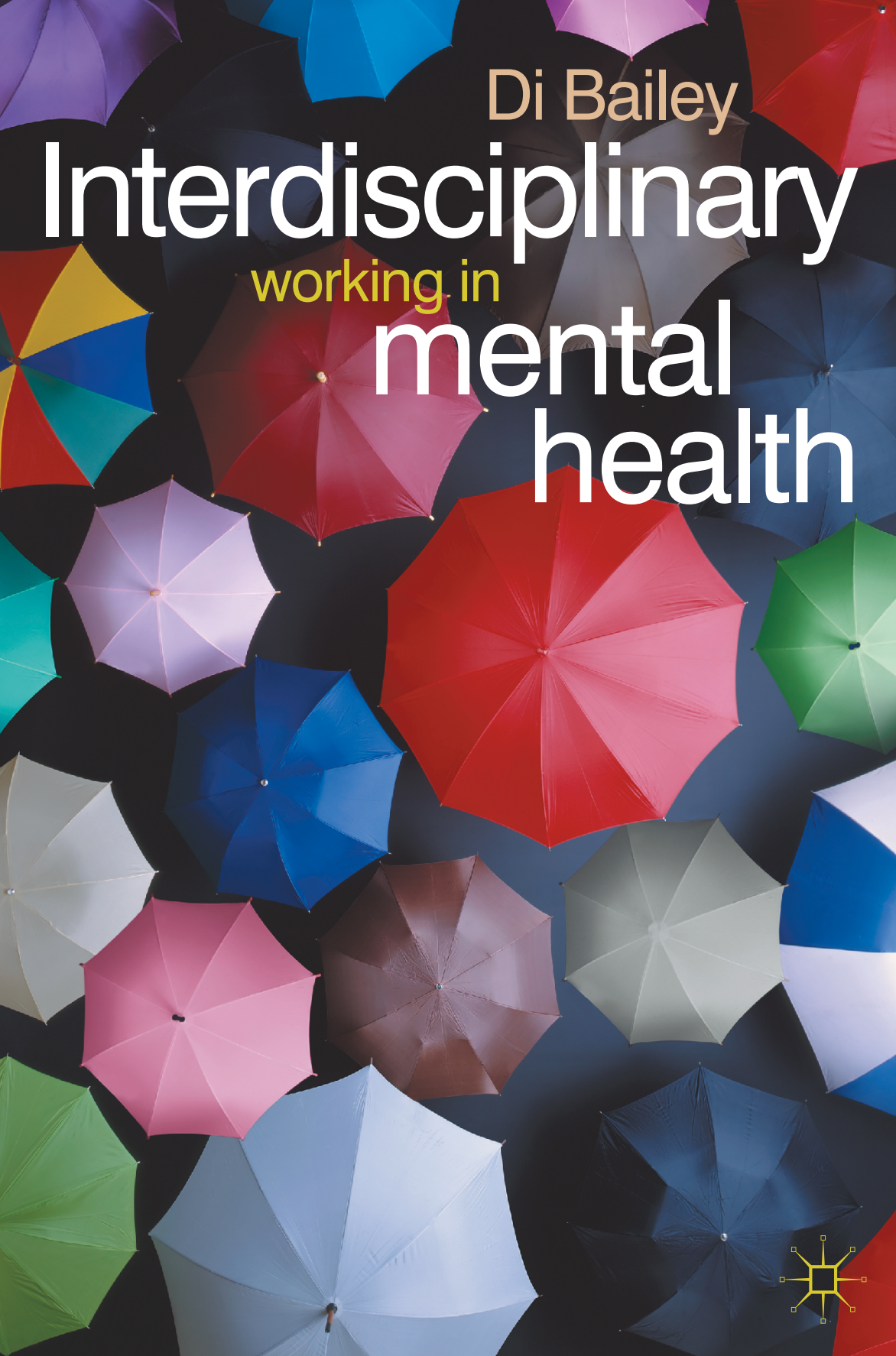
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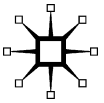

