# Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health

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**Abstract**

This paper reports on an investigation of three interdisciplinary mental health teams. The discussion of the responses highlights the boundaries that exist between different professional roles and areas of responsibility. Whereas there is some evidence of role blurring, which was welcomed by a few respondents, others sought to preserve their own professional identity within the multidisciplinary environment. In a paradoxical sense, the lack of managerial direction and the encouragement of generic working seemed to make some respondents all the more insistent on separate professional identities. We conclude that, far from being a relic of the past or a product of 'ingrained attitudes', boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working.

**Keywords:** boundaries, community mental health, interdisciplinary teams, professional identity, role blurring, teamworking

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## Introduction

This paper takes as its starting point the debate over professional roles, boundaries and identities as they have been played out in teamwork. We shall focus on the set of concerns that have been expressed about the issue of boundaries and roles in community health, and illustrate this theme by reference to a recent study of community mental health teams in a rural area surrounding a market town in the Midlands, UK.

The question of roles and the boundaries between them has been debated for the last 20 years in the literature on health care. As long ago as 1982 the idea of blurring roles between different kinds of caregivers was considered beneficial to the patient in hospice medicine (Munley *et al*. 1982). Equally, recent initiatives to expand the roles of nurses so that they take on activities traditionally reserved for doctors have been welcomed in some quarters (Snelgrove & Hughes 2000). The decrease in formal role demarcations between staff and clients in mental health initiatives has met with some approval from clients (e.g. Williams *et al*. 1999), where increased friendliness and a decrease in formality are appreciated. Indeed, Williams *et al*. see the traditional role frameworks of mental health care, with psychiatrists and patients in clearly defined clinical roles, as a legacy of nineteenth century asylum medicine and increasingly out of step with devolved, community-based initiatives (see also Martin *et al*. 1999).

This suspicion of sharp, institutionally demarcated divisions between groups of professionals and the advocacy of a more flexible, blurred-role approach on the part of professionals themselves has been strongly promoted in the literature. However, other authors document some equally strong objections to role blurring and a desire to hang onto traditional specialisms amongst health professionals. One such warning about role blurring concerns the unforeseen costs it has for the practitioner. For example, Moller & Harber (1996) link role blurring with role strain and role confusion.

Our paper will attempt to interrogate one aspect of that experience, namely the implications of this teamwork approach for professional identities and occupational boundaries for those working in community mental health. Team-based working, especially when it is of a non-hierarchical kind, can come into conflict with the notion that it is most efficient for everyone to do the work for which they are specifically trained (Wall 1998). When staff share tasks and operate outside their area of expertise, such as when clinical psychologists help organise accommodation for clients, or when social workers implement psychotherapeutic programmes, Wall (1998) argues that there will be a loss of efficiency.

Whatever its costs and benefits, role blurring and the erosion of traditional professional practices and roles has become a salient issue for many practitioners. Partly, it has come to the fore due to shifts in management emphasis, which have been noted by observers of a whole range of public services. The tendency is to move away from what are regarded as bureaucratic, hierarchical and over-centralised modes of working and implement more 'arms-length' management styles (Foster & Hoggett 1999). Additionally, traditional role boundaries, especially those between doctor and nurse, are breaking down under the influence of 'work pressures, differences between clinical areas and the changing knowledge context of nursing' (Snelgrove & Hughes 2000, p. 661).

To some extent the erosion of traditional roles is a corollary of some deliberate changes in policy. For example, Gerrish (1999, p. 367) describes how community nursing initiatives in the UK have often been set up without the traditional layer of middle management structure, so that teams of community health professionals themselves 'could take greater responsibility for managing both their day-to-day practice and a devolved nursing budget'. The idea of nursing staff taking responsibility for their management has been promoted especially in the US under the more formalised title of 'shared governance' where nursing staff are expected to make a full contribution to the corporate agenda of health organisations (Gavin *et al*. 1999).

At the same time there are concerns that nurses – a substantial grouping in community health – have failed in their professional project. They have not gained control over their area of expertise or their practice environment (Gavin 1997). The additional responsibilities thus come with little additional authority.

Despite these discussions in the literature, we still know very little in a systematic way about the flavour of mental health team working or the experience for team members and clients 'on the ground', despite the large numbers of such initiatives. Onyett *et al*. (1995) were able to identify 517 community mental health teams in 144 district health authorities in the UK, each involving an average of 15 professionals.

