

# Interprofessional working in mental health



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This assignment aims to critically analyse the working relationship between mental health and social care professionals. It is argued barriers exist between these two key providers of services that prevent service users receiving the best care. (Milburn A 2000).

This working relationship can be defined as inter-professional working and this assignment will examine what these barriers involve, why they have developed, how they might be overcome and what the implications for service users and Approved Social Workers (ASW's) if increased inter-professional working is required under government policies as is expected. McDonald (1999 p123) proposes inter-professional working to be when multi-disciplinary professionals work in highly integrated teams where the team priorities are the strongest influence upon the individuals work decisions, Therefore, teamwork theories will be analysed to highlight what factors are necessary for success, and what are the possible difficulties that may inhibit co-operation between health and social care professionals, and how this impacts on their practice. Finally, whether or not inter-professional working is empowering for the service user will be critically analysed. People with mental health problems are at the centre of a complex network of services provided by a range of organisations and professionals. For people detained under the Mental Health Act 1983 this is especially true, and for whom social services and health each have explicit statutory responsibilities.

(SSI 2001) The Government has stated they are committed to reforming the current mental health legislation and have published a white paper giving details of these reforms. (BASW 2001)The complexity of mental health services requires inter-professional working at all levels of strategic planning,

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management and delivery of services. The National Service Framework for Mental Health has raised the profile of the need for effective collaboration between these two agencies and the Health Act 1999 introduced provision for greater flexibility in commissioning services and the pooling of their resources. (DoH 1999/2000) Current mental health legislation contained in The Mental Health Act 1983 requires ASW's to protect the rights of individuals facing admission to hospital against their will or sectioning. Central to the ASW role is their ability to look at all aspects of need and consider the social context of the service user.

(MHSIG 2001) However, the mental health white – reforming the mental health act, proposes other mental health workers could undertake this important role. Consequently, approved social workers are facing changes to their role not least the loss of their exclusive role within mental health services. Wellard (2001) believes this is causing increased tension between health and social workers that may increase working barriers still further. Similarly, Sheppard (1996) argues that managerialism due to a narrow administrative definition of tasks is wearing away at a social workers discretion and autonomy leading to insecurity's that do not equip workers well to further grow and adapt into partnership roles. The number of formal admissions to hospital under the Mental Health Act 1983 has increased from 18, 000 in 1990/91 to 26, 700 in 2000/01 (DoH 2001). Consequently, it could be argued the implications for service users if they lose the independent voice of the ASW might be even more compulsory admissions as health workers err on the side of risk management instead of rehabilitation.

But the government maintain the reforms will enhance the rights of individuals, for example by the setting up of independent tribunals, however, Johnson (2001) argues the primary objection of the reforms to be protecting the public at the expense of the rights of the individual, consequently the role of the ASW should be strengthened and not lost. However, the reforms are controversially proposing establishing community treatment orders under which patients in the community could be subject to compulsory treatment. The implications of this involves civil rights issues that health workers may not be able to advocate independently from the psychiatrist who is more powerful than them in their profession, should they take on responsibilities currently done by ASW's. Furthermore, if the boundaries of someone's work is changing this may result in resistance as the worker feels their professional knowledge is being ignored or undermined.

This resistance may affect their professional ability or their own mental health. Furthermore, in dealing with complex mental health problems the need to be cognisant of other contextual issues is second nature to social workers. Whereas health workers who work to the medical model of illness may not have the skills to look at any contributory factors. This may result in increased distress to the service user not least from getting caught in the 'revolving door' scenario- the service user comes in gets a quick 'fix' then sent on their way only to return again because contributory factors have not been addressed e. a dysfunctional family life.

When Asw's undertake statutory obligations there needs to be a clear understanding that it is in his or her best interest. Should this responsibility be assumed by health workers their aims might be different, as social

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workers might advocate reasonable risk-taking and self-determination, health workers might make purely clinical judgements based on risk (BASW 2001p3) However, in response to this argument it is argued the Human Rights Act 1998 will protect service users facing compulsory admission to hospital or compulsory community these would only be undertaken by well-trained professionals with reference to the Human Rights Act 1998.

(Reforming the mental health act 2001) It is not just ASW's who may feel de-skilled and de-motivated through role changes, mental health professionals too may feel threatened, as they do not have the same dominance they previously had since the implementation of community care legislation that required a move towards a corporate approach. Mechance 1991)

Furthermore, mental health workers might be reluctant to undertake compulsory admissions and take on ASW responsibilities as it might compromise their therapeutic relationship with the service user. Given these tensions between the workers it could be argued there is wariness about working together even though, the Social Services Inspectorate (2001) found the most common method of delivery of approved social work services - 38% to be through a multi-disciplinary model.