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Key Concepts

List of Practice Focus Boxes

Acronyms

AC	Approved Clinician
ACCT	Assessment, Care and Custody in Teamwork
AO	Assertive Outreach
AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
CAMHS	Child and Adolescent Mental Health Services
CAIPE	Centre for Advancement of Interprofessional Education
CBT	Cognitive Behavioural Therapy
CCA	Community Care Act
CCfW	Care Council for Wales
CHC	Community Health Council
CIPW	Creating an Interprofessional Workforce programme
CMHC	Community Mental Health Centre
CMHT	Community Mental Health Team
CMHT-OP	Community Mental Health Team for Older People
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRT	Crisis Resolution Team
CTO	Community Treatment Order
DALI	Dartmouth Assessment of Life Inventory
DAT	Drug Action Team
DH	Department of Health
DHSS	Department of Health and Social Services
ECT	Electro Convulsive Therapy
EIP	Early Intervention in Psychosis
FG	Focus Group
FGM	Focus Group Managers
FGSU	Focus Group Service Users
FST	Family Support Team
GP	General Practitioner
GSCC	General Social Care Council
HoNOS	Health of the Nation Outcome Scale
ICP	Integrated Care Pathway

IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
IPE	Interprofessional Education
LIT	Local Implementation Team
MCA	Mental Capacity Act
MDO	Mentally Disordered Offender
MHA	Mental Health Act
MHRT	Mental Health Review Tribunal
MMHP	Manchester Mental Health Partnership
NHS	National Health Service
NHS&CCA	National Health Service and Community Care Act
NICE	National Institute of Clinical Excellence
NSF	National Service Framework
NSF-OP	National Service Framework for Older People
NWW	New Ways of Working
OT	Occupational Therapist
PCG	Primary Care Group
PCMHW	Primary Care Mental Health Worker
PCT	Primary Care Trust
PHCT	Primary Health Care Team
PQ	Post-qualifying
PRAMS	Person centred, Risk Assessment and Management System
RC	Responsible Clinician
RL	Received Learning
RMO	Responsible Medical Officer
SAP	Single Assessment Process
SEU	Social Exclusion Unit
SOAD	Second Opinion Appointed Doctor
SSD	Social Services Department
SSI	Social Services Inspectorate
STR	Support Time and Recovery
SURGE	Service Users Research Group England

Preface

This book is the first of its kind dedicated to interdisciplinary working in mental health. The proceeding chapters take as their reference point a definition of interdisciplinarity that includes contributions from service users and carers alongside professional and non-professionally affiliated staff who comprise an increasingly diverse mental health workforce.

Whilst the term 'service user' is adopted throughout the book to signify the status and contribution increasingly afforded to individuals with direct experience of using services the term 'patient' is used in Chapter 1 to intentionally reflect the comparatively powerless status of individuals who received mental health treatment between 1900 and the 1980s.

The book draws on the extensive experience of the author as a mental health practitioner and the lessons learned from the many years of working as a member of multidisciplinary teams. The messages in each of the chapters reflect an overriding policy agenda in mental health, that as effective treatment approaches diversify and contemporary services are reconfigured to respond to the heterogenic mental health needs of service users, a combination of discipline-specific and shared ways of working are required.

As well as the challenges for interdisciplinary working some solutions and suggestions for how to achieve this to better effect are offered. These insights are offered based upon the invaluable expertise gleaned from working collaboratively with service users and colleagues in a range of practice and education settings.

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This book is dedicated to Guy Wishart a trusted friend and valued colleague who travelled a 10 year journey in mental health education alongside me and died on 11th August 2011.

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Introduction

The landscape of mental health services in Britain has been subject to unprecedented change since the introduction of the National Service Framework for mental health in 1999. Not only have community-based services been reconfigured to include increasingly specialist teams working with those with the most severe and enduring mental health needs, but also new roles and new ways of working for existing professionals have been introduced into the mental health workforce. The mental health care system remains in a state of flux with the expectation that embedding the changes of the Mental Health Act (2007) will bring about further challenges for mental health workers, people who use mental health services and their families.

Despite this level of complexity, the message from these combined developments is simple. Contemporary mental health care is predicated upon a greater degree of service integration that draws from a range of disciplines, combining skills, theories and expertise in response to the diverse needs of service users. The flurry of government policies such as the Care Programme Approach (1991 and 2008), the NHS Plan (2000) and the New Ways of Working initiative (NWW) (2005) are amongst the strongest determinants that can foster or undermine such collaborative practice.

The move towards increased partnership working and collaboration in mental health care is also inevitable because of the cost and complexity of services together with the more informed demands and expectations of the people who use them and their families. The alternative according to Horder (2003) is confusion, duplication and inefficiency. By bringing together professionals from the range of disciplinary backgrounds in mental health it is expected that they will engage in an open exchange of ideas and skills to solve service users' problems in cost-effective ways (Colombo, 2002).

