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COLLABORATIVE PRACTICE:  
A PRACTICE APPROACH TO JOINT WORKING BETWEEN AGENCIES  
PROVIDING MENTAL HEALTH SERVICES

A THESIS PRESENTED IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF

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## **ABSTRACT**

### **Collaborative Practice: A practice approach to joint working between agencies providing mental health services**

This project was undertaken to explore principles important to good collaborative practice and to identify practice guidelines. It explores the "how to do" collaborative practice successfully. The project did not set out to provide solutions to specific situations. It did set out to explore a process which could provide a culture for the collaborative addressing of issues. The proposed approach involved working interactively with key people, trialling a model of collaboration which used the clinical practice of case management and applying this to work between agencies. Through this participative trial key components of collaboration were identified and incorporated into a proposal for future practice. The project methodology used action research.

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# COLLABORATIVE PRACTICE : A PRACTICE APPROACH TO JOINT WORKING BETWEEN AGENCIES PROVIDING MENTAL HEALTH SERVICES

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## **CHAPTER ONE: INTRODUCTION**

### **1.1 Collaborative Practice**

Collaborative practice, or joint working between agencies who provide services, concerns principles of partnership and is a core concern of social work practice. In mental health, as in other health areas, a focus is accepted that, in supporting a person to manage the impact of their psychiatric disorder, their personal environment is important (see Cohen, 1993; Means et al, 1997; Caplan, 1969; Payne, 1997). A range of support agencies has been generated, with both specialist and generic functions, who have roles with people, for example, requiring help in medical treatment, financial support, seeking work, support for families, support in understanding disorder and associated impairment, supported accommodation and living skills, social and relationship support, consumer advocacy and legal advocacy. A person's life and support needs do not easily divide into separate compartments for each need. Although needs for support are interrelated, supports are provided by discrete and separate agencies who view their 'client' from the particular philosophy or service contract held by that agency. Social work can offer a useful bridging role between diverse services, as well as providing knowledge about the range of services, how to access them, and advocacy for appropriate integrated support.

Efforts to provide integrated support often founder on the shores of agencies who are working independently, who do not communicate or understand the work of other agencies, and who work in besieged or elitist ways. Where services do not work together, the person needing support can be inadequately or inappropriately supported and can be in a situation of personal risk:

The complexity in the multiple presentations of clients in mental health...demands the recognition and use of diverse professional skills in a biopsychosocial approach to finding solutions in mental health care. The evidence is that ineffective organisational structures and resistance to the facilitation of collaboration among the people whose work dictates that they work interdependently. Lawrence perceives the core issues of concern are those of elitism, dissension in the team, territorial disputes,

sibling rivalry and jealousy. More important is the disservice to the client. (Orovwuje, 1995, p. 3)

A call for collaborative working by providers, carers and users of mental health services has been made nationally and internationally, regionally and locally. It is targeted in the literature, in reviews of mental health services, contractual requirements, consultation forums and in planning individual support services; these all identify reasons for working together (see Mental Health Commission, 1997, 1999; Health Funding Authority, 1998; Ministry of Health, 1997; Ottawa Charter, 1986). Generally, this rationale has been suggested through identification of risks, barriers and impediments imposed by non-collaborative working.

In my practice as a social worker with a leadership role in a psychiatric service I have responsibility for co-ordination of support services and liaison with other agencies. This role involved both practice issues of service delivery and policy and management issues of service development. A key task of my psychiatric social work has been liaising with other agencies providing mental health services and maintaining and developing these linkages, as well as supporting and initiating the development of community resources so that there can be effective support for people who experience ongoing impairment from their mental illness. My perspective arises from involvement in both clinical and management roles and the dynamics involved in integrating both these viewpoints.

I have found interagency contacts to be fraught with conflicting boundaries, philosophies, contract requirements and distrust. At the same time, I have also found a willingness from practitioners in other agencies to recognise and address our mutual process of collaboration.

The genesis of the project lay in my experiences of social work as a linking or bridging role. I found commonly voiced dissatisfaction with the existing processes, to the extent that commitment to change, albeit at varying levels, was endorsed and advocated both by Mental Health Service staff and agencies providing community supports. The purpose of the project was to develop



practice guidelines to enhance joint working through the medium of a participative approach. It was designed to explore the actual collaborative practice involved in interactions between the Mental Health Service and the range of agencies providing mental health services in the community.

The objective of the research process was to explore current collaborative practice and to explore the effect of focusing on improving those practices, with a projected outcome of identifying the key components of collaborative working and building these into a guideline for future practice. Thus, the project involved exploring the dynamics of interaction between organizations and, through that process, developing change in the nature of that interaction.

A process of structured dialogue seemed indicated by existing practice and a process of introducing and testing the most favoured developments in interactive practice was needed.

The approach involved using a participative approach with an invited sample group of 'stakeholders' from a range of agencies. The cyclical process of action research: action – evaluation – change – new action, involving reflection, discussion, understanding, and learning, was used to identify the factors needed for effective collaborative practice.

The aim of the research model is to provide knowledge and action with direct practical use to a group of people – through research, adult education, and action, as well as to empower people at a second and deeper level through the process of constructing and using their own knowledge. (Reason, 1994, p. 334)

## **1.2 Project Design**

The project developed along two fronts. Firstly, the introduction of a model of practice that could be used as a basis for exploring interaction. The model used was that of case management. Case management has many features of liaison and support in clinical work and it was proposed to trial this as a practice in work between agencies.

Secondly, a process of reflection and change was applied to the case management trial to gradually identify, trial and modify collaborative practice principles.

Ethical issues related to the participation were addressed by the participants themselves. They were able to involve themselves or not in aspects of the project and were substantially responsible for the way in which the project developed.

Although the project itself took place over four months, the project work went on for much longer. Action research is a particularly time intensive research method. Following through and separating themes and trends from within the project information and cross checking with participants to maintain an accuracy in interpretation is a slow process.

The project undertaken in this study needs to be seen in the context of a particular community at a particular time and is dependent on the quality of the interpretation. However, in terms of practice guidelines, it is suggested that these principles of collaborative practice have been well grounded and could be effectively considered in similar interagency situations.

### **1.3 Language**

The language of discussion about mental health issues is an ongoing subject of debate. The project began with adopting words commonly used within the mental health service environment that the participants were drawn from. For example, the word "consumer" was used as a generic term, with the more specific word "patient" to identify those in an acute hospital situation. The group immediately addressed the use of language and identified terms that would be acceptable. Thus, for example, "consumers" were re-identified as "people who use the services". This tended to be modified, in the course of group discussions, to "service users", although this usage did not fit the intent of the original change where the emphasis was on "people".

To reflect the changes that occurred as the participants took responsibility for the project, the wording in the proceeding chapters begins in the language with



which it was commenced and adopts the changed wording at the point this was introduced.

#### **1.4 The Structure of the Thesis**

The first section addresses the methodology of the project. The development of action research as a methodology is outlined and the current issues are discussed with reference to literature. The approach taken by this project is outlined with reference to aspects drawn from other research contexts. The potential for risks and pitfalls is canvassed.

The second section explores collaborative practice generally and in relation to this project. The practice issues, such as challenges and barriers, are discussed as well as the role of the Social Worker in relationships between agencies.

The practice of case management is used as a basis in the project for joint working. Case management is a professional approach to organizing the service's interaction with people whose support needs are more complex. However, case management is implemented and interpreted differently within and between services. This section explores different models of case management and identifies the aspects which were utilized.

The third section discusses the context of the project. Because a key focus of participative research is empowerment, an analysis is offered concerning current configurations of power relationships and the setting this provides for interaction between agencies. This section looks at the role that the development of quasi-markets has had in defining the scope of these relationships.

The fourth section describes the research project as it developed. It shows the process of the development of themes and emergence of practice changes. This section outlines the experience of the participants and the way that they responded to challenges thrown up by the process. The resulting practice guidelines were developed from the themes that came to dominate the project.

The fifth section looks at the themes in summary and interprets and integrates these into recommendations for change. Issues raised during the course of the process are drawn together. The conclusion then reviews the project and reflects upon whether the research project was able to address its initial aims.

Relevant literature has been reviewed and this is discussed in the sections which introduce the theory and methodology, the background and the process of collaborative practice. The literature review is not presented as a discrete section but is dispersed into the appropriate sections (Massey University, 1999, p. 44), in order to contribute to the framework and discussion of issues.

The focus of collaborative working is improving the support for people who need to access services. This project has not attempted to increase the amount of community supports, but rather to look at the functioning of existing support and to explore ways in which these can operate more effectively in practice with better outcomes for people who use services.

## **CHAPTER TWO: ACTION RESEARCH**

The exploration of collaborative practice in this project uses action research. In initiating the project, I needed to use a methodology which would enable mutual engagement and participation from those taking part. By engaging in a practical experience of collaboration, the input of we, the participants, could be directly relevant to our real interactions.

Action Research strategies incorporate evaluation alongside inquiry and action as integral parts of a cyclical process in a context of participatory problem-solving. (Hart and Bond, 1995, p. 76)

In this chapter the development of different approaches and interpretations of action research, characteristic criteria of the methodology, difficulties that the methodology presents, and the particular application of action research to this project are discussed.

Action research can be distinguished from other social science methodologies by characteristic criteria, although within action research different approaches can be identified. Action research offers a collaborative approach and seems to be:

...non-hierarchical and non-exploitative... may be used to make changes, and closes the theory-practice gap. (Wood, cited in Hart & Bond, 1995, p.33)

Four significant approaches or traditions can be seen as sources for the development of action research. These lie in social psychology (the experimental approach of Kurt Lewin, 1946), organizational change, the social sciences (particularly education and nursing), and community development.

During its development, action research has moved from the applied psychology of rational social management (Lewin, 1946) towards an approach to change which focuses on empowerment (e.g. Friere, 1972). Action research can be seen as developing in the context of social constructivism as an increasingly influential philosophy which supports collaborative research approaches.

## 2.1 History of Action Research

While not the originator of the term 'action research', Kurt Lewin is generally acknowledged as introducing action research as a term for a distinctive methodology which involved accumulating knowledge about a social system at the same time as influencing change within it. Lewin referred to action research as rational social management (Lewin, 1946, p. 206).

Lewin saw research as a circular process generated from a general idea and a general objective. The circular process involved planning, fact-finding, evaluating and modifying which preceded a first action step which would then invoke further evaluation, planning, and modifying before a further action step might be taken.

Evaluation and fact-finding are central to Lewin's approach, ensuring that the relationship between action and change can be established. Lewin's approach to the practical application of social science involved attention to democratic participation rather than the autocracy of management. Lewin's approach differs from later practice approaches in three ways: he sought understanding for universal laws of human behaviour which could underpin measurement of behaviour and engineer social change; he saw action research as a mode of re-education with an advance agenda; he saw action research as a technique for introducing democratic principles rather than the research process itself being democratic in enabling participants to collaboratively address their own social conditions (Lewin, 1946).

As action research developed, it was argued (Susman and Evered, 1978) that positivist science was inappropriate for study of human organizations and organizational problem solving. Positivist traditions did not acknowledge the impact of the researcher and are substantially different to an action research

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<sup>1.</sup> Attributed by Hodgkinson (1957) to Buckingham, Research for Teachers, (1926), and by Coey (1957) to work of Collier (1933-45), Commissioner, Bureau of Indian Affairs, North America...(from Hart.E. and Bond.M., Action Research for Health and Social Care, Open University Press, 1995).

approach, which enables organizational adaptation and generates and incorporates new knowledge, by a process of active participation.

An approach to organizational problem solving based on psychoanalysis and social psychology was developed by the Tavistock Institute, founded in 1947, although not known as action research. This approach addressed conflict through a therapeutic process using action research methods to monitor and implement change. The later work of the Tavistock Institute was the basis for development of (PAR) participatory action research (Hart and Bond, 1995, p. 23).

In education, action research has had a significant place. Since the work of Lewin (1946), the application of action research in United States' education became used for collaborative research. Its popularity increased until the mid 1950s when it became criticized for lack of rigour.

Further development of action research is seen in the work of Kemmis (1993). Kemmis introduced the self-reflective spiral as a basis for problem solving. The cyclic aspect became more complex, with an increased focus on the importance of collaboration and the potential for determining practical applications. These developments were prescriptive and observational, outlining what to do rather than possible ways of how to do. The generative aspects of action research have been developed by researchers such as McNiff (1988), who have addressed inquiry in action and recognized the potential for action research to develop grounded theory in practice.

Although not mutually exclusive, four methodologies within the Action Research genre can be identified (Dick, 1999): **PAR**, (participatory action research) which includes the "critical action research' developed by Stephen Kemmis (1993); **action science** developed by Argyris et al. (1985), involving a systems and intervention approach which involves the behavioural dynamics of people's functioning within systems and focuses on communication and interpersonal skills; **soft systems methodology**, which involves an immersion in the system, an interpretive step which develops an ideal, comparison of this to the real situation, followed by planning and action steps, with this cycle likely to be

repeated several times (Checkland,1981,1992; Checkland and Scholes,1990; Davies and Ledington,1991; Patching,1990); **evaluation**, although not a single methodology<sup>2</sup>, can be used diagnostically to understand the effects of actions, processes, resources and inputs which can lead to effective system improvement.

## 2.2 Characteristic Criteria

This chapter draws on the work of McNiff (1988) and the later work of Hart and Bond (1995), (who address the application of action research in nursing and social work), as well as on further research in organizational change (e.g. Torbert,1976; Wakefield,1995).

Action research developed as a research methodology which concentrated on process. It strives to address the gap between theory and practice which has been identified in the delivery of human services. Interest has developed in action research as a means of critical reflection, evaluation of process as well as of outcome, grounding in daily practice and use of a problem posing technique. The action research approach incorporates a generative flow, in that the participants are open to issues which underlie the initial, probably symptomatic, problem and, thus, can include these in the collaborative process.

Action research is seen as a cyclical process. McNiff (1988) has developed the 'Kemmis/Elliott/Whitehead action-reflection spiral' to accommodate the generative element and describes the process as "three-dimensional" (McNiff, 1988, p. 45). Thus, the exploration of associated themes and 'spin-off' projects can be followed through without losing the thrust of the main inquiry. McNiff (p. 45) visually presents this as a "spiral of spirals", in which the main project focus can be seen to retain its integrity while issues which it has generated are developed in further cyclical process. McNiff's visual representation of the process is shown in Diagram 1 :

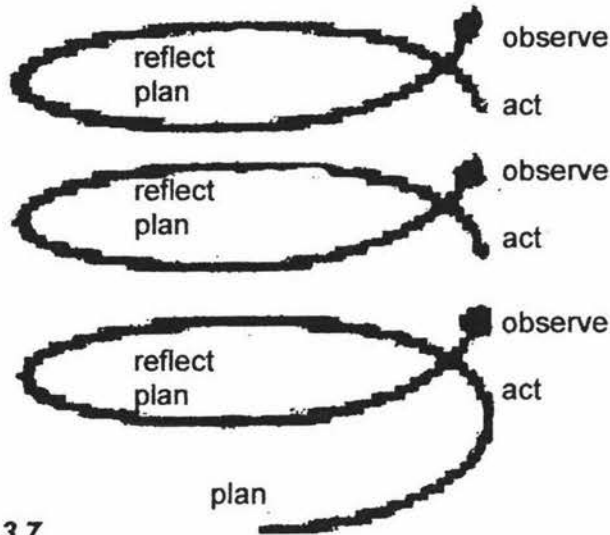
---

<sup>2</sup> Varying from a very positivist stance (Suchman,1967) to anti-positivist (e.g. Guba and Lincoln, 1989)

### Diagram 1: Cyclical Process - McNiff (1988) Spiral of Spirals

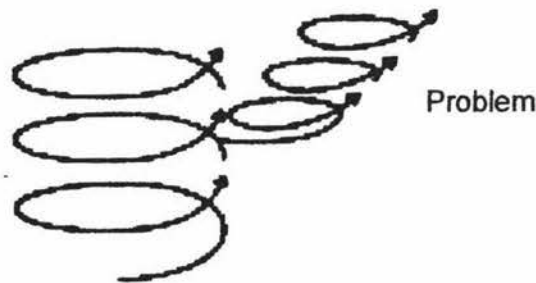
(from: McNiff, 1988, p. 45, Figures 3.7, 3.8, 3.9)

In Fig. 3.7 the central column is the main issue. It follows the Kemmis/Elliott/Whitehead action-reflection spiral, except that visually it is three-dimensional



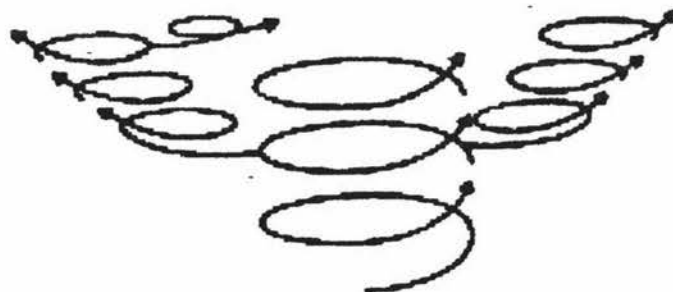
**Fig. 3.7**

Add to the main column an action-reflection spiral to follow through the problem (Fig. 3.9)



**Fig. 3.8**

Other problems may be explained as and when they arise without the researcher losing sight of the main focus of the enquiry. The visual which would reflect the action is a three-dimensional spiral of spirals (Fig. 3.9)



**Fig. 3.9**



The strengths of action research lie in its generative ability to develop theory, in its focus on collaboration or participation, its clear process, its interaction of research and intervention for practical change, its problem focus and its function of empowerment. Hart and Bond (1995) have distinguished seven criteria as a working framework. These criteria distinguish different types of action research and show underlying consistencies. Their seven criteria stress that action research:

1. Is educative.
2. Deals with individuals as members of social groups.
3. Is problem-focused, context specific, and future orientated.
4. Involves a change intervention.
5. Aims at improvement and involvement.
6. Involves a cyclical process in which research, action and evaluation are linked.
7. Is founded on a research relationship in which those involved are participants in the change process (Hart & Bond, 1995, pp. 38-9).

Henry and Kemmis (1985) identify four things that action research is not.

Firstly, action research is not just thinking about practice. It involves systematic collection of evidence as a base for reflection which has rigour. Secondly, action research does not focus on problem solving but on problem posing. Thirdly, action research is by people looking at their own work, not on other people. People are taken to be autonomous and consciously involved in the making of their own histories. (Henry & Kemmis, 1985, p. 3)

Lastly, action research, with the double dialectic of the researcher and the researched, is an evolving process. Where all the participants in research are autonomous, responsible and taking a purposive role, a political stance is apparent:

It acknowledges the democratic ideals of liberty and equality, self-determination and self-empowerment, accentuates the obvious link between science and society, and in particular draws attention to the societal relevance of science... Mutual enrichment implies



that one and the same class of activities serves to enrich both the social sciences and the practical concerns of man. (Van Beinum et al., 1996. p.182)

Action research is a creative process, which connects theory to practice. It is emerging as an interest in social work practice, although it has been well established in Education. It is suited to social work in its promotion of improvement through the systemic and collaborative approach. Action research is familiar and compatible with a social work approach in that it reflects a core of social work theory. It is:

method-focused, incorporat[ing] psychological and social theories of understanding, and provid[ing] the middle-range theoretical connections to a social workers day-to-day reality. (Halmi, 1996, p. 374)

### **2.3 Criticisms of Action Research**

Action research has the weaknesses and problems of qualitative research, such as the time consuming and labour intensive nature of data collection and data analysis, the need to maintain a manageable range of information from the volume of data generated, and the need to establish a system for data analysis which has meaning (Miles, 1983). In particular, action research methodology is criticized as lacking detachment, controls and universality. That the process is situated in individual contexts mitigates against generating theoretical understandings (Toulmin and Gustavsen, 1996).

Action research projects continually confront these challenges. The perceived shortfalls of action research as valid social research can however be presented as strengths rather than weaknesses.

Wakefield (1995, p. 17) identifies a similar risk, which he associates with a constructivist approach. He suggests that any method looks good when there is community agreement about its results. An approach which sees truth in consensus rather than correspondence with objective reality, has the inherent

risk that, although answers may be hard to establish, we may often be mistaken in conclusion. Wakefield, in exploring the role of qualitative research, emphasizes the importance of exhaustive and systematic questioning and humility. His views draw attention to the difficulties of validation in interpretation and thus the need to expose interpretation to different processes of evaluation.

Gambrill (1995, pp. 40-1) emphasizes the clear description of data accumulation to enable readers to evaluate for themselves. She advocates pursuit of triangulation – "gathering of information about validity via use of multiple data sources" (Gambrill, 1995, p. 41). Presentation of support for interpretation needs to be 'acceptable, relevant and sufficient' and argument needs to be well reasoned. Gambrill is concerned that qualitative research is interested in generating theory and is:

less interested in testing whether assumptions are accurate and accepts a justification rather than a falsification point of view... They seek corroboration by confirmation, rather than seeing whether assumptions can be falsified by making and testing risky predictions. (Gambrill, 1995, p. 41).

Gambrill stresses that quantitative research uses tools of accurate measurement and is judged on validity, representativeness and reliability. The importance of evaluation is a constant concern in the use of qualitative methodology, in contrast to quantitative studies.

In contrast, the aim of a good qualitative study is to access the phenomena of interest from the perspective of the subject; to describe what is going on; and to emphasize the importance of both context and process. Evaluative criteria, therefore, are different and should be based on credibility, transferability, confirmability and dependability (Lincoln et al., in Bustin et al., 1998, p. 198)

This distinction seems to be a core defence for qualitative methods. The challenges faced by qualitative research create an exciting dynamic. Practice is not an end in itself, it is the means of working effectively with the person(s) who is/are the client(s). An approach which seeks to understand and identify processes which contribute to improved practice using a system of structured

inquiry and triangulation of collected data, should result in a model which, although relevant to its particular context, could be extrapolated to other situations. The proposed outcome is likely to be useful in understanding and approaching other and similar situations, and can be further tested in other contexts.

## **2.4 Difficulties Associated With Action Research**

Difficulties are inherent in the action research approach. The effect of power relationships, environment and cultural values, are not static but ongoing realities in day to day interactions. Clear identification of the effects on the dynamics of the project requires an objectivity that is not always possible when the researcher is a participant. Involvement of stakeholders as mentoring agents needs to be incorporated at an early stage, with the task of consistently evaluating the process as well as the findings. Process oversight, from a standpoint which is removed from the interrelationship dynamics, is also useful to ensure the collaborative aspect is not skewed by a collusive or controlling agenda.

Addressing power dynamics is important, as is identifying the differing purposes that might motivate involvement. This is likely to invoke decisions about levels of control and the ability of participants to achieve their ends:

choice of strategy is likely to be bound up with much broader considerations relating to power and knowledge... most notably... basic orientations about what counts as 'reliable knowledge'... [and] fundamental dispositions as regards the exercise of political power, swinging between paternalistic and participatory philosophies, and between individual (or private) and collectivist (or public) processes. (Beattie, cited in Hart and Bond, 1995, p. 80)

Essential to this process is the way boundaries are drawn in the group and the research relationship. In my opinion, collaboration cannot be achieved by obligation, the outcome cannot be predetermined and the problem focus must emerge from a balance of understandings. Ground rules and clarity about the

purposes of the project need to be constantly reviewed as part of the process to avoid the 'capture' of the problem by one or more participants.

In my opinion, a difficulty met in action research projects appears to be the limitations of the power of the participants to effect change. Change routes and processes can be identified, both in theory and practice, but often meet boundaries of influence imposed by those who are not participants. It seems that a growing sense of empowerment and an integration of change in practice approaches can disintegrate into frustration and disillusionment if initiatives are thwarted by organizational processes. It seems important to build into projects both an understanding of the practical arena of influence and power structures, and a strategy that will work within the organizational structure. Unless strategies for empowering change are integrated into the reflective/rethinking level of the action research cycle, participants are at risk of experiencing an increased sense of oppression or devaluation. It is important that the identification of stakeholders and participants includes those in the organization who have power to influence and implement change.

Because of the generative capacity of action research, the initial focus requires simplicity and to be well understood by participants. Simple starting points generate their own complexities, whilst complex aims are easily interpreted in different ways, and can be at risk of raising unrealistic expectations.

Particularly in Participatory Action Research (PAR), key aims can be identified. These are: knowledge and action which are directly useful; empowerment through a process of using knowledge and experience; and an equality in collaborative participation in which:

the subject-object relationship of traditional research gives way to a subject-subject one, in which the academic knowledge... works in a dialectical tension with the popular knowledge of people to produce a more profound understanding of the situation. (Halmi, 1996, p. 371)

The adoption of a strategic approach in social work sees action research as a key tool in envisaging change and how this can and should be measured. Social work practice of assessment, intervention and evaluation is the basis of action research with its problem solving approach. It is a useful tool in opening up a problematic situation. Action research is a process. It relies on the skills held by the researcher and the other participants. It relies on awareness of competencies and boundaries, and recognition of limitations of skills.

Action research is "based on a clear logic and procedural analysis of ...systems" (McNiff, 1988, p. 124). Conclusions are drawn and opened to public scrutiny and debate. Appraisal methods are clearly identified and experience of others is used in testing standards of judgement. The key strength of action research is in its commitment to democratic participation.

## **2.5 Focus On Collaboration / Participation**

The focus on collaboration is a key aspect of action research in that the researcher has to start from the community perspective in the context of the particular community environment, culture and values. The process of effective collaboration involves a practical outcome for the members of the project, which is likely to involve a change in the dynamics of their interaction.

Collaboration has to address issues of power both within the group and the organizational environment, as well as between the researcher and the other participants. Action research can be a useful approach when a balance of power is at odds, when informal and formal power structures are not compatible in their assessment of needs and the means to meet these needs. Because collaboration involves a mutual approach, a consensual definition of improvement is intrinsic to the process.

The approach taken in this study incorporates aspects of these methodologies, but the flow of the research has most in common with the soft systems approach

(see section 2.1: History of Action Research, p.10), which incorporates the cycles of 'action – reflection – evaluation – revision' from a point of immersion within the system.

## **2.6 Methodological Approach In This Project**

This section looks at the methodological approach – action research - taken in this project. The detail of the application of action research used in this project is described in chapter six.

### **2.6.1 Development of the Project**

The position of the researcher is one of being already immersed in the mental health system. The research focus has arisen from concerns commonly expressed within the community of mental health service providers. Interpretation was applied to the system and a way of working - an 'ideal' – was proposed which could alleviate the problem being posed. Through a group process this was acted upon and evaluated. The data arising from this was evaluated and drove a new cycle of interpretation, modification, action, evaluation and planning.

Although a consultant facilitator, external to the group was involved, the role of the consultant was primarily one of support for myself (as facilitator of the project) by providing a point of liaison with the Mental Health Commission, rather than active participation.

A model of collaborative practice was incorporated and used to explore the practice issues. This was amended and evolved as the project developed as a 'lived process'. The consultant was provided by the sponsoring body, the Mental Health Commission. She provided a review of the setting up of the project and then stepped back, continuing as an administrative link between the project and the sponsor.

While the case management model was proposed as a hypothetical model of practice, the project was not set up to test this hypothesis. Rather, the model provided a framework which allowed aspects of collaborative practice to have a focus, to be experienced, and to be modified in response to actual situations:

Action research is not about hypothesis-testing or about using data to come to conclusions...action research is concerned with changing situations, not just interpreting them. Action research is a systematically-evolving, lived process of changing both the researcher and the situations in which he or she acts. Neither the natural sciences or the historical sciences have this double aim (the living dialectic of the researcher and the researched). (Henry and Kemmis, 1985, p. 3)

This approach requires ownership of the process by the participants together with good integration and understanding. Participant ownership was central to the process and, for example, participants in this project asserted their ownership by i) addressing the language and changing terms used; ii) their involvement in collection of data by contributing to the design of the questionnaire; and iii) altering the pace of the project by shortening the time frame and increasing the frequency of meetings.

Triangulation of data sources was developed with the intention of minimizing the risk of mistaken consensus. The approach collected data through participant meetings, textual meeting minutes, a questionnaire exploring attitudes to interaction before and after the project, individual interview, and a literature survey. Investigator triangulation was approached via the independent review of the interpretative analysis by participant agencies, by the independent consultant, and the sponsoring body. A further review at a time distance (1 year) after the conclusion of the project considered the ongoing practical value of the findings. Methodological triangulation - using multiple methods to study a single problem - was developed by using the trial project of case management, by the participant working group reflecting, moderating and re-evaluating their practice, and by the comparison of data collected at discrete



intervals – before, after and one year post project. These aspects are further discussed in section 6.4.1: First Steps.