In addition, another feature of the debate on teamwork in health care has been the concern over 'creeping genericism'. That is, putting people in cooperative work groups may well erode their sense of professional identity as a nurse, psychologist, social worker and so forth. Early work on the concept of multidisciplinary teams (e.g. Payne 1982) saw professional identity as important and desirable so as to survive the knockabout environment that a multidisciplinary team could become. Moreover, multidisciplinary team work is seen as isolating members from the departments and professions from which they originated and thus deprive them of a sense of support and professional identity from others of a similar background (Berger 1991). This was believed to be particularly acute for social workers who were often outposted from their own departments into an environment dominated by others with NHS backgrounds. More recently, observers who have detected some professional groups thriving in multidisciplinary settings have questioned this gloomy picture. This is particularly true of mental health nurses, where those in community settings may have more work satisfaction, and lower feelings of detachment from their patients than their hospital-based peers (Leary & Brown 1995). In addition, multidisciplinary community settings have been noted to encourage nurses to challenge the traditional authority of other professions (Mistral & Velleman 1997). In this way, then, they may be able to challenge the picture of stunted professional development outlined by Gavin (1997) and achieve some positive professional identity.

An influential account from the Sainsbury Centre (1997) highlights the way that these new ways of working impose new pressures on staff by creating confusion over overlapping roles and the new leadership roles which they find themselves having to take on. It is in this uncertain climate that the teams in the present study are operating. Thus, we shall devote some attention to the sense of 'creeping genericism' as it impacts on their working lives.

As a corollary of this concern over professional and service identity, we shall be examining the data collected in this study for evidence of difficulty which the respondents may be experiencing over boundaries (Hirschhorn 1988, Menzies Lyth 1988, 1989, Miller 1993, Willshire 1999). The issue of boundaries – in terms of professional identities and responsibilities – has been a feature of much work in organisation theory and studies of intergroup communication (Petronio *et al*.

1998). Mental health teams in the community are fertile grounds for the exploration of this issue as they challenge a number of traditional notions concerning health care, which have dominated care delivery for the last one-and-a-half centuries. For example, treatment is delivered in clients' own homes rather than in specialist surgeries, clinics or hospitals. They transgress the 'ingrained' medical dominance in health care (Samson 1995) and they are disruptive of assumptions about expertise and professional groupings (Berger 1991, Wall 1998).

Thus, boundaries in the professional sense are sometimes seen as a ritualistic or entrenched relic of a bygone age. The present and future are characterised as if they represented a set of new possibilities for generic working, role blurring, shared governance and flexible, local team-based initiatives. Hierarchies are perceived to create barriers to change, at least by some of Gerrish's (1999) respondents. Moreover, an overly restrictive sense of professionalism was seen as a barrier to effective teamwork: 'Some nurses are weighed down with professional baggage and want to stick rigidly to what they think a qualified district nurse or health visitor can or should do. Unless they discard this they can't work effectively' (Gerrish 1999, p. 372). Whilst this was being said of primary care, it might just as easily have been said of community mental health initiatives. The professional 'membership sets' (Dollar & Zimmerman 1998) are worked upon and displayed by participants despite official discouragement.

Indeed, some writers see the persistence of old attitudes as being particularly problematic for the transition to new ways of working. Perhaps, Minghella & Ford (1997) argue, a clear team philosophy underpinning service delivery can supplant the erstwhile mindset and modes of working (Martin *et al*. 1999).

However, it may be that the boundaries which respondents express, far from being a relic of the past, are profoundly embedded in the present. To make sense of this, we need to consider how language and practice are forms of social action (Potter 2000). They are ways of persuading the hearer of the truth of a worldview, of presenting one's identity and accounting for the work one does. Moreover, professional identity or 'face' as Goffman (1967, p. 31) called it, is a 'ritually delicate object'. Indeed, 'when a face has been threatened face work must be done' (p. 27). It is therefore our intention to examine how these boundaries – and their blurring – are a site where participants actively work to establish the nature of their professional identity and even express ideals as to how community mental health should exist in a utopian world. Boundaries between professional roles, then, may serve to bolster workers' sense of themselves.

