Partnership and interprofessional practice

Health & Medicine, Mental Health

Partnership and Interprofessional Practice Working in partnership is a negotiation to working together by different agencies with the intention to secure the delivery of benefits, or added value, which could not be provided by one agency alone (Glasby and Dickinson, 2008). Interprofessional practice it is the ability of professionals to work in collaboration, applying knowledge and skills, to improve the service users experience of the service provided. For the purpose of this essay it will be assumed that Marilyn has capacity under s. 1 Mental Capacity Act 2005 as there is no indication that she lacks it. Being the primary partner, Marilyn she should be involved in the planning, delivery and evaluation of the services she will receive. For there to be a straight forward path between the different service to be offered, it is essential that that the professionals within the collaboration share information, clarify their respective roles and overcome barriers which may become apparent due to differences in status, culture, values, and organisational structures. The NHS and Community Care Act 1990, placed importance on effective interprofessional and partnership practice through giving local authorities the responsibility to assess individual needs in collaboration with health authority staff and publish community care plans through consulting with service users and independent sector to provide housing, training and employment (Leiba, 2003 in Weinstein, Whittington and Leiba, 2003). The Building Bridges Guidance (DoH, 1995), the Health Act 1999, Partnership In Action (DoH, 1998) and the National Service Framework for Mental Health (NSF) (DoH, 1999a) together clarify the responsibilities of the health and social services, giving them greater flexibility to facilitate cooperation, jointly plan care, make payment to each other and improve

services by creating pooled budgets (Whittington, 2003 in Weinstein et al, 2003). The legislation and policies place a legal duty on the professionals to collaborate and provide timely interventions to mental health patients through a single assessment (Leiba, 2003 in Weinstein et al, 2003). However, differences in priorities, organisational styles and cultures within the two services had led to the reluctance to work together (Audit Commission, 1992 in Leathard, 2003). This resulted in scattered support, with each professional having its own bit of person to take care of (Tuner, Brough and Williams, 2003). Service users expressed that they needed services that were easy to negotiate and focused on their needs (Rose, 2001). Service users valued good communication (Townsley, Abbott and Watson, 2004) and expressed the important of knowing that professionals shared information between themselves, which they felt would give them a better understanding of their needs, viewing them as a whole person (Miller and Cook, 2007 in Newham and Clarke). Marilyn was sectioned under s. 3 Mental Health Act (MHA), therefore aftercare services should be provided under s. 117 MHA, and under s. 27. 11 Mental Health Act 1893 Code of Practice (MHACP) (DoH, 2008), aftercare should be delivered within the Care Programme Approach (CPA) (DoH, 1990). The CPA highlighting that service user involvement is an essential part of the delivery of effective services and therefore should be planned with the patient, their family and carers looking at both health and social care needs. Marilyn’s sister, Sandra, is her the nearest relative as defined under s. 26 MHA but this does not automatically make her a career. However, Sandra cared for Marilyn in the past and should she wish to continuing to provide this care, Sandra will be entailed to a carers

assessment under The Carers (Recognition and Services) Act 1995, Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004. Together the Acts place a legal duty on the interprofessional team to work in partnership with Sandra and to inform Sandra of her right to an assessment; furthermore Standard 6 NSF 1999 places a duty on social services to carry out the assessment of Sandra's needs and wishes which may help her to continue provide care for Marilyn. Even if Sandra doesn't want to care for Marilyn, if Marilyn wishes so, then professionals could arrange contact as part of the care plan as it was found that mental health patients felt that supportive family networks were a significant factor likely to increase resilience to relapse (Bates and Coren, 2006). But if Marilyn doesn't want contact with Sandra, her decision is backed by the case of R (on the application of E) v Bristol City Council where the court ruled that the nearest relative did not have to be contacted just because it is physically possible to do so, because it may not be reasonably practicable due to the distress that would result to the service user. Sandra is experiencing domestic problems with her partner and placing Marilyn back in such an environment may cause her great distress. An effective intervention would have all professional, who are to work with Marilyn and Sandra on the CPA to attend the interprofessional meeting together, meet with Marilyn, and have her attend the interprofessional meeting to fully understand what she would like as part of the CPA. The professionals must explore what Marilyn sees as relevant to her psychological health, develop cultural awareness, have thorough understanding of the impact of stigma and use a holistic approach when addressing Marilyn's wishes and needs. Marilyn is part of the Black and