Given these tensions it could be argued the services currently being provided cannot be effective. It could be argued the tension in the situation stems from ASW's defending their 'territory' but Hitchon (2001) believes the crucial issue to be how strong the individual making the decision is professionally, not which profession they stem from, and that they feel they have status within the decision-making group. Historically, the psychiatric professions have held most of the power in mental health services. This

power stems for being able to define illnesses, who is diagnosed as having them, determining their treatments, treating people against their will in hospital, to organise services and spend huge budgets and the ability to select who can or cannot have these powers.

(Watkins et al 1996 p350) This power has remained unquestioned and this is arguably because it is seen as being benign - for the good of society and individuals in society. In contrast a social care approach believes that many mental health problems are not symptomatic of a disease. Rather it is an indication of social and psychological factors that cause distress. Given this it could be argued that because these factors are complex all professionals involved in mental health services have something to offer, the implications of this impacts upon the type of services that should be offered, the understanding on which they are based and the training of the professionals involved in them.

Loxley(1997p90) argues that inter-professional working is a device for organising and managing resources and a technique for delivering services. Whilst Ovretveit et al (1997) define inter-professional working as goal orientated e. g. achieving a positive outcome for a patient e. g. independent living.

This is too simplistic a definition as it fails to take account of different agency agendas and the problems that result. In comparison McDonald (1999p123) defines inter-professional working as - a ' network' team which although it sees the same ' type' of clients is organised as a collection of disparate professional services each under its own management with its own policies,

priorities and procedures, a definition reflecting the long standing problems inherent in inter-professional working between health and social care.

Ovretveit et al (1997 p1) believes the quality of care a person receives depends as much on how professionals work with each other as on their individual competence within their own field of expertise. Their argument reflects the growing criticism that inter-professional working between health and social care workers at present is often poor. (Ovretveit 1997 p 55)

Although, Detained (2001) a SSI inspection report found that joint working between agencies was generally good there were regional variations whilst care planning systems were being integrated, information systems and recording were often confused and poor.

Furthermore, service users and carers were often left out of decisions making processes and were not aware of their rights. DoH (1998) comment 'often services are not planned and provided in a way that would best help service users. For example, the Mental Health Foundation (2001) has said risk of suicide among mental health patients could be reduced if all services supporting them used standardised methods of assessment, shared information and involved service users. In the government's second white paper on reforming the Mental Health Act this aspect is being taken seriously as the Risk Assessment Management and Audit System (RAMAS) is emphasised as effective and best practice when used across agencies.

Mental Health Foundation 2001) However, Dobson (2002 p21) argues within mental health services there is more and more emphasis on the medical model at the expense of the social care model. He points to a recent survey undertaken by MIND which found that recovery to service users does not

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necessarily mean a life free of mental health problems, but they learnt how to cope with them better and that support from family and friends underpinned their coping strategies rather than prescribed medication. Given this, MIND propose the social care model based on therapeutic interventions as being effective but underused for instance, SANE which runs a national help-line for people with mental health problems say that out of their 1, 000 calls a week only 8% say they are receiving non-drug services whereas 49% say they are receiving medication. But it is argued Community Mental Health Teams that include ASW's and have access to a wide range of expertise can offer comprehensive services to the community. Combining a social care and medical model to offer service users a broad range of skills and provide greater opportunities to respond to a wide variety of referrals, (Watkins et al 1996 p201) Currently, ASW's provide an important independent balance in such a team – between the health professional and the service user, as often they are the only people who can challenge a doctor's recommendation. Arguably this is because they are separate from the hierarchical power structure inherent in the health service whereby other health workers feel unable to challenge a consultant's decision even if they believe it is not in the best interest of the service user.

(Wellard S 2001) However, decisions may not be independent if increased inter-professional working develops in a blurring between the roles of health and social care workers if ASW's independent status is compromised. A number of attempts to obtain collaboration between the two agencies through joint financing and joint planning initiatives, have been tried, but, researchers. Stockford 1988, Wislow & Brooks 1988, Lewis & Glennerster



1996) agree they were ineffective largely due to poor co-ordination. (Ovretveit et al 1997) Also despite policy guidance it was rare for services to actually be planned jointly. (Wistow & Brooks 1988). Watkins et al (1996 p 12) point to difficulties arising from policy guidance that has not been sufficiently thought through, for example, policies that are too rigid, or that require members of the team to consult every decision, waste time, make workers feel disgruntled and has the paradoxical effect of deskilling professionals.