## The present study: method and participants

The data we shall discuss were derived from a study of staff in three interdisciplinary community mental health teams based in a semirural area in the Midlands (UK). The staff in question had until recently been working in single-discipline teams (referred to as community mental health teams or CMHTs) but a new structure had latterly been developed where each team had been constituted in an interdisciplinary fashion such that they contained a variety of professions such as community mental health nurses (CMHNs), occupational therapists (OTs), clinical psychologists, psychiatrists and mental health support workers (integrated mental health teams or IMHTs). During the fieldwork they were questioned about their perceptions of their work and organisational context by one of the authors as part of a comprehensive evaluation of the new way of working. An interview guide containing a list of the topics covered in the interviews can be found in Appendix 1. At the time, the abovementioned author was a relative newcomer to the area and was able to facilitate candour by the fact that his allegiances had not yet crystallised – it was relatively easy for him to distance himself from management issues and establish a rapport with the informants.

To aid exposition and to preserve anonymity we shall identify the teams as A, B and C, with 11, 10 and 8 members, respectively. The teams each included a broad skill mix, involving expertise from psychiatrists, psychologists, occupational therapists, social workers, community mental health nurses and mental health support workers. Their working practices were complicated by the fact that many of them carried over a caseload from their previous working arrangements, which was not necessarily shared with other team members, although efforts were being made to harmonise the caseloads and the catchment areas. Two teams (A and B) had a highly distributed way of working, using offices in a variety of establishments, whereas many members of the third (C) used facilities in what we shall call the advice centre. The teams were managed by means of weekly meetings of team members, which were deliberately kept nonhierarchical, inasmuch as they took it in turns to chair the meetings, which dealt with clinical and business matters. In addition, a steering group met periodically to manage the three teams. This consisted of three team members, senior managers from the local mental health trust and social services, as well as two senior managers from the local health authority.

Whereas the idea of a multidisciplinary integrated mental health team (IMHT) differed from the earlier single-discipline community mental health team (CMHT)

model in that it recognises the heterogeneity of the professions which go to make it up, the process of genericism may still be a source of contention.

The corpus of interview material in the present study is derived from 29 interviews with diverse occupational groups across three teams. The topics covered in the interview were determined through discussion with a subset of practitioners formed into a research subgroup so that the interviews would reflect the practitioners' concerns. Following transcription, the corpus of material was examined via a close reading by the first two authors.

The analytic strategy was informed by two major strands in qualitative analysis. First, the method has a basis in the well-established approach of grounded theory (Glaser & Strauss 1967, Strauss & Corbin 1998). Here, theoretical developments are made in a bottom-up manner such that they are anchored to the data. Thus, an initial intuition that the issue of boundaries and role blurring could shed light on what the participants were expressing was extended into a close reading, to extract themes relating to the management and self-government of these boundaries. The strength of the grounded-theory approach is illustrated by the way that existing theoretical presuppositions about the nature of boundaries were challenged by the data. Much of the literature we had reviewed earlier led us to expect that traditional boundaries would appear as a thing of the past. Indeed, for some informants this was true, but we detected much counterintuitive evidence that they were also a feature of social action in the present.

The second strand of our analytic strategy was to follow the lead of Potter, Edwards and their colleagues at Loughborough University (e.g. Potter & Wetherell 1987, Edwards & Potter 1992, Potter 2000). These authors argue that language – such as that in which people talk about professional identities, role boundaries and the like – is a form of social action. Rather than merely describing the state of the world, language is a transaction in which the actors try to perform some social business. Thus, in the forthcoming presentation we will be attentive to how formulations of job roles and their boundaries might facilitate courses of action – for example, how they might delimit demands, secure the speaker's status or assign blame elsewhere.

Having examined the corpus of material in the light of the above concerns, a selection of quotations and views expressed will now be presented so as to illuminate the meaning of teamwork and perceptions of how the new working arrangements were impacting on the practitioners' boundaries. The thematic structure of the analysis is based on the kinds of themes that emerged in the participant's discussion of the issues – as grounded theorists would advocate – and quotations are used extensively so as to allow an appreciation of how respondents expressed their views.

## Results and discussion

The first important question concerning the interviews is what we should make of the comments elicited from the participants. The business of changing working practices and forms of employment is often a contentious one and a matter on which feelings run high. Moreover, as well as concerns that interviewers might lead respondents or bias their answers, the question arises as to how frank the interviewees will be when they know that their senior colleagues may see the report.

This is one aspect of the boundaries which surrounded the team members in their places of work. They disclosed some concern about the status of the material and who might read it and act upon it. There was an explicit attempt to address the issue of the participants' political sensitivity by asking at the end 'What wouldn't you like to see in the final report?' This resulted in comments such as: 'I wouldn't like to see anything that damaged the team in any way' (social worker) or 'I wouldn't like you to say that it doesn't work' (occupational therapist). Participants were concerned that the research should identify the improvements and not recommend what they saw to be the retrograde step of going back to earlier ways of working.