The action research model suited this type of approach in that analysis of findings could generate practice responses, which in turn could be further explored. The action research model incorporates a cyclic development in which action is monitored, evaluated, and revised through a process of reflection, discussion, understanding and learning. Particular emphasis is placed upon the construction of reality and taking account of how those involved used their perspective of the 'real' situation in governing their actual interactions and their expectations of interactions with other agencies:

For the organization or community, collaborative inquiry involves explicit shared reflection about the collective dream and mission, open rather than masked interpersonal relations, systemic evaluation and feedback of collective and individual performance, and direct facing and creative resolution of these paradoxes that otherwise become polarized conflicts. (Torbert, 1976, p. 128)

The cyclical process developed a breadth of themes which are discussed in Chapter Nine: Project Outcomes. The range presented difficulties, with a need to discriminate between themes that fell within the ability of the project to address and themes that were beyond the ambit of the project. The group continued to work with themes that were identified as progressing within the boundaries of the project. Themes arising that appeared to generate further exploration were passed to other appropriate forums.

The cyclic process also pointed to actions which were governed by others outside the project. This raised frustration, but also led to planning of strategic collaborative approaches. The context of change in the health sector environment had significant affect on the outcome of the project as the relationship between the participants underwent an imposed reconfiguration soon after the practical effects began to be experienced.



This related to the amalgamated into one body of the four Regional Health Funding Authorities and the subsequent move, from Wellington to Christchurch, of Health Funding Authority (HFA) control in Nelson. Changes were experienced in contracts, in approach by the HFA to various providers, and in processes of consultation. The change of the funder appeared to affect the balance of relationships between local providers, depending on their ability to develop relationships with the Southern HFA. However, it is likely that the collaborative practice enhanced by the project was then more able to sharply focus and address the divisive nature of the changes.

The next chapter addresses the dimensions of collaborative practice and outlines the approach in this project.

## **CHAPTER THREE: COLLABORATION**

### **3.1 What Is Collaborative Practice?**

Collaborative practice involves joint working between agencies. It entails concepts of joint ownership of processes, authority and responsibilities. Collaborative practice invokes a partnership alliance that is active and ongoing and, while it may have lead agencies, it is not subject to interference or domination by lead agencies.

Collaboration between agencies providing mental health services has been continually endorsed as good practice. Much of the writing about rehabilitation practice in mental health services has focused on inter-agency collaboration as being important to the potential well-being of people who have mental illness (Anderson et al., 1993; Parker, 1997; Means and Smith, 1994). The scope of the research in this thesis looked at the health and social services literature prior to 1998 and found considerable reference to the barriers to collaboration. However, up to 1998 little had been identified that indicated how collaborative practice can be initiated and maintained. Post 1998, there is a growing body of work in these fields which addresses collaborative methods in organisational settings. Participatory and collaborative approaches have been developed increasingly over the past 20 years in the domains of natural resource management, ecosystem management and community development, particularly in relation to sustainable development. Allen (1999) provides a comprehensive web-site resource in this area.

In accessing resources and writings, a wide range of domains could be canvassed. I have found that references relating to collaborative practices are much less extensive in mental health and social service literature compared to the extensive work in the field of sustainable development. I have drawn on the web-site resource work of Allen (1999) as a starting point for my focus on collaborative practice, although my study has focussed on mental health and social services. In the literature relating to mental health and social services most

references (with the exception of Means et al., 1997) address collaborative practice by focussing on the barriers that impede its development.

In considering the literature resources available, I decided that identifying these barriers could be a starting point for exploring practice guidelines. My survey of the literature on collaborative practice resulted in a list of barriers and challenges which I then presented to the project working group. The purpose served by this list (Appendix II) was to put the difficulties we were experiencing in our community into a much wider perspective. An awareness of barriers and challenges can set the scope for work that is needed to moderate these blocking factors, and could also identify areas in which agencies might recognise their universal rather than personal nature. That is, that these factors are common to agencies who have interdependencies and interactions. By beginning to identify common challenges, agencies may be introduced to areas of shared experience which have often previously been seen as individual pressures.

In drawing up a definition of collaborative practice, it is useful to firstly explore what it is not. In collating the factors that mitigate against collaboration, an understanding of an environment that will provide positive interaction can emerge.

### **3.2 Barriers And Challenges To Collaborative Practice**

As a first step, drawing out and defining the barriers seemed useful as a way of marking out common ground in the experience of the project participants. I found that listing and presenting the challenges and barriers to collaboration at the beginning of the project was helpful in enabling the group to acknowledge their common frustrations. In seeing these as commonly identified barriers, the group was able to express and identify these as experiences they had in common, rather than as peculiar and unique to their individual situations. In finding common ground, the working group began to recognize itself as a group rather than as discrete individuals.

Many factors have been identified which create challenges and barriers to full engagement in collaboration. In endeavoring to present these in an easily digestible way for the project group, I drew out, summarized and listed these as a topic for discussion.

The challenges and barriers that I was able to identify in the literature are outlined here:

- Foremost is lack of trust between agencies, in each other's skills and motives (Means and Smith, 1994; Plamping, 1997; Miller, 1991; Poole, 1992; Briggs and Koroloff, 1995; Turner et al., 1997). Mutual suspicion hinders contacts and flow of information. Lack of trust can have an impact on people who need to use the services of agencies by limiting access and by inhibiting confidence.
- Competing and conflicting roles create barriers (Biegel et al., 1995; Briggs and Koroloff, 1995; Lewis et al., 1995; Hoge and Howenstine, 1997; Means and Smith, 1994; Orovwuje, 1995). This is particularly so when roles cross over or when there are unmet needs for services which are beyond agencies' roles.
- Different methods of working and different philosophies can add to misunderstandings, so that negative past experiences are accumulated both by workers in agencies and by people who use services (Biegel et al., 1995; Burns et al., 1994; Turner et al., 1997). Means et al., (1997) note the impact of conflicting dimensions within agencies at management and field worker level. Lack of common language and the use of professional jargon also create division. (Ridgley et al., 1998)
- Within services, the priority and attention paid to networking and collaboration can be affected by the amount of administrative paper work and high caseloads, disproportionately high number of crises (Biegel et al., 1995), and by lack of time (Plamping 1997; Briggs and Koroloff, 1995; Means and Smith,

1994). Social support can be seen as having a lower priority than other support needs which draw on the internal resources of the agency (Biegal et al., 1995; Commander et al., 1997; Lewis et al., 1995). A lack of agency support for network interactions, particularly if gain to the agency cannot be immediately identified, can inhibit staff maintaining contacts and result in poor information flow (Turner et al., 1997; Means and Smith, 1994).

- Lack of knowledge and skills within agencies (Biegal et al., 1997) can result in reduced or inefficient networking. Skills deficits that impact on networking and collaboration include skills of working with systems and agencies as well as with individuals, lack of experience in social support interventions, lack of support in training and supervision, imposition of confidentiality requirements, lack of knowledge about formal and informal community resources, and lack of knowledge of cultural issues. Cultural issues include those of cultural perceptions within an agency about the practice differences between itself and other agencies. Strong group identity (Twigg and Atkin, 1995) can create barriers to co-operative working when assumptions about differences are made. When responsibility for networking or joint working is not seen as an agency role, blame and costs may shift to other agencies (Plamping, 1997).
- A lack of agreement about roles and points of intersection can result in a lack of congruence of perception between agencies (Stein et al., 1995) and an interpretation of threat from the interagency relationship (Twigg and Atkin, 1995; Poole, 1992). Lack of compatibility between professional ideologies (Means and Smith, 1994), lack of clarity in boundaries and a reluctance to change them (Turner et al., 1997; Hoge and Howenstine, 1997), professional competition and differing infrastructures (Plamping, 1997) contribute to communication difficulties. Tension between needs and resources and between a desire for co-operation and competitive dominance (Lewis et al., 1995) can pose a fundamental dilemma.
- The environment that agencies work in can affect their ability to relate to other agencies. Networks can simply be 'burnt out' (Biegal et al., 1995);

Parker, 1997; Orovwuje, 1995), or lack the resources to invest in building relationships with other providers (Means and Smith, 1994). Factors which create barriers can be their geographic isolation and wide dispersal of consumers (Biegal et al., 1995; Rousseau, 1993) and the people who use the services of the agency not wanting to be involved with other agencies (Biegal et al., 1995). Consumers may actively discourage interagency working if they feel discriminated against or experience differences in understandings about their support needs (Twigg & Atkin, 1995). A barrier to collaborative practice is strongly identified with a general lack of local community resources (Plamping, 1997; Biegal et al., 1995; Ridgley et al., 1998; Hoge and Howenstine, 1997; Burns et al., 1994; Means and Smith, 1994).

- A climate of stigma and bias towards mental illness can also affect collaboration (Gask et al., 1997; Biegal et al., 1995) because of the thicket of assumption and misunderstandings which ensue.

A New Zealand study (Orovwuje, 1995) particularly identifies barriers to collaborative practice as including the high degree of management and service changes within a short time span, communication systems that are inadequate, and a poor level of bi-cultural input and the effects of racism. Functional deficits within organizations - such as marginalisation of the non-physician staff, lack of consistent systems of care management, poorly functioning interdisciplinary teams - lead to clients being lost in the system and a lack of co-operation and support. In addition to this, the dichotomy between clinical and management perspectives internal to an organization can further handicap its ability to form sound relationships externally. The functioning of the power dynamic within agencies may impose a significant challenge to successful partnerships between agencies.

Much of the work that has focussed on collaborative practice has thus identified the difficulties and barriers. The advantage for ongoing work in these studies is that in identifying the difficulties, the commonality of these difficulties can be seen. Without relationships with other organizations that have a trustful, co-operative basis, agencies can become quite isolated and inward looking in their

own practices. That agencies equally face the same challenges can be difficult to appreciate. A recognition of commonality in the impact of similar stressors can be a starting point for a potential partnership.

### **3.3 Addressing Challenges To Collaboration**

Less work has been identified that poses practical ways of redressing the difficulties of collaboration, although preconditions for success have been suggested. These include concepts such as - interagency homogeneity, incentive strategies rather than authoritative sanctions, domain consensus, network awareness, organizational exchanges, absence of alternative resources, existence of trust, low risk threshold, respect based on addressing agencies own objectives and tasks, models of choice and empowerment rather than hierarchical structures (Means and Smith, 1994; Plamping, 1997, Biegel et al., 1995). Such concepts seem to indicate that, for example, good understandings of one another's services, free and open agreement to work in tandem, and a lack of perception of threat will enable collaboration to flourish. However, such concepts are restating the challenges and barriers in a prescriptive way, and do not suggest practices that will enable collaboration to be achieved.

The addressing of power factors appears to be an underlying and important component:

The pooling of sovereignty to achieve ends which individual agencies are less likely to secure alone. (Knapp et al., cited in Means and Smith, 1994, p. 163)

They note that mental health service provision

remains an area fraught with difficulty for those who aspire to a collaborative approach (*Ibid*, p.164),

and identify the process of community care planning as an appropriate opportunity to address this situation.



Preconditions for successful collaboration thus provide guides to strategies which can provide a conducive environment. However, the practice of establishing collaborative working has been minimally addressed. A specific work (Means et al., 1997) provides a working model of establishing joint working between agencies. This comprehensively covers the type of information that needs to be exchanged, networking, joint planning and referral processes, and methods of ongoing interaction.

In my opinion, in practice, inter-agency collaboration is fraught with misadventure. Differences often appear and, unless ongoing priority is given to liaison processes, grievances can quickly undermine relationships. For collaboration to be successful, it seems important to pay attention to the environment in which these relationships are expected to flourish. This environment includes factors such as power dynamics, contracted functions, sphere of activity, and perceived role boundaries. Often the challenges to interaction that agencies face can be seen as the presenting symptoms of a dysfunctional relationship. Thus, if only the symptoms are addressed, the underlying tensions will continue to reappear in other guises.

People who work in the Mental Health Service and agencies providing mental health support have clinical expertise in developing and maintaining good working relationships with the individual people who use their services. It would seem useful if these skills could be also drawn upon to develop and maintain work between agencies. Surprisingly, professional skills seem, in my opinion, only intermittently applied in an objective way to these relationships. More often, the relationship between services is approached from a subjective level in which judgmental and personal feelings are introduced. Being both participant and objective seems both crucial and difficult.

Thus, identifying challenges and identifying the commonality of agency experience is a starting point. Analysis of the particular factors of interagency difficulties in achieving collaborative practice gives an understanding of the situation, but does not get the participants far towards doing anything practical to address developing the skills and practices of collaboration.



In identifying factors which contribute to a collaborative culture, Means et al., (1997) draw on practitioner skills of 'user involvement'. They note three important skill areas:

- i) involvement – by providing information, individual consultation, joint working (on projects and groups) and delegation of control<sup>1</sup>;
- ii) Provision of information – that is widely available, easily read and understood, accessible in a range of languages, accessible to translation and in a non-written form, and forms which are easily used;
- iii) group consultation with users and carers by - offers of training to and from users and carers, accessible meeting venues, avoidance of jargon, adequate time for feedback, and full information about action following consultation.

These three skills that Means et al (1997) identify for enhancing joint working between agencies can be seen to be skills that would be regarded by practitioners as good practice in their work with individuals. Continuing to practice these skills in their relationships with other agencies seems to be a part of the challenge.

Caplan (1969), in discussing the community approach to mental health, suggests that, as well as direct and indirect interventions with individuals, indirect intervention which provides for face to face mental health consultation with the community caretaking agents who have the direct contact with individuals is a key preventative strategy. These caretaking agents may be family, funded providers such as residential services, peer supports, or voluntary agencies. Caplan sees this role for mental health specialists introducing knowledge of the psychological needs of individuals, groups and interpersonal forces into the mental health response of the whole community. If the culture of the community is a system of interdependent forces, then input of a clinical approach on a community wide scale could moderate specific cultural change in a healthy

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<sup>1</sup> Source: d'Aboville (1994) Promoting User Involvement, London: Kings Fund

direction. In 1969, Caplan saw this as a "promising direction", and specifically identified the social work role as important.

### **3.4 Social Work Role**

Caplan (1969) saw the ecological model of social work as being extrapolated from work with individuals and their environments to the environment of mental health community supports:

We are beginning to realize that we should think of a field of forces; of a unit of society – whatever the size of it – rather than of an individual patient... In other words, we are thinking of webs of forces with the individual we happen to be looking at as part of them and as reacting to them. (Caplan, 1969, p. 186)

Caplan proposes that:

We must work out methods whereby a small number of highly trained people can work with the many caretaking agents of a community who are in so strategic a position (during crisis periods) to affect the mental health of so large a population of the community. If we can succeed in working out some techniques of this nature, and if we can get ourselves trained in it, we shall have developed for the very first time a potent instrument whereby we may achieve some kind of approximation of community coverage. (Caplan, 1969, pp. 201-2)

Caplan, however, tended to advocate that the role of mental health professionals should be that of working with individual "caretaking agents" within other services to promote their therapeutic skills. If "caretaking agents" can also be understood to include service agencies this role can usefully help to build and enhance relationships between the agencies. That is, to address interagency collaborative relationships from a standpoint of clinical skills rather than an enmeshed participant.

Caplan sees the social worker as the "specialist in assessing environmental phenomena"(1969, p. 189).

The social work role in the Nelson/ Marlborough Mental Health Service currently involves the responsibility of community liaison and service co-ordination. As the clinical psychiatric service has a lead role in determining the focus of rehabilitation and treatment, the psychiatric social worker is in a pivotal position to facilitate coherence in the community of mental health service agencies. In terms of a practical response to collaborative practice, the skills of psychiatric social work offer a useful starting point. Particularly relevant are strategies of empowerment and group work, as well as understandings of dynamics of interpersonal equilibrium.

### **3.5 Four dimensions Of Collaborative Practice:**

Four dimensions may be identified (Jones, 1999) which need to be addressed in seeking to establish effective collaborative practice. I have utilized these four dimensions in a health or medical model, which invokes symptoms, clinical intervention, remedial intervention and causative agents.

Firstly, identifying the barriers and the community of this experience amongst agencies. This can be compared to the symptoms of lack of effective interaction.

Secondly, the conceptualizing of agency roles as a community web of forces and legitimizing the healthy maintenance of this as a professional role of individual participants. This can be compared to the clinical intervention.

Thirdly, the tools of interaction, such as network mapping and communication channels, which can be compared to remedial intervention.

Fourthly, the underlying character of forces which impact on practice, such as power dynamics, perceptions and understandings of roles and boundaries, and the influence of obtaining and meeting contracts. This can be compared to the pathogens, the causative agents.

To effectively address the exercise of collaborative practice, attention needs to be paid to all of these four dimensions. If useful changes in practice can be achieved, which can be continued in situations beyond the life of the project, the participants need to look beyond 'fixing' the immediate day to day issues. There is a need to explore the process of collaborative practice and to identify specific skills and ways of working which will generate a healthy relationship.

### **3.6 The Project:**

The project which is the subject of this study, identified strongly with the dimensions outlined above, and the social work role as facilitating the process. The focus of this project was to develop a model of collaborative working that would have practical application. Many of the practice steps outlined by Means et al., (1997) were replicated in the findings of this project. Specifically these were the emphasis on training, education and information sharing; structuring the exchange of written information; and the importance of opportunities for networking.

However, an important aspect emerged relating to the prevention of practice deteriorating again into conflict and mistrust, and the factors that needed to be built in to ensure that collaboration could be maintained. This, the fourth dimension, seems very important to the understanding of the workings of collaborative practice and this is discussed more fully in Chapter Five: Context. I have taken the barriers to collaborative practice, that I drew from the literature, as a starting point for the project and re-expressed them as challenges. The project could then focus on looking for practices which could mitigate against their negative effect. This is discussed in the section of this study which discusses the progression of the project.

In designing the project, I looked for a model in clinical practice which might provide a way of trialling collaborative practice. I proposed to use the clinical practice of Case Management, which staff of the Mental Health Service use to maintain contact and initiate intervention with people who use their service. I suggest that case management is an appropriate model as it has many aspects

(as identified by Means et al, 1997; Burns, 1997) of collaboration, and also provided a familiar clinical practice which could be potentially be extended from work with individuals to work with agencies. The next chapter discusses the practice of case management and how it could be expanded to work with agencies

## **CHAPTER FOUR : CASE MANAGEMENT**

### **4.1 Overview: Models**

Case management, also known as care management, has developed in various models. The dynamic which affects practice has depended on the context of operation and interpretation of function. Case management has functions that are generally present:

The central components of case management (*that Intagliata<sup>1</sup> identified*) are still recognized in most programmes - assessment of needs, planning comprehensive services, arranging delivery of services, monitoring and assessing those services, and evaluation and follow-up. The emphasis has varied between services and over time. (Burns, 1997, p. 393)

The aim is to "enhance the continuity of care, and its accessibility, accountability and efficiency" (Burns, 1997, p. 393). Case management can be understood to be a process working towards appropriately supporting clients in an individual way. Case managers also take on roles as key workers, although this is usually seen as a separate role from that of case management.

Case management indices of effectiveness relate to numbers of people with psychiatric impairments remaining in contact with the mental health services, effect on hospital admissions, clinical and social outcome, and costs (Marshall et al., 1998). Although research into case management is sparse and contradictory (Mental Health Services Research Consortium, 1994, p. 22) a common defining theme can be seen in the task of integrating hospital and community services, and in being responsive to individual need and individualized planning.

The contracting environment of today's mental health service providers may limit access for potential service users. Because contracting can influence providers to be contract-focussed rather than 'client'-focussed, service delivery issues can be quite narrowly defined:

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<sup>1</sup> Intagliata.J. *Improving the quality of community care for the chronically mentally disabled: the role of case management*, Schizophrenia Bulletin, 1982, pp. 655-674

There is no 'duty' or 'obligation' on them, other than professional standards of loyalty to their community, to offer services outside of those specified in contract. ("We will not provide services that we are not contracted to provide"). It is the purchasing agent, the regional health authority, and not the provider, who legally has the responsibility for the service as a whole. Opportunistic interpretations of potential 'customers' ... may limit access in two areas. Some clients may fall through the gaps left by contracts for unbundled services, or they may be deterred from seeking help altogether by having to bear the opportunity costs of being shunted between services... Even if the chain of referrals is not broken the client can bear considerable costs from being repeatedly re-assessed before treatment can begin... There can be considerable staff time spent in negotiating with other agencies or sub-services. (Mental Health Services Research Consortium, 1994, p. 21)

Case management has a key role in clinical practice in endeavouring to protect the person who needs to access services from the alienating task of finding and engaging fragmented and competing services and melding these into a comprehensive and individual support plan. It provides one point of comprehensive assessment and one key health professional who can be a central point of contact and advocacy for the person.

Case management has developed as a response to forming consensual and cohesive planning in an uncohesive and non-consensual environment and, internationally, it has appeared in different guises and models.

Models of case management (Marshall et al, 1998; Burns et al, 1997) include:

- **Brokerage:** This is an administrative model, which co-ordinates care and access to supports. It involves assessing needs, developing a care plan, arranging suitable service provision, and maintaining contact. Case managers often lack clinical qualifications and tend to work outside psychiatric services.
  - **Clinical Case Management:** Focussing on individual responsibility for clients, this emphasizes the professional status and therapeutic skills of the case manager and tends to have a 'psychodynamic' flavour. Particular importance is placed on the healing power of the therapeutic relationship.
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- **Intensive Case Management:** This stresses the importance of small caseloads and high intensity input.
- **Strengths Case management:** Emphasizes working with the client's skills rather than deficits.
- **Care management:** (British model - "case" has been considered offensive to consumers) "extended brokerage care management" involves both identification of support needs and responsibility for purchasing support care from a budget managed within the service. Care managers are usually professionally trained and usually involved in direct service provision as key workers. The defining characteristic is the central brokerage function with a degree of budgetary control.
- **Care programme approach (CPA):** Introduced in 1991 in the UK to provide a framework for the support of people with psychiatric disorder outside hospital, it has four main elements:
  - Systematic arrangements for assessing the health and social needs of people accepted by the specialist psychiatric services
  - The formulation of a care plan which addresses the identified health and social care needs
  - The appointment of a key worker to keep in close touch with the patient and monitor care
  - Regular review, and if need be, changes agreed with the person to the care plan, which is flexible and responsive to the person's ongoing situation

Overall, CPA places a high emphasis upon involving users of the specialist service and those providing care, and upon multi- disciplinary assessment:

If properly implemented, multi-disciplinary assessment will ensure that the duty to make a community care assessment is fully discharged as part of the CPA and then should not need separate assessments. (Department of Health, 1994, p. 15)

It is likely that case management (in both trials and every day clinical work) is eclectic, being practiced at varying levels of intensity and combining elements of brokerage, clinical case management, and strengths models. Great emphasis is placed on individual responsibility of case managers for 'clients' (Thornicroft, 1991).

Case management is often confused with Assertive Community Treatment (ACT) (or PACT - Programme for Assertive Community Treatment) (Marshall et al., 1998).

- **Assertive Community Management (ACT):** This is the dominant approach in the USA, involving small caseloads and a broad clinical remit. Emphasis is on team working being the vital link between team and its clients rather than between particular team members and individual clients. ACT is multi-disciplinary and often involves psychiatrists. Several members of the team routinely work with the same client. Rather than brokerage, ACT teams attempt to provide the necessary interventions themselves, preferably in clients' own environment. ACT aims to have a low staff to client ratio (usually 1:10-15). The practice approach uses assertive outreach, which means that services are continued to be offered and contact is maintained with reluctant or uncooperative clients. Particular importance is put on medication and 24-hour emergency cover. ACT is characterized by individualized treatment, flexibility of service responses, outreach, care of the most severely mentally ill, interagency co-operation and continuity of care.

Care (or Case) management is more widely practiced than ACT, and, outside the USA, is now accepted as an "indispensable element" of care in the community – for example, The Care Programme Approach, UK (Burns et al, 1997).

In New Zealand, case management is integral to Health Funding Authority service descriptions of process, whilst:

not providing the complete range of activities associated with each process,...indicate the nature of the process and ... outline minimum

expectations in regard to each process type. (HFA Draft Definitions, Feb 8, 1999, p. I)

The Health Funding Authority has determined case management to be care management, and provides the following definition:

**Care Management:**

Interpretation and application:

A Care manager (key worker) is responsible for co-ordinating the development, implementation and review of an individual management/treatment plan. The plan identifies the responsibilities of each person and agency involved in implementing the plan. Activities include:

- Establishing a rapport with the service user, family/whanau and significant others
  - Ensuring full assessment of the service users needs is completed
  - Co-ordinating an individual rehabilitation plan which:
    - Identifies goals and how they are to be achieved;
    - Specifies timeframes for implementation;
    - Identifies risk factors and strategies to minimize each risk;
    - Reflects the participation of the service users family/whanau and significant others;
    - Specifies the service users daily activities, medical requirements, abilities, disabilities, preferences, support needs and goals;
    - Has a review date.

Care management includes:

- Education and support to the service user and caregivers.
- Ensuring assertive follow-up occurs when needed.
- Providing ongoing input into clinical decisions regarding the range of interventions for the service user.
- Co-ordinating and ensuring involvement of the service user and caregivers in decisions relating to care.

(Health Funding Authority, 1999)

A similarity can be seen with the CPA (UK) process, with less reliance on multi-disciplinary input, less commitment to consultative Need Assessment, but with a robust use of limited staffing which is adaptive to a provincial service setting.

This interpretation provided by the Health Funding Authority does not promote a specific model but does provide for an eclectic approach. Provision of case management varies even within individual services. Generally, case management in New Zealand seems to provide an approach which is identified as the most appropriate for the person. In our service, Nelson/Marlborough Mental Health Service, aspects of all the models can be found. Each of the three teams responsible for case management use different models, including ACT. Case and Care management are provided. However, all case managers integrate their case management practice with the aim of meeting the person's needs as identified by the Health Funding Authority definition. This forms part of their contractual responsibility.

## **4.2 Evaluation of Case Management**

The Health Funding Authority contracts case management to the specialist Mental Health Service. Thus, through the contracting process the Mental Health Service has a powerful involvement in the every day life of people who use its services and the services of other providers. It has the ability to improve or to gatekeep access to supports:

Everyday life has in it elements of risk to health. These facts take on a paramount importance not only when health becomes a paramount value to society, but also a phenomenon whose diagnosis and treatment has been restricted to a certain group. For this means that this group, perhaps unwittingly, is in a position to exercise great control and influence about what we should and should not do to sustain that 'paramount value'...not only is the process masked as a technical, scientific, objective one, but one done for our own good...I must confess that given the road down which so much expertise has taken us, I am willing to live with some of the frustrations and even mistakes that will follow when authority for many decisions becomes shared with those whose lives and activities are involved. (Zola, 1972, pp. 498-593)

Case management is a means of sharing with the person who is using the psychiatric service, the direction and responsibility for their health care. It is a bridging between the specialist service and the person, enabling a personal and human contact. Case management is a collaborative practice involving the establishment of a mutual relationship, but also involves risks for the person – of gatekeeping and of inappropriate control.

The effectiveness of case management, as an approach to caring for severely mentally ill people in the community, has been the subject of a number of studies internationally. Studies, which compare forms of case management against a control treatment, have been reviewed by the Cochrane Collaboration (Marshall et al., 1998). ACT has generally demonstrated advantages over standard care showing increased 'community tenure' (reduction in need for in-patient care), whilst the review of care management suggests that it is effective in maintaining contact with clients, although a costly approach with few other obvious benefits for clients. Implications for practice, drawn from the research, (Marshall et al., 1998) suggest that help to maintain contact is gained, although hospital admissions are not reduced but increased. Case management can not be found to improve outcome, in mental state or in social functioning, but is not found to reduce these. Case management is not proven to be more or less costly than other approaches:

In summary, case management is a poor alternative to standard care because a small advantage in numbers remaining in care is off-set by a large increase in admission rates, no obvious clinical gains, and considerable uncertainty over costs...(Marshall et al., 1998, p. 9)

In my opinion, whilst it does not alleviate illness according to the indices of frequency of admission to hospital or improvement in mental state functioning (Marshall et al, 1998), the increase in these indices could also be interpreted as an increased trust and willingness to be involved with the specialist services. Both these indices can be used to indicate a higher level of contact between the person and the specialist service, and may indicate a higher level of responsiveness to the person's clinical support needs. It is my opinion that caution should be used in interpreting these measures to show lack of effectiveness of case management because, as Marshall et al., (1998) concede:

Case management does increase the services' chances of keeping in touch with people with serious mental illness in the community... It also seems to promote admission to hospital. If this is acceptable to clinicians the case management has something to offer. (Marshall et al., 1998, p. 9)

### 4.3 Extending Case Management To Work With Agencies

There is recognition in the case management approach of the need to work with staff of other agencies. However, initial research suggests that this is not happening on a systematic or regular basis. For example, in assessing the Care Programme Approach, the Department of Health (1997) found that "links between community care and housing assessment processes varied and formal triggers for joint assessment were rare" (p.23). The report concluded that housing agencies needed to be brought more centrally into the assessment and care management process.