Minority Ethnic (BME) community and under s. 27. 13 MHACP, Marilyn's assessment should involve consideration of her cultural needs. Research identified that BME members often experience prevalent use of restraint, higher levels of detention under MHA 1983, over-reliance on medication, discriminatory treatment and less access to talking treatments in mental health services (Gould, 2010 and NSCSTHA, 2004); therefore professional should never make assumptions relation gender, race and culture as this can lead to the clouding of judgements and resulting in services that are not adequate or wanted. Professional should ask Marilyn what her needs are in relation to her ethnicity and culture, her views on faith and address any language barriers (DoH, 2007). By understanding what Marilyn's ethnicity and culture means to her, suitable adaptations can be made. Marilyn has a dual diagnosis due to the co-existence of mental health and substance misuse problems. In high secure hospitals, between 60 — 80% of patients have a history of substance use prior to admission but less than 20% of psychiatric patients receive treatment for their substance use, making relapse more likely (Turning Point and Rethink, 2004). Furthermore, service users have said to experience stigma and feelings of shame but this can be more severe or BME members as they may also experience stigma within their own communities (Turning Point et al, 2004). The interprofessional team should work in collaboration with substance misuse specialists whilst taking Marilyn's cultural differences into consideration. This will help to reduce the effects of stigma and the likelihood of relapse. The Lewisham Dual Diagnosis Service is an example of good practice that could be followed. It collaborates with trained specialist dual diagnosis practitioners,

providing an integrated service to clients, whilst develops skills within the current services and addressing both issues concurrently, in one setting, by one team (Turning Point, 2007). Marilyn found spirituality to be a positive experience whilst she was in detention. Religious behaviours and beliefs can have a positive influence on mental health (Bhui, King, Dein and O'Connor, 2008), and recognising a person's spiritual dimension is one of the most vital aspects of recovery in Mental Health (NIMHE, 2003). S. 1. 4 MHACP identifies that professionals should recognise and give respect to the diverse spiritual needs and values as it could help Marilyn build resilience. Furthermore, it was highlighted by the Mental Health Foundation that friendships are the most valuable relationships that mental health patients have (Bird, 2001); Marilyn's friendship with the pastor should be honoured and taken into consideration when planning her services. S. 1. 4 MHACP and the Equalities Act 2010 s. 149 place a legal duty on professionals to eliminate discrimination in relation to gender. Studies indicate that 50% or more of women in mental health services have experienced violence and abuse (Rethink and Turning Point, 2004); furthermore, women are twice as likely as men to experience depression as a result (Holen—Hoekseman, 2001). Marilyn was in an abusive relationships and fears that her ex-partner might find her, therefore it is important that she is provided secure accommodation and that the mental effects of the abuse are addressed alongside her depression. By working in partnership with specialist services for abused women, the interprofessional team will be able to gain knowledge and skills that can help support Marilyn better. Marilyn was homeless when she was sectioned, therefore s. 18 of MHACP states that the housing services should

be offered to Marilyn as part of the CPA. Under s. 27. 12 MHACP a representative of the housing authority will be consulted and the accommodation provided to Marilyn's will reflect her needs. If Marilyn wishes so, an option for housing could be an outreach support apartment which encourages support between residents and provides Marilyn with a support worker that will help her take her medication whilst providing help with daily living (Rethink Mental Illness, 2005). The accommodation is designed to enable Marilyn to make a transition into independent living, if this is something she wishes. No Health without Mental Health (DoH, 2011) identifies that Marilyn should be placed at the centre, in ownership of her own recovery, changing her thoughts and feelings, and developing of new meaning and purpose in life, as she grows beyond the effects of mental illness (Anthony, 1993). However the use of recovery within government policy maybe contentious. The focus of the policy is on Marilyn taking ownership, which in turn means taking full control of her recovery, but such control is not unlimited. Being a policy, it entails government agenda which will suit the government's wider objectives. Although the policy, aims to ensure the professionals are sensitivity aware of Marilyn's needs, wants and wishes, Marilyn's decisions might become shaped professionals through various power relations, placing inconspicuous limits on the control Marilyn has. Power is an attribute held by an individual or body and it is not an isolated element, but one which interweaves occupational and organisational structures with the actions of professionals, individually and collectively (Hugman, 1991). Legislation and policies have given Marilyn the power to impose her will on the professionals, but given her mental illness she is in a