In addition, there were comments about the audience for the report. Some topics evoked a jocular caution as to whether the participant would be identified:

Interviewer: What did you make of the steering group, and?

Respondent: Where does this go? (laughs)

Interviewer: (laughs) Your name is not on, so you can say what you like.

Respondent: People won't know it's me, erm, this is fine, I ain't particularly worried about that. (social worker)

Despite this self-referential concern, the respondents in many cases were well able to express their objections to features of their working lives which they found problematic, thus yielding a narrative formulation of the issues. What these concerns disclose, however, is the participants' tacit theories about the boundaries and stratifications in the working environment, and the suspicion that the agendas and policies of their senior colleagues may not be the same as their own. This boundary is clearly not an historical residue, but is being worked upon on a daily basis as the participants orient to the strata in the organisation.

In addition to these stratified boundaries in the organisation there were a series of typological boundaries perceived between the professional groups involved in community mental health work. There were some who saw progress as being about removing and eroding boundaries and who felt that they were antithetical to the purpose of the team.

I think it's got a way to go yet, and I think we need to overcome some of these, as I see it, ingrained traditional boundary things that are cocking up the way that we all work. Well they're cocking up the way that I work, but you know, which is a shame and I think that probably has knock on impact on client care ultimately as well, you know. So we've got to ask who are we working for, are we working for our own traditional boundaries, and maintaining the status quo, or are we trying to move forward and offer the best of services to the clients really. (community mental health nurse)

This participant then sees the boundaries as a relic of the past and as being about self-interest rather than the interests of the clients. Thus their legitimacy is undermined in favour of an ethic of services to clients, which is implicitly different.

One of the most significant and intractable boundaries in health care has been that between doctors and nurses. So entrenched is this aspect that some authors have called it 'the doctor–nurse game' (Stein 1967, Stein *et al*. 1990). Although some authors are beginning to note a 'blurring' here (Snelgrove & Hughes 2000) it is ordinarily thought of as a substantive divide. However, our informants were able to pinpoint what were, in their view, beneficial erosions of this division:

Respondent: By, coming in from the social model really, into what is predominately a health model, a medical model [yes], and offering another way of viewing the situation, having a different focus really from my colleagues. Which, again can lead to conflict, but, but more often than not that doesn't really, we reach a compromise, an amalgamation of all those view points really, which to me is going to benefit the client, a kind of holistic viewpoint, rather than being uni-disciplinary.

Interviewer: Yes, any blur, is there any blurring of roles?

Respondent: Certainly, I think that's inevitable, and, and I welcome that.

Interviewer: And where would you say are the main areas of blur?

Respondent: I mean I'm biased so I would say that it's among health colleagues [right]. Accepting a bit more of kind of my viewpoint, maybe looking at things with a social focus.

Interviewer: So you see them tracking onto your ground, rather than you tracking onto their ground?

Respondent: I think there's, I mean I would accept that there's, it's a two way thing, I wouldn't suggest that there's one way, but I would suggest that some of the bigger leaps have come, from, from my colleagues. (social worker)

The dominance, then, of the medical model in both hospital and community health (Plews *et al*. 2000; Snelgrove & Hughes 2000) is, in this view, being blurred by the more medically-oriented practitioners 'tracking' into more social territory. This is in line with developments which other authors have noted in community mental health (Williams *et al*. 1999).

In some cases this was accompanied by a utopian vision of mental health care workers sharing a common set of skills and activities:

Interviewer: Do you feel there's, how much role blurring is there?

Respondent: I think there's always been a lot of role blurring in that, in mental health work anyway.

Interviewer: You don't think that's, there's anything different then [no] to what was there before?

Respondent: No, no, no. I mean to be honest I think, my political views are that I'd like to more of that.

Interviewer: More role blurring?

Respondent: Yeah, and that maybe there is a, you know, a case for mental health workers rather than being a nurse, being a social worker.

Interviewer: Right so actually have more of a generic title?

Respondent: Yeah.