The poor co-ordination and communication of care between practitioners across settings is a major source of frustration for service users and their carers as resources are squandered, inappropriate referrals are made and time is wasted with administrative work duplicated. (Sainsbury 1997) Furthermore, it is argued that poor co-ordination decreases the ability of the various workers to respond adequately to workload variations that would impact upon clients experiencing delays for services. (Cochrane D et al 1999) Poor co-ordination can leave the service user feeling oppressed and dis-empowered through the practitioners having their own agenda's e. g. pursuing individual and professional controls can omit the user from decisions and obstruct the exchange of information due to the hierarchical relationship that often develops.

Clients may feel further dis-empowered because their subjective feelings are ignored, and respect for the individual is lost when situated in a control-orientated relationship that de-personalises the service user. (Smale G et al 2000) It can be argued that hierarchical relationships and stereotyping other agency workers promote tightly defined decisions that are jealously

protected leading to poor communication and distance between workers that can restrict creative problem solving. Furthermore, the skills of 'lower status' workers may be devalued and subsequently underused. It has been proposed that the resistance to share decisions may be due to workers believing there to be a transfer of some responsibilities from one professional to another resulting in a what the professional may feel as losing some of their 'power'. Banks 1995p 18). But it can be argued power is not a commodity to be shared as such and that these types of feelings only serve to dis-empower the service user, because if the workers feel they are having a 'tug-of-war over this intangible 'power' the focus of the interaction between all parties e.

g. meeting the needs of the service user is lost. (Payne M 1996 p41) In 1998 the government introduced 11 pilot areas to test 'collaborative' models of care, to be achieved through pooling health and social care budgets and by having networks of one-stop primary care centres. All the schemes began in 1999 and are expected to run for five years. Their key aim is to break down the barriers between health and social care and to trial the provision of a seamless service.

(DoH 1998, Audit Commission 1997). It is argued that despite positive feedback from the pilot schemes, without structural changes that break down the boundaries existing between health and social care the government is only tinkering with improving the situation and not much will improve. (Rothwell-Murray C 2000p45)But Hancock & Villeneaur (1997p33) are more optimistic arguing that inter-professional working can be effective without major structural changes so long as there is a joint strategy, good

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information sharing, joint training and crucially management support for a culture of inter-professional communication. Fundamental to this optimistic view must be the recruitment, development and maintenance of a strong team. Ovetveit (1997) describes a team as ' a bounded group of people with a common purpose and a formal or informal organisation. If this is so, it causes problems for teams of professionals working in community mental health teams because different workers although working together often have different purposes for being there e.

g. the social worker may be taking a needs-led approach to assessment whilst the health worker may be more inclined to fit the user to a service available because of a reluctance to pursue risky or imaginative solutions (Ovretveit et al 1997) Problems could arise as workers negotiate their different views of need as well as the different professional values underpinning their practice. Hudson's notion of interorganisational homogeneity points to how the understanding of mental distress will profoundly affect the type of service offered. Although it may not be necessary for each different worker on the team to share the same view of mental distress there should be a shared understanding of the role and function of the team. Watkins et al 1996 p 366) Watkins et al (1996 p67) point to the dominant frames of reference by which health workers and social workers address presenting problems. Health workers tend to adopt a biophysical frame emphasising disease, pathology and its treatment contrasting with the psychosocial frame of reference that social workers use that emphasises the psychosocial context and definitions of problems and which is suspicious of pathological models of human problems.

Another problematic area affecting the outcome of successful inter-professional working are structural differences between the agencies, for example, mental health services have different career patterns, management structures, and conditions of service and pay scales to social work. When working together this result in each person having different decision-making, and different access to resources resulting in power imbalances that may influence decisions and an individual workers ability to negotiate their 'corner'. Issues of loyalty will have to be addressed as Ovreit et al (1997 p14) point out there may be confusion within the team as professionals, are unclear where their 'loyalties' lie - to their team or their profession. Bowen, Marler and Androes (1965) define the psychiatric team as a process whereby various professionals who make individual decisions concerning patients and who share a common purpose meet together to communicate and share knowledge from which plans are made.

Therefore, it can be said that a team is not just a physical collection of individuals, but a process, central to this process Campbell et al (1998 p71) believe should be the aim of the team. However, Watkins et al (1996p67) argues because the predominant value orientation of health and of social work differs significantly there will be difficulty in reaching an agreement, for example, the guiding value for social work is 'respect for persons' the corresponding value for health workers is 'respect for life'. Consequently, this could lead to conflict when for example joint assessing the need for someone to be sectioned. What constitutes membership of the team needs to be agreed as people view being a member of a team differently, and this causes problems when one worker may see their contribution to the team as

more important than another's who only comes to the team once a week, and internal problems affect member's individual and collective abilities. But Galvin & McCarthy (1994 p264) point out that inter-professional teams have an over ambitious remit. Teams have to overcome differences of history, policy, mechanisms and goals.