vulnerable state and might not be able to exercise this power effectively. In such circumstances, Lukes identified that this can lead to professionals exercising power over Marilyn, and affect her in a manner contrary to her interests (Lukes, 1974). The collusive power found in Tew's matrix might manifest through control of information whereby some professionals working in partnership with Marilyn might prevent Marilyn's wishes from being discussed in certain team situations (Tew, 2006), leaving Marilyn feeling vulnerable. Although polices have placed duties on professionals to empower Marilyn, the ultimate power in empowerment rests in the professionals whom set the parameters in which Marilyn can operate (Hardy and Leiba-O'Sullivan, 1998). To avoid an imbalance of power, professionals should seek to work in mutual agreement with Marilyn without influencing her decisions, leading to a negation of power and neutrality. Expand+ It was identified that 83% of professionals felt that the introduction of the CPA had acted as the catalyst to interprofessional working (Larkin and Callaghan, 2005). However differences in relative status, power of professionals, professional identity and territory, and the different patterns of accountability between professionals prevented the professionals from effectively collaborating (Hudson, 2000 in Brechin, Brown and Eby, 2000). Research carried out at Summerset Council revealed that staff felt confused about the element of reorganisation of identity, leading to concerns about the changes in the professional role, the loss of identity and the lack of management clarity (Gulliver, Peck and Towell, 2001). The reorganisation created a new health and social care structure, but this did not necessarily lead to a shared culture, instead it lead to the strengthening of attachments to existing

cultures when workers felt threatened by the change and perceived lack of identity (Gulliver et al, 2001). Each profession has a different culture, which includes values, customs and behaviours. This culture is passed on to the neophytes and remains obscure to other professions (Schroeder, Morrison, Cavanaugh, West, and Fache, 1999). This process starts to foster a hierarchical power structure through establishing prestige and status. The medical profession is synonymous of this and in contrast, social workers have not been able to share the same level of professional status, resulting in inequalities of status and power between the professionals (Wilson, Ruch, Lymbery, and Cooper, 2009). The professionals working in the collaboration will need to foster a status-equal, share knowledge and skills which will in turn create a positive synergistic influence on patient care (Hall, 2005). Patient care should be placed above the power and status struggles of cultural differences. This can be achieved by the professionals through giving each other mutual respect and understanding by enabling one culture to continue, enriching it with the other cultures. Professionals are required to develop a more shared identity, values and philosophy, based on the mutual sense of loyalty to the service user under the mental health legalisations. Abbott argued that delineation of boundaries is essential as it enables the professionals to determine what is and is not part of its sphere of influence (Abbott, 1988 in Allen, 2001). However it was found that people with complex needs, spanning both health and social care, felt good quality services were sacrificed for sterile arguments about boundaries, resulting in vulnerable people finding themselves in the ' no man's land' between both services, placing the needs of the organisation above the needs of service

users, which is not wanted (DoH, 1998 in Glasby, 2005). However, the consequence of not upholding boundaries could lead to role blurring resulting in some professionals feeling underutilised or over worked (Mariano, 1999 in Hall, 2005). However, it was found that staff in integrated teams identified more strongly with their teams then with their profession, experiencing less role confusion. Professionals saw themselves as part of a team, with shared positive attitudes and values for practice (Carpenter, Schneider, Brandon and Wooff, 2003). Effective interprofessional practice can be achieved through professionals working out how they see themselves and how other professionals see them and use this understanding to achieve a closer working relationship (Peck and Norman, 1999). Lack of knowledge of other professionals gives rise to a tendency to stereotype other professionals, leading to defensive attitude forming round accountability (Nolan and Badger, 2002), resulting in an ineffective collaboration where needs are seen as fragments, informed choice is limited and access to suitable service is restricted, ultimately increasing the service users risk of deterioration. An important change for the future must be the drawing of a clear line of accountability, reducing doubt or ambiguity about who is responsible for the wellbeing of the service user (Laming, 2003). By drawing this line, the professionals can ensure that the information shared is managed rigorously and monitored, giving responsibility and role clarity to each member of the team. Efficient collaboration can be achieved through bringing individual attributes, such as role, structural characteristics, personal characteristics and professional histories together to create a new professional activity, enabling a more collective ownership of goals