Interviewer: So it doesn't matter what route you've come to that through …

Respondent: Yeah, yeah that's just …

Interviewer: You've all got the same level of description? (community mmental health nurse)

This then is a vision which sees the erosion of boundaries as being future oriented, progressive, politically desirable and yielding a flexible and socially oriented service to clients. Thus our informants in this camp are aligning themselves with some progressive trends in the literature on community mental health too (Martin *et al*. 1999, Williams *et al*. 1999).

In contrast to this there are other opinions about the boundaries between professional groups. Some wished to reinforce these divisions – for precisely the same reasons – by means of an appeal to the client's interests. In terms of how individuals felt they fitted into their team on a professional level, there was some concern over role-blurring, confusion or overlap: 'the lines of accountability and responsibility get blurred within the team' (social worker). In line with the

observations of other commentators (Department of Health 1994, Sainsbury Centre 1997) blurring seemed most prevalent between nurses, OTs and social workers:

Respondent: I think working as a team, should mean that all the professionals are involved where relevant, so there's no kind of role blurring or.

Interviewer: Say a little bit more about role blurring, I'm interested.

Respondent: I think, when people have got individual caseloads, it's quite easy to fall into the trap, and I know that I've been there and done it as well, and fall into the trap, of taking on perhaps, for myself taking on the nursing role for part of a time or for nurses perhaps do more activities of daily living (ADL) tasks with the client, because it's just easier because you know the client and you've always been working with them and perhaps that doesn't get passed back to the relevant professionals. And I think perhaps that's where people don't, teams don't work in the way in which you would expect. (occupational therapist)

In this case the teamwork situation is seen as an opportunity to preserve areas of professional expertise, as the above respondent would not have to take on nursing roles. Other respondents echoed this theme of role blurring as problematic:

Respondent: You get a blurring of professional roles, which I think is dangerous [mmm]. Because at the end of the day social workers think they know what nurses and doctors do but they don't, similarly nurses …

Interviewer: … the other way round.

Respondent: think they know what social workers do, but they don't. And, and it's quite common to see where social workers have been meddling in medical matters, and nurses have been meddling in social care matters. (social worker)

The moral tone of this description – 'meddling' – reinforces the way that this respondent objects to the overlapping of activities, with the implication that it might not be in the interests of clients – indeed that it might be dangerous for them. Thus, we have not only the idea that role distinctions between professionals are in the clients' interests but that far from being 'entrenched' or 'traditional', these distinctions have their origins very much in the present and that the nature of teamwork is actually seen by some as preserving them. Moreover, they are supported most powerfully by the discourses of benefit to the client.

In counterpoint to the advocacy of erosion of roles advocated by some, and the sense of impending danger expressed by others, there was a third point of view which took more of a middle line on role blurring:

Respondent: I think I should concentrate on what I'm good at, and allow the other person to do what they're good at. And that way everybody will feel fulfilled, in their roles in the team.

Interviewer: So, some blurring is …

Respondent: There is some blurring, and that's good …

Interviewer: … and that's OK.

Respondent: I think that's good. But also, we need to be self-aware and know when to stop [right], you know and to clearly identify, well hang on I can't do this anymore, I need to hand you over, or I need the input from such a one.

Interviewer: So knowing boundaries?

Respondent: Yes. (community mental health nurse)

The distinctive feature about this position is that, as we can see, the boundaries are not codified organisationally but are seen as subjective and intuitive. Once they are defined in this solipsistic way they will be relatively robust in the face of attempts to change them by changing the organisation. Paradoxically, the attempts to develop more organic, generic, overlapped nonhierarchical ways of working are in some cases reinforcing the boundaries that these managerial changes were set in place to erode. It is driving them into the subjective territory of the worker's own intuitive framework – of what constitutes, say, nursing work or social work – where they will be relatively immune to change. Their immunity will be vouchsafed by the fact that everyday practice will be seen as supporting this worldview, as we can see in the quotes above. Thus the boundaries are very much in the present, in the realm of everyday social action, rather than relics of a hospital-based past.