Such concern about joint working between agencies at the operational level is based upon a belief that its success is important from the point of view of both partners. (DOH, 1997<sup>2</sup>, cited in Means et al., 1997, p. 38)

I took the identified factors in case management as practiced by the Mental Health Service in Nelson as a base to develop a case management system to cover agencies in the same way as clients. In taking account of the findings of Marshall et al., (1998), I considered that it would be likely that case management would offer better liaison and joint working.

The conclusions drawn by the Cochrane Review (Marshall et al., 1998) have implications for suggesting case management as a model for interactions between the Mental Health Service and agencies in that the primary focus is improving contact and liaison. However, it could be expected that more critical issues or problems would be identified which would require addressing and this would lead to a higher number of more specialist interactions.

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<sup>2</sup> Department of Health (1997) Implementing Caring for People: Housing and Homelessness, Department of Health, UK



The focus of developing and enhancing collaborative practice is to help maintain contact/liaison and improve the service linkage. The aspects of collaboration, empowerment, responsiveness to users and carers, needs-led interactions and flexible response, which are active in the case management model, are integers that hold potential for enhancing interactions between Mental Health Service and agencies with which it networks. In assessing case management with individuals, Marshall et al., (1998) did not consider that functioning was improved in relation to the indices they recognize. Thus, appropriate indices for improvement needed to be identified for work with agencies. In the project, I suggested to the working group that indices indicating usefulness of care management as a model would be:

- satisfaction with the liaison (measured by the questionnaire and individual comment);
- commitment to the interaction;
- increase in levels of contact and liaison.

These indications were considered to be meaningful to the working group.

As a main aim of enhancing collaborative practice is to improve the functioning of services in relation to the quality of the support offered to users of services, it would be important to identify whether case management with agencies would result in improvement.

The familiarity of the Mental Health Service and the community providers with case management practice did provide a mutual basis for collaboration which was worth exploring. Confirming agreement about this mutual understanding was a first task of the working group. A summary of attributes of case management that was recognized by the working group is attached (Appendix III). Understanding was established that case management in this project would involve close communication, development of shared understandings (particularly about differences in culture and philosophical approaches), be orientated and enabling, focus on the individual needs and supports of the agency, as well as being an avenue for exchange of information. The expectation of the group was that better practice of collaborative working would result in better support for the users of the services. They were prepared to use the case management model to explore this.



## **CHAPTER FIVE: CONTEXT**

### **5.1 Introduction**

This chapter considers the character of the fourth dimension affecting collaborative practice (identified in section 3.5: Four Dimensions of Collaborative Practice). The underlying character of forces – power dynamics, perceptions and understandings of roles and boundaries, influence of contracts – form the context in which services are provided. This chapter offers a perspective about the current context in which mental health services are delivered.

The working group discussions focussed on the practice of collaboration. However, they also commented on aspects of the current environment which affected their practice. These included :

- The way in which the funder (the Health Funding Authority) determined which providers would be offered contracts. This frequently did not involve tendering.
- The way in which the funder (the Health Funding Authority) determined the level and type of services to be provided.
- The role of the specialist psychiatric service and how this related to the growing responsibilities undertaken by community providers.
- The role of consumers and their ability to influence the provision of services
- The differences in approach and involvement between those in clinical and in management roles

The working group used these observations as a basis for finding useful practice responses – such as the importance of written information - and did not discuss underlying power dynamics. However, because I believe the context underlying the relationships between agencies and the Mental Health Service is of consequence, this chapter I have developed a perspective on context. The model discussed below ('neo-feudal' model) is not a model formally practiced or subscribed to by organizations involved in mental health service delivery. Whilst services may not accept that they operate on this model, it is discussed to

provide a useful tool/ perspective of how agencies, including the consumer and family groups, view their relationships with the Mental Health Service.

## **5.2 Power/pathology**

Collaborative practice – or joint working - is a process which takes place within a context. In the case of this project, this context is the local mental health community. Context can be seen as containing both practice – the delivery of services to people - and process – the management of service delivery. A modern health system, medicine or psychiatry, is heavily loaded with rapidly expanding, specialized, clinical practice. This tends to be the province of clinicians, who believe that this should be driving the system as clearly and authoritatively as possible. This practice is in a dynamic with a process which concentrates on enabling third party funders to understand and control the practice of service delivery. The balance of power and authority between practice and process is the determinant which drives the service's ability to meet the health needs of the community. Focus within organizations seems to have shifted more emphasis to process and away from practice. This can lead people in that power system to mould themselves to managerial processes and easily marginalise practice. Too strong a focus on parts of organizational process, combined with power to make the judgments on how that process determines clinical practice, can jeopardize the target of providing a health service which meets needs of people who use services. The type of power structure which elaborates process at the expense of practice has a side effect in enabling destructive and opportunistic behaviours:

Once upon a time the organization had a purpose, and the function of management was to assist that purpose. Nowadays, those on the sharp end – teachers, researchers, health and other professionals, the suppliers of services – increasingly feel their task is to generate funds to support an enlarging and isolated management structure that seems to have objectives of its own, independent of the apparent purpose of the institution.....A recent government review reported that hospital managers were doing well. Their main problem was that their health professionals treating the patients would not conform to the managers' requirements. The view was offered without any sense of irony. After all, the presenters

were managers. But the public wants managers who have emblazoned on their heart (not to mention in their personal development files): "My job is to assist the health professionals to help their patients." – Apparently for modern management it is not. (Easton, 2000, p. 56)

In order to address 'best practice' in joint working between agencies, an understanding of the context in which agencies operate and a consideration of how agencies respond to this context is critical. From this, a proposition regarding the dynamics of power which operate can be made which can then be used as a basis for an empowerment approach. One of the functions of action research is to empower the participants. Thus, attention to dynamics and balance of power is integral to a critical examination of the context.

The following interpretation of the market environment is drawn from Jones (1999), although a different conclusion is offered to that reached by Jones (1999). The proceeding discussion about structures of power within the Mental Health Service is developed from work by Christopher Hodgkinson, (1996).

### **5.3 Market Structures And Managerialism**

Mental health services are delivered in the context of the quasi-market structure adopted for New Zealand health service provision. Conventional markets have a direct interaction between the person who requires or receives a product or service and the provider of that product or service. Factors, such as cost, quality, accessibility and need, provide a competitive framework in which providers can target their product or service and purchasers can exercise choice.

Quasi-markets have a different structure in that a third party is introduced between the purchaser and the provider. Central government is responsible for provision of health services and has rested this in a funding body – the

Health Funding Authority<sup>1</sup>. Within the Health Funding Authority, Mental Health provision is capped and contracting is ring-fenced from other health and disability provision. Based on priorities which it determines, the funder contracts with providers for the provision of services. The factors such as cost, quality, accessibility and need are regulated by contracts.

The provision of services is dependent on the funder's interpretation of need, followed by the prioritising of diverse needs, and a requirement to moderate services to fit capped budget limitations. Whether services then adequately support the health and disability experiences of the community is dependent on the skill and integrity that the funder applies to these tasks.

Health service delivery is complicated by the quasi-market structure in a number of ways. Jones (1999) identifies that information about health and health needs is difficult to obtain, is difficult to interpret and is difficult to define (Jones, 1999, p. 46-59). The uncertainty raised by complex information results in a difficulty in consistent and reliable forward planning. Uncertainty allows for a high acceptable variation in service provision responses, an increasing reliance on the representation by powerful groups and a diminishing ability to heed individual advocacy. Jones suggests that the role of the funder as 'champion of the people' and thus, the needs it is prepared to identify in the community, is compromised by conflict between the funder's own interests, its relationship with providers, and the needs of service users.

In endeavouring to 'champion the people' the funder has developed defined populations. The rationale for this shows a concern to provide an even-handedness in the allocation of resources, and a breaking of historical patterns, as well as providing value for money and cost effectiveness. Thus, a function of contracts is to define populations (for example, by region, by diagnosis, by disability, by age), for whom services will be provided. In determining the

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<sup>1</sup> At the time of writing it appears that the role of the Health Funding Authority will revert to the Ministry of Health and that individual regions will have input into service priorities through the formation of District Health Boards. However, the quasi-market structure will still operate in that a third party will continue to control the relationship between the provider and the person who receives a service.

configuration of service provision, the funders are faced with balancing expert and lay opinion, resourcing acute versus community care, prevention versus intervention, quality of life versus saving life, and priority of services across care groups and within care groups (Jones, 1999).

Jones (1999) identifies that the difficulty in accessing good, objective information results in a reliance by the funders on the providers. Whilst initially set up as competitive, the contracting environment of quasi-markets has led to a consolidation of preferred providers. Providers who face high risk (for example, in maintaining residential or institutional facilities, specialist or acute services or services in rural areas), have become entrenched, in that they are protected as preferred providers because of their investment in the service.. Because delivery of health services and health needs are difficult to determine, the funder has grown to rely on providers to supply information. In a quasi-market environment the people who use services are supposed to have a choice of service provider operated on their behalf by the funder. When providers become entrenched, the funder has ceased to operate choice. Service delivery by providers with monopolies can then become open to opportunistic behaviour such as discriminating against high cost users or reducing the quality of services.

A response to managing delivery of service has been the increasing use of regulation, auditing and accreditation. The heavy reliance on recorded measurements has increased the domain of provider managers/administrators over the clinical areas.

#### **5.4 Power Relationships In Health Services**

Jones (1999) identifies (in the context of the British Health Service) a change in power relationships, and ascribes this to medical elites and the "pressures that quasi-markets brought to bear on physician behaviour when budgets were capped" (p.51), with interpretation of medical need aligning with the available

budget. Jones invokes an analysis of Habermas (by Scambler, 1987<sup>2</sup>) to warn that:

the capacity of the medical establishment to absorb changes whilst retaining their power should not be underestimated. (Ibid, p. 57)

In applying the quasi-market structure to health service delivery, Jones has looked at the relationship between organisations rather than within organisations. If his analysis is also applied within provider organisations, the same introduction of a third party can be seen to operate – in the development of a management/ administrative level which controls the contracts, the relationship with the funder, and the delivery of the clinical service. The power associated with control of service delivery within provider organisations can be seen to have migrated from the medical professionals to the management professionals. Thus, the health services interaction between the clinician (or other health worker) and the person with health needs is under the control of third parties who are neither service users nor directly providing service. At the same time the authenticity of the service rests with the clinical interaction.

This is not to make a judgement about the values of this structure of power, but an attempt to clarify the context.

In discussing power, Jones (1999) draws on Foucault's concepts of counterpower – that

...in his analysis of power, Foucault searched for those who resist power to gain the perspective of a counterpower. He was careful however to state that every counterpower moves with the horizon of power it challenges and at the point of transformation into a new power it also stimulates a new counterpower. (Jones, 1999, p. 55)

Thus, within health services, it can be argued that the medical and managerial professionals operate in a power dynamic which fluctuates between power and

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<sup>2</sup> Scambler .G.,(1987) *Habermas and the power of medical expertise*, in G Scambler (ed.)Sociological Theory and Medical Sociology, London:Tavistock



counterpower depending on the policy direction of a higher funding level given substance by contracts.

### 5.5 Dual Power Dynamic

The dynamic of dual power within organisations is reflected in duality of hierarchies – clinical and management. Thus the attributes of hierarchies, such as loyalty, deference, safety and role clarity, experienced by those at lower levels are subject to the uncertainty of which hierarchy has dominance.

Hodgkinson, (1996) provides a description of hierarchical organisational structures as “neo-feudal”:

In the pluralistic society where traditional values are under threat the patterned order of neo-feudal organisation may be a source of psychological assurance. For here, as in the microcosm of a ship, each man knows his role and all are guaranteed sustenance and identity in return for fealty. Even in the old medieval feudalism this was so. (Hodgkinson, 1996, p.196)

Administration then is not simply a function of the [State], an entailment of governance, but its very style and form is a product of an overlooked and often invisible ideology of statism... Philosophically, the question posed by these trends towards what might be called neo-feudalism (in which the individual identity is first and foremost a national one) is this: If organisations are goal seeking entities, what are the goals of the State? Or better, What is my nation for? (Ibid, pp.196, 263)

Jones clearly identifies the hierarchical role of the clinicians; Hodgkinson clearly articulates the hierarchical role of the administrator/ manager. The concept of neo-feudalism is thus given further coherence in the dominance dynamic of two powerful elites. The difficulties faced by those who need to interact with or within these services can be compared to those in medieval feudalism of the power dynamic between church and state. In asking, ‘what is this organisation for?’, the person using or delivering the service is caught in the dual demands of rationing and clinical imperatives.



The neo-feudal concept can be extended by other references to power in organisations. Barker (1998) takes Weber's<sup>3</sup> view of bureaucratic control as hierarchical (and the continually rationalised structures of control becoming less negotiated, more structured and ultimately immovable objects of control), and extrapolates this to apply to the "collective organisational interaction" (p.155).

Barker (1998) suggests that the demand for loyalty and adherence to group norms lead to:

...concertive value-laden rules increased the overall force of control in the system, making it more powerful than bureaucratic control had been ... an ironic paradox occurs: the iron cage becomes stronger. The powerful combination of peer pressure and rational rules in the concertive system creates a new iron cage whose bars are almost invisible to the workers it incarcerates. (Barker, 1998, p.156)

The dual demands of loyalty to a clinical and a managerial elite create a balance of power dynamic which plays itself out in strategies designed to exert control over the work force. Because staff are both employed by the organisation and have professional allegiances, they have a dual fealty to their discipline and to their employer. The contracts which govern the health system delivery are negotiated between the funder and the organisation. Therefore the prescription for service delivery lies with the organisation, but the actual delivery lies with clinicians. The need for fealty and for evidence of allegiance inherent in a neo-feudal model ensures that any tension in the balance of power between clinicians and management will be played out in tensions at the work face.

## 5.6 Bound Populations

The contracting system reinforces the neo-feudal model in that, in empowering key providers, it also binds people who use services to their regions of residence. Because the contracted services are bound to discrete populations, the people in

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<sup>3</sup> Weber, Max. 1958. *The Protestant Ethic and the Spirit of Capitalism*, New York: Scribner's \_\_\_\_\_. 1978. *Economy and Society*. Guenther Roth and Klaus Wittich, eds. Berkeley University of California Press.

those populations cannot seek services outside their region of residence. The development of contracts, a 'gift' of the state agency, currently the Health Funding Authority, with patronage of preferred providers and a demise of a tendering process has allowed contract holders to become completely powerful within the terms of the contract. The focus of contract compliance is upwards towards the 'gifter' and the service recipients' role is determined in the scope of the contract. Service users have moved from 'patients' to 'clients' or 'consumers', reflecting an introduced notion of choice of service. That the users of services are in fact the funders and purchasers, as part of the community of taxpayers, is not compatible with a system which has a traditional perception that those receiving services are at the base of the hierarchy. Neo-feudal practice is reinforced by the containment of services in areas delineated by locality or definitions of disability, and by restriction of services to the population within those areas.

### **5.7 Neo-Feudal Model**

The neo-feudal model involves a population dependent on its region of residence, the financial resources controlled by regional functionaries, the healing and protection of those made vulnerable by mental illness being the responsibility of a separate hierarchy who have a specialist and collegiate power separate but parallel to the state, offices to provide services appointed by a hierarchical bureaucratic system, and providers dependent on the good will of the funding hierarchy. Loyalty and vassalage, which involve concepts of mutual and reciprocal responsibilities, remain important and the focus of customer service is directed towards those who are paying, that is, upward in the hierarchy. Public policy analyst John Martin (1991) notes how the ambiguity of 'devolution' speaks to widely shared concerns, whilst enabling radically different prescriptions for change. The policy of developing the quasi-market system was couched in the rhetoric of community empowerment, responsiveness, accountability and consumer control. Yet:

[e]fficiency and effectiveness as organisational goals require a strong sense of direction set from the top and the ability to control behaviour so

that it is aligned with the preferences of those who hold power. (Martin, 1991, pp. 289-90)

Because the contracting system is presented as a democratic practice in a freely operating market, the functioning of a vassalage relationship is not overtly recognised and, thus, cannot operate in a way which could harness any of the strengths of such a relationship. However, the mutuality and reciprocity of a vassalage relationship rely upon recognition of the important and skilled contribution provided by other agencies and mitigates against control or expectations of rights without responsibilities. If the "neo-feudal" basis is recognised, the understanding of contracts as mutual obligations involving compliance from both the contractor and contractee can enhance the development of services which are practically useful to the people who need to use them. Mutuality and reciprocity are the strengths of a "neo-feudal" understanding. Neo-feudal practices can incorporate an interdependence of roles which have clear responsibilities.

## **5.8 Interagency Context**

Dynamics of power also operate between agencies and services as well as within them. The "neo-feudal" model can be seen to operate in relationships between service providers and the hierarchy of the funder and the government policy makers. In letting contracts, when the funder uses practices of preferment, an environment is set for ingratiation and capture of the funder's patronage.

The context, in which agencies providing mental health services operate, appears to require a well-honed sensitivity to the relative influence that other agencies enjoy with the funder. The ability to increase the contractual base or to influence development of services appears to coincide with the amount of contact and empathy the provider can establish with the funder. Whilst this observation may only be a popular myth, it has enough currency to affect relationships between agencies. A focus on collegial support through collaborative working has the potential to be successful because it promises to enhance the activity of

those favoured by funders and enables integration by those not enjoying favour. If a collaborative practice environment eventuates, the people who use the services can benefit from the better attention to their support needs with the more effective service fit and the decrease in tensions between providers.

## **5.9 Mutuality And Transparency**

For collaborative practice to be successful, power relations need to be transparent. Collaborative practice involves disbursement of control and a willingness to incorporate mutual and reciprocal activities. The emphasis on the development of collaborative practice, which relies heavily on mutuality and reciprocity, is consistent with an effort to strengthen a "neo-feudal" system.

People who use mental health services and mental health service providers have developed many formal and informal linkages which contribute to mutual understanding. Collaborative practice in this context can assist and provide support for agencies to define and disburse their services in relation to a local collegiate instead of in relation to a downward pressure from the hierarchy. In strengthening the focus of loyalty towards the needs of service users rather than loyalty to the bureaucracy, collaborative practice can traverse the artificial boundaries imposed by contracts. The risk is that this traverse is viewed as a transgression against organizational loyalty.

Addressing of power relationships in a context of neo-feudal structures can help to implement the exercise of rights and responsibilities in a practically useful way. In my proposed model of power relationships, enhancing collaborative relationships would provide the mutuality and reciprocity which is the practical strength of this system. In seeking to enhance collaborative practice skills, this project aims to be a practical and useful contribution towards this end.

## **CHAPTER SIX : DATA COLLECTION**

### **6.1 Introduction**

The project was undertaken in 1998 to explore the process involved in collaborative practice and to attempt to identify ways of working which would enable good collaboration to succeed. Collaborative practice is not an end in itself. Collaborative practice is a process of joint working and mutual interface which provides cohesive provision of service to those who rely on supports. The people who use the mental health services provided by agencies rely on the ability of the agency to refer appropriately and to work in a professional relationship with other services. Knowledge of and access to community resources is important if a person, who has an impairment related to a psychiatric disorder, is to develop their integration into their community.

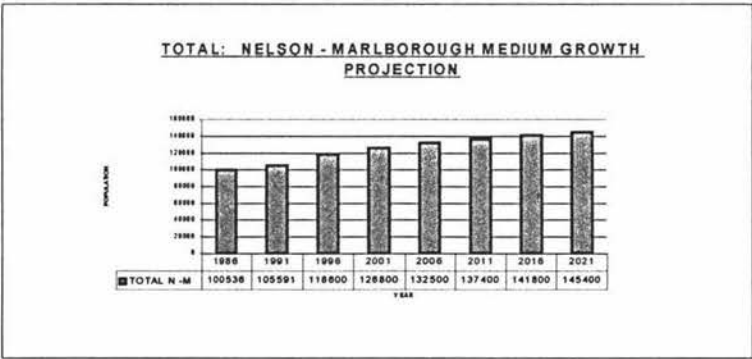
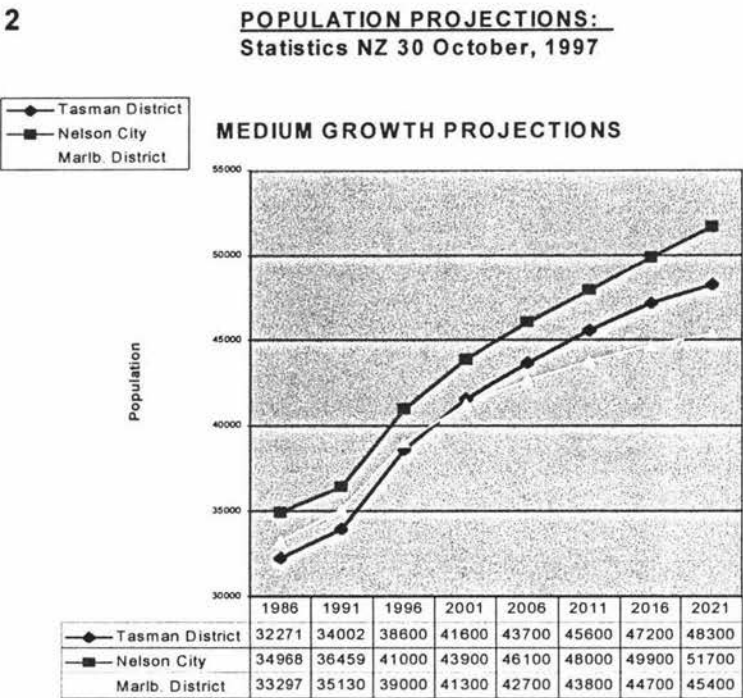
The role of community providers has increased to the point that no one agency can meet all the support needs of its clientele. Mental health needs assessment has moved assertively into a holistic approach (Ministry of Health, 1994), endeavouring to identify the range of environmental and psychosocial supports, which would combine in a practical and comprehensive way. In moving to co-ordinate a service delivery plan with a person, which would address identified needs, input is needed from a range of service providers. Typically, the agencies approached to provide appropriate supports would then initiate their own assessments and would develop their own support strategies, which might overlap with other providers, lead to other referrals or create gaps in supports.

### **6.2 Population Base**

The population base is provided to give an indication of the size of the requirement for service provision from providers involved in mental health service delivery. The project is based in the Nelson region of the Nelson/Marlborough Health Service

Ltd catchment. Projected population estimates<sup>1</sup> are taken from Statistics New Zealand (1997). Recording of numbers of people receiving mental health services is combined for the two areas - Nelson City and Tasman District. Both the Mental Health Service and the agencies involved in this project have a catchment population across Nelson City and Tasman District, although the smaller agencies (two:) would only provide service to Nelson City.

Diagram 2



<sup>1</sup> For this projection Statistics NZ use as a base the estimated residential population at 30 June 1996. They suggest Medium Growth projections are most suitable for assessing future populations as Low or High projections show conservative or optimistic demographic scenarios. Medium Growth projections are gained via cohort component method. The base population of the specific area is noted and projected for 5 year intervals by calculating the separate effects of fertility, mortality and migration within each sex and 5 year age group according to the demographic assumptions formulated for each specific area.. (Statistics NZ 1997)



In estimating a population projection for the year 2000, a regular interval is assumed of an annual increase of 1180 persons over the two areas of Nelson and Tasman. This would show a population projection of 84,320 for Nelson and Tasman in 2000.

The numbers of people who receive support from the Mental Health Service is estimated as 877, which is a monthly figure (able to be accessed for August, 2000) for people having contact with the Mental Health Service. This figure is taken as representative in that the variation from month to month is small (+/- 25 in the current year). It can be assumed that mental health support services for people involved with the specialist service is in the region of 1%, (which can be compared with the national target of 3%). The size of the population is approximate, since up to date statistics are not available beyond 1996.

### **6.3 Project Considerations**

In looking at the ad hoc development of the pattern of service delivery, from my role in the Mental Health Service as the co-ordinator of service support, it became apparent that: a) knowledge of the range and level of available services was not comprehensive amongst those who had responsibility for suggesting appropriate supports; b) expectations held by agencies about the service delivery of other agencies often led to dissatisfaction with outcomes; c) dialogue between agencies, particularly during assessments, was underdeveloped, leading to duplication of interviewing for the person concerned and a lack of significant information at the appropriate point; d) the dynamics of the liaison between agencies were allowing gaps in support to exist which could have been closed; e) assumptions about roles of providers led to inappropriate referrals or no referral; and f) interagency frustrations were influencing the attitudes of some of the service users towards some service providers (and vice versa), and thus limiting supports which could be accessed. Based on these observations, and my discussions with various community service providers, a need was generally recognised for seeking a process of collaboration and empowerment which could be led from the support needs of people with mental health disability, and which could draw strength from the different perspectives of service providers rather than develop tension.



As the specialist psychiatric service in its region, the Mental Health Service has a key role which impacts upon the expectations and responsibilities of other agencies. The Mental Health Service is contracted by the Health Funding Authority to provide Need Assessment and Service Co-ordination for people with psychiatric disorders. This involves the responsibility for working with the person and their own knowledge of their impairment to identify support needs and then accessing appropriate supports, ongoing evaluation of the effectiveness of interventions, and also identifying the gaps between support needs and support services. Such gaps which cannot be met from existing services are a focus of ongoing discussion with the Health Funding Authority. Thus, the Mental Health Service has a strong interest in improving the practice of liaison between agencies and developing a practice model of initiating proactive support and consistent contact.

This next section describes the setting up of the project.

#### **6.4    The Project**

The project began with some basic premises. In seeing a role for itself in facilitating agency collaboration, the Mental Health Service needed to recognise its quite dominant and powerful role in the sector. If empowerment was to be a key goal, then a provider with significant power had to be committed to the project. Secondly, the Mental Health Service already used, in its clinical practice with consumers, a model of liaison and brokerage – case management – which did have a focus on the process of partnership and collaboration (see Chapter Four: Case Management). Case management focuses on individual consumer needs, it is responsive to the culture and values of the individual consumer, and it involves brokerage, advocacy, monitoring and empowerment. Case management operates with principles of good information, ownership of information by the person with the support needs, and relies upon flexible and responsive contact. Whilst the case management role is practised inconsistently and is not clearly articulated by the Service, it is, nevertheless, a model which provides a common means of focussing and orientating debate about process. The aims of case management are a part of the common understanding of providers, even though they had different

experiences of it and different ideas about its efficacy. The practices of clinical case management seemed to provide a useful basis for examining and improving the interagency relationships.

In developing the project I, therefore, proposed exploring and developing the *process* of interagency partnership and collaboration through the establishment of agency case management by the Mental Health Service. The project was initiated from the Mental Health Service, which also needed to be able to challenge its own practices that mitigated against effective collaboration. The basic concept of the project was discussed with key providers and considerable support was gained. This support was directed towards establishing more effective liaison practices and towards the Mental Health Service behaving in a more integrated way with other providers and agencies. There was also an expressed expectation that the responsible clinical position of the Mental Health Service gave it responsibilities towards other agencies. I have interpreted this as an expression of a neo-feudal power relationship (Hodgkinson, 1996) in which power is not simply hierarchical and authoritative but involves clear reciprocal duties and responsibilities which create interdependency. I proposed that the case management model could be adopted to provide a vehicle to enable work on the process of collaboration to be trialled.

At this time, the Mental Health Commission (the national body with responsibility for improving mental health services) invited projects to establish 'Best Practice' guidelines, using an action research approach. This project – using a case management model to explore a process for developing collaborative practice – was accepted as one of six projects to be sponsored by the Commission. This resulted in access to a consultant psychologist who would provide oversight and liaison between the Mental Health Commission and the project group, and some funding to cover the costs incurred by participants. From my point of view, as the project facilitator, this also provided a siting of the project outside the Mental Health Service itself, and thus enabled the Mental Health Service, rather than leading, to participate in a more equal partnership with other project group members. It should be noted that, as the project developed, it was more the existence of the consultant from the Mental Health Commission, rather than her active involvement, which provided this aspect. The consultant was instrumental in

providing the link to the Mental Health Commission and was involved in reviewing the setting up of the project, and in commenting on the questionnaire, time frame and the representative breadth of the participants. Once the project was underway, the consultant's role became one of liaison with the Mental Health Commission.