Whilst, in principal, there are few counter arguments to this approach, which is now broadly accepted as the blueprint for mental health teams and services, problems with interdisciplinary working arise because of a number of interrelated factors that are particular to mental health care delivery.

Firstly there is an absence of a shared philosophy of practice between mental health workers. This has arisen largely because of the tensions between social, psychological and medical explanations for mental distress.

In addition, the growth of the survivor movement in psychiatry has encouraged the recovery model as an alternative to more traditional explanations of signs and symptoms. These tensions are reflected in mental health professionals' preoccupation with their own identity either as a nurse, social worker, or psychiatrist and their propensity to practise in a uniprofessional manner. The result is that workers resist a greater blurring of professional boundaries and shared areas of expertise.

In addition, the lack of a common language to define and describe interdisciplinary working does little to assist mental health professionals articulate how their respective unique contributions can be augmented by collaborative practice for the benefit of service users.

Finally, comparatively speaking, community mental health services have a brief history of development compared with hospital provision that dominated since the asylum era of the 1800s. It is therefore not surprising that despite political moves to support a more seamless approach to services, care provided in the hospital setting continues to be construed as separate from the increasingly diverse range of community provision.

Book Structure and Chapter Outline

This book is written with the explicit intention of unpacking the above issues in a way that makes interdisciplinary working more understandable and accessible. The content is tailored to a readership of mental health students and practitioners of all disciplines who are currently working or destined to work in mental health services in the future. The book is divided into two parts.

Part one outlines the development of interdisciplinary working including the policy and legislative contexts. It identifies the recovery model of mental health as synonymous with an interdisciplinary approach.

Chapter 1 chronicles the evolution of interdisciplinary working, drawing upon the changing policy context and the language used to describe how mental health professionals work together. In Chapter 2 the exploration of models and values that underpin interdisciplinary working are explored with the intention of helping readers develop a shared philosophy on which to build collaborative practice.

The legislative context for mental health is discussed in Chapter 3 including the recent changes to the Mental Health Act 1983 and the impact of these on practice. Chapter 4 provides a more focused discussion of the Care Programme Approach (CPA) as the mechanism underpinning interdisciplinary care planning and related to this Chapter 5 addresses the specific issue of risk assessment, planning and management as part of the remit of the CPA.

Part two provides a more in-depth look at interdisciplinary working with different groups of people who use mental health services. This begins in Chapter 6 with a consideration of the issues for involving service users in general in mental health service design and delivery. Chapter 7 focuses on people using primary mental health care as the largest group with more common mental health problems. The needs of young people with mental health issues are explored in more detail in Chapter 8 before moving on in Chapter 9 to consider how older adults experience interdisciplinary mental health care delivery. Chapter 10 discusses some of the issues of working with people with complex mental health needs drawing upon issues explored in earlier chapters around issues of risk and inter-agency working.

The final chapters focus upon the current agenda for workforce change in mental health and suggest some ideas and practical strategies for leading and developing an increasingly interdisciplinary mental health workforce. Thus Chapter 11 draws together the growing body of literature in interprofessional education and training while Chapter 12 focuses upon how to lead and manage increasingly diverse teams and services.

Learning Features

In order to assist readers to make links between the conceptual issues being explored in each of the chapters and how these impact on mental health practice, key issues for interdisciplinary working are set out at the start of each chapter. In addition, case studies are used as illustrative examples of interdisciplinary practice throughout. These case examples are provided as suggestions of good practice but it is acknowledged that readers may have their own strategies and ideas for contributing effectively to collaborative working with mental health professionals, service users and their families.

PART ONE

The Contexts of Interdisciplinary Working

1

The Evolution of Interdisciplinary Working: Definitions and Policy Context

Key Issues:

- A definition of interdisciplinary working needs to reflect contributions from professionals, service users, carers and the increasing number of non-professionally affiliated staff in the mental health workforce.
- Over the past century, interdisciplinary working has evolved – beginning with uniprofessional working synonymous with the asylum era of care and the dominance of the disease model for understanding mental ill health.
- The 1983 Mental Health Act marked a significant legislative milestone in promoting multidisciplinary practice.
- Many services are now at different stages of developing interdisciplinary ways of working depending upon the extent to which they include professionals and service users interacting in order to work collaboratively.