A further aspect of roles, boundaries and their potential blurring, which came to the fore in the interviews, concerned the running of the teams' business and clinical matters. This was done by means of a weekly meeting, which team members were encouraged to attend. The structure of teamworking, insofar as it was codified, seemed to be deliberately designed to avoid hierarchies developing, yet some features of this were perceived to be problematic. For example, sharing of the task of chairing and writing minutes for team meetings resulted in some difficulties:

You get this problem with, we don't have a, we have like a different person chairing it taking the minutes and that gets a bit confused sometimes because, it's a trivial matter, but you find that you could be chairing the meeting and you didn't know you were and you haven't gone through the stuff so you don't know what you're doing. And you know writing the minutes you tend to miss out on what's going on, you know. (community mental health nurse)

The idea of having a 'rolling chair' for meetings, where team members took the chair in turns, was appreciated for its democratic quality but led to operational difficulties in that some members felt unprepared for this task. Again, the absence of formal structure helped to create the sense that there *should* be such a structure, and that some members were ill equipped to undertake the leadership role (Sainsbury Centre 1997). The absence of durable hierarchies, then, reinforces a sense of inadequacy rather than creating empowerment. The boundaries thus become more conspicuous despite attempts to do without them.

A further aspect which our informants made a great deal out of was the issue of geographical and catchment area boundaries.

Respondent: Years ago you used to call this a jigsaw puzzle, but it isn't it's a rubic cube [right], because it's on layers.

Interviewer: Various levels yes.

Respondent: And, I don't know which bits are coterminate, it would have been better if they had been.

Interviewer: How does that make you feel?

Respondent: It's sometimes quite embarrassing. (social worker)

Thus, team members were working with a series of different geographical boundaries, such that team members do not share the same catchment areas, and hence may attend to different groups of clients. Despite the desire for coterminosity – in the sense of common catchment area boundaries and client lists – which has been expressed in policymaking circles for some time now (Exworthy & Peckham 1998), the teams in the present study do not enjoy coterminosity in the full sense of the term. Most members share some clients, yet there are those who share few clients with other members, or even none at all. This was seen to be a further source of unwanted boundaries in collaborative work:

I'd hope that probably the coterminous boundary which is the catchment boundaries would be a team. I think it is a joy to be a defined area, I think it makes it that much easier, both from referral point of view and people feeling that they're not in two teams [right], because I look after part of Stafford as well [yes]. Now that team should be part of this team, because there are patients dealt with, for example, in Rugeley but live probably out in the Stafford area [yes]. That's an anomaly. (psychiatrist)

Thus, despite the nominally integrated nature of the new model of teamwork, the different client lists attended to by the members are a source of isolation and fragmentation. In addition to the fragmentation imposed by the different client lists, and catchment areas, there was some further dislocation introduced by the fact that the new team structure existed in parallel with our informants' previous working attachments and organisational affiliations. As a result of this, there was a marked uncertainty about which teams people were in – or which was their 'main' team:

Yes I am part, I am working with a Cannock, I am part of a team. I think we're all part of so many teams, I'm part of the [Advice Centre] team, the [National Health Service Trust], the Acute sector. (community mental healthnurse)

This uncertainty appeared to make some people feel uncomfortable. One participant summed up this feeling of being in several teams:

I'd like more, people to feel more ownership of being in the team, not to say that people would have to decrease their ownership and feelings of belonging to the other existing teams that they're also part, whether it be professional or whatever, but for people to bear the team in mind, so that the team becomes more than just a once a week meeting. (clinical psychologist)

It is almost as if, in this formulation, there is a limit to how many team allegiances an individual can hold and that being part of other teams dilutes the sense of ownership of the integrated mental health team (IMHT). As a corollary of this, these other attachments exist to shore up the boundaries between professional groups. These boundaries, then, are not the residua of previous generations of working but are explicitly promoted by particular aspects of the current organisational structure.

## Discussion

The blurring of roles, which a few respondents identified as a liberating experience, was a source of concern to some other respondents. This latter concern has been identified by several other authors as a source of problems in teamwork. As soon as studies of team working began to emerge in the early 1990s, there were debates about the degree of importance members could ascribe to their professional group and their team (Ovretveit 1991, Berger *et al*. 1991). Antai-Otong (1997) identifies confusion about individual roles as an important feature in individuals not functioning well as team members. The movement towards a generic model of mental health working was seen as something that the management were actively encouraging: 'the agreed plan was that we'd all become generic' (CPN). Whereas the more generic model of mental health work fits in well with the desire of some practitioners to determine their own practice on the basis of presenting need as they perceive it (Onyett *et al*. 1997), it challenges traditional, socially valued role definitions. Some authors, such as Patmore & Weaver (1990), found this creeping genericism to be a handicap to teams and staff were left

unclear about the limits of their responsibilities and to whom they could turn if they felt their capabilities were being overtaxed. Thus, far from being relics of an institutional past, boundaries are firmly embedded in present-day social action, as team members struggle with their working lives.