#### 6.4.1 First Steps

Having made the commitment to exploring the process of interagency collaborative interaction, I proposed a design model which involved the following components: a) the research approach would be action research; b) a stakeholder group would be formed which would provide a sample of the agencies which reflected the range of mental health service provision, and those participating would be involved in the scope, design and implementation of the project; c) information would be drawn from literature relating to collaborative practice; d) a hypothesised method of enhanced collaboration (case management model) would be trialled which could provide a practice framework for exploring the dynamics of interaction; e) changes in the practice of interaction would be identified and consolidated; f) data would be collected by participant meetings, textual meeting minutes, a questionnaire exploring attitudes to interaction before and after the project, individual interview, literature survey (*data triangulation – use of a variety of data sources*); g) interpretative analysis, which could be subject to review by participant agencies, by the independent consultant and the sponsoring body (*investigator triangulation – use of several different evaluators*).

The action research methodology was discussed and confirmed with the Mental Health Commission consultant. The project was designed to explore collaborative practice principles by trialling a system for case management of agencies. A working group was to be set up by invitation to key stakeholders. Evaluation of the project was to be through feedback from these stakeholders via a pre and post project questionnaire and their individual feedback, as well as the independent review by the consultant. Changes in practice that were sustained would also be identified. The requirement for the project to be chosen for sponsorship by the Mental Health Commission was that it was to use action research methodology. The focus of the Mental Health Commission

via the consultant was that of identifying changes in practice which could be maintained. The understanding of action research methodology, the development of the project, the methods of evaluation and the ongoing practice were my responsibility as the facilitator of the project.

A key measurement, to establish that a good workable *process* of collaborative practice had been identified, would be what happened after the project. If successful, the project would generate practices and spin-off projects that assertively used the developed process.

I could identify a stakeholder group. This group needed to be representative yet small enough to work effectively. At the same time, it needed to be large enough to account for those who would not continue through the project and still maintain a viable group. The key stakeholders were all support service providers and included consumers, family, Maori providers, residential providers, statutory/government providers, community providers, General Practitioners, and Mental Health Service staff. The composition of this group was reviewed and approved by the consultant and the Mental Health Service manager. A further two members were identified and included by the initial group (see 6.4.2).

Members of the initial group invited were:

- Gateway Housing Trust (residential)
- The Bridge (residential)
- Consumer Advocacy Group (consumers)
- Schizophrenia Fellowship (family)
- Ngati Koata Disability Support (Maori)
- Beneficiaries and Unwaged Workers Trust (BUWT) (community  
frontline)
- HomeBuilders (community)
- Income Support (statutory/ government)
- General Practitioner
- Village Community Trust (community employment)
- Police (statutory/government)
- Mental Health Service

The group was to have the Mental Health Service staff in a case management role and Service managers were asked to enable appropriate staff (or themselves) to take part.

#### **6.4.2 Community participation**

The response I received from canvassing and inviting membership of the stakeholder group was supportive and I found people who wanted to be involved. The immediate feedback from the potential participants was about the composition of the group – more people wanted to join, particularly consumers. Consequently, at its first meeting, the initial group (see section: 6.4.1) identified that there should be a higher number of consumer agency members and that Practice Nurses should be invited as they were often a first point of contact for many people. Thus, the group was enlarged to include:

The White House (consumer drop-in)  
Practice Nurse Association.

The Consumer Advocacy Group was invited to have two representatives, because they indicated this would enable them to be appropriately supported as participants and would give better input of consumer perspectives. Thus, the group had grown to what we (the working group) considered a high maximum size (14 community stakeholders) for effectiveness of working. However, this number would allow for an expected attrition.

The fourteen community participants included seven people in management positions who were also actively 'hands-on' workers, four in key fieldworker positions, and three who were active members of their organization.

It was hoped that each agency would be paired with a Mental Health Service staff member who would provide case management. In practice, Mental Health Service staff were less in number and each worked with more than one agency, because of difficulty in gaining and retaining their involvement. This is discussed in the next section.

### **6.4.3 Mental Health Service participation**

At the same time as the community participants were discussing their involvement, Mental Health Service staff were canvassed and invited. The positive endorsement of the project was not lacking, but staff prepared to take part were limited. In exploring the reasons for this limited involvement, with those who were prepared to take part, suggestions were that a) staff already had demanding work loads, b) that it was thought to be unlikely that other staff would be prepared to take over case work; and c) that, although positively endorsed by the Manager, staff were skeptical about achieving changes in practice and were already overloaded with consultation.

The project was actively promoted by the Service Manager. Eight staff, as well as myself as the project facilitator, were prepared to become involved. These staff were from:

- Mobile Community Team (3)
- Acute Unit (2)
- Extended Care/Rehabilitation (2)
- Service Co-ordination (1)
- Oranga Toi Ora (1)

The group included two managers, one new graduate, and included people employed as Nurses (4), Occupational Therapists (1), and Social Workers (4). Of the group, four had active roles in clinical case management, all carried out direct work with consumers, and all had active roles in co-ordinating of support services and working with the range of agencies. All the group had a Need Assessment role and worked in the case management process.

### **6.4.4 First Set-Up Meeting**

The group (met to discuss setting up the project and to really clarify what it was all about. This first meeting was attended by nineteen participants - nine mental health staff and ten agency members – two agency members not attending the first meeting. This meeting was also attended by the Mental Health Commission consultant and the Service Manager. For this meeting I



had prepared overheads (see Appendix II) which outlined the Challenges to Collaborative Practice, the principles of case management and the basic principles of collaboration. The information on the overheads was generally drawn from my literature survey, although the principles of collaboration were drawn together from my previous discussions with individual group members when we were thinking about the need for the project. The purpose of presenting the overheads was to facilitate discussion and primarily to enable the group to see that difficulties in working collaboratively were not an issue specific to our community but were widely recognized wherever communities tried to work together. The overheads were effective in achieving this understanding and led to a unanimity within the group. They decided that they could address the issue of working collaboratively as a group rather than seeing their difficulties as the shortcomings of another individual agency. This was particularly useful in shifting the focus from 'blaming' the Mental Health Service, towards a preparedness of the whole group to explore their liaison processes. The group endorsed the basic principles for collaborative working and saw these as a basis for development by the group.

The first meeting addressed the format of the project and this was the point at which the extra community members were identified by the working group, and invitations to participate were extended by the group via myself as the facilitator. The group identified that there should be a higher number of consumer agency members and that Practice Nurses should be invited as they were often a first point of contact for many people. The aspects of the project discussed were the length of the project, ethical considerations, impact of the time needed to take part and measurement.

At the first meeting two participants were unable to attend and subsequently left the project. One of these worked with their case manager alongside the project to develop a liaison model which met their needs, and the other decided that their liaison process with Mental Health Service and other groups was already satisfactory.



#### **6.4.5 Length of the project**

Originally, the project was envisaged as taking place over a year. This would allow for an integration of the process into practice in a way that might consolidate improvements. However, the working group modified this to a period of four months, concentrated into frequent meetings and ongoing tasks. In assessing the pressures affecting participation, the group decided that a shorter, more concentrated project would be more likely to have higher commitment and more focussed results. The use of action research methodology also meant that developments from the short focus could be initiated as separate projects as necessary, so that this project could remain clearly targeted on task.

#### **6.5 Ethical Considerations**

This project was first undertaken as part of my social work in co-ordinating services. In seeking to facilitate a mutual exploration of the collaborative process with others who had a similar role or interest, the project was offered to The Mental Health Commission for inclusion in their Action research series of projects. Following discussion with the Mental Health Commission consultant and the Service Manager, it was decided that issues of ethical safety would not affect individual consumers and were more an issue for group participants themselves rather than an Ethics committee. In discussing this with the working group, they decided that any individual identification and consents would be a decision that they would make themselves, and they would continue to participate or not as they themselves decided. The group clearly identified that they were all participating as service providers and were actively choosing and wanting to participate in order to improve their ability to work together. The group considered, in relation to ethical approval, that they were both participants and part of the researching process. It was noted by the group that the usefulness of the project would depend on their commitment and input. Using the project as a thesis topic was approved by the working group. The collaborative process of setting up the project meant that it

was underway by the time this thesis was begun. Discussion about our ethical approach with my thesis supervisors supported our process as appropriate.

The group also discussed their roles in representing their agency. It was identified that several people did not feel that they could act as representatives, but should be seen as contributing a specialist but individual view, that could be used as probably typical of their agency members. This position was particularly important for those participants who came from consumer agencies and the General Practitioner (and later, the Practice Nurse). Other participants also commented that whilst they could represent their agency, they similarly could not represent the service sector (such as residential providers). It was agreed that members would participate with their individual but informed, specialist perspectives.

## **6.6 Impact of Time Needed To Take Part**

This concern was common to all the participants and needed to be addressed before the project could progress. Firstly, members from agencies with little or no funding suggested that the project should fund their time. This was also a concern of the GP representative. With the help of the consultant, a rate was negotiated with the Mental Health Commission, as the sponsoring organization, which enabled a payment for meeting and travel time to be made to some members - those from voluntary agencies with limited funding or private professionals where loss of income was anticipated.

Mental health staff also felt that this (agency case management) was another role added onto their workload, which would have no recognition and no time allowance. The Service Manager made it clear to Unit Managers that those taking part should have this as part of their legitimate work and that this needed to be accommodated in the workload. The involvement of the Service Manager and the Mental Health Commission signaled a higher than normal recognition for work.

## 6.7 Measurement

### 6.7.1 Questionnaire

I had prepared a draft questionnaire prior to the first meeting, which had been reviewed by the Mental Health Commission consultant and the Service Manager. The purpose of the questionnaire was to provide an indication of satisfaction of both the agencies and the Mental Health Service with their contact and would be used prior to the project and following the project in order to measure change over the project period. A panel in the Mental Health Commission to whom the consultant reported suggested that the base line data should be reviewed by the stakeholder group, and that this would assist in having the stakeholder group "much more on board with the final measuring tools that are used". In incorporating this suggestion, the questionnaire was introduced to the group at the first meeting for their input and was, thus, circulated early in the project rather than prior to the start. Evaluation needed to consider to what extent case management could be successful as a liaison model, what the key elements were in securing collaboration and ensuring continuation, and whether services were improved.

The group made some wording changes to the questionnaire and included a question seeking comment on points of contact within agencies and services. The questionnaire format was finalized at the second meeting (see Appendix I).

The questionnaire was structured to provide grades of response to twelve questions. These questions focussed on different aspects of contact and liaison, and the respondents were asked to indicate their level of satisfaction. As well as scaling satisfaction, respondents were also asked to provide comment on their response. In response to these reviews, one change was made to my proposed format. The questionnaire scaling was changed, from the five-point scale I had proposed, to a four-point scale in order to remove a middle ground response.

The questionnaire was used at the beginning and the end of the project. The agencies and the Mental Health Service staff received the same questionnaire early in the project and at the end (pre- and post- project). The agencies were asked about their satisfaction with the Mental Health Service, and the Mental Health Service staff were asked about their satisfaction with agencies.

Although the number of people involved was not large, the questionnaire was given to everyone participating in the project. In proposing to use the questionnaire as a measurement of project outcomes, I intended that it could be used to identify changes in perceptions of each individual as well as a measure the satisfaction level of the group as a whole.

The findings from the use of the questionnaire are discussed in Chapter Eight: Project Results.

#### **6.7.2 Other measurements**

- 'Spin-off' projects:

The most practical measurement would be whether collaboration improved in practice beyond the project. This could be seen in the life of the 'spin-off' projects. A 'spin-off' project is one which had its genesis in this project, but which developed a life of its own. It was not within the reach of this original project and was an ongoing development of one or more participants. I have considered these "spin-off" projects in Chapter Nine (see 9.3).

- Also, I considered it useful to know whether the processes initiated in the project were sustainable over time. This required review at a later time, and I informally contacted agencies and Mental Health Service participants after one year.
- During the project, the working group decided that the questionnaire was a useful tool and should be used more widely. Because the General Practitioner (GP) had identified that he was not a representative of GP's as

a group, he and the Mental Health Service case manager, with the approval of the group, used the questionnaire to canvas the satisfaction of all GP's with their interaction with the Mental Health Service. I have regarded this as a 'spin-off' project, and it is discussed further in Chapter 7: Project Results.

## **6.8     Language**

Discussion in the group arising from the overhead summaries (see Appendices II and III) developed a sense of the group ownership of the project. In particular, the language being used at this point was seen to be Mental Health Service jargon, and the group identified wording that they preferred to use. Wording changes included: "Agency Case management" became "Agency liaison"; "Consumers" became "people who use services"; "Providers" became "Agencies"; "Stakeholders" became "people taking part in the project"; and "Agency case managers" became "Agency Liaison facilitators" – ALFs. The ALF was adopted because it was a friendly 'gnome' like word, and also, co-incidentally, to our amusement, corresponded with the initials of the Clinical Director.

## **6.9     Conclusion**

In discussion at the first meeting, the people taking part in the project positively anticipated an enhanced relationship, particularly in relation to dissemination of information, crisis intervention, and in addressing the impact of challenges to their interagency relationships. The group expressed a hope that the project would be an opportunity for agencies to negotiate their contact with the Mental Health Service in a way which would meet the needs of the people who used their services. Also, that exchanges of information could be improved and less reliance would need to put onto the "grapevine".

At the first meeting the people taking part in the project significantly took on responsibility for the project and adapted its structure to one that they could commit to and manage. The ALFs were paired up with agencies. Both ALFs and agencies undertook to develop this liaison and report back on its progress and

effectiveness. Although the group had agreed on their understanding of case management, the practical relationship would rely on their existing experience and understanding of case management practice. Aspects relating to this experience is further discussed in Chapter Seven: Development of the Project.

## **CHAPTER SEVEN : DEVELOPMENT OF THE PROJECT**

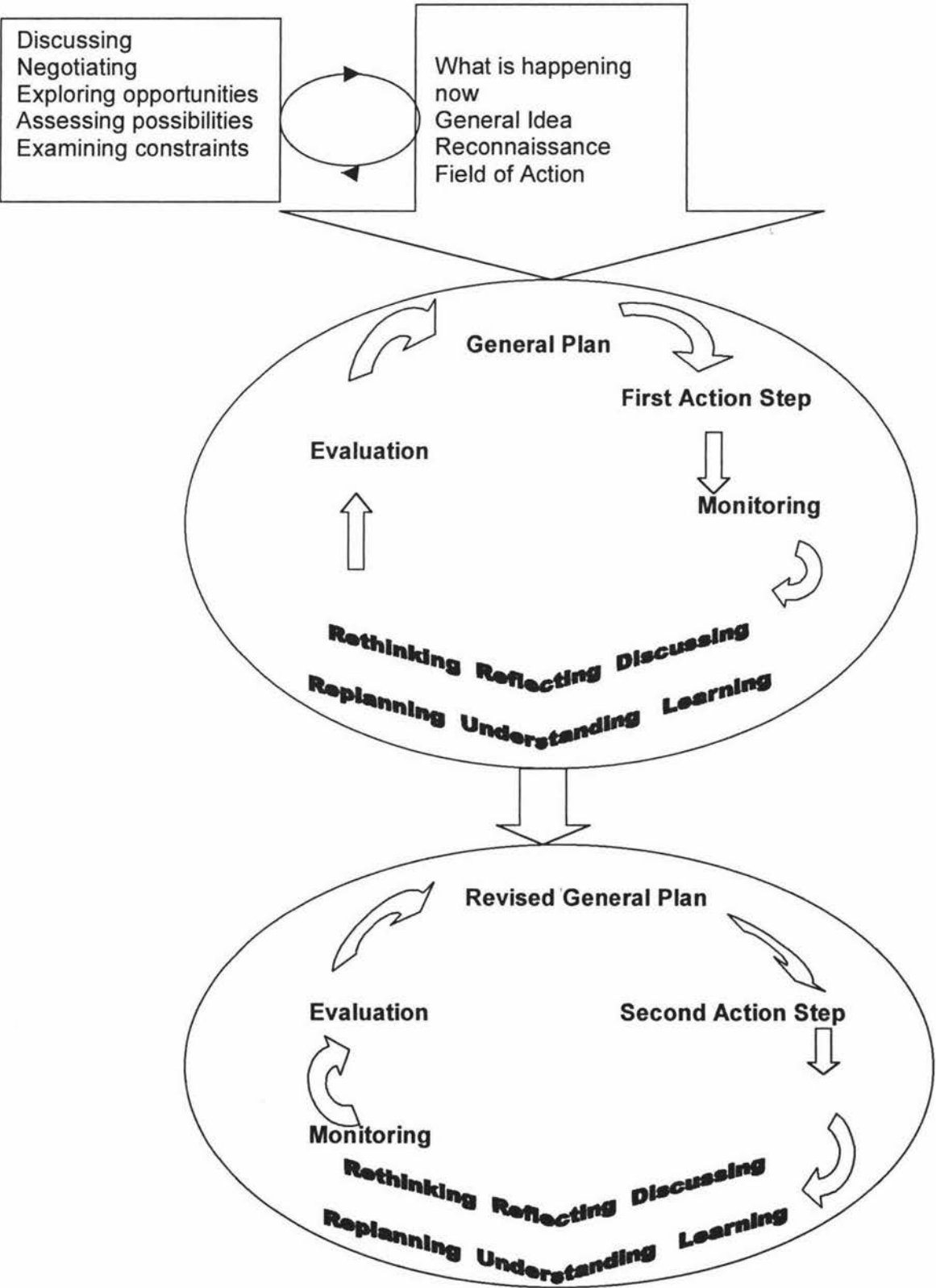
The group met at a minimum of every three weeks over a four month period, and used the meetings to progress the action research cycle - **rethinking, reflecting, discussing, replanning, understanding, learning** - as they monitored, evaluated and revised what they were doing. The action research approach was useful in developing a collaborative culture within the group. The group identified this as a change in how they addressed issues. At the early meetings, people would advocate a specific solution that they brought to the group. As the meetings progressed, people began to address issues by exploring a range of possible options that might help resolve the issue and decide which would be the best way to proceed.

Attached is a 3 page diagram (following a key to the diagram) representing the progress of the project showing the cyclical development and the movement towards the strategy for collaborative practice which was the outcome of the group process. The diagrammatic representation shows, in summary, the nature of each cycle of the project as it moved from the general plan to the first action step and monitoring. Reflection, rethinking and learning led onto evaluation and extraction of issues which formed the basis of the next cycle. As the cycles developed, ideas and themes started to emerge and were incorporated into practice. The diagram is intended to convey a sense of how each cycle generated the next. The diagram key is based on a scheme from Lewin (1946).

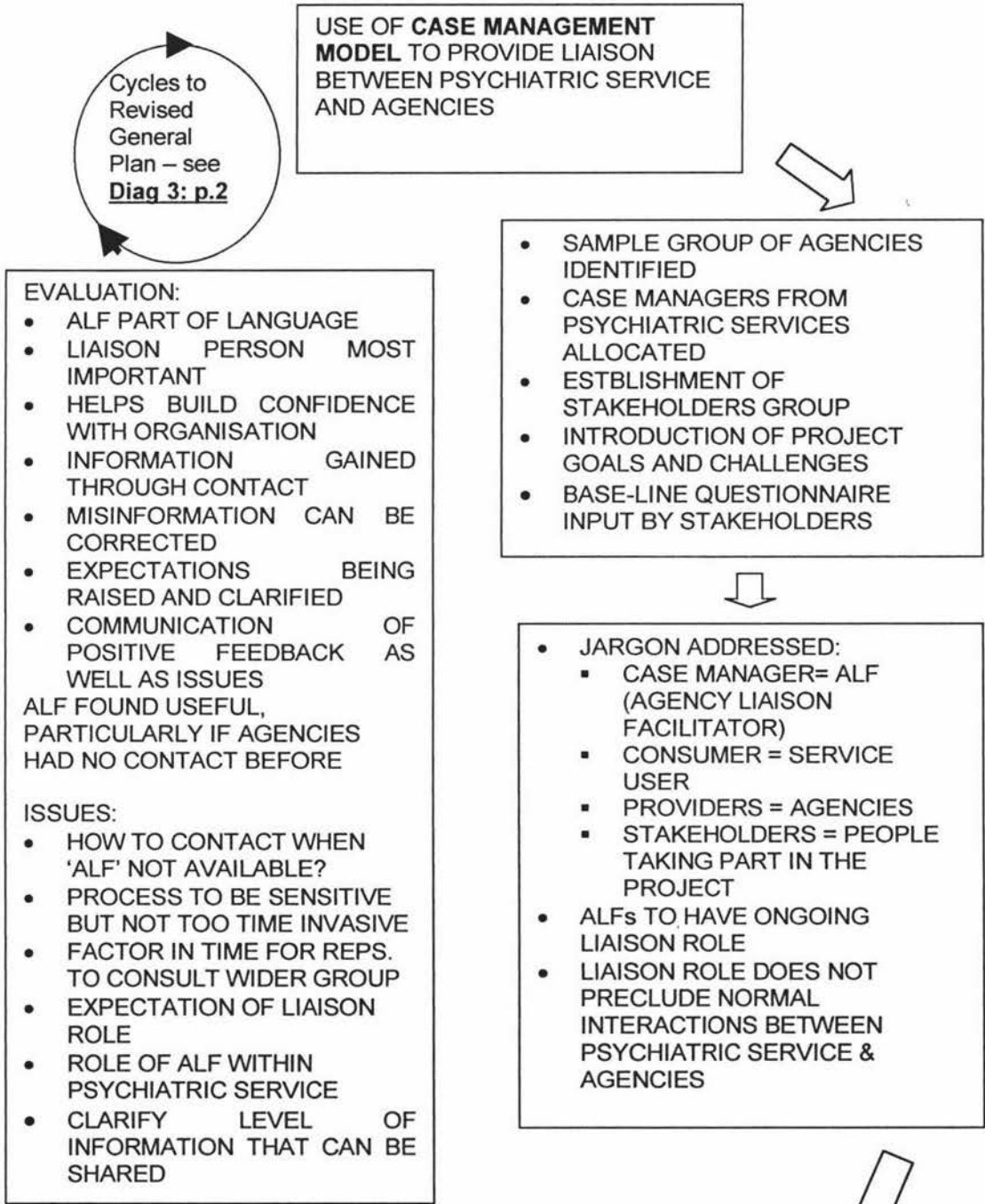


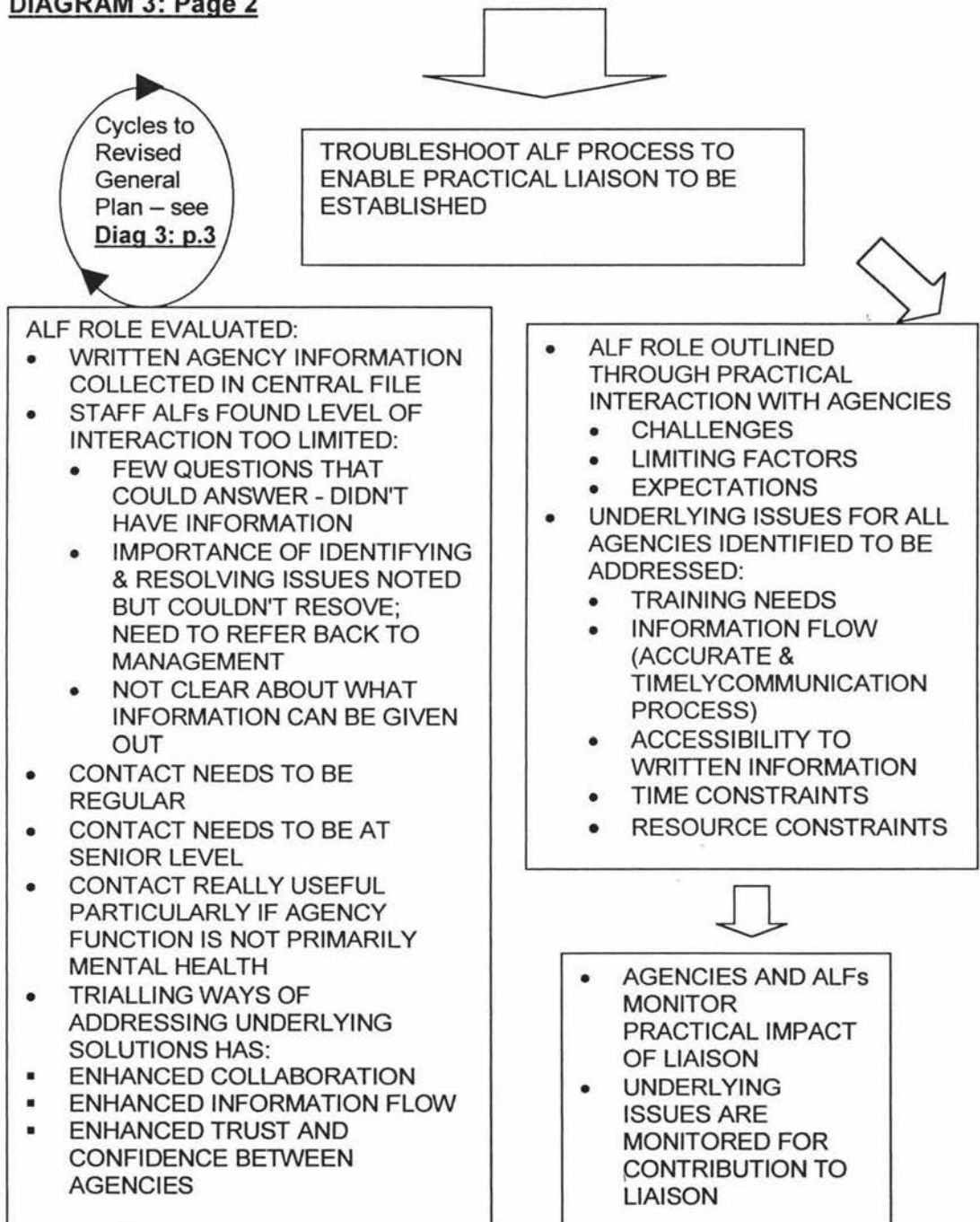
DIAGRAM 3 (Key):

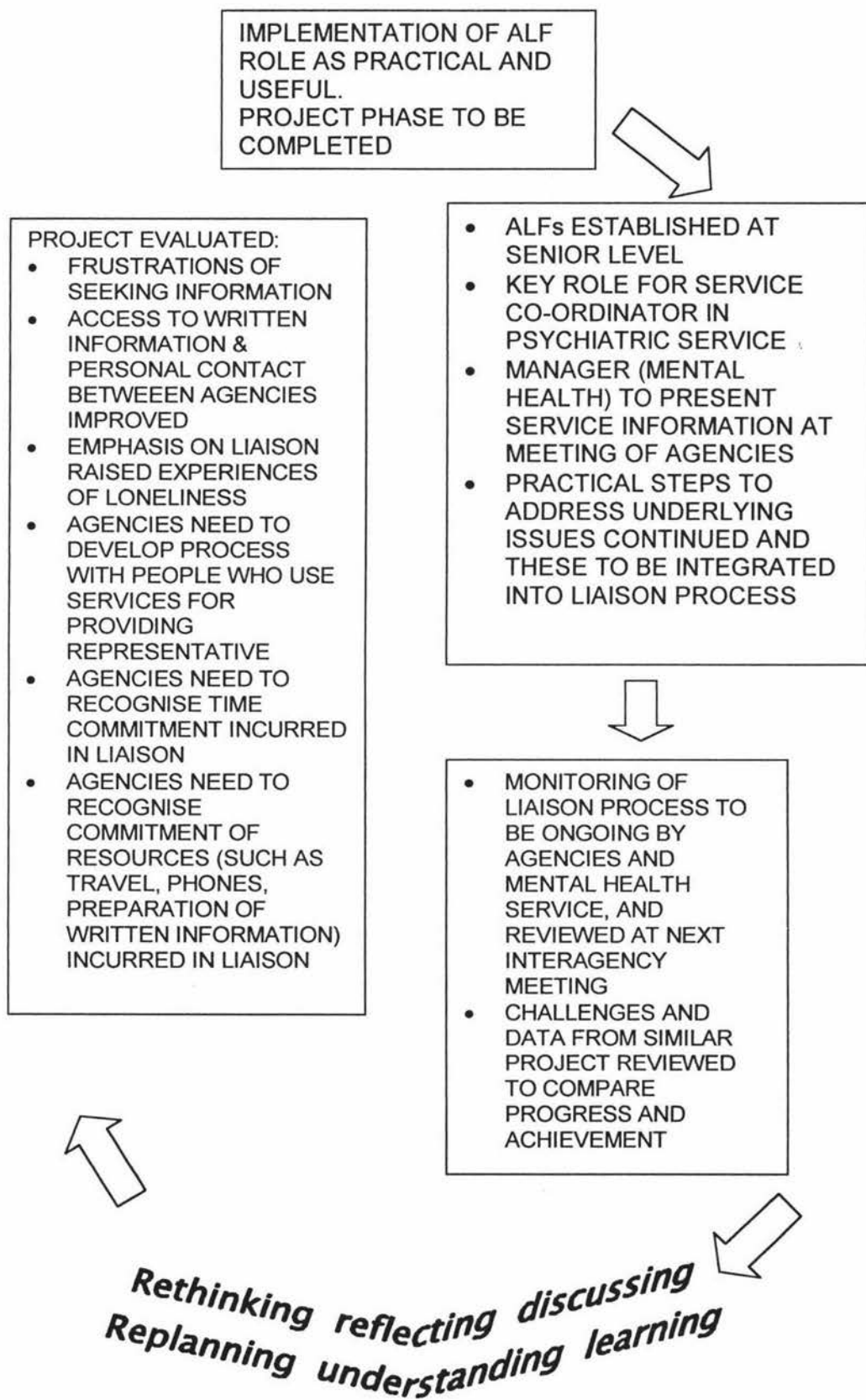
Action Research Model (adapted from Lewin, 1946)



**DIAGRAM 3: Page 1**



**DIAGRAM 3: Page 2**

**DIAGRAM 3: Page 3**

## **7.1 Progress Of The Project**

In this section, I cover the progression of the project.