' Teams are expected to resolve complex issues such as the status of individuals, professional training, levels of competence, legal status, entitlement to practice autonomously and the functional interrelationships between professionals without any definitive central policies or guidance. Rummery K 1998 p433) identified some of these issues that cause barriers between social workers, GP's and other health care workers, notably social workers are viewed as being slow, uncooperative and unable to take decisions on their own. Whilst health workers are viewed as being unreachable and unwilling to share information This has led to mistrust and misunderstandings, partly due to a lack of knowledge of how the different professions operate, different languages and jargon of exclusivity of the institutions for which they work.. (Suchman AL et al 1998 p102)But Campbell et al (1998) argue that inter-professional working is worth pursuing as it could stimulate new ways of thinking and may forge a common sense of purpose that both mobilises and aligns the strengths of users, families' carers and the inter-professional team with division of labour organised around common goals with practitioners contributing their expertise as needed. Loxley (1997 p45) believes that to be effective, individual workers as such are irrelevant when structural constraints exist that restrain individual working practice.

It can be argued that whilst some workers may overcome structural problems through their own personal commitment to providing a good service for their client, others may not due to tensions caused by funding and resources. Recent government initiatives show that the government is prepared to make structural changes. . This will mean shifting boundaries to meet needs and allows for different professionals to work within the same management structure. (Health Act 1999). Critics of the NHS Plan have argued it is a take-over of social services by the NHS but the government emphasise this is untrue the issue is to work in partnership, to develop a culture change between the departments that results in a new kind of relationship between the two departments.

(Hutton J 2000). Teams of collaborative workers with the expectations that service users and carers will participate fully in decisions of seamless care. (Smale G et al 2000) It could be argued that in a Care Trust with a large team there may be an ambiguous allocation of responsibilities resulting in longer negotiations before a decision is reached. Challis D 1999) On the other hand the delay should be less than current practice that may take weeks for appointments and referrals to come through when several organisations have different geographical boundaries. A fictitious case study demonstrates how effective a care trust style one-stop centre could be when staffed by a team that have trust and mutual support between the team members of different professions:- E. g.

Mr B an elderly gentleman visits the one-stop centre, He is upset and tearful, he says he is feeling low and has never felt the same since his wife died. He says he has trouble sleeping and this has affected his appetite and ability to

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care for himself. He states he cannot see the point of keeping himself clean and tidy as he never leaves the house and nobody visits him anyway. He then states he has considered suicide and feels it appears a good option to his feelings of hopelessness but is resisting because he believes his two children would be upset by it. Mr B obtains help from his GP who despite national trends does not prescribe medication, because he is part of a skilled and effective team he has other options open to him and feels confident that no time will be lost in getting Mr.

B help so can take a risk not to prescribe medication. Instead he refers him to the counsellor in the office next door. The counsellor offers bereavement counselling, anxiety management, and cognitive therapy and Mr B begins to feel listened to and valued. A social worker in the next office has been alerted to Mr. B's need and provides an assessment immediately that highlights ways in which to gain Mr.

B more community support, identifies that Mr. B is not getting all the financial help he is entitled to and arranges to visit him at home the next day. Mr. B. is able to speak to someone down the hall from the community mental health team who is able to offer advice about services provided in the community that Mr.

B says he is interested in e. g. a widowers support group that meet every week and arrange outings and social events. During this meeting Mr. B says as well as having no appetite his hands have become stiff and sometimes he does not have the strength to turn the knobs on his cooker. The worker says

Mrs Jones the occupation therapist would be able to help overcome that difficulty and if Mr.

B agreed could visit together with the social worker to look at options with him. This visit to the one-stop centre results in Mr B feeling less hopeless and overwhelmed, he feels he has been listened to, and had a say in what services would meet his needs, The workers involved are glad no wrangling over budgets have had to be made and have a sense of professional achievement i. e. continuity of care that was individualised, sensitive and appropriate to needs.

Rather than the only option being to prescribe anti-depressants the doctor felt confident to trust the rest of the team. However, the process of delegation can only be advantageous if the team is functioning well. In this team the various members of the team do not find themselves involved in endless discussions over sovereignty and feel confident to express their own limitations especially when new to the team. Effective inter-professional working would benefit clients through ensuring there is an avoidance of duplication and overlap of services, a reduction in gaps in services, and clarification of roles and responsibilities.