This chapter seeks to explain how the practice of interdisciplinary working has evolved in mental health services. In order to explore this journey it is first of all necessary to define what is meant by interdisciplinary working and the related concepts of professions and professionalism. As McClean (2005) neatly puts it:

> It is not possible to understand interdisciplinary practice without first understanding the phenomenon of professionalism. (McClean, 2005, p. 324)

Defining Interdisciplinary Working

Farrell et al. (2001: p. 281) refers to an interdisciplinary health care team as 'a group of colleagues from two or more disciplines who co-ordinate their expertise in providing care to patients'. In Britain, Marshall et al. (1979) use both interdisciplinary and multidisciplinary to refer to teams of individuals with different training backgrounds. According to Lethard (2003, p. 5) multiprofessional and multidisciplinary are preferred terms to denote a wider team

of professionals and she suggests that interprofessional is a key term to refer to interactions between these groups.

A mental health professional is a person who provides care and treatment for the purpose of improving an individual's mental health. In Britain, mental health professionals have traditionally included:

- Psychiatrists who are medical doctors specializing in the treatment of mental illness using a biomedical or disease model approach to understand signs and symptoms.
- Clinical psychologists with an undergraduate degree in psychology and postdoctoral training to understand and intervene with people with psychologically-based distress and dysfunction.
- Mental health social workers who have received additional post-qualifying training with a focus on social causation and labelling as explanations for mental distress, some of whom will have completed additional training to become 'approved' to undertake statutory duties as defined by the 1983 Mental Health Act.
- Psychiatric nurses who specialize in a branch of nursing that provides skills in psychological therapies and the administration of psychiatric medication.
- Occupational therapists who assess and treat psychological conditions using specific, purposeful activity to prevent disability and promote independence and wellbeing.

These professionals often deal with the same symptoms and issues and deliver the same types of interventions but their approach and scope of practice will differ as a result of their education, training and professional codes of conduct. Their roles are also associated with different statutory responsibilities.

The difficulty therefore with the use of terms like multi or interprofessional working is the assumption that this is solely the business of professionals, qualified as such because of their membership of a particular group as a result of their training and in some cases their license to practice by a particular professional body.

This negates the contribution to contemporary mental health care of the growing numbers of non-professionally affiliated staff such as Support Time and Recovery (STR) Workers and graduate Primary Care Mental Health Workers. It also excludes people who use services, who as such are experts by their own experience, together with their families and carers who by virtue of their crucial support role also have a contribution to make.

According to the Oxford English Dictionary a discipline is defined as 'a branch of instruction or learning, shaped by the mental, moral and physical training undertaken'. Such learning can be acquired and influenced by a person's lived experience of using mental health services and is as valid as

that taught on professional courses or through reading textbooks. Given the growth of the service user movement in mental health since the 1950s, contemporary mental health care can no longer be anything other than inclusive of service users and carers' disciplinary contributions.

Lethard helpfully points out that Latinists translate 'inter' as between and 'multi' as many (2003, p. 5) and Barr et al. (Barr, 2003, pp. 265–79) defines interprofessional work as reliant upon *interactive* learning. Similarly McClean (2005, p. 323) differentiates as follows:

- *Multidisciplinary practice* – a team of professionals working together but retaining their professional autonomy.
- *Interdisciplinary practice* – a team of professionals working as a collective.

It is this 'betweenness' and interaction that delineates collaboration in contemporary mental health care as distinct from the fragmented joint working seen in the past. No longer are service users and their carers passively involved with services and so the boundaries between professional groups and between community teams and hospital care are becoming increasingly porous.

Thus because of the expanding range and complexity of mental health services across the care spectrum the system becomes increasingly dependent on effective interactions between the different elements and groups that contribute. This is why a step beyond *many working together* to *many interacting to work collaboratively* is required.

In the light of these issues the remainder of this chapter will discuss the historical developments towards this more interdisciplinary way of working as the cornerstone of contemporary mental health practice.

Uniprofessional Working in the Asylum Era

The nineteenth century marked the beginning of the uniprofessional era of mental health care: *professional* because it lay in the hands of professionals and *uni* because of the dominance of the medical discipline. Although initially the large number of asylums built in England provided confinement and physical restraint of those considered to be criminally insane or morally defective, between about 1830 and 1860 a period of therapeutic optimism paved the way for a greater reliance on the contribution of medical doctors to the treatment of the mentally disordered. The introduction of the 1828 Madhouses Act saw mentally ill people moved from depraved, poverty stricken communities into the closed but more humane and disciplined asylum environment that aimed to cure their disorder particularly if caught early on, thus reducing the numbers dependent on poor relief.