### **7.1.1 Participants**

Over the four months, there was an expected attrition of group members. The final working group consisted of nine community members and five Mental Health staff, one of whom was myself as the project facilitator. The greatest drop-off was from Mental Health staff and this put the project in some jeopardy as they were in the ALF role. The two groups who had left the project at the start continued to develop their own liaison models with specific Mental Health staff, although this was no longer specifically part of the project. One of the Mental Health staff, (working in Maori Mental Health) continued to use the action research approach and considered their progress as a spin-off from our original project.

We met the handicap of depleted Mental Health staff by restructuring the project so that four Mental Health staff were in an ALF role for four agencies, and the other five agencies all worked with me as a control group. As already stated, my role in the Mental Health Service was that of Service Co-ordinator and I had a key role in maintaining liaison/networking with community agencies. We decided that this allocation of the ALF role would enable us to see whether the ALF role could be effective if spread across different staff or whether it was more effective if done by one central person. The reasons why the other Mental Health staff were unable to continue were considered when we evaluated this question of where the liaison was best sited.

### **7.1.2 Meetings**

The meetings developed other roles besides that of progressing the project. The group members began to find the regular gatherings a useful forum to update and exchange information, and also to discuss the ongoing changes in contracts, resourcing and policies. The advantage of interagency forums was quickly acknowledged and we had to allow time in the meetings for this to happen. Discussions on networking/liaison began to plan for a way to continue this contact.

### **7.1.3 Themes**

Over the four months, a number of themes relating to liaison arose and were explored. These were: training; exchange of information; networking/liaison; and trouble-shooting.

The themes wove in and out of the discussions. Sometimes they were addressed directly and at other times they appeared as adjuncts to other issues. However, the group consistently developed their thinking about these specific themes and found useful practices to enable them to work more effectively. These themes ebbed and flowed throughout the cycles of the project. My task, as the project facilitator was to draw these out and identify their components. This was largely done after the end of the four months when I then checked back with group members to ensure that my interpretation was a valid reflection of their findings.

The themes first arose in the discussions as issues and difficulties and, as we worked through the action research approach, we began to develop strategies that would provide solutions and thus themes of interest began to emerge. The strategies developed then emerged from the project as separate cycles of action/evaluation which continued on beyond the life of the project.

## 7.2 Summary

This chapter has outlined the setting up and the development of the project. Action research is a participative and cyclical process. This chapter has highlighted the ways in which the group members became participant, ways in which they were able to take ownership of the project and how the cyclical adaptation of the practice (case management) being trialled took effect.

The next chapter looks in more detail at the outcomes of the project, what was and what was not achieved.



## **CHAPTER EIGHT: PROJECT RESULTS AND REFLECTIONS ON RELEVANCE FOR COLLABORATIVE PRACTICE**

This chapter considers the results and outcomes of the project and discusses how these might enhance collaborative practice.

### **8.1 Case Management:**

#### **8.1.1 Outcomes that worked:**

One of the key strengths of case management is its liaison and brokerage function. It was found by the group that clinical case management as practiced with individuals, readily transferred to work with agencies. The most important aspect in achieving this was deceptively simple. We found that liaison tended to operate in an environment of professional peers. The relationship was subject to the relationship contexts of power, previous history, organizational culture, expectations and assumptions about the professional practice of others. The value of the case management model was to emphasize a clinical perspective and to seat the relationship in clinical practice. Thus, the ALFs were required to use their clinical skills and to be sensitive to the needs of their 'client' agency. By stressing the importance of using clinical skills, such as assessment, early intervention, building rapport, conflict resolution, and professional knowledge of interaction, the role of the ALF was recognized as supportive and useful by agencies and ALFs. The mutual understandings that developed from this approach then moderated assumptions and expectations that had previously impeded agencies' ability to work effectively together. An indication of the usefulness of this approach was that a further agency left the project part way through because their contact and liaison needs were resolved and recognized. Therefore, the most effective and useful tool for good collaborative practice that we gained from using the case management model was that liaison is a professional skill and has to be undertaken with the same care and attention as other clinical interventions.

The use of the case management model also resulted in agencies identifying their key liaison people. As well, in recognizing collaboration as a necessary function of the agency, the agencies gave more prominence to the awareness of this role. For example, Income Support (now Department of Work and Income New Zealand) identified three Customer Service Officers who were given responsibility for working specifically with the people using their service who had an impairment associated with psychiatric disorder. These three were then the people who could develop their understanding of psychiatric disability, come to interagency forum meetings and discuss issues that people experienced with Income Support, develop their networks, and be recognized and identified by consumers in other settings. Thus, although the group had initially focussed on the relationship between the Mental Health Service and other agencies, it began to use the project to explore the interactions between community agencies themselves. In my interpretation, this reflected a measure of empowerment within the group. In a neo-feudal model, the 'upward-downward' power relationship is important and needs a reciprocal understanding to function effectively. As the group began to look at other liaison relationships, I believe they began to feel more satisfied that the Mental Health Service/ agency relationship was showing reciprocity. That improved association conferred power, which enabled the agencies to also look at their own practices.

The case management model readily provided an accountable framework for liaison. The ALFs established information files on their agency, accessible to other staff, recorded contacts, and provided a contact point within the Mental Health Service when difficulties or misunderstandings were experienced. Having a central role in the Mental Health Service in relation to a particular agency, the ALF was able to identify whether issues were peculiar to a specific situation or were being more widely experienced and thus needing to be addressed at a policy or system level. This was helpful in enabling an issue, which had been continuously arising for different staff as an individual frustrating experience, to be addressed between the Service Manager and the agency Manager.

Using the case management approach of liaison enabled both the agency contact person and the ALF to begin to develop a positive history and to establish a trustful relationship which grew from understanding about roles, philosophies and pressures. This relationship and recognized by the Managers was then able to gradually extend into the wider Mental Health Service and the wider agency because it was positively endorsed and recognized by Managers.

### **8.1.2 Outcomes that did not work**

The case management model was not entirely successful. Some aspects did not work.

The working group had divided, using two different approaches to case management. Six agencies had contact with ALFs who were front-line Mental Health staff. The other five were in contact with myself as Service Co-ordinator and in a management as well as clinical role.

The ALFs who were front-line staff found that they were unable to be very useful to the agency when issues arose that related to policies or services. They were able to develop good relationships, and to provide and receive support and advice in the day to day interaction between agencies and the people who use their services. This was useful in enabling the agencies to respond more effectively. However, both the agencies and the ALFs needed information about the direction and development of services, which could only be provided from a management level. As front-line staff, the ALFs had little direct access to this information or any ability to negotiate or change the established protocols. The ALFs agreed that the ALF role would be more effective if sited at a management level where interagency issues could be directly addressed and negotiated.

The group of agencies with whom I worked as Service Co-ordinator did not experience the same difficulty. As a professional worker, I was still able to provide and receive the support and advice for day to day interactions, but at the same time was able to address and negotiate interagency issues. I had a direct contact with the Service Manager which enabled wider issues to be quickly addressed. A similar experience was reported by agencies where their nominated contact person was a front-line staff person rather than a manager. They also found that the relationship could not be effective beyond day to day concerns.

This conclusion - that the ALF role needs to be based at a management level - created some difficulty in the practical logistics of having to sustain effective relationships with a number of agencies. The Mental Health Service has a group of managers who could all take a role in liaising with the agencies with whom they have most contact. However, for agencies with one manager and small staff numbers, it was recognized that collaborative liaison could become an onerous task. As an option to address this, we suggested that agencies with greater staff resources, such as the Mental Health Service would need to take a greater responsibility to facilitate and effect the networks between agencies. In deciding to develop this option, a further specific networking project was undertaken by the Mental Health Service as another separate 'spin-off'.

A second aspect that caused difficulty with the ALF model was the one to one relationship that developed. Because the ALFs who were front-line staff were out in the community with people who need to access the Mental Health Service, and because they were often employed on 4 day rather than 5 day weeks, they were not consistently accessible to agencies. Nor could they easily establish regular times for contact that would suit agencies. As clinicians with active case loads, they continued to see the priority for their time to be the individuals who have psychiatric disorders and who need to access the Mental Health Service. Although Units were encouraged by the Service Manager to make accommodation for agency liaison, this could not take precedence over their usual work. ALFs were reluctant to divert work to

their colleagues in order to support agencies, as the ALF role did not seem their "real work". The clinical caseloads that Mental Health Service staff carry tend to require a full time commitment.

I believe that the difficulties experienced with interactions of front-line staff and agency managers, and also between Mental Health Service managers and front-line agency staff, can also be related to the dynamics of the power relationship. Within the Mental Health Service, policy and negotiation roles are held by management levels and are not accessible to front-line staff. The importance of these aspects of the interagency relationship over the day to day support, (which was seen as effective), can be related to that siting of these roles at a management level. Associated with liaison at this level is recognition that implies status and credence. In a neo-feudal model, it is important that interaction acknowledges rank. The level of the interaction implies standing and helps define influence. Because the policy/negotiation roles are associated with more powerful roles, these must be included in the relationship for the relationship to be recognized by both the agency and the Service.

The power dynamic could also be a possible interpretation of the high participation in the project from the agencies and the reduced participation from Mental Health Service staff. It is likely that there was a perception by Mental Health staff that empowerment of agencies would lead to a disempowerment of Mental Health staff.

## **8.2 Measurement Outcomes**

### **8.2.1 Questionnaire**

The format of the questionnaire is appended in Appendix I. The same format was used pre- and post- project for agencies and Mental Health Service staff, although agencies were asked about the Mental Health Service and

Mental Health Service staff were asked about their experience with agencies.

The purpose of the questionnaire essentially changed over the course of the project. I made a comparison between pre- and post- project responses, but I do not consider this to be reliable because of the inconsistent response rate. The original working group comprised twenty-three people, fourteen who were from agencies and nine from the Mental Health Service. Of these, five agency members and three Mental Health Service staff completed the pre-project questionnaire. At the end of the project, the working group had dropped to fourteen - nine agency members and five Mental Health Service staff. Of these, all nine agency members and three Mental Health Service staff completed the post-project questionnaire. The Mental Health Service staff returned three (two completed) questionnaires for both the pre- and post- project. Two respondents completed both pre- and post- project questionnaires and the third response from Mental Health staff was completed pre- and post- project by different participants, who thus only completed one each. One of the post-project responses was a collaboration between two participants, who had responded separately in the pre-project questionnaire.

The results of the scaled responses were analyzed by expressing them as a mean of the group response, in order to identify any trend in a change in the satisfaction of the group as a whole. The responses were analyzed with the help of a colleague, and we used the software programme Survey Pro (Apian Software©1992-1998), to generate frequencies and means of responses which were then graphed to provide simple comparisons. The comparisons indicated a general rise, even though minimal, in levels of satisfaction of the group as a whole.

The comparisons are displayed as graphs and are attached as Appendix V. These results cannot be taken as reliable or meaningful, because of the limited and inconsistent response rate and therefore the questionnaire cannot be seen to function as a useful measure of changes in levels of



satisfaction over the course of the project, although some indication of trends might be noted. The most useful application of the questionnaire results is whether or not the levels of satisfaction reflect and support the themes identified and addressed by the working group discussions.

### **8.2.2 Discussion: Usefulness of the Questionnaire**

The usefulness of the questionnaire was affected by the limited response rate, and cannot be viewed as being reliable. Responses may suggest a higher commitment from agencies than from Mental Health staff. The responses also may suggest a higher commitment from participating agencies over the course of the project, in that five pre-project questionnaires were returned and nine post-project. The comparison of the pre- and post- project questionnaire responses showed some movement towards a more positive experience of liaison and contact.

The questionnaire was intended to identify whether participants had experienced better liaison and covered contacts by telephone, written information, reception, general and specific enquiries, response time, specific liaison, clinical input, and general comments. Although the results could not be regarded as statistically significant, when the responses were collated, an overall slight improvement was found post- project in agencies' level of satisfaction with the Mental Health Service, although they indicated a lowered satisfaction level with the amount of time taken to address problems and with improvement of clients' situation after contact with the Mental Health Service. The Mental Health Service responses were generally less satisfied post – project in their view of agencies, with the exception of time taken to address problems and with the amount of written information received. The overall areas in which a low level of satisfaction was indicated – time taken to address problems, amount of written information, time spent educating on mental health issues – are reflected in the discussion of the working group and give an indication of issues that need to be addressed in ongoing collaborative liaison. These are also the areas where there were



differences in the perceptions of the Mental Health Service and agencies, which also suggests that the success of ongoing collaborative practice needs ongoing attention to these aspects.

Consistently in the agency results, both pre- and post- project, levels of satisfaction are noticeably lower for amounts of written information received. Satisfaction levels for time spent on educating about mental health issues are noticeably lower for agencies. Both written information and education/training emerged as important themes from the working group.

Mental health staff seem generally more satisfied than agencies with their liaison, and this was slightly improved by the end of the project. The higher commitment to the project from the agency members compared to Mental Health staff suggests that agencies identified more need for change. However, the post- project responses for the agencies case managed by individual Mental Health staff have leveled out at a "usually" to "always" satisfied point. This may reflect a better understanding of each other's roles, and a reflection of the time that the individual case managers spent in liaison with the agency they were case managing.

More useful were the comments made in explanation of the gradings. The pre-project questionnaire resulted in a small number of comments when compared to the post project questionnaire. There were many positive comments about the work of front-line staff in both the Mental Health Service and the agencies. There were also many comments reflecting inconsistent service, accessibility difficulties and lack of good written information. Both agencies and the Mental Health Service expressed strong views about being excluded from receiving information that was crucial to the supports that they provided. Corresponding with the slight grading improvement in the post-project questionnaire, the post-project comments reflected more consistent contact and improved communication.

The responses suggested to me that each participant who had continued to the end of the project, was comfortable with expressing their views once and

the value of the questionnaire could not reliably rest in comparing pre- and post- project responses. A one-off measure did not contribute anything to comparison of levels of satisfaction in terms of the project, although this could be used to indicate satisfaction at a point in time (end of project). However, what did appear to have changed was the attitude of agencies towards the questionnaire. At the end of the project all the agencies showed a willingness to respond and a full complement of questionnaires was received at that point. However, the responses which were the individual comments from agencies showed a marked difference between the pre- and post- project questionnaires. Where all the pre- project comments were small notes, the post- project were elaborated and fulsomely expanded. I suggest that the comments made in the post-project questionnaires from agencies were the most useful in terms of understanding and moderating future interactions.

Although the questionnaire was intended to measure change over the course of the project, I came to assume that unless the participants experienced change in their every-day interactions that were not associated with a 'project' environment, it might be unlikely that they would record a marked change in their general level of satisfaction. However, even though the project necessarily had a 'project' environment, it was grounded in 'real' interactions, and thus may be seen to provide a sharpened focus to practices which could continue beyond the project itself.

The graphing of the results shows little difference between Mental Health Service staff levels of satisfaction of the agencies as a whole group and the group of five agencies who completed both the pre- and post- project questionnaires. However, a difference can be noted, although small, between the satisfaction with the Mental Health Service of the group of agencies as a whole and the group of five agencies who completed the pre- and the post- project questionnaire. There is a noticeable trend however towards a higher level of post-project satisfaction from those agencies who worked with individual case managers.

The questionnaire can be used as a basis for a more subjective interpretation. It seems to me that the most useful task that the questionnaire provided was in displaying the willingness of agencies to respond to the post- project questionnaire, both in that they all responded and in that their comments were expansive.

The information provided by the questionnaires seemed to indicate a higher willingness, post project, for participants to expose their concerns and to give more considered responses about where they were experiencing difficulty. That is, the comparison of the pre- and post- project questionnaires did not reliably show a change in people's experience of liaison, but did show a difference in the quality of communication. Respondents provided more comprehensive comments in the post- questionnaire, related more of their experiences, and suggested improvements that they were expecting to implement. An extra dimension in the post-project responses was the comments made by participants about adapting their own approaches. The pre-project responses had concentrated on the behaviour of the Mental Health Service.

I have interpreted this as a measure that the project had engaged their participation. As such, the marked difference in response between pre- and post-project suggests that the participants from the agencies became more committed to the project as it developed. The increased responsiveness also suggests that they had experienced their responses as being more valued by the Mental Health Service than they had initially anticipated. Conversely, it can be suggested that the Mental Health Service staff were least engaged in the project and were not expecting their response to be important.

I suggest that this pattern of responses can be interpreted as agencies – as non-government organizations – having increased recognition as service providers by the powerful hierarchy of the service funders, the Health Funding Authority. The transfer of power to provide services in the community from specialist providers to community providers is reflected in

the increased attention given by agencies in asserting their position with the Mental Health Service. I suggest that the ascendance of some agencies in the gaining of contracts from the Health Funding Authority and the increased scope of service delivery accessible to agencies rests in a manifestation of the clinical and lay management dichotomy of the neo-feudal model. The interplay of power between clinical and management within the Mental Health Service is mirrored in the relationship between the Mental Health Service as a specialist clinical service and agencies who are empowered by their community perspective. The increased engagement by agencies in this project can be interpreted as an increase in engagement in opportunities through which they can demonstrate their responsible provider behaviour, as a further strategy in a goal of recognition, by the both the funding provider and the community, as a legitimate source of service provision.

The willingness, shown in this project, of agency members to engage in effective collaboration is at a divergence from the willingness (as shown in this project) from the majority of Mental Health staff. This may indicate a coherence in the perception of agencies of having the responsibility to provide services that are now vested by the funders more in agencies than in the specialist services. I believe this can be seen as an ongoing dynamic of power distribution between agencies and specialist services which ebbs and flows. For whatever reason, the project indicated a higher willingness from agencies to engage with more commitment in collaborative practices.

Over the four month time span of project it is legitimate to expect that participants would not have experienced improved liaison to the extent where they would be confident that any change was significant or lasting. However, the increased communication about their experiences suggests that they had gained confidence that interagency issues were being taken seriously and that their opinions had standing. A recognition also seemed to have emerged that liaison and collaborative practice requires addressing on both sides of the relationship. Thus the questionnaire reflected individually the progress of the project. It was apparent that participants did not feel that answers had been explicitly found. However, they had gained support and

endorsed the process and had more confidence that communication was happening.

### 8.3 Individual Interviews

A request for individual participants to comment on the outcomes of the project for them had positive results. Comments reflected that the project was seen as a project rather than a real change in practice. However, real and practical change was recorded in their responses. Examples of these changes will be found in the section Identified Themes, p.100. Participants were also prepared to positively endorse the project in a presentation at the 'Best Practice' conference (1999) and to provide written comments to the Mental Health Commission and the Mental Health Foundation.

Included here are comments in the participants' own voices about their experience of the project

- i) Comments provided by a participant who was a person who used the Mental Health Service. She was initially asked to participate as a representative of The White House, which is a drop-in centre run by consumers. She was clear that she could not act as a representative, but could participate by providing the perspective of a service user.

The White House is a consumer run community service. The most significant outcome of the project was the links I was able to establish with other community/government organizations that provide services to people who are members of the White House.

For example: At that time changes in benefits and the uncertainty of how these changes would affect people, especially those on invalid Benefit were of great concern to us. Through the project we were able to identify a contact person within WINZ who would "case manage" The White House as an organization. This has meant that this person has come to us to discuss changes, answer questions and clear up difficulties individual members may encounter in their dealings with WINZ or their individual WINZ

case managers. This has proved to be an ongoing relationship that is working very well.

Being part of the stakeholder group has also given me the opportunity to get to know people and their roles in the various other organizations as well as promoting and explaining how The White House worked. I think it was an opportunity to clear up some of the 'negative' myths about consumer run mental health provision. This, in turn contributed to a more positive relationship between the Mental Health Service and The White House (Consumer representative)

- ii) A second participant who provided comment was the field worker from SF Nelson, which is the family advocacy and support organization in Nelson. As a participant he contributed from the perspective of families whose members include those who have a psychiatric disorder.

The use of action research methodology enabled all participants to contribute to design, implementation, monitoring, feedback, refinement and modification of the concepts, practices, and procedures.

..I can report that there have been genuine benefits for several of our families/whanau and carers as a direct result of the knowledge I gained and the relationships I developed during the project.

The value of dealing directly and immediately with an Agency Liaison facilitator, known to have an awareness of the issues confronting mental health service users and their family/whanau and carers, has led to actual solutions based outcomes, rapidly and effectively achieved, for or by individuals in need of interagency support or reliable and accurate information from any of the participating groups.

The project did not require participants to commit much of their time because the time involved was well used and very well facilitated. Yet, while meeting[s] were conducted in a very effective and efficient manner, there was time permitted and encouraged for generous amounts of human input allowing for the nurturance and development of relationship between individuals, as representatives of services.



... This project was inexpensive to carry out, yet I think has already returned valuable outcomes far exceeding the costs as measured in worker time away from their normally defined responsibilities.

It was a wise investment and I expect it to continue to pay generous dividends likely to improve the quality of life of mental health service users, their Families/whanau and carers in the Nelson/Marlborough region.  
(Fieldworker, SF Nelson)

- iii) A third comment is provided from the Oranga Toi Ora staff member. Oranga Toi Ora is the Maori Mental Health Service. This staff member was to work in liaison with a Maori Mental Health service provider. As there is not another specific provider besides Oranga Toi Ora, we had invited the major disability support provider. However, they did not consider their involvement with mental health was significant enough to warrant their time commitment to the project. However, the staff member continued to discuss the process with this agency and this resulted in a move to enhance their collaborative approach. This is described in the voice of the staff member below:

I am one of the two Maori staff, the sole nurse, and was invited to participate in the Collaborative Practice project. The primary purpose for my being involved was to provide a culturally appropriate link with the Mental Health and Social Service providers in our region. Representatives from those services were also invited to participate.

As a key step, a Hui for Maori service Providers was organized; written and verbal invitations were extended. The Hui was held at the premises of one of the Service Providers.

From my perspective, the most interesting aspects of this meeting were the large number of participants, the diversity of their employment roles and individual motivation for attending.

An informal liaison process for consultation between Maori Health Service Providers and Oranga Toi Ora regarding Maori individuals and families has been in operation since 1996, having been developed as part of establishing this section of the Mental Health Service. The Health and Social Service people reaffirmed their satisfaction with that process and that they would continue to use it. It was not part of their written procedures.



The group as a whole was enthusiastic about the concept of Best Practice. Approximately 50% of meeting attendee's were the only Maori in their respective work places and expressed their sense of isolation, or difficulty/inability to make changes that would enhance service practice and customer/client satisfaction particularly for Maori. Some people quite quickly recognized potential for application in their areas of employment and gave examples of how their practice might be improved and customer/client satisfaction be heightened.

Most people knew who they would contact for advice regarding the need for mental health services. They did not see the need for a formal liaison process. The meeting focus shifted to how Maori workers in Health and Social Service, and education and training agencies could follow through with the concepts presented and decided to collaborate with each other by holding monthly meetings. The first was to be convened by the Maori worker in Public Health.

This process has proved useful for all who have been involved and has led to changes in some agencies practices. Many of those agencies may never have a need to access Mental Health Services, however individuals have identified personal gains from their involvement.

I have appreciated my involvement and, with a colleague, plan to utilize this Collaborative Model in a Mental Health project with Maori children and their families.  
(Oranga Toi Ora staff member)

- iv) A final comment was the viewpoint of the manager of Mental Health Services. Endorsement of the project was important from this quarter since integration of outcomes into practice was dependent on the recognition and resource allocation by management.

I believe this project has reduced confusion, reduced barriers and reduced stigmatization. In doing so it has increased understanding of mental health issues as well as increased the understanding of services in our area. This in turn benefits the consumers and staff of the services.

It has greatly facilitated inter-agency liaison and networking, is easy to set up requiring no complicated methodology or technology, took little time to generate results, is easy to generalize to other areas...and it was inexpensive! Definitely a "best practice" to pursue  
(Manager, Mental Health Service)

#### 8.4 **Identified Themes**

The themes that appeared and developed continuously during the life of the project time involved: Language; Trust and Mistrust; Communication, Liaison, and Practical Support. These themes appeared and were developed during the discussions of the working group. Unravelling the development the themes was my work as the facilitator of the action research process. The practice responses developed by the group addressed lack of access to Training, Exchange of Information, Networking, Use of a liaison model, and Trouble shooting. These first appeared as problems and participants' initial approach was to find someone (or agency) as responsible for the problem and expect it to be addressed. Issues appeared fragmented in that the focus varied between participants and solutions tended to be strongly advocated. For example, the issue of lack of accessibility to training had differing impacts on agencies. The responsibility for the Mental Health Service to provide training was strongly advocated. The lack of response from the Mental Health Service to provide training sessions contributed to the dissatisfaction of agencies with the Mental Health Service. The strongly negative opinions towards the little time that the Mental Health Service spent in education with agencies reflected in the questionnaire at the beginning of the project and also showed some positive movement in the post- project questionnaire. In contrast to the agencies, the Mental Health Service staff showed satisfaction with training from agencies. Although the questionnaire responses were not representative nor to be viewed as reliable, these differences in satisfaction between agencies and Mental Health Service staff may also suggest different understandings about training / education. This is an area for ongoing discussion which the working group can be seen to have uncovered. In exploring the issue, a movement could be noticed in a focus on the issue of access to training, an awareness of the pressures on the Mental Health Service, and a move away from blame for non-provision of training.

Through the action research process, the group began to explore what factors contributed to the 'problem', how it was differently experienced and interpreted, and proposed different optional approaches. It was generally possible to trial

these approaches in the course of the project and then the group could rethink possible solutions or processes. In this way, these issues appeared and reappeared through the course of the project and final processes for addressing them were developed. This was final for the project, but not necessarily final for these processes, as they continue to be refined in practice.

#### **8.4.1 Language – discussion**

At the beginning of the project, the participants addressed the use of jargon. Particular words were identified as contributing barriers to the group's collaboration and contributing to de-personalized labeling. The group identified preferred words which were more acceptable for the group to own. The changed language was readily integrated into the discussions and contributed to the group ownership of the project. I would suggest that by committing to using the language identified by the group, both in our meetings and in other settings, the participants deliberately fostered trust and identity in the group 'community'.

The theory of constructivism views meaning as experientially based, actively developed by individual and cultural construction of knowledge in a lived context:

There is therefore not a concern towards discovery of an ontological 'real' world, but only a focus on how people construct knowledge within an individual and social context. Descriptions of social reality are not independent of language or mental abstractions. The nature of the inquirer and the inquired-into is in itself, interactive and self-influencing (Gale and Lindsay, 1997)

The language and metaphor of verbal expression has taken precedence in articulating constructivist approach to social work. In social work, the language of constructivism is of narrative, storyable experience, vocabulary, and giving voice to individuals. Constructivist philosophy can be seen as an overarching meta-narrative in which the theoretical basis of clinical practice is

grounded. Constructivist tenets underpin theories of collaborative intervention, narrative therapy, participatory action research, environmental theory and holistic practice. Recognition of the complexity of cultural (and subcultural) interaction and the contextual nature of values and beliefs, as well as the dominance of language in maintaining individual and social identity are incorporated. Recognition is also given to culture not being static and that individual meaning structures are unique and have equal value. However, meanings may be expressed compatibly and common understandings are achievable. An ability to use effective collaborative skills requires an ability to seek compatible and effective points of overlapping and areas of common understandings from which to build. Whilst this needs an ability to think laterally, it also requires a recognised system from which to offer collaboration. The constructivist role in social work is to enable the differing paradigms of, for example, agencies and clients, to intersect functionally and advantageously. Constructivism can inform theories of practice which involve macro-systems as well as micro-systems. That is, in terms of creating an empowering interaction on both sides of the exchange the social worker's role with agency and organisational change should not be avoided.