However, it could be argued that this might lead to a reduction in choice for the individual or the absence of diversity of services. But if inter-professional worked it would be an empowering approach for the service user as partnership strategies to improve services were turned into operational reality. It can be argued that having an ASW perspective was beneficial as it



gives access to social services to those people previously unknown to the system. (McLeod 1995).

On the other hand it can be argued that if ASW's through these pilot schemes identify many people needing services then the increased costs this will incur may influence the continuation or expansion of the schemes.

However, if the approved social worker role is adopted by health workers there is the possibility of oppressive practice resulting from them not taking a needs led approach as practised by social workers this may result in unmet needs being neither identified or recorded. One could cynically assume from this then that government changes to the ASW role could be a way to ration and restrict services. Watkins et al (1996 p68) argue that whilst social work training emphasises the importance of being aware of the possibility of oppression by professionals in relation to disadvantaged groups along with anti-discriminatory and anti-racist issues this is not the case with health professionals. Furthermore, whilst on the one hand there is the potential for conflict should a social worker challenge another member of their team from a different profession about anti-oppressive practice. g.

psychiatric services are organised on a eurocentric model. This model does not acknowledge different cultural ways of responding to mental health problems and alienates anyone not from Europe. Research shows that people from black and minority ethnic groups are over-represented in those assessed under the Mental Health Act. (SSI 2001) On the other hand Ovretveit et al (1997) point to the possibility of collusion against the client by the workers involved that is difficult for the client to challenge e. many workers versus one client. Workers suggest a particular service whilst the

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client prefers another so it may be difficult for some clients especially those who are already experiencing oppression to challenge the workers decision.

Whilst it is argued inter-professional working is empowering through promoting independence and choice it can be argued that a client may feel powerless despite the best efforts of the team of workers due to social and economic inequalities. Just being 'clientised' as 'in need' of services can be dis-empowering especially as the 'expert' team can seem overwhelming. It is argued that empowerment is part of the language of efficiency, cost-effectiveness, quality and standards through distinguishing between client and agency, working towards self-sufficiency and ignoring societal inequalities. (Morley L 1995 p 67) therefore the service user may feel at the bottom of a hierarchical relationship that exists to deliver the services they need. The service user is dependent upon these services and it could be argued that being dependent does not relate with empowerment.

However inter-professional working should ensure only one assessment takes place. Much of the literature on empowerment suggests that there is often a quasi-evangelical approach to the concept and process, the notion of rescuing the unfortunate (Morley L 1995 p39). This could equate to the inter-professional team viewing the client from the medical model. If the inter-professional team of workers have little support, work long hours and are often unable to provide the services that assessments have identified this can lead to the workers feeling dis-empowered.

. This leaves the workers having to facilitate changes in client's lives in a framework of their own dis-empowered positions this will affect the quality of

service provided and how a worker fits empowerment into their practice's. (Smale G et al 2000) But inter-professional workers who are supported and have been pro-active in their approach have constructed two useful inter-related tools for addressing effective practice. Firstly, morally navigating systems defined as the ability to work well within a system whilst bringing a moral compass to them and, secondly, sociological consciousness which is the ability to think critically and reflexively about systems and the role they play in them.

(Castellani B ; Wear D p89) In conclusion, it would seem inter-professional working will be better for service users if the boundaries are broken down, different types of teams could be put together from the outset, moving away from the 'co-ordinated profession team' towards a 'collective responsibility team' where workers are fully integrated and members are accountable as a group for pooling and using their collective resources including their time to meet the needs of the local population' (Ovreit et al 1997 p14). Joint training initiatives could be undertaken not only during initial training but also for workers who are currently working in an inter-professional capacity, whereby the different professionals train alongside each other to equip them to be more flexible in their working boundaries. This may allow the each worker to grow and develop individually as well as together resulting in confident workers that are less fearful of change, more secure focused on achieving best outcomes and less wary of others trying to 'take over their jobs'..

(Rummery K 1998 p433) Inter-professional workers will need to have increasingly fluid identities and boundaries, a new type of worker who can spread across health and social care. Although it could be argued extra

training may lead to undue stress and pressure for workers as they feel compelled to 'know' everything, It is argued that more user involvement at the planning stage increases their power to influence by providing more choice and making services more flexible and accountable, working with people's strengths rather than pathologising people in order for them to get services. Morris et al 1989) There is evidence to show that outcomes are better for some treatments where clients have more information, a greater sense of control and more involvement in decisions (Morris et al 1989). To summarise, the reasons for the difficulties in inter-professional working are many and complex and this assignment has only highlighted some, to tackle the problems there needs to be changes on many levels; political, organisational, managerial, educational and individual. All involved therefore have to understand the principle and purpose