(Bornstein, 2003 in Lishman, 2007). For Marilyn's intervention to be effective and prevent relapse, good communication between professionals and service users is required, together with a shared understanding of each person's role and culture, clear role boundaries and lines of accountability. The collaboration should aim to provide a holistic approach, facilitate informed choice, enable access to the needed services and provide the most timely and suitable services for Marilyn. By placing Marilyn at the heart of the interprofessional team and working in partnership with her and other agencies, power dimensions need to be shared equally enabling equality to prevail, allowing Marilyn's voice to be heard and implemented clearly. Critically Evaluate Collaboration By The Study Group In Preparation For And Delivery of the Presentation And Your Contribution To It The process of collaborating brought with it some difficulties due to the group size. For most tasks a five-person group appears to be the optimal size (Thomas and Fink, 1961) yet we had ten members in our group leading to a mechanical mechanism for producing information which was less sensitive to the point of view of others, and a more direct attempt to control others and reach solutions was used. In result not all members of the group indicated agreement to decisions that were made, giving rise to oppressive practice and low moral because members did not feel valued. It is important that the group structure matched the particular personalities within the group (Luft, 1984). In the beginning the group adopted a lassie faire style of leadership. Everyone was given space to express their ideas, however this lead to many members of the team leaving feeling confused, underappreciated and dissatisfied at the level of productivity. This is where the ' check in process'

at the start and end of each meeting was found to be fundamental in order to achieve balance and efficiency (Morran and Stockton, 1980). It allowed members to express their views in an open safe space, resulting in the team resolving sensitive issues by changing the leadership style. Leadership is the mechanism that drives a group forward to achieve the set goal, this where I found the power of the chair to be crucial to the group process. Power does not always constitute domination, but rather the ability to accomplish goals (Iannello, 1992) and when practiced in a democratic manner, like it was in our group, it can result in high team moral, leading to the team accomplishing the goals of the task set. The democratic style initiated participation from all members of the group, and all members were given equal time to voice their views, resulting in members feeling more satisfied and motivated, yet this did result in low productivity in the initial stages as valuable time was taken up with irrelevant content but this was resolved as the group process became more tasks orientated. As a person that searches for safety and security, I felt that an authoritarian style of leadership would have improved my performance better. After completing Belbin’s team roles questionnaire it was revealed that I take on the role of a company worker within the team (Bebin, 1981). As a team member I can be tough minded and experience little anxiety and tend to work in a practical and realistic way. Trusting in others contributions I sway away from control, and share my opinion in a conservative manner. However after the groups storming session (Tuckman, 1965), it was decided that a different approach and direction should be taken to complete the task. Being an implementer by nature, I was inflexible to the changed and was slow to respond to new

possibilities, which in turn slowed down the group's productivity. I recognised this within myself and changed my behaviour to be more open to change, because change and adaptability can be a positive element to effective team working. Legal Glossary BME = Black and Minority Ethnics CPA = Department of Health (1990) The Care Programme Approach for People with Mental Illness, London: The Stationary Office MHA 1989 = Mental Health Act 1983 as amended by the Mental Health Act 2007 MHACP = Department of Health (2008) Code of Practice: Mental Health Act 1983 London: Stationary Office NHS and Community Care Act 1990 = National Health Service and Community Care Act 1990 NSF = Department of Health (1999) National Service Framework for Mental Health: Modern Standards and Service Models, London: Stationary Office Bibliography Allen, D. (2001) The Changing Shape of Nursing Practice: The Role of Nurses in the Hospital Division of Labour, London: Routledge Anthony, W. A. (1993) Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990's, Psychosocial Rehabilitation Journal, 16, (4), 11-23. Bates, S. and Coren, E. (2006) Children and Families Services Systematic Map Report 1: The extent and impact of parental mental health problems on families and the acceptability, accessibility and effectiveness of interventions, London: Social Care Institute for Excellence Belbin, M. (1981) Management Teams, Why They Succeed or Fail, Oxford: Butterworth-Heinemann Bhui, K., King, M., Dein, S. and O'Connor, W. (2010) Ethnicity and Religious Coping with Mental Distress, Journal of Mental Health, 17, (2), 141-151 Bird, L. (2001) Is Anybody There?: A Survey of Friendship and Mental Health, London: Mental Health Foundation Brechin, A. Brown, H. and Eby, M. A. (2000) Critical Practice in

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