Constructivist theory focuses on personal constructs and social constructionism holds

"that expressions of people's constructions are socially negotiated and linguistically mediated. Practitioners', and clients', values and beliefs are then socially derived and verbally expressed, in the practice context." (Anderson, 1997, p. 14).

Social constructionism interprets meaning systems as evolving in the context of shared and commonly understood expression. Responsibility for interpretation is jointly shared. Anderson (1997), in citing Shotter (1997)<sup>1</sup> suggests that language does not

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<sup>1</sup> Shotter, J. (1995) The social construction of our inner selves. *Journal of Constructivist Psychology*, 10 (1), 27-44

'comprise reports of our "inner selves" but is rather used, in collaboration with others, to construct possible new experiences. (*Ibid.* p. 10)

Anderson suggests that a social work approach which melds constructivist and social constructionist theory would allow an opportunity to

"facilitate personal as well as societal change... language may provide the links between separate social construct, and personal construct, systems" (*Ibid.* p. 17)

Working collaboratively with larger scale systems can assist systems, in which values and beliefs tend to be more reified, to become more fluid in their ability to deliver their service. Once the social worker stands at a point where it can be recognised that 'culture' is not a tool for engaging disadvantaged clients, but is existent in all systems, individual or social, then constructivism melded with social constructivism can become a powerful meta-narrative. Where the approach can be seen as bridging, then empowerment can be gained through common points of overlapping activity and recognition of a common life that is informally nurtured:

Common devotion to place, common time, common story (of myths and reference points), common propositions, common constitutionalism and common affection. (Marty, 1993)

Change can be achieved in agencies and organisations by effective bridging if their culture, beliefs, values and language are given the same attention as those of individual clients. Unless language style is part of a lived context, it will become a façade. Authenticity is gained from confidence in the stylised expression of one's own lived context.

Kuspit (1993) suggests that the effect of experiential verisimilitude depends more on the context of communication: "whom the language addresses, and the intimacy of the situation of communication, which would indicate the receptiveness and the attunement of the listener (spectator) – than on the language per se" (Kuspit, 1993). Because language is a vehicle for meaning it

can become reified as experience moves on and has to be 're-adequated' – returned to experience:

The real struggle is to start out from real experiencing and find a language that seems adequate to it – ecstatic- if only for a short time... We have become so habituated to façade – so cynical – that we no longer know what substance is, or want to experience the struggle to experience the difference between substance and façade. (Kuspit, 1993, pp. 280-281)

Although Kuspit is primarily discussing art as a medium of expression, he interprets medium of expression as a mediation or mode of transition between the individual and the world. Kuspit draws from Ortega y Gasset in seeing expression as circumstantial. Circumstance is always local, insistently particular...a constant search to find and orient oneself to circumstance" (*ibid*, p. 298). Kuspit sees authentication in the local and provincial where style can retain its eccentricity and not be reified. The local or provincial expression is always improvised and unstable and must always be reinvented.

The elusiveness of authenticity is the fundamental crisis of our age... There is a fundamental irony...which shouldn't escape us. These [people] ...have none of those things which our society decrees to be important (money, prestige, success, fame) and yet they have a monopoly on what we're actually in most need of - The Real. (Polhemus, 1994, p. 7)

Polhemus identifies a 'bubble-up' process, in which localised style of a subculture influences the market. He reflects Kuspit in locating the well spring of authenticity in the idiosyncratic expression of identity in 'street credibility', and its power of association that implies a connection to the 'Real'. It is the powerfulness of this association which ascribes value to the expressions of a subcultural context in the wider culture or society. Polhemus suggests that the 'bubble-up' process does not advantage those whose subculture is stylistically influential. Polhemus suggests that the attention to social context and culture is not necessarily empowering for those at the bottom end of the market. In its ability to express complex ideas, attitudes and values, linguistic style is an effectively expressive medium. When not functioning in a lived context, it can quickly become reified. In context, it is improvised and



unstable and constantly must be reinvented. Polhemus recognises style in subculture as:

Not just a superficial phenomenon, it is the visible tip of something much greater. And encoded within its iconography are all those ideas and ideals which together constitute a (sub)culture. (Polhemus, 1994, p. 134)

The development by the working group of its' own language terms can be seen as an expression of 're-adequation'. It can be interpreted as the group authenticating its real experiences in finding words that reflect its current lived context. Because the language terms are generated in the particular and local understandings of the people involved their energy and aptness must be seen as living only within the context of this project. If the terms used by this group are abstracted to other situations it is likely that these terms will become as reified as the terms they were replacing. I suggest that the sense of identity, which these expressions carried for this group, would be lost without the reference to the original experience. Use of these terms beyond the project context may well undermine the value for those who created them. A constructivist approach suggests that context, values and human perspectives cannot be solely or adequately addressed by seeking meaning in objectively understanding the role of expression, but involves an openness to participation in subjective experience in which meaning is intensely personal and is shared through a creative meaning such as language.

The defining of the group understandings by the development of its own meaningful language terms expresses a confidence in their own lived experience. The application of a neo-feudal model of power suggests that terms generated at 'street' level become disenfranchised once they enter the vocabulary of those who hold power. Following Polhemus, I suggest that once 'street' level linguistic styles are adopted and commodified by those holding power they lose their connection to lived experience and become reified and alienating. In seeking to use the power of language that has a 'street' credibility, the hierarchy can only empower itself and those who generated the language for a minimal time until those who remain disempowered create their own new terms and expressions.



In order to address the disempowerment inherent in the reification of their language terms, those experiencing the 'real' interface situations will continue to generate new expressions. These will in turn be adopted and reified by those in power. I suggest that this results in the plethora of words that are now in use to describe, for example, people who use mental health services – consumers, clients, patients, *turoro*, *Tangata whaiora*. I am confident that, if adopted outside the working group, our terms will also become reified and lose their lived meaning. Thus the language that was identified by the group as having relevance to its members, needs to be seen as functioning effectively in this context only. Future groups exploring their mutual practice are likely to generate their own terms, which have meaning for them.

The use of these language changes has extended well beyond the life of the project. It remains to be seen whether the positive connotation attached to this language within the project survives, or whether in turn these become new labels.

#### **8.4.2 Trust and Mistrust**

Trust and mistrust were discussed as general statements. Mistrust was identified as being commonly experienced by agencies. Trust was seen as being generated by accumulation of positive interaction, which needed time and commitment to develop. Whilst it was fragile, it could also be quite resilient. Initiative for action had to be taken by each party, a group member commented that it was "*a 2-way process*". It was agreed that interagency relationships relied on developing a trustful liaison, and that this relied upon credibility and reliability of the liaison process. Development of trust, or mistrust, was identified as an important dynamic and was a factor in deciding the usefulness of processes for collaborative liaison. The development of trust was noted as reliant on the practical processes of liaison and interaction.

Agency expectations of each other were also a factor in developing trust. Experiences of agencies showed that expectations of service were not always met. Accurate alignment of expectation with service delivery relied on trust as well as on communication. People taking part in the project reported experiencing "*a difference in credibility*" in different referrers to the Mental Health Service, in that information appeared to be taken less seriously in terms of action if the referrer was an individual, a family member or another service user. "*There seems to be a hierarchy*" (group member comment). In their discussion, the group determined that a trustful relationship could not be fabricated, but could grow out of the practical steps towards collaborative practice, which they were identifying.

The evidence of the working group discussions suggests that the development of mutual and reciprocal interaction provided a climate for understanding, if not for trusting, other agencies.

#### **8.4.3 Liaison**

Liaison was initially discussed in general statements, as a response to the focus provided by the project. Much of the ongoing discussion about liaison developed general principles which were felt to be important, and in exploring effective methods of liaison. Liaison between agencies presented different challenges depending on how the person saw themselves in relation to their agency. If the person was acting in a position of responsibility, or clearly representative in the agency, they were prepared to speak on behalf of that agency. Others identified themselves as an individual who needed to consult back to a wider group (who may in fact not be a 'group' but operate as discrete individuals with a common interest). Important factors identified included – time to consult more widely, confidentiality of individual information, integration of liaison into agency systems so that it does not depend on the effort of one person, and that interaction should be collaborative not collusive. Again, these aspects were

trialled in practical ways and the practice responses were developed.  
*"Liaison is valuable but it is work"* (group member comment).

#### **8.4.4 Communication**

Communication issues were entwined throughout the discussions. Communication was identified in general statements as integral to collaborative practice. *"Keeping safe involves integrating communication in strengthening relationships and building trust"*, and needs to be practiced in a two way process. Although the questionnaire responses were too limited to be viewed as reliable, communication, specifically written information, was an area of low satisfaction in the pre- and post – project questionnaires completed by agencies. Mental Health Service staff also recorded low satisfaction pre- project, although they were more satisfied in the post – project responses. Communication gaps were discussed and the group identified key contact people who seemed to be outside existing communication patterns. This resulted in the invitation to the Practice Nurse Association to join the group.

The group explored existing liaison methods and looked for positive or successful processes that could be used as models. As the discussion about communication developed, agencies identified the role of liaison meetings between agencies with similar interests. A residential provider group already existed. The ALF liaising with Maori service providers reported that they were forming their own group to address their own support and communication needs. The GP and Practice Nurse experienced being outside the current communication links and a project was explored, separately as a "spin-off", to provide greater integration into mental health linkages.

The key components of communication that were identified as important were:

- Written information – was widely noted to be lacking.
- Accessibility - knowledge of who to contact, and availability of those persons.
- Reliability - need to be able to trust the communication processes.
- Timely - that communication was active, regular and frequent.

Communication was seen as a key component in developing collaborative working. The role of people communicating needed to be clear. People did not always act in a representative role for their agency, and were sometimes liaising as individuals with relevant experience. Time for feedback to the wider agency was sometimes needed to enable communication to be effective. The role in which people were communicating needed to be transparent.

The group identified that currently effective communication often relied on the commitment of individuals within agencies and they proposed that communication strategies should be integrated into agencies' policies and practices as a legitimate and planned activity. Resource allocation for liaison was needed. Income Support reported that it had three customer service officers to specifically work with people who experience mental health associated impairment.

#### **8.4.5 Practical Support**

This was a major focus of discussion throughout the project. Perceptions, experiences and expectations of practical support coloured most discussion on all aspects of collaboration and liaison. The exploration of practical support grew from initial statements made in the group about the current situation. At the first meeting, I had prepared an outline, drawn from my literature survey, which was a collation of statements suggesting obstacles, challenges and the positives of collaboration. The group recognized these as mutual concerns and went on to identify current issues. These focussed on training, cost, information and service delivery.

- Training was raised as an issue of access. For example, the Mental Health Service was perceived to be responsible for providing training. The service was seen as the source of specialist training. Positive mention was made of regular training sessions that had been accessible to the community in a limited way, but had now ceased after a restructuring closed the Training and Development Unit. Expectations still remained of the Mental Health Service, and the Service recognized the pressure of these expectations, and explained the limitations that the Service currently experienced. The group was supportive in recognizing that the role of the Mental Health Service had changed and its resources were now more limited.

The group went on to explore ways in which they could develop training options collaboratively. Practical solutions were trialled, which recognized and used the expertise and skills of different agencies, and different ways of providing training were identified.

The questionnaire responses from agencies, both pre- and post- project indicated a low level of satisfaction with the amount of time the Mental Health Service spent in educating about relevant mental health issues, although their satisfaction was slightly higher post – project. The Mental Health Service staff indicated a low level of satisfaction with the time agencies spent educating about relevant mental health issues in their pre-project responses, and were more satisfied post – project. Whilst the results from the questionnaire are not reliable, these responses may suggest that education / training is a key area for successful collaborative practice.

- Cost was raised as a contributing factor in accessing practical support. Costs included time, travel, access to phone and fax, and the personal costs incurred in the pressure to meet one's own and others expectations. The group raised cost as a factor affecting their ability and will to participate in activities, such as networking and liaison, beyond the day to day service delivery. When cost began to appear more and more as part

of other discussions, and when the group identified it as a separate area, the aspects with the most affect on agencies were the non-financial costs. For example, although the project was able to access payment from the Mental Health Commission for those who identified a financial barrier to their participating, not all those who could receive payment claimed it. The recognition of financial costs by the group and the willingness of the Mental Health Commission to contribute towards these seemed to be a point of completion – not all members used the financial help offered. What was identified was the impact of other costs, such as time, and the recognition of this in the offer of payment was considered sufficient.

The discussion about non-financial cost carried considerable effect in the group. The personal, time, and access costs were emotional areas of discussion. The group looked at ways to support these costs and reinforced the value of collaboration and networking. The group identified the need for liaison to be more a responsibility for those agencies for whom cost was a lesser factor. That is, those agencies where costs were significant could expect liaison to be initiated and sustained by the more established groups. The practical outcome regarding the problems of non-financial costs was one of recognition.

In my opinion, the costs and pressures being carried by agencies can be related to the power structures of the neo-feudal model (which I have proposed in Chapter Five as a way of interpreting the relationships within mental health service provision). With power there is an equal obligation to duty and responsibility. This is a reciprocal relationship in which the more powerful have responsibilities towards the less powerful. It can also be seen that, by not alleviating or by not openly recognizing these pressures, the more powerful can flaunt their power and take justification by blaming the less powerful for their failure to initiate the interaction.

- Discussion about information developed throughout the group meetings. Beginning as a series of general statements about the high value placed on good information, concern about its lack, and the need to share



information, a frustration developed within the group taking part in the project about the difficulties experienced in exchanging information. *"We're all going up the ladder, but no-one's coming down"* (participant comment). This moved to identifying a need to clarify misinformation and the limited or negative value of ad hoc or grapevine information, which was a well-established source. The group moved to suggesting and trialling better ways of disseminating information, and these are discussed below in the section on Practical Outcomes. Discussion about information began to identify that the most sought after information concerned existing patterns of services, contacts, and contracts, and reliable information about new or proposed services, service direction and change. The latter type of information was held at the management levels of agencies and to be effective input was needed from the people at this level. People in information roles tended to be inaccessible at times and planning was needed to provide alternative sources.

- In relation to service delivery, a theme of practical supports developed out of the discussions. It related to information issues, support and cost, as well as agency concern about ongoing change. The general statements that drew out service delivery as a theme related to a perception that there was no clear blueprint for actual service delivery – that there needed to be a focus on day to day business rather than anticipating change, and initiatives from larger or central services to ensure information was available. Smaller agencies expressed their experiences of isolation in the existing patterns of dialogue between agencies. People providing support for service users noted that they experienced falling outside information links. Community agencies not specific to Mental Health also experienced that communication often depended on their initiatives.

A discrepancy in information, about available services and actual service delivery, was noted. Expectations about services that could be accessed were not always met when services were sought. Some expectations had been based on misunderstanding of the service criteria, while some



services were restricted by gate keeping. Agencies seeking to access services for people had difficulty with boundaries between services, particularly when they were responding to an immediate or urgent need and the identification of disability was an issue. Gaps in service provision were noted and a need identified for a process of service development.

#### **8.4.6 Practical Outcomes – The Guidelines**

The practice responses developed by the group addressed training, exchange of information, networking, use of a liaison model and trouble shooting. These are also presented in a guideline format (see Appendix IV). The key aspect, which came up again and again, was that of using good clinical practice skills and applying these to interactions with other agencies.

- i) Training: The group accepted that their current expectations of training support from the Mental Health Service could not be met and that the service did not have the resources to provide training. In turning to resources which could be accessed, the group explored all of their resources, and the following strategies were developed:
  - Individual speakers/presenters - depending on time and work pressures, individual staff members can provide sessions for other agencies. This focussed primarily on knowledge needed to enhance day to day support services. This might involve, for example, a member of the Mobile Community Team talking to a residential agency about their crisis intervention role or about psychiatric disorder. It might involve a community support agency talking to the Community Outreach team about their services and their philosophy. Both of these examples were done in practice, and, as well as providing training, also generated good will. The group identified that most agencies had people with expertise and that, over the whole community there were many people who could be drawn upon to share their knowledge. The organization of this would vary between

agencies although would tend to rest with a person who had a management or delegated responsibility for co-ordination.

- External Speakers - conferences and forum gatherings are not always accessible to many staff. Access and involvement can be gained by inviting speakers from outside the region and providing an open forum. Whilst some agencies have the capacity to fund speakers, a group of agencies can seek funding or sponsorship by combining together. Not all speakers are costly, many are freely provided by government or national bodies, and these people have value because they have a national rather than local profile. They can also bring a different perspective which can invigorate or add ferment to commonly canvassed topics. This could be organized by individual agencies, and was also considered to be a useful role for the Mental Health Association Incorporated, which is a meeting of people involved and interested in mental health issues and which undertakes networking and mental health promotion. Most of the agencies participating in the project and the Mental Health Service were involved with the Mental Health Association branch in Nelson.
- Reciprocal training – Training is often perceived as more specialist agencies providing to those with more generic services. Training is just as important in the other direction. The group considered that both training parties should benefit if agencies provided mutual training. That is, if a training session was provided for an agency, that agency should respond with a presentation of their own. This experience helps to establish an equality in the relationship rather than a specialist hierarchy. An example, was the Department of Work and Income, which provided sessions and developed points of contact for the consumer organization, which in turn provided the Department with presentations about their experiences as consumers and the role of their organization.

- ii) Exchange of Information: Linkages between agencies are structured in different ways. Formal Memoranda of Understanding exist where protocol needs to be clearly articulated; minuted agreements may build up a linkage protocol; flow charts describing the practical process of interaction may provide a guide; and day to day interaction may develop a custom of practice that becomes a usual expectation. The group found all these useful in different situations. They did consider it important that each agency had a nominated contact person at a management level who could ensure that issues were addressed. This person should either be accessible or needs to provide back up for when they are away. The participants undertook to provide such a person. In the Mental Health Service this would usually be my role as Service Co-ordinator or be a role of the Unit Managers. The Department of Work and Income was particularly successful in setting up three Customer Service Officers who would have specific responsibility for working in the mental health area, as well as facilitating good access to their Branch Managers.

Written information was seen to be crucial in agency interaction. (This is also reflected in the questionnaire responses as an area of low satisfaction, with the exception of Mental Health Service staff who were more satisfied in their post – project responses). Service providers needed to improve the exchange and availability of written information by sharing maps of service and personnel information; how, when, who, where to access; clear referral process; complaints/feedback process; and a record of understandings about the liaison process i.e. how/why/when/what. It was stressed that exchange of information must be reciprocal. The group recommended that each agency that had established interactions with other agencies should set up an information file. In drawing upon their clinical practice, the group determined that record keeping was important and that the history of the interaction should be documented in the file, as well as agency information.

It was also important that information about other agency services is available widely to users of each service, and that this should be accessible in the way in which it was originally presented. Therefore, pamphlets and information material should be obviously displayed and available wherever there are people using services. For the Mental Health Service, this meant ensuring that there was comprehensive information about community support services accessible in the acute inpatient unit, in the community resource centre and with the outreach teams.

From discussions about misinterpretation and misunderstandings, it was considered important to develop a strategy of recording agreements and interactions. Agreements needed to be in writing, pamphlets and handouts needed to be up to date, and phone conversations needed to be backed up by informal but regular use of faxing.

- iii) Working model: In our project, the working model of collaborative practice was that of case management. This is discussed in the Case Management section in Chapter Three: **Collaborative Practice**. Use of a model can provide a basis for understandings and practice, and form an agreed underpinning for dialogue about the process.

The case management model was found to work well and was endorsed by the group with some modifications. The case management model involved close contact with a focus on developing relationships and shared understandings. The model uses skills of brokerage, liaison, advocacy, and troubleshooting. Dissemination of information between and within agencies was crucial, as was documentation. The modifications proposed by the group resulted from the difficulties experienced by case managers who were front-line staff. Thus, the case management responsibility needed to rest with a person who had knowledge of and input into policy and the

external relationships of the agency. The case manager needed to have good communication links within their own agency. In the Mental Health Service, this needed to be a person at management level with a responsibility for co-ordination of services. As the Service Co-ordinator in the Mental Health Service this was obviously going to be my role, and I have maintained this on an ongoing basis beyond the project.

- iv) Troubleshooting: In stepping back and looking at our experiences during the project, we identified that we had been working collaboratively and that we had developed some skills and processes to enable this to happen. In my opinion, this was the most rewarding outcome of the project. The Troubleshooting points address issues and dynamics of power and how these can be identified and managed for positive outcomes.

Skills, processes and issues that we identified were:

- Options Before Solutions -  
Traditionally, we found, that in working with each other, preferred solutions are often determined before discussion and then advocated. In contra-distinction, a collaborative approach seeks to first identify the dimensions of the question, then goes on to explore optional solutions. A focus on the problem, and how this is experienced by different people, can open up responses which reflect the needs of all involved. Understanding the impact of the problem on other agencies can help create understanding of the impact and the consequences of the solution.
- Defended Boundaries -  
Service boundaries and limits were found to be often strongly asserted and referrals were refused that did not meet criteria.

Collaborative working does not widen boundaries but does allow lateral thinking and flexibility. If a referral is to be refused, discussion about why the person's support cannot be provided may open up suggestions for more appropriate help or identify a situation that may indicate a gap in resources, which can then be discussed with the wider group and quantified. Unmet expectations of help are found to be very damaging to interagency relationships.

- Complaints / Disagreements / Issues -

Collaborative working can be damaged by unresolved issues, and by complaints that are directed upwards before those directly involved have been approached. If dissatisfaction can be sorted out at the lowest possible level, people are more likely to be committed to making the relationship work, than if they were instructed. In the same way, higher authorities need not take responsibility for resolving every appeal.

- Disappointed Expectations -

Feedback from interactions between agencies often showed dissatisfaction with each other. Disappointments are closely linked to a mismatch of expectation, particularly where groups of people are involved. It is useful to seek out from the other agency in advance what they have assumed and are expecting from the proposed contact. Those contacts, which are anticipated with huge amounts of goodwill, are often those most vulnerable to disappointed expectation.

- Collaborative - not Collusive -

Firstly, liaison between agencies is working towards a better relationship between the agencies not just between the people who liaise. The liaison people need to be "in" their agency role and not represent their relationship as exceptional in their agency.

Good internal feedback about interactions and understanding with other services is important so that the whole agency is working positively to maintain relationships.

Secondly, when agencies are dissatisfied with each other this unhappiness is often shared with other agencies. Collaborative working provides support by focussing on the issue and refrains from becoming enmeshed in the individual perspectives of another agency. Collaborative working depends on developing trust and needs commitment to a fair and honest relationship with all of the other services.

- Symbols - Real or Empty? -

Liaison which does not place real value on interaction for the common goal of meeting the support needs of people with impairment associated with psychiatric disorder, or which is undertaken to meet other agendas (such as contract requirements) creates an empty symbolism. If liaison only happens so that it is seen to be happening, the interaction loses credibility and can become alienating. Symbolic interaction, which is empty of meaning, is readily transparent to those upon whom it is inflicted.

- Authentic / Inauthentic communication -

The expression of agencies' roles and identities can be seen to happen in a dialogical way, in conversation and interaction with others. As Taylor (1991, pp. 33, 52) says:

It's not just that we learn the languages in dialogue and can go on to use them for our own purposes on our own. This describes our situation to some extent in our culture. We are expected to develop our own opinions, outlook, and stances to things, to a considerable degree through solitary reflection. But this is not how things work with important issues, such as definition of our identity. We define this always in dialogue with, sometimes in struggle



against, the identities our significant others want to recognize in us. And even when we outgrow some of the latter...and they disappear from our lives, the conversation continues with them as long as we live...

To come together on a mutual recognition of difference – that is of equal value [to] different identities – requires that we share more than a belief in this principle; we have to share also some standards of value on which the identities concerned check out as equal. There must be some substantive agreement on value, or else the formal principle of equity will be empty and a sham. We can pay lip service to equal recognition, but we won't really share an understanding of equality unless we share something more. Recognizing difference, like self-choosing requires a horizon of significance, in this case a shared one. (Taylor, 1991, pp.33, 52)

Authentic communication requires that difference is recognized and that the interaction between people in different agencies is empathetic. Interaction needs to be pursued with an active recognition of shared values and common significant goals, in relation to the practical service to be provided. Communication becomes inauthentic when it is used to pursue ends other than the enhancement of the delivery of the service – ends such as service dominance, resource capture, or favour from higher powers. Inauthentic communication undermines collaborative working by fostering disempowerment. While it is usually readily identified by those upon whom it is practiced, it is difficult to address without the co-operation of both the agencies involved in dialogue.

## 8.5 Spin-Off Projects

A measure of the effectiveness of the project can be seen in the development of 'Spin-off' projects. These were interests and issues that began in the project, but which then developed a life of their own. The project kept a close focus on developing a *process* for collaborative practice. The 'Spin-off' projects generally appeared when people went on to put this process into practice. Therefore, they weren't seen as part of the original project, but, since they explored and

developed practice, they identify the extent to which the project influenced real life practice.

### **8.5.1 Maori Community**

In seeking to invite participation from the Maori community, I was aware that there was no Maori community provider of mental health supports. Within the Mental Health Service, there is a small Maori Mental Health service – Oranga Toi Ora – which has only 1.5 staff. With the help of the staff nurse in Oranga Toi Ora, the major Maori disability support agency was approached. They were interested and supportive of the project, and initially determined to take part. However, when they were unable to attend the first meeting, they reassessed their involvement and identified that their service had no role in mental health service delivery. They were, however, still interested in collaboratively supporting and liaising with other Maori support agencies. With the help of the staff nurse from Oranga Toi Ora, who remained linked into our project, they initiated a Hui and began to explore collaborative working within their own networks. This resulted in ongoing monthly contacts and a much greater understanding of each other's support needs. This is explained in the feedback comments from the Oranga Toi Ora staff member (see preceding chapter).

### **8.5.2 Case management:**

The case management model of interaction with agencies was integrated into the Mental Health Service practice. It was modified by being largely incorporated into my role as Service Co-ordinator, and written into the Service's strategic and business planning. It was not possible to have frequent contact with every group, but a routine of regular meeting and contact was established with those agencies where there were common boundaries. With the help of Unit Managers within the Mental Health Service, we were able to address the difficulties in information flow and work on an ongoing process to improve it. Instead of becoming defensive about complaints from other agencies, the Mental Health Service reviewed

individual staff practices and provided clear guidelines and training to develop a better standard and consistency of information. This is not as yet the best it can be, but, through this process, we have been able to explore with staff members the pressures and priorities which affect their work which

### **8.5.3 Networking /Liaison**

mitigate against providing good information.

The working group put a high importance on the value of regular networking forums. We identified that networking couldn't happen in a vacuum, rather that it had to take place in the context of another purpose. In the Collaborative Practice project, the project work had provided a valid context for meeting and useful networking and communicating had then happened. We found that we had to allow specific time during meetings to enable people to pursue conversations with other group members. At the same time, the group accepted that they would be unlikely to meet just to network without some other legitimating purpose.

We, therefore, proposed to hold a community wide forum, probably 3-4 monthly, and to begin with a Mental Health Expo, which would have a training and information as well as networking focus. It was determined that this would need to be organized by an agency which was not susceptible to capture by the agenda of any one agency. The group approached the Mental Health Association in Nelson (a confederation of mental health groups) to take on responsibility for the Expo and subsequent forums.

The Expo was arranged for Mental Health Awareness week, (two and a half months after the end of the project). The Expo development actively sought to incorporate the practical principles of collaboration that had been identified in the project. Invitation was extended to all the agencies providing mental health support services and to all the agencies who were not specifically mental health but who also numbered people who have psychiatric disability amongst their client group. The agencies were invited to prepare a display of

their services in a central venue over two days, and to enable as many of their staff as possible to be involved in their display. We wanted to have good, comprehensive information available about services, and to enable frontline staff to be able to meet each other and to understand the work of other agencies. The Expo was presented as a training opportunity and specialist speakers were invited to provide presentations on specific mental health issues. The Expo was open to the public, which provided exposure for the agencies, and an opportunity for people who may not otherwise have made contact to explore support in a safe way.

The Expo was very successful, and the evaluation from participants reflected this. Requests were made from participants and from agencies who had not attended for an annual event. We have not been able to provide this because of the amount of organization, but it has been planned as a biennial event.

In terms of meeting the networking need, the planning for the Expo provided significant interagency liaison and understanding and considerably developed people's skills in working together. The second Expo, planned for the year 2000, has already generated an overwhelming commitment from agencies wanting both to participate and to help organize.

Following the evaluation of the first Expo, some change will be made. More emphasis will be on attracting a greater number of presenters, and the focus will be less on the public exposure and more on the interagency exposure. We found that the general public did not attend in a casual way. Those who did come were specifically seeking information about support services and at least six contacts were made that may have otherwise been unlikely.

