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PART ONE

The Contexts of Interdisciplinary Working

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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.

Reflecting the greater emphasis on the moral conditions in which the mentally insane were kept, together with a greater emphasis on more human treatment approaches, asylums built under the 1808 and 1828 Country Asylums Acts tended to be managed by doctors. By the late 1800s doctors openly recognized mental disorder as a form of illness and the symptoms of schizophrenia were first described by Kraepelin in the 1890s.

In the second half of the nineteenth century although the emphasis on curing insanity was revisited in the light of Darwinist beliefs that being insane was the result of a person's genetically inherited biology, interest still continued in medical procedures such as post-mortems to unearth the physiological lesions in the brain that were to blame.

The reliance on psychiatry as a profession, intertwined with medicine as a discipline, was reinforced by the 1930 Mental Treatment Act that provided voluntary treatment and psychiatric outpatient clinics. Many men who displayed symptoms of shell shock and were discharged from the army in the First World War on psychiatric grounds were believed to be suffering as a result of physiological damage to their brains caused by explosions rather than the psychological impact of war which was completely ignored in favour of a medical response.

Post-War Developments in Uniprofessional Working

Between the 1940s and the late 1970s there were a number of developments that signified a yo-yoing between support for hospital care and moves to undermine it.

Following the Second World War, the National Health Service Act of 1948 defined hospitals as places of treatment for people suffering from illness or defectiveness and the NHS inherited a system of over 100 'mental hospitals' with an average population of 1,000 people in each. However, in order to deal with the psychological dysfunction experienced by those returning from war in the armed forces, psychological treatments rooted in psychodynamic psychology found favour. These included the beginnings of psychometric tests, small group psychotherapy and the establishment of therapeutic communities.

By 1955 bed numbers had risen to a peak of 150,000 after which they began to decline so that by 1992 this figure had dropped to just a third at 50,000. This was largely because the plans to reduce bed numbers and increase discharges had been put in place prior to 1955 and needed time to take effect. The introduction of drugs like chlorpromazine and imipramine in the mid 1950s supported these moves to reduce the hospital population of people with mental health problems.

The medicalization of mental disorder was legally recognized by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency which resulted in the Percy Report in 1957. The key themes were that mental disorder should be regarded 'in much the same way as physical illness and disability' (para 5) and that mental hospitals should be run as nearly as possible like hospitals for physical disorders. This message was reinforced by Enoch Powell's famous Water Tower Speech in 1961 and the ensuing Hospital Plan in 1962 that increased the role of psychiatry in District General Hospitals and emphasized re-institutionalization albeit in different settings, not community care.

The 1959 Mental Health Act provided the legal framework for compulsory admission to any hospital facility thereby retaining medical decision making. This Act also introduced informal admission for psychiatric disorders and separated out social care for people who did not need inpatient treatment by handing over this responsibility to local councils.

By the 1970s, the asylums were in crisis as largely isolated institutions with significant political concerns being expressed about the standards of care delivery. Visiting multiprofessional teams set out to improve care standards by highlighting poor practices which were fed into a Department of Health and Social Services working group. The outcome of this process was the Nodder Report (DHSS, 1980) which recommended more clearly defined management structures for services with management teams working to embed clear objectives, standards and targets. The Nodder Report underlined joint planning at a strategic level between health and the Local Authorities, together with the involvement of community groups such as Community Health Councils and voluntary organizations. This, together with the emergence of psychological treatments, was perhaps the first suggestion that uniprofessional working in mental health was on the wane.

Against such a backdrop of ambivalence regarding hospital versus community care it is therefore understandable that the uniprofessional approach to treating mental ill health continued from the early 1900s to the 1980s. Although 35 hospitals closed between 1980 and 1990, 89 were still open in 1993. Medical treatments continued to be controlled by the psychiatrists with day to day administration of drugs on the wards provided by nurses as 85 per cent of government funding for mental health continued to be spent on hospital services (Sayce, 1989).

The psychiatric social work departments that had developed following increasing