions prior to the interviews. This could have given the individual teams time to pool their ideas which would have been presented by participants. In this
context the results could be generalized within the Trust, though not necessarily to other Trusts.

**Conclusion**

This study set out with the aims of exploring whether problems exist between the CRHT and the CMHTs and more specifically the form that these problems take and how they impact upon both team aspirations to achieve their goals and upon service users.

By using a qualitative methodology that involved using a semi-structured interview through two focus groups, which provided data that was transcribed in preparation for thematic content analysis, it has been shown that problems do indeed exist between the CRHT and the CMHTs in the Trust, which is not helped by the lack of a formal protocol to guide the two service teams in their collaborative relationship, as observed by Rees et al (2004). It emerged that there was role overlap between teams (CRHT and CMHT), with each team not being sure of where to start or finish their roles. Furthermore, the study identified individual role confusion, with participants demanding clarification. Instances were reported of some team-members failing to communicate care plans or information about service-users to members of the other team, which has led to the service-user either feeling confused, left to become very unwell to the point of hospitalisation or not being followed up after discharge, which is consistent with the findings of Higgins (1999), where a correlation was made between the lack of collaboration and poor patient outcomes. Team-members reported feeling angry, frustrated and irritable at times, and had no means of discussing their feelings, which is consistent with the study by Carmel (1999). It could therefore be inferred that some team-members have no forum to discuss their differences or the impact of poor relationships with the other team and the consequences of such.

As shown, the findings replicate those of some previous empirical studies and are consistent with a number of theoretical perspectives (DH 2000, 2001, 2002, Higgins 1999, Jehn et al 1999, Rummery 1998, Turnbull 1999, Rees et al 2004, Freeman and Peck 2006). The findings are also consistent with suggestions that problems / conflicts do exist in inter-agency collaboration (Rummery 1998, Turnbull 1999, Rees et al 2004), and that these problems are exacerbated where there are no protocols guiding how collaborating teams should interact.
This study contributes to understanding the relationship between inter-team collaboration and conflict, and individual staff and team performance, suggesting that protocols are needed to guide interacting teams. There is evidence to suggest that where guidelines are in place to map out the roles and responsibilities of collaborating teams, these problems / conflicts can be minimised. This evidence has implications for team-members, teams and for policy makers when commissioning new teams within a system where others are already in existence.

References
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