Ovretveit (1986, 1989) identifies some of the inhibitory factors in multidisciplinary community health teams, in particular lack of leadership, especially where there is no one with overall responsibility for team operations. In Ovretveit's formulation also, there are difficulties when there is no broader plan of how the team fits into the wider service of which it is a part (Ovretveit 1989, 1993). In our data we were able to see respondents alluding to this where they discuss the rolling chair at meetings, the sheer number of teams of which they are members, and where they are unsure of how their remit intersects with that of GP practices, hospital-based care and voluntary or charitable organisations. It is as if these various agencies operate in parallel, with potential areas of conflict and overlap intersecting at the very site occupied by the IMHTs themselves. It is not surprising, then, that the teams are a site where concerns about boundaries proliferate because of their lack of formal boundary structures. This situation is compounded by the difficulty the teams experience in liaising formally with some of these other groups – 'you can't get a GP for love nor money' – despite their central role in providing referrals and often being the first point of contact for clients in distress. This finding parallels the elusiveness of GP involvement in teamwork detected elsewhere (e.g. Tinsley & Luck 1998). Given the centrality of GPs in primary care, and in ongoing care for distressed clients, this is an area of liaison that could be profitably strengthened. In the meantime, it reinforces what one informant called the sense that they were 'a team in a vacuum'.

A number of features which we mention here have been highlighted by other researchers examining the operation of health care in the community. Parry Jones *et al*. (1998) identify underfunding, role conflict and relations with management as factors which their respondents derived most dissatisfaction from, including the sense of a lack of leadership, support and infrastructure. Commentators on team building in nursing contexts (e.g. Antai-Otong 1997) have stressed the need for clearly defined goals and a sense of member involvement.

A good deal of the literature on organisations and the roles of people in them has stressed the issue of boundaries (Menzies Lyth 1988, 1989, Hirschhorn 1989, Miller 1993, Willshire 1999). This issue was a central concern to a number of our respondents. Moreover, the boundary conflicts in loyalty between the integrated mental health team (IMHT) and other teams and groups to which they belonged were also highlighted. The issue of boundaries is especially problematic in community-based health care because their functioning is not limited to a single physical location (Willshire 1999). Boundaries in more traditional, institutionally-based care have been documented by Menzies Lyth (1988, 1989) who showed how well-defined institutional boundaries contributed to the strengthening of the individual's own psychological ones. Institutional roles contribute to the individual's sense of selfhood. Hirschhorn (1988) goes further and suggests that boundaries are important in making individuals feel secure in their work and good about achievements. We can see some of these issues rehearsed in our own data, perhaps especially because the institutional codification of boundaries appears to have been withdrawn. This theorising about boundaries also helps to explain the concerns about role blurring and the lack of firm boundaries of responsibility. It might also explain the comments some people made about being puzzled about the apparent free-for-all in meetings where members could interject and comment on other members' cases, and the misgivings some had about the 'rolling chair' model of organising meetings.

The precursors of teamwork in health and social care can be traced back to the 1950s when the forerunners of our respondents began joint work on social and psychological problems in the recently established health service and social services departments, as well as in organisations such as marriage guidance. At this time, scholars from the Tavistock Institute with a psychoanalytical focus studied the running of these organisations (Main 1957, Gabbard 1989, Miller & Rose 1994). In the present project our community-based professionals sense that they are suffering from a lack of structure, and have a sense of being abandoned by management. As a result of this, some of them are left trying to reconcile what they are doing with ideologies of client care, as well as trying to come to terms with the ambiguous structure of working which paradoxically seems to reinforce boundaries as well as blur them.

The classical way to make sense of professional roles and boundaries in community health is to see them as a relic of the decades of hospital- or other clinically-based care which have left their mark. From this point of view it is customary to see care in the community as still being hampered by the models of hospital-based medicine in which most of the staff in the present study would have been trained. Whereas the respondents are keen to assert that the changes

have been beneficial, both they – and a large body of literature on the subject – see the transition to community-based, team-delivered mental health care as a potentially difficult one. Staff then are faced with a possible loss of boundaries in several ways. For example the boundary between clients and staff is put under strain as respondents visit clients in their own homes, and the boundaries between different clinical specialisms are eroded by the multiple functions that team members are expected to fulfil. As one respondent put it, 'there was a lot of groups which went to make this integrated team that still wanted to hang onto old structures' (CPN). Whilst this is not the first experience of community team-based working in Staffordshire, the transition to the new integrated model represents a further break from the familiar cultures of clinically-based care. In the context of this regular process of reorganisation it is perhaps understandable that staff hang on to a sense of what it is that a social worker, say, or a nurse, or a medic should be doing. Rather than a residue of history, these boundaries are continually remanufactured and reinscribed in the day to day folkways of community mental health work.