The Expo is not an expensive undertaking financially, although is costly in time and personal resources.

#### **8.5.4 GP project**

The General Practitioner and Practice Nurse taking part in the project became very interested in developing a greater integration between GP's and the Mental Health Service clinicians. This was pursued separately between the clinicians and GPs, and two North Island projects, which had established this interaction, were explored. The consensus grew that impetus for this development would need to come from a committed GP group. This initial interest died down, but was persistently followed up by the GP who had been involved in our project. After 18 months, he is ready to re-explore the development of this relationship.

#### **8.5.5 Addressing Isolation**

In the course of the project, two individual people who took part in the project became very aware of their isolation from support and contact with other agencies. With the help of the ALFs, they initiated direct supports, and also explored their job descriptions and service contracts with their management. This led to an increased access to training and supervision, as well as education for other staff about their roles.

### **8.6 Final Check**

As a final check on the progress of the group, the participants compared their progress against reports of a study that had had a focus on collaborative practice (Orovwuje, 1995;). In discussion, the group decided that they had identified similar problems and achieved similar outcomes to those reported by Orovwuje, but that also they had identified more in the way of a practical process to achieve these outcomes. The Orovwuje paper did have a higher emphasis on the importance of specific training for staff in interaction skills (anti-discrimination and recognising value conflict), and the group recognised that this would be a valuable focus of future training.

## **CHAPTER NINE : CONCLUSIONS**

In setting out to look at useful ways of establishing good collaborative practice between agencies, this project trialled a case management approach. Identifying and exploring practical collaboration can be seen to have been achieved. Use of a collaborative methodology – action research – and a collaborative practice model – case management – provided a setting in which participants could experience interaction and reflect on this experience.

I have proposed an interpretation of the dynamics of interaction within the mental health community as a 'neo-feudal' power dynamic. In reviewing the project, I consider that this interpretation has been strengthened. The project involved pairing agencies with case managers who were at different levels within the Mental Health Service. These included staff members from different disciplines who were both front-line staff and managers. The practical experience reported by participants found that, although front-line staff could accomplish effective liaison, this did not meet the expectations of the interaction. A clear expectation of collaborative practice by our participants, was that it would help to improve the relationship by addressing and resolving problems, by initiating and developing interactive practices, and by providing information. To meet these expectations, the case managers needed to have a level of responsibility within the Mental Health Service that would enable the outcomes to be integrated into the response of the service as a whole. Thus, the relationship needs to recognize hierarchies and the power attached to these roles. The engagement of the majority of the Mental Health Service staff waned throughout the project, which may suggest that they did not identify that the process of interaction needed changing.

The difference in commitment between the Mental Health Service and the other agencies noted over the course of the project seems an outcome that could affect the success of collaborative practice. The project outcomes show that this may result from basically different perspectives, for example about training / education roles. That specific people in organizations need to be responsible for interactions with other agencies seems a useful way to



address this. In the Mental Health Service this responsibility is held by the Service Manager, Unit Managers and Service Co-ordinator. To achieve commitment to community interaction from Mental Health Service staff who are in clinical roles, it would also seem important to also have this responsibility undertaken by clinical leaders. If liaison is achieved by management without the involvement of clinical staff, it is probable that the clinical needs of people who use the services are not being fully met. However, because this interaction is the responsibility of management, involvement of clinical leaders is likely to give rise to issues of power within the organization.

The participants also identified and endorsed that reciprocity was needed in the relationship. A mutual engagement was essential if the liaison was to endure. This mutuality recognized that both parties have responsibilities towards maintaining the relationship. However, the responsibility for initiating and enabling the interaction lay with the party who had the more responsible role in the mental health hierarchy.

The 'neo-feudal' model identifies that hierarchical relationships have reciprocal and mutual responsibilities. The power dynamic contains clearly understood roles and expectations. Mutual observance, whilst reinforcing the hierarchy, also enables the dynamic to work for those who are less powerful.

I suggest that the 'neo-feudal' model can be noted to be operating when liaison is preferred with staff who are higher in the responsibility of the service. Acknowledgement and credibility can be conferred by association, and thus, the higher the level of recognition the higher the outcome of associated power.

It was interesting to note that agencies felt comfortable with liaison from managers. Collaborative practice, in the form of inter-agency liaison, appears to have aspects both of clinical practice and of management process. The content of the discussion between agencies often relates to the actual practice of support services, needs of service users and understanding of psychiatric disorders. The discussion often also involves the framework of policies,



boundaries and resources, for example. It has been noted that within the Mental Health Service and the agencies, the liaison roles are seen as being in the domain of management process. This seems to be a conclusion that can be drawn from firstly, the importance attached to liaison with unit managers by agencies, and secondly, by the attrition rate of Mental Health Service clinical staff from the project. As Unit Managers tend to have strong clinical backgrounds, they assume a quite powerful position in terms of reinforcing management dominance in authoritatively speaking for the service. This dominance is recognised by agencies by their identifying that these are the key liaison people.

It could be considered that clinical staff also identify liaison as a management/ administrative process and strengthen their clinical specialist role by not engaging in collaboration or liaison. When specialist clinicians have stepped into liaison and collaborative roles, this has, in my observation, required a very careful delineation of their role with management if a clash in the power structure is to be avoided.

The project group clearly identified advantages in frequent communication and opportunities for networking. The subsequent events, such as the Expo, increased agency understanding of each other's roles and introduced real people to each other. This also identified a community of interest which was taken into account by the Health Funding Authority, the source of resourcing and contracts. It can be assumed that this increased generation of communication played a part in enabling a flow of information which considerably increased the understanding by individual agencies of the pattern of service delivery and contracts set up by the Health Funding Authority. Consequently, agencies seeking private advancement or preferred provider status without going through the tender process, were quickly subject to the scrutiny of the wider mental health community. The outcomes of this continue at the current time, as the preferential treatment by the Health Funding Authority of certain providers has become more transparent.

A corollary of more open communication and information, particularly when service gaps are identified, is the more active use by agencies of channels of power. As the mental health community becomes more aware of the approach of the Health Funding Authority and other funding providers to apportioning contracts, providers are seen to be actively courting the funders to gain preferred provider status. A better understanding of the process has empowered those who work effectively in a 'neo-feudal' model to enhance their standing with the funders and to attract a growing responsibility for service provision. I believe that this has further disempowered those providers who continue to expect democratic processes.

### **9.1 Collaborative Practice Guidelines**

The most effective outcome of the project was the guidelines developed to inform good collaborative practice. These have continued to be used both to maintain relationships and to provide a framework for identifying difficulties. For example, a recent visit by a consumer group to a Marae was highly successful from the perspective of the consumer group. In a later networking meeting with Maori providers, the people from this Marae expressed their disappointment with the visit. They felt that the consumer group had accepted their hospitality but had given little back, that the people from the Marae were no wiser about what it means to be a mental health consumer. With reference to the collaborative practice guidelines, we were able to establish that both parties had different expectations of the visit – the consumer group was expecting a Marae experience as a group of people, not as consumers. The Marae were expecting a presentation or an insight into psychiatric disorder from a consumer perspective. Many of the consumers who went to the Marae were not confident about discussing their psychiatric experiences and understood they were engaging in a normal community interaction. We found that these expectations had not been clearly discussed prior to the visit and that no one had taken responsibility for a collaborative approach to the visit. In addressing this, a reciprocal return visit was arranged for the people from the Marae, during which they were able to hear consumers, who were prepared to talk about their experiences.

The guidelines were developed from people taking part in the project looking at their professional practice with individuals and applying this to working with agencies. The group did not introduce skills or practices that they did not already have. What they did identify was that professional skills tend to be reserved for clinical or support service situations where there is clearly an individual 'client' and an individual professional, but that mental health skills were not invoked when interacting with peers. The most significant development the group made was in applying their skills in working with individuals to their work with other agencies. Whilst this is apparently a simple conclusion, it was arrived at over the course of the four month project through the trialling, rethinking, and reworking of a practical process. The action research approach enabled participants to own the project and to critically examine and modify their practice.

The outcomes for people who use services are not readily quantifiable. We have found that an ease in communicating with other agencies can provide quick and accurate information. People seeking support are less likely to become frustrated by services which do not understand the support needs associated with their individual situation. Referrals are being made more appropriately and gaps between service boundaries are more readily identified and addressed. For people who use services, this does not translate into increased support but can be seen in support which is more readily accessed, which is appropriate and which does not involve them in interagency tensions. Thus, the gains could be said to be invisible. This fits very comfortably with social work practice, in that, if, for example, the support for empowerment, removal of barriers, clarification of expectation and attention to process are addressed professionally, the tensions and stressors will be eased and notable only by their diminution.

Finally, the project provided a reason for collaboration and networking to take place. One of the key factors that we found important to maintaining relationships with other agencies was the opportunity to work together and to have a reason to meet, which the project provided. People wouldn't meet simply to network, communicate and share information. The understandings developed

from these processes needed to happen as an adjunct to some other legitimate reason for meeting. Therefore, the continuation of ongoing training interactions, speakers' forums and Expos provide a means for collaborative practice to mature and grow. We continue to be careful in organising such events, that time and opportunity for people to meet and share conversation is not only fitted in but also nurtured and actively promoted.

The guidelines and practice approaches to collaboration, that were developed through this project, continue. The case management model, now based with individuals at management level, is being used within the Mental Health Service in its ongoing relationships with other agencies. Constructive change appears to be developing the approach of different agencies towards collaboration and in their understanding of its practice and value.

## **9.2 Postscript**

In 2000 the Nelson / Marlborough District Health Board established short term working groups to advise direction to the new Board. As a member of the Intersectoral Linkages working group, I introduced the aspects of collaborative practice that this project had seen as useful guidelines. The working group supported these and included the guidelines in their recommendations to the Board. The project participants had thought it important that collaborative practice needed to be endorsed and supported by organizations if it was to be successfully implemented. Thus, the recommending of these guidelines to the District Health Board seems a useful step in this direction.

## AGENCIES

11. In general, are you satisfied with the contact between yourself / your group and the Service?

- ☐ No/Not at all
- ☐ Occasionally
- ☐ Usually
- ☐ Yes/ always

Can you tell us why (if you answered "usually" or "yes/always") or why not (if you answered "no/not at all" or "occasionally")?

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12. In general do you feel your clients' situation is improved as a result of their contact with the Service?

- ☐ No/Not at all
- ☐ Occasionally
- ☐ Usually
- ☐ Yes/always

Comments

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Would you care to identify ways in which the Service could meet your needs more or make other comments?

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ID Number

NELSON-MARLBOROUGH HEALTH SERVICES

MENTAL HEALTH SERVICES

TE WAIORA



**Nelson Marlborough  
Health Services Ltd**

## MENTAL HEALTH SERVICES

### Agency Satisfaction Survey

#### Instructions

The purpose of the rating scale is to find out how satisfied you are with your contact with the Mental Health Service.

Your ratings, comments, suggestions will provide us with valuable feedback that will be used to make changes to enhance or improve service delivery, and, in particular, to provide baseline data as we set up an Agency Case Management. This involves each agency we work together with having an assigned Case Manager to meet with them on a regular basis or to contact SOS. We hope this will facilitate our services interacting in the community.

Please respond generally to the Service. If you want to specify individual service areas in Mental Health, these could be noted separately under the appropriate ranking – however, we are wanting your response to the Service as a whole.

We appreciate your time and co-operation.

Thankyou

AGENCIES / NELSON/ MARLBOROUGH MENTAL HEALTH SERVICES

1a Who do you contact in the service when you have a general enquiry? \_\_\_\_\_

1b Who do you contact in the Service when you have a specific enquiry? \_\_\_\_\_

Comments \_\_\_\_\_

2a Is it easy to contact the Mental Health Service by telephone?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

2b Is it easy to contact the Mental Health Service by written communication?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

Comments \_\_\_\_\_

3 Are you satisfied with the time interval between contacting the Service and your issues/concerns being addressed?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

Comments \_\_\_\_\_

4 Are your calls returned if messages are left?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

Comments \_\_\_\_\_

5 Are you satisfied with the frequency of liaison between yourself and the Service?

☐ Yes

☐ No

Comments \_\_\_\_\_

6 Is the phone/counter reception courteous?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

Comments \_\_\_\_\_

7 Is the reception informative and able to put you through to the appropriate area?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

☐ Comments \_\_\_\_\_

8 If you are a referrer are you satisfied with the amount of written information received from the Service?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

☐ Comments \_\_\_\_\_

9 Are you satisfied with the contact your clients have with the Service?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

10 In addition to therapeutic interventions, do you feel the Service spends enough time educating yourself or clients on relevant mental health issues?

☐ No/not at all ☐ Occasionally ☐ Usually ☐ Yes/always

Comments \_\_\_\_\_

## APPENDIX II

**FORMING PARTNERSHIPS** : This shows the overhead which summarizes the challenges identified in the literature and which was used as a basis for discussion in the Working Group

### **CHALLENGES**

- PAPERWORK / ADMIN
- HIGH CASELOADS
- SOCIAL SUPPORT LOWER THAN OTHER NEEDS
- LACK OF TIME
- TOO MANY CRISES
- COMPETING / CONFLICTING ROLES
- NEGATIVE PAST EXPERIENCES
- PROFESSIONAL JARGON
- LACK OF RELATIONSHIP BUILDING SKILLS
- LACK OF KNOWLEDGE ABOUT FORMAL / INFORMAL COMMUNITY RESOURCES
- NEED FOR SKILLS OF WORKING WITH SYSTEMS / AGENCIES AS WELL AS WITH INDIVIDUALS
- LACK OF KNOWLEDGE OF CULTURAL ISSUES
- COMMUNITY STIGMA / BIAS RE MENTAL ILLNESS
- LACK OF COMMUNITY RESOURCES
- NETWORKS "BURNED OUT"
- LACK OF AGENCY SUPPORT FOR NETWORK INTERACTIONS
- GEOGRAPHIC ISOLATION / DISPERSION
- NOT WANTING TO IDENTIFY SUPPORT NEEDS
- UNWILLINGNESS TO BE INVOLVED WITH OTHER AGENCIES
- LACK OF EXPERIENCE IN SOCIAL SUPPORT INTERVENTIONS
- CONFIDENTIALITY REQUIREMENTS
- LACK OF SUPPORT BY SUPERVISION
- LACK OF SUPPORT BY TRAINING
- LACK OF INTEREST IN NETWORKS
- SHIFTING 'BLAME' OR COSTS TO OTHER AGENCIES
- LACK OF TRUST IN AGENCY SKILLS



### **APPENDIX III**

*This shows the overhead which summarized attributes of case management recognised by the working group and used as a basis for discussion.*

#### **CASE MANAGEMENT**

- **ASSERTIVE**
- **ADVOCACY ORIENTATED**
- **ENABLING**
- **VALUES BASED**
- **CLOSE COMMUNICATION**
- **SHARED STAFF UNDERSTANDINGS**
- **UNDERSTANDING OF INDIVIDUAL NEEDS, CULTURE, RESOURCES, PRESSURES**
- **INFORMATION RESOURCE**
- **SUPPORTIVE INTERVENTION**
- **MONITORING & CRISIS INTERVENTION**
- **LINKAGES**
- **EDUCATION / TRAINING ROLE**
- **ADMINISTRATION – meeting, planning, paperwork**
- **FREQUENCY OF CONTACT**
- **ACCESSIBLE INFORMATION**

**CASE MANAGEMENT – OBJECTIVES**

- PRACTICAL SUPPORT A HIGH PRIORITY
- COMMUNICATION...UNDERSTANDING...TRUST
- PROMOTE DEVELOPMENT OF SERVICES
- CLARIFY RESPONSIBILITIES OF AGENCIES
- PROMOTE DEVELOPMENT OF COLLABORATIVE PARTNERSHIP
- MAXIMISE IMPACT OF SERVICES
- USEFUL TO YOU – USEFUL TO US

**APPENDIX IV**

*Appendix IV presents 9 overheads which were prepared to summarize project discussion, information and findings.*

*The first four 4 overheads summarize the key findings by the Working Group related to each of the main identified themes.*

1. **TRAINING / EDUCATION / INFORMATION SHARING:**

- **LIMITATIONS**
- **INDIVIDUAL SPEAKERS**
- **EXTERNAL SPEAKERS**
- **RECIPROCAL TRAINING**

**2. WRITTEN INFORMATION:**

- **SERVICE MAP**
- **PERSONNEL MAP**
- **ACCESS – how, why, who, when?**
- **REFERRAL PROCESS**
- **COMPLAINTS / FEEDBACK**
- **RECORDED UNDERSTANDING OF LIAISON PROCESS -  
how, why, when, who?**
- **WRITTEN CONFIRMATION OF INTERACTIONS OR  
AGREEMENTS**
- **AGENCY PAMPHLETS**
- **FAXING**

3. INTERAGENCY FORUMS

- PLANNED OPPORTUNITIES
- OWNERSHIP BY WHOLE GROUP
- NOT AFFILIATED TO ANY SPECIFIC AGENCY
- SPECIFIC PURPOSE
- NETWORKING TIME
- ONE – OFF - NOT TIED TO ANOTHER
- INVOLVEMENT ACROSS GROUPS
- LARGER EVENTS

**4. TROUBLESHOOTING:**

- **OPTIONS BEFORE SOLUTIONS**
- **DEFENDED BOUNDARIES**
- **COLLABORATIVE –NOT COLLUSIVE**
- **COMPLAINTS / DISAGREEMENTS / ISSUES**
- **SYMBOLS – REAL OR EMPTY?**
- **DISAPPOINTED EXPECTATIONS**
- **AUTHENTIC / INAUTHENTIC  
COMMUNICATION**

*This overhead shows the main themes identified by the Working Group as the underlying framework process of collaborative practice*

**FRAMEWORK FOR COLLABORATIVE PRACTICE  
& ONGOING LIAISON**

- **NOMINATED CONTACT PERSON AT  
MANAGEMENT LEVEL**
- **BACK-UP FOR PERSONAL CONTACT**
- **EXCHANGE OF WRITTEN INFORMATION**
- **TRAINING INTERACTION**
- **WORKING MODEL**



*This shows the overhead which summarized the findings of the Working Group about the important aspects of the ALF (Agency Liaison Facilitation) model:*

**ALF MODEL**

**(Agency Liaison Facilitation)**

- **CASE MANAGEMENT MODEL**
- **LIAISON AT MANAGEMENT LEVEL**
- **RESPONSIBILITY TO:**
  - **MAINTAIN LIAISON**
  - **DEVELOPING RELATIONSHIP**
  - **IDENTIFY & WORK THROUGH ISSUES**
  - **MAINTAIN ACCESSIBLE AGENCY FILE**
  - **ACCESSIBLE CONTACT & BACK UP**
  - **CONTACT POINT WITHIN OWN ORGANIZATION**
  - **NOT SOLE CONTACT**

*This shows the overhead which summarized attributes of collaboration which were drawn from discussion with group members, recognised by the Working Group as a whole and used as a basis for discussion.*

**COLLABORATION**

- **USEFUL – TO ALL OF US**
- **IMPROVED SERVICE FOR CONSUMERS**
- **SERVICE LINKAGE**
- **CONSUMER ADVOCACY**
- **EFFECT ON FRAGMENTATION**
- **EFFECTIVENESS OF INTERVENTION**
- **TIMELINESS OF INTERVENTION**
- **INCREASED CONGRUENCE IN PERCEPTION OF THE  
RELATIONSHIP**
- **DEVELOPMENT OF POSITIVE HISTORY**
- **DEVELOPMENT OF SKILLS**
- **RESOURCE SHARING**
- **REFERRAL & CO-OPERATION ACROSS AGENCY  
BOUNDARIES**

*This shows the overhead which summarised the practical findings of the Working Group about the project:*

**CASE MANAGEMENT MODEL: PROJECT FINDINGS**

- EMPHASIS ON LIAISON RAISED EXPERIENCES OF LONELINESS
- LIAISON WITH ONE PERSON HELPS BUILD CONFIDENCE BETWEEN AGENCIES
- INFORMATION GAINED & MISINFORMATION CORRECTED
- EXPECTATIONS MORE REALISTIC
- USEFUL WHERE CONTACT NOT WELL ESTABLISHED
- SEPARATE C/M ROLE DISPENSIBLE WHERE GOOD LIAISON ESTABLISHED
- NEED TO INVOLVE STAFF AT POLICY LEVEL
- LACK OF CLARITY ABOUT WHAT INFORMATION CAN BE SHARE
- INVOLVEMENT COMPROMISED BY EXPERIENCE OF BEING INEFFECTIVE - identify issues but unable to resolve
- LIMITATIONS NOT EXPERIENCED WHEN LIAISON AT 'HIGHER' LEVEL
- CONTACT NEEDS TO BE REGULAR
- ACCESS TO WRITTEN INFORMATION
- NEED TO RECOGNISE TIME COMMITMENT
- NEED TO RESOURCE
- USEFUL IF AGENCY NOT PRIMARILY MENTAL HEALTH
- 'ALF' ROLE USEFUL IN :
  - LIAISON,
  - DATA BASE,
  - POINT OF CONTACT,
  - INCREASED INTERACTION,
  - DEVELOPMENT OF TRUST,
  - ALIGNING EXPECTATIONS,
  - REDUCING DISSATISFACTION

*This shows the overhead which summarized the Action Research approach, used as a basis for discussion and agreement by the Working Group at the beginning of the project*

### **ACTION RESEARCH**

- **Trying to understand and improve the way things are now, with a focus on how they could be better**
- **Activist: aims to create a form of collaborative learning by doing**
- **Participants learning from change in a process of making change evaluating and trying again**
- **Aims to help people understand themselves as the agents, as well as the products, of history**
- **Possible to focus on the wider processes which structure social life – in discourses, in work, in organizations, and interpersonal relationships, in which we recognize relations of power**

**APPENDIX V**

***Figures (on pages 139 –148 following) showing graphing of results of questionnaire.***

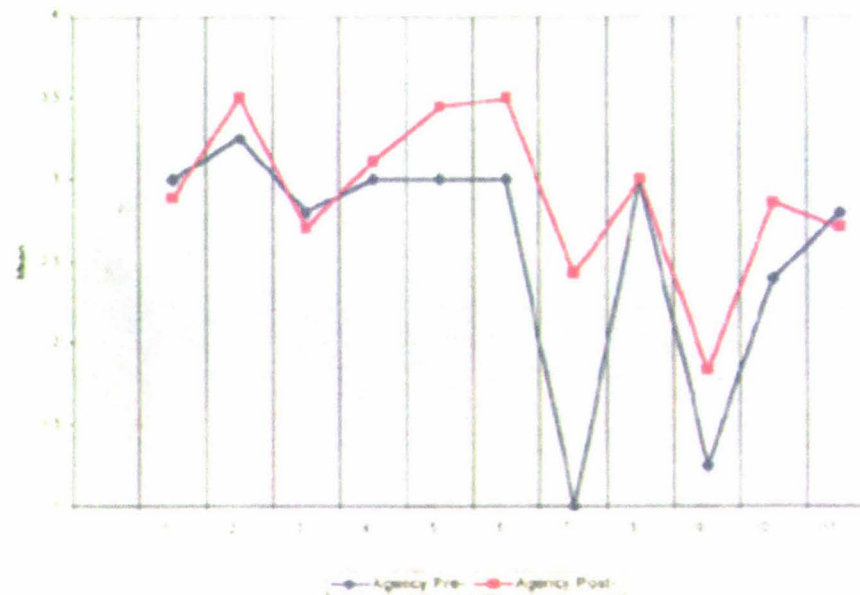
***For discussion, see pages 82 - 88***

**Explanation of Figure 1:** Using the mean of responses, this compares the responses for all agencies as a whole group. Five only of the nine agencies completed the pre-project questionnaire and nine agencies completed the post-project questionnaire.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 1: Comparison of pre- and post- project satisfaction ratings for all agencies (Mean)**

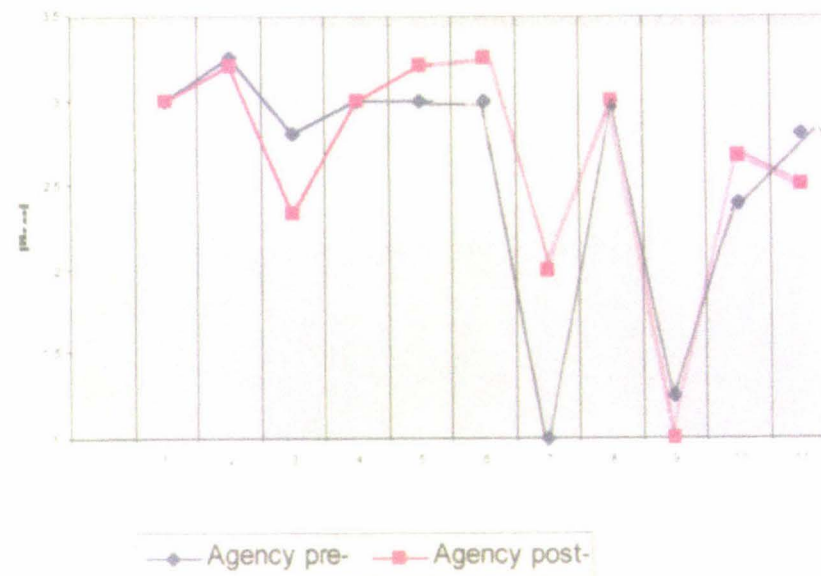


**Explanation of Figure 2:** Using the mean of responses, this compares responses only for the five agencies who completed both the pre- and post- project questionnaire. The pre- project responses are the same responses as shown in Figure 1. Comparison between Figure 1 and Figure 2 shows a slightly better satisfaction rate post- project when the responses from agencies are considered as a whole group.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 2: Comparison of pre- and post- project satisfaction ratings for agencies who completed both questionnaires (Mean)**



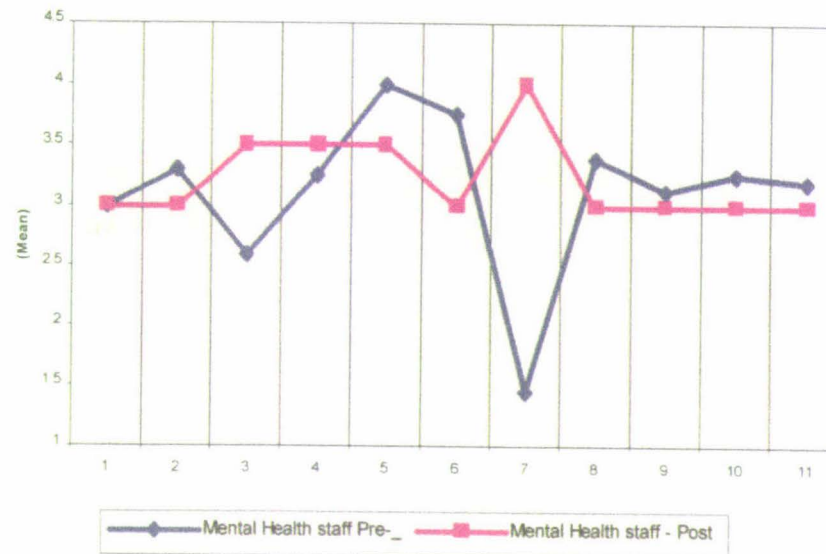


**Explanation of Figure 3:** Using the mean of responses, this compares pre- and post- project satisfaction shown by the Mental Health Service staff for all agencies. The post-project responses shows the increased satisfaction with written communication, time taken to address problems and return of calls, but otherwise shows a decrease of satisfaction with agencies.

**Questions Key:**

- 1 – Is it easy to contact by telephone?
- 2 -Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11- Has clients' situation improved after contact with the agency?