Whilst the present integrated mental health team initiative is only the latest part in a succession of attempts at community-based work in the area studied, the following statement from Lang (1982, p. 160) is as relevant now as it was 18 years ago:

> The concept of community mental health calls for an unlearning of traditional patterns of professional interaction and of traditional conceptions of the nature of psychiatric disorders. Mental health workers are asked to break free of the historically grounded frameworks which have shaped their ideas, their respective professional identities and the habits of their collective and individual work.

The concept of professional boundaries, then, is particularly likely to be problematic in community work in rural settings (Backlar 1996), because of the variations and changes in the delivery of mental health services in these areas.

It may be that the intention of the integrated mental health team initiative was to allow links, collaborations and liaisons to grow organically between team members and between teams and other organisations and individuals with which they interact. However laudable this strategy, it is perilously close to the situation described by several authors (Hackman 1990, Onyett *et al*. 1997) as a recipe for disaster. The two conditions the latter authors identify are 'failing to exercise appropriate authority over the team leaving it to clarify its own aims and operations' and 'providing inadequate internal structures for operational management – leaving the team to work out the details' (p. 42). From a policymaker's point of view, then, it may be advisable to move further along the continuum from autonomy, informal networks, cooperation and collaboration, towards stronger and more formalised partnerships. The presence of conflicting sets of boundaries in therapeutic organisations has been noted to be problematic by other authors (Rose 1998), especially where pressure from senior management or governmental guidelines does not accord with the therapeutic imperatives as seen by the practitioners and clients themselves.

The boundaries between professional groups are perceived to be eroding. Whereas some see this as an opportunity, many others see it as a threat. If this 'creeping genericism' is felt to be a good thing, then it will not be easily achieved by means of the approach to teamwork used in the teams in the present study. Again, from a policymaker's or manager's point of view, the benefits to all team members of a less precious approach to disciplinary boundaries need to be explained and a culture that facilitates flexibility needs to be promoted. The present arrangements are to some extent deepening the boundaries and making them phenomenological rather than institutional, as a result of which they will be much more difficult to shift in the future.

Staff defining their professional boundaries personally can also perhaps be seen as a strategy for regulating and limiting the demands made on them. The interdisciplinary teamwork and the associated increase in administrative loads means that it is perhaps especially important to establish the limits of what one can and cannot be legitimately required to do. Attending to one's own professional 'voice', then, allows workers to 'limit the number and extent of caring demands as well as to draw on self-knowledge to order their caring' (Wuest 1998, p. 39).

## Conclusion

Students of community-based initiatives in health care have traditionally seen the issue of boundaries as being about a historical sediment of 'professional baggage' from an earlier epoch. As we have attempted to show in this paper, it might be productive to look at the contemporary practices and issues which may be helping to create and sustain these boundaries, even when the manifest posture is to erode them. Staff who retain a strong sense of boundaries in interdisciplinary settings are not merely backward-looking laggards, but are engaging in a politically canny dialogue with the present. If policymakers and managers are genuinely keen to promote flexible, generic working, they will have to take very seriously the possibility

that the new, flatter, less demarcated structures are actually encouraging boundaries rather than eroding them.

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**Appendix 1** Interview guide

The items included in the interview schedule can be summarised as follows:

1. The meaning of team working.
2. The meaning of 'integrated' teamwork in practice.
3. Advantages of IMHTs.
4. Disadvantages of IMHTs.
5. Client perceptions of change in services since introduction of IMHTs.
6. Identification of new resources, structures or systems that would benefit the teams.
7. Identification of systems, structures or elements that are unhelpful to the teams.
8. Professional role within the teams.
9. How participants fit into the team at a personal level.
10. Changes in workload since IMHTs were introduced.
11. Appraisal of the clinical section of team meetings.
12. Appraisal of the business section of team meetings.
13. Appraisal of the IMHTs' steering group.
14. Other concerns about team functioning.
15. Major steps for improving performance.
16. Additional personnel requirements.
17. Satisfaction with accommodation.
18. Examination of the notion of 'team'.
19. Expressed preferences for the content of any final research report.