**Figure 3: Comparison of pre- and post- project satisfaction for Mental Health Service staff (Mean)**

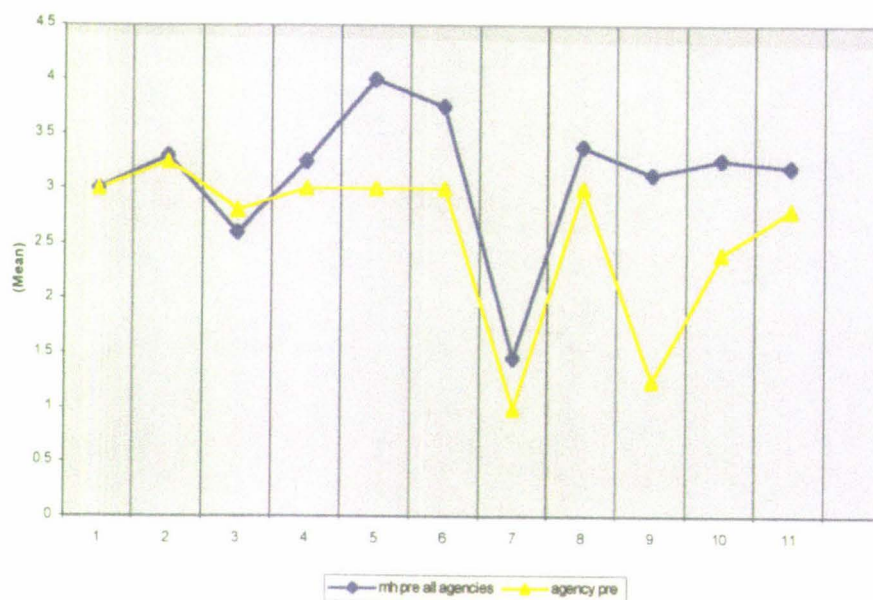


**Explanation of Figure 4:** Using the mean of responses, this compares the satisfaction pre-project for the agencies, (only five of whom completed the pre-project questionnaire), with the Mental Health Service staff response for all agencies as a group. This can be compared to Figure 5, which distinguishes the Mental Health Service staff satisfaction with the group of agencies (five) who completed both the pre- and post- project questionnaire. Small increases of satisfaction can be noted when the agencies are considered as a whole group.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 4: Pre-project comparison of satisfaction between agencies' view of Mental Health Service and Mental Health Service staff view of all agencies – pre-project (Mean)**

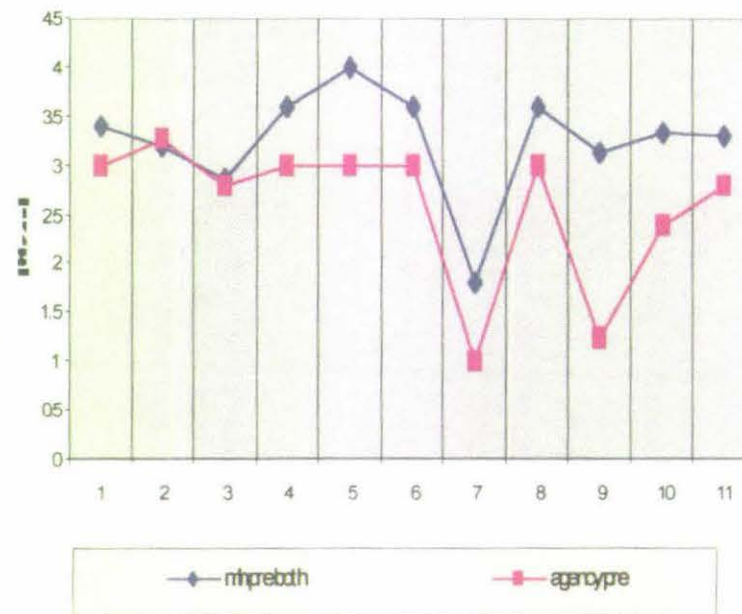


**Explanation of Figure 5:** Using the mean of responses, this compares the satisfaction of Mental Health Service staff with that of the five agencies who completed the pre- and post- project questionnaire. A small decrease in satisfaction can be noted compared to Figure 4, which compares agencies as a whole group.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 5: Pre-project comparison of satisfaction between Mental Health Service staff view of all agencies and Mental Health Service staff view of agencies who completed the pre- and post- project questionnaire (Mean)**



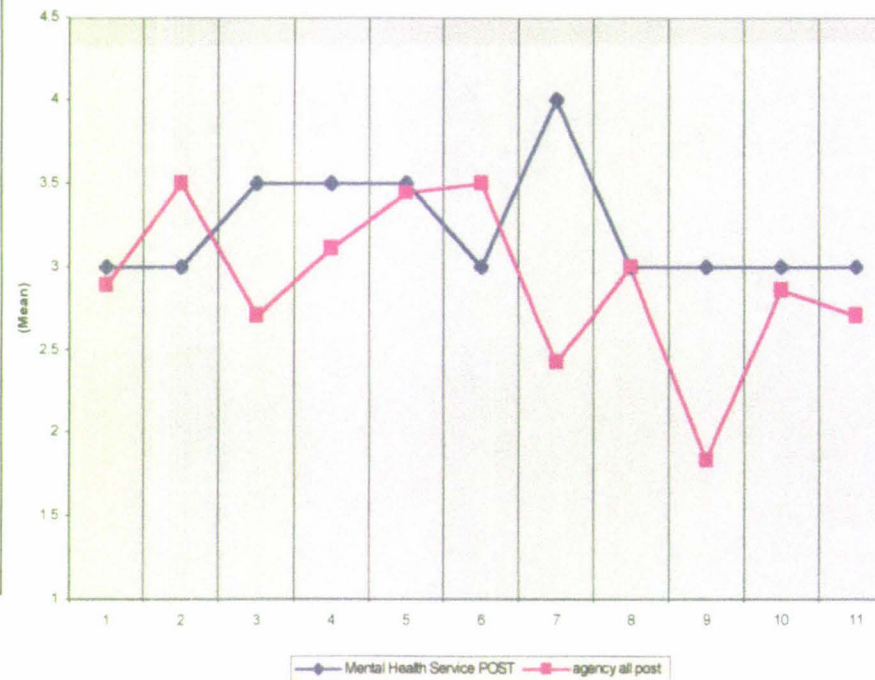


**Explanation of Figure 6:** Using the mean of responses, this compares the post-project responses of all agencies as a group with those of the Mental Health Service staff. This can be compared to figure 7, which involves only agencies who completed both the pre- and post- project questionnaires. The comparison of Figures 6 and 7 shows little difference between questionnaires

**Questions Key:**

- 1 – Is it easy to contact by telephone?
- 2 -Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11- Has clients' situation improved after contact with the agency?

**Figure 6: Post-project – comparison of satisfaction between all agencies and Mental Health Service staff  
(Mean)**

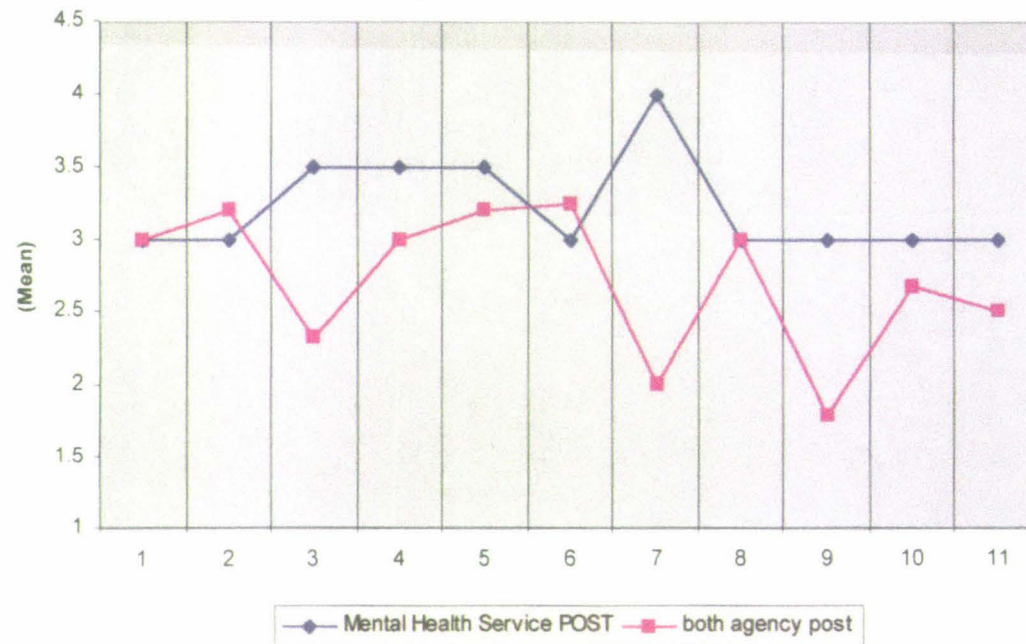


**Explanation of Figure 7:** Using the mean of responses, this compares the post-project responses from agencies who completed both pre- and post- project questionnaires with the Mental Health Service staff responses about these agencies. Compared to their pre- project responses (see Figure 40, the Mental Health Service staff show increased satisfaction with written information which is marked as a difference from the perception of agencies.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 7: Post-project - comparison of satisfaction between agencies who completed both pre- and post-project questionnaires, and Mental Health Service staff  
(Mean)**

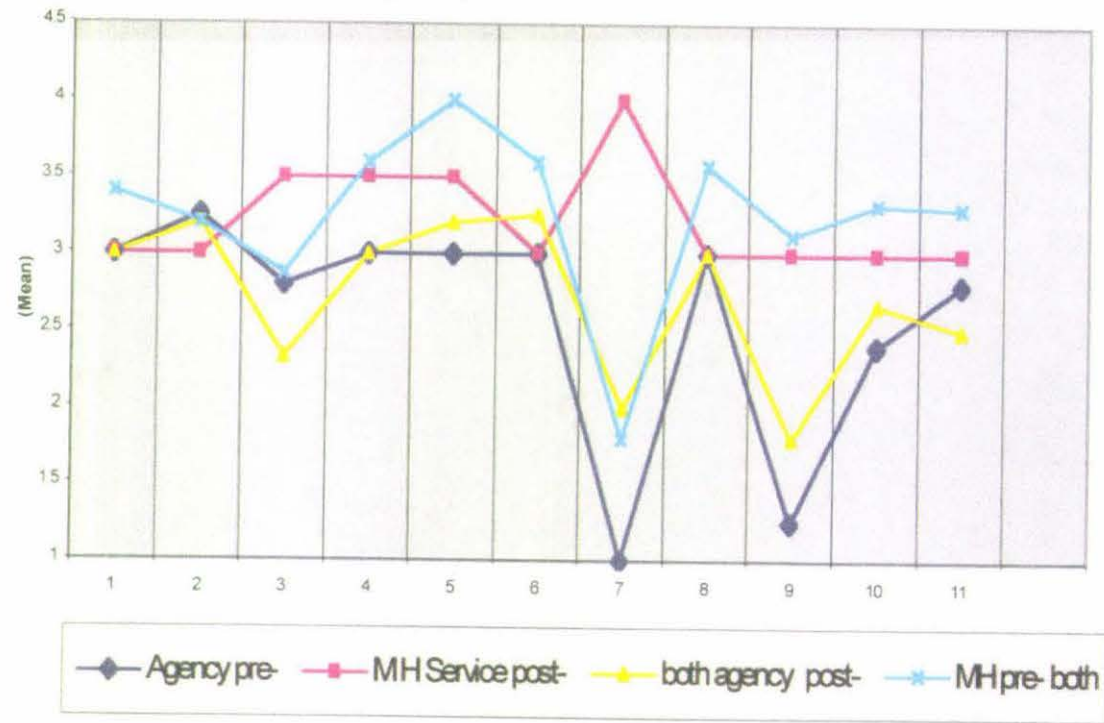


**Explanation of Figure 8:** Pre- and Post-project - Using the mean of responses, this figure compares pre- and post-project responses for agencies who completed both pre- and post-project questionnaires, with the Mental Health Service staff responses about these agencies. This can be compared to Figure 9, which shows satisfaction levels of the agencies as a group, pre- and post-project. It can be noted that question 7 and question 5 show an increase in Satisfaction for Mental Health Service staff post-project which indicates a difference in perception to the experience of agencies.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 8: Comparison of pre- and post-project satisfaction between agencies who completed both pre- and post-project questionnaires and Mental Health Service staff view of those agencies (Mean)**



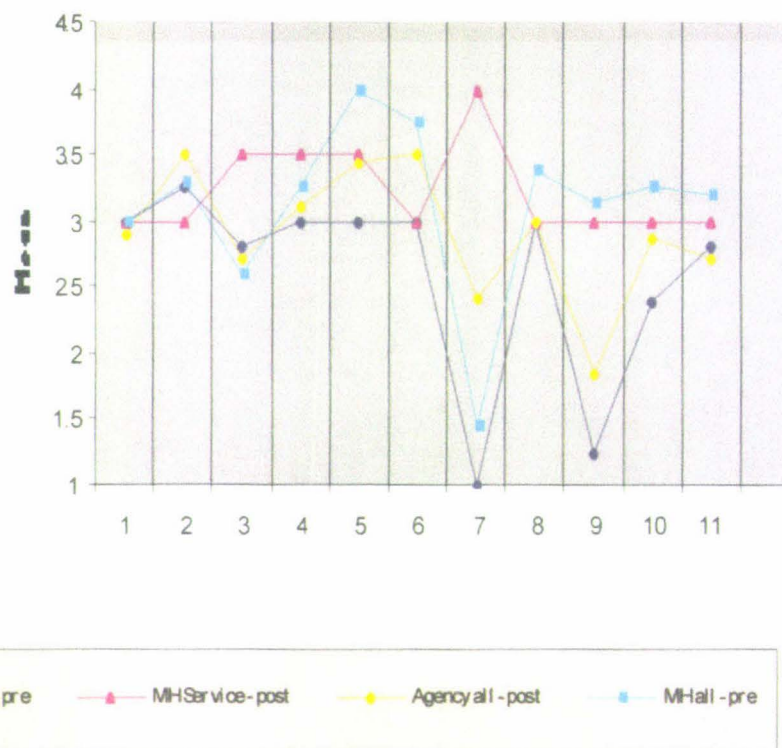


**Explanation of Figure 9:** Pre- and Post- project - Using the mean of responses, this compares pre- and post- project responses for all agencies as a group with the Mental Health Service staff view of the agencies as a group

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 9: Comparison of pre- and post- project satisfaction between all agencies and the Mental Health Service staff (Mean)**



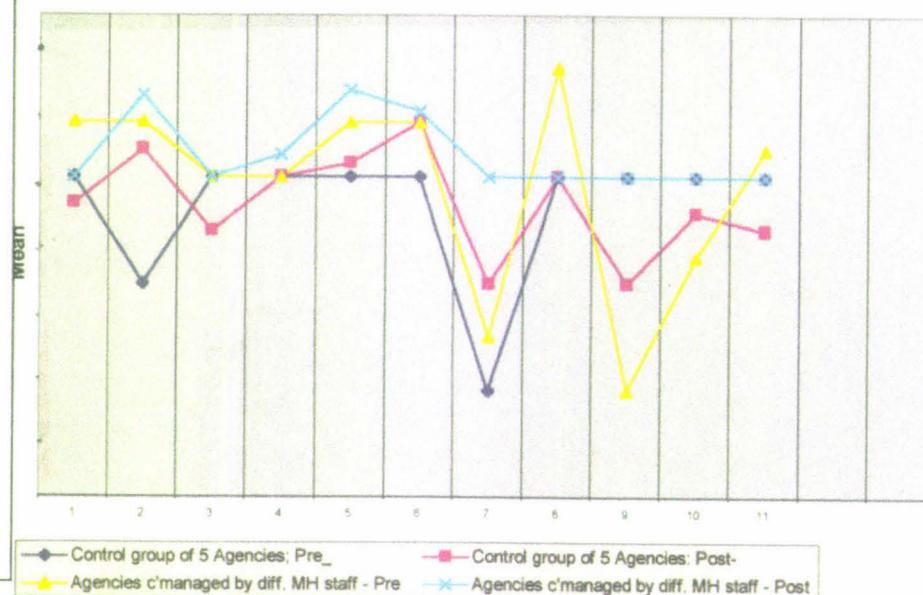


**Explanation of Figure 10:** Using the mean of responses, this compares the pre- and post- project levels of satisfaction expressed by two groupings of agencies, those who were individually case managed by different Mental Health staff, and those who were all case managed by one Mental Health Service staff, (myself as the Service Co-ordinator). This can be compared to Figure1 which compares all the agencies pre- and post- project. The higher satisfaction levels expressed by agencies who experienced individual case management are apparent.

**Questions Key:**

- 1 - Is it easy to contact by telephone?
- 2 - Is it easy to contact by writing?
- 3 - Satisfaction with time taken to address problems?
- 4 - Are your calls returned if messages left?
- 5 - Is phone/ counter reception courteous?
- 6 - Reception informative, puts you through to appropriate area?
- 7 - Satisfaction with amount of written information received?
- 8 - Are you satisfied with the contact your clients have with the agency?
- 9 - Enough time spent educating on relevant mental health issues?
- 10 - General satisfaction with contact between agency and Service?
- 11 - Has clients' situation improved after contact with the agency?

**Figure 10: Comparison of satisfaction responses from agencies case managed by different Mental Health Service staff, and agencies (control group) case managed by one Service Co-ordinator: Pre- and Post- Project (Mean)**



## REFERENCES:

Allen,W. (1999) <http://nrm.massey.ac.nz/changelinks/>

Allen-Meares,P. (1995) *Applications of qualitative research: Let the work begin*, Social Work Research, 19, 1, pp.5-7

Anderson,J., Dayson,D., Wills,W., Gooch,C., Mangolis,O., O'Driscoll,C., Blett,J. (1993) *The TAPS Project.13 : Clinical and Social Outcomes of Long-Stay Psychiatric Patients After One Year in the Community*, The British Journal of Psychiatry, 162,(sppl.19), pp.45-56

Anderson,R.H. (1997) Envisaging a Constructivist Approach to Clinical Social Work, Paper presented at the XIIth International Congress on Personal Psychology, Seattle, July 9-12

Argyris,C., Putnam,R., Smith,D.M. (1985) Action Science, San Francisco: Jossey Bass

Barker,J.R. (1998) *Tightening The Iron Cage: Concertive Control in Self-Managing Teams*, in Van Maanen.(ed) (1998) Qualitative studies of Organizations, Thousand Oaks, Calif : Sage Publications

Becker,T., Thornicroft,G., Leece,M., McCrone,P., Johnson,S., Albert,M., Turner,D. (1997) *Social networks and service use among representative cases of psychosis in South London*, The British Journal of Psychiatry, 171, pp.15-19

Biegal,D.E., Tracey,E.M.,Song,L. (1995) *Barriers to Social Network Interventions with Persons with Severe and Persistent Mental Illness: A Survey of Mental Health Case Managers*, Community Mental Health Journal, 31, 4, August, pp. 335-349

Briggs, H.E., Koroloff, N.M. (1995) *Enhancing Family Advocacy Networks: An Analysis of Roles of Sponsoring Organizations*, Community Mental Health Journal, 31, 4, August, pp. 317-333

Bulmer, M. (1984) *Concepts in the Analysis of Qualitative Data*, in Bulmer, M., (ed) (1984) Sociological Research Methods: An Introduction, London: Macmillan

Burns, D., Barrett, D., Daley, V., Duignan, P., Saville Smith, K. (1994) Towards a Post-Institutional Response to Mental Health : Consensus Statement from the Beyond Care and Control? Workshop, Health Research Council of New Zealand, June, p. 3

Burns, T. (1997) *Case management, care management and care programming*, British Journal of Psychiatry, 170, pp. 393 - 395

Buston, K., Parry-Jones, W., Livingstone, M., Bogan, A., Wood, S. (1998) *Qualitative Research*, British Journal of Psychiatry, 172, March, pp. 197-199

Caplan, G. (1969) An Approach to Community Mental Health, London: Tavistock

Checkland, P. (1992) *From framework through experience to learning : the essential nature of action research*, In Bruce, C.S., Russell, A.M. (1992) Transforming tomorrow today, (2<sup>nd</sup> World Congress on Action Learning): Brisbane, Action Research and Process Management Association

Checkland, P. (1981) Systems Thinking, Systems Practice, Chichester, Sussex; New York: Wiley

Checkland, P., Scholes, J. (1990) Soft Systems Methodology in Action, Chichester, Sussex; New York: Wiley

Cohen, C.I. (1993) *Progressive Psychiatry: A Research Agenda*, Community Mental Health Journal, 29, 6, December, pp. 561-567



Commander,M.J., Sashi Dharan,S.P., Odell,S.M., Suikes,P.G. (1997) *Access to mental health care in an inner-city health district. II: Association with demographic factors*, British Journal of Psychiatry, 170, pp.317-320

Department of Health (1994) Implementing caring for people: housing and homelessness, Department of Health, UK

Dick,B. (1993) You want to do an action research thesis? Available on line at <http://www.scu.edu.au/schools/gcm/ar/art/arthesis.html>.

Easton,B. (2000), *The cult of the manager*, Listener, 172, **3120**, February 26, p. 56

Elliott,J. (1991) Action research for educational change, Milton Keynes: Open University Press

Fraser,M.W. (1995) *Rich, relevant, and rigorous: Do qualitative methods measure up?* Social Work Research, 19,1, pp. 25-27

Friere,P. (1972) Pedogogy of the Oppressed, Harmondsworth: Penguin

Gale,J., and Lindsay,E. (1997) Three (or Four) Paradigmatic Models, Course material Clinical Social Work 70.763, Massey University

Gambrill,E. (1995) *Less Marketing and More Scholarship*, Social Work Research,19,1, pp. 38-47

Gask,L., Sibbald,B., Creed,F. (1997) *Evaluating models of working at the interface between mental health services and primary care*, The British Journal of Psychiatry, vol.170, pp. 6-11

- Guba,E.G. and Lincoln,Y. (1989) Fourth Generation Evaluations, Newbury Park, Calif: Sage Publications
- Guba,E.G. and Lincoln,Y. (1994) *Competing paradigms in qualitative research*, in Denzin,N. and Lincoln,Y. (1994) Handbook of Qualitative Research, Thousand Oaks, CA: Sage Publications. pp. 105-117
- Halmi,A. (1996) *The qualitative approach to social work: an epistemological basis*, International Social Work, 39, 4, Oct, pp. 363 -376
- Hart,E., Bond,M. (1995) Action Research for Health and Social Care, Buckingham: Philadelphia, Open University Press
- Health Funding Authority. (1999) Draft Definitions, Health Funding Authority, Feb 8
- Henry,C., Kemmis,S. (1985) *A Point-By-Point Guide To Action Research For Teachers*, The Australian Administrator, 6,4, Aug
- Hodgkinson,C. (1998), Administrative Philosophy : values and motivations in administrative life, Oxford: Pergamon
- Hoge,M.A. and Howenstine,R.A. (1997) *Organizational Development: Strategies for Integrating Mental Health Services*, Community Mental Health Journal, 33, 3, June, pp. 175-188
- Holley,H.L., Hodges,P., Jeffers,B. (1998) *Moving Psychiatric Patients From Hospital to Community: Views of Patients, Providers, and Families*, Psychiatric Services, 49, 4, August
- Jones,I.R. (1999) Professional power and the need for health care, Aldershot: Ashgate

Kemmis,S. (1993) *Action Research and Social Movement: A Challenge for Policy Research*, Education Policy Analysis Archives, 1, 1,January

Kuspit,D. (1993) Signs of the Psyche in Modern and Post-Modern Art, Cambridge University Press.

Lewin,K. (1946) *Action Research and Minority Problems*, Journal of Social Issues, 2, pp. 34-46

Lewis,J., Bernstock,P., Bovell,V. (1995) *The Community Care Changes: Unresolved Tensions in Policy and Issues in Implementation*, Journal of Social Policy, 24, Part 1, pp. 73-94

Markowitz,J.C. (1998) Taking Issue: Clinical research as Community Outreach, *Psychiatric Services*, vol 49, 2, p. 147

Marshall,M., Gray,A., Lockwood,A., Green,R. (1998) *Case management for people with severe mental disorders (Cochrane Review)* in The Cochrane Library, Issue 3,. Oxford: Update, software

Martin,J. (1991) *Devolution and Decentralisation*, in Boston.J., et als (eds) Reshaping the State: New Zealand's Bureaucratic Revolution, Oxford University Press, pp. 268 -290

Marty,M. (1993) *Religio-Secular Society*, New Perspectives Quarterly, 10,3,Summer p. 55-59 ; in Anderson.W.T. [ed.], (1995) The Truth About The Truth, Tarcher Putnam

Massey University: School of Social Policy and Social Work (1999), Thesis Writing: Guidelines For Masterate Students at Palmerston North and Albany, Massey University: Palmerston North

McNiff,J. (1988) Action Research: Principles and Practice, Macmillan



Means,R., Smith,R. (1994) Community Care: Policy and Practice, The MacMillan Press, pp. 232-262;138-165

Means,R., Brenton,M., Harrison,L., Heywood,F. (1997) Making Partnerships work in community care: A guide for practitioners in housing, health and social services, Bristol: Policy Press

Mental Health Services Research Consortium (NZ). (1994) Research Report No 1: Barriers to Mental Health Care in the Community: Towards an Economic Model, \_Wellington [NZ]: Health Services Research Consortium

Miles,B.M. (1983) *Qualitative Data as an Attractive Nuisance: The Problem of Analysis*, in Van Maanen,J.(ed). (1983) Qualitative Methodology, Beverly Hill : Sage

Miller,C. (1991) *Split Vision*, Social Work Today, 19 Sept, pp. 24-25

Mullen,E.J. (1995) *Pursuing knowledge through qualitative research*, Social Work Research, vol 19, 1, pp. 29-37

Orovwuje,P.R. (1995) Collaborative Work with Different Client Populations in a Regional Forensic Psychiatry Service: the Task of Social Work, paper presented at the Asia Pacific Regional Social Services Conference, Christchurch, New Zealand

Osher,F.C. (1996) *Response to "Consultation to Residential Psychosocial Rehabilitation Agencies*, Community Mental Health Journal, vol 32, 4, pp. 415-418

Ottawa Charter For Health Promotion. (1986) First International Conference On Health Promotion, Ottawa, Canada, 17 –21 November, 1986



Parker,G. (1997) *Public Mental Health Service Delivery: A Modified Model*, American Psychiatry, vol 5, 4, pp. 167-169

Patching,D. (1990) Practical soft systems analysis, London: Pitman

Payne,M.S. (1997) Modern Social Work Theory, 2<sup>nd</sup> ed, Macmillan: Basingstoke

Plamping,D. (1997) *Joint Working*, Community Care, 23 – 29 Oct., pp. 23-29 ,19-21

Polhemus,T. (1994) Street Style, Thames and Hudson

Poole,R. (1992) *Living with Reason*, Inquiry, vol 35, 2

Reason,P. (ed.) (1988) Human Inquiry in Action: developments in new paradigm research, Newbury Park: Sage

Ridgley,M.S.,Lambert,D.,Goodman,A.,Chichester,C.S.,Ralph,R. (1998) *Interagency Collaboration in Services for People with Co-occurring Mental Illness and Substance Use Disorder*, Psychiatric Services, vol. 49, 2, pp. 236-238

Rousseau,C. (1993) *Community Empowerment: The Alternative Resource Movement in Quebec*, Community Mental Health Journal, vol 29, 6, Dec., pp. 535-546

Statistics NZ. (1997) Hot Off The Press: Subnational Resident Population Projection 1996 base – 2021, Statistics NZ, released 30/10/1997

Stein,C.H., Rappaport,J., Seidman,E. (1995) *Assessing the Social Networks of People with Psychiatric Disability from Multiple Perspectives*, Community Mental Health Journal, vol. 31, 4, August, pp. 351-367

Suchman,E.A. (1967) Evaluative Research: Principles of practice in Public Service and Social Action Programmes, New York: Russell Sage Foundation

Susman,G. and Evered,P. (1978) *An Assessment of the Scientific Merit of Action Research*, Administrative Science Quarterly, 23, 4, pp. 582-603

Taylor,C. (1991) The Ethics of Authenticity, Harvard University Press: Cambridge, Massachusetts and London, England

Thornicroft,G. (1991) *The concept of case management for long term mental illness*, International Review of Psychiatry, 3, pp. 125-32

Torbert,W.R. (1976) Creating a Community of Inquiry: Conflict, Collaboration, Transformation, John Wiley and Sons

Toulmin,S., Gustavsen,B.(1996) (eds) Beyond Theory: Changing Organizations Through Participation, Amsterdam; Philadelphia: J.Benjamin Pub.

Turner,A., Quilayis,D., Bines,W. (1997) *Perfect Links*, Community Care, Jan, pp. 30-31

Twigg,J. and Atkin,K. (1995) *Carers and Services: Factors Mediating Service Provision*, Journal of Social Policy, vol 24,1, pp. 5-30

Van Beinum,H., Faucheux,C. and van der Vlist,R. (1996) *Reflections on the Epigenetic Significance of Action Research*, in Toulmin,S.,Gustavsen,B. (eds.) Beyond Theory ; Changing Organizations Through Participation, John Benjamins: Amsterdam/Philadelphia, pp.179 - 202

Wakefield,J.C. (1995) *When an irresistible epistemology meets an immovable ontology*, Social Work Review, vol 19,1, pp. 9-18

Weisberg, S. (1996) *Increasing the Effectiveness of Frontline Workers Through a Model Mental Health Training Programme*, Community Mental Health Journal, vol 32, 4, pp. 363- 376

Zola, I.K. (1972), *Medicine as an institution of social control*, Sociological Review, 20, pp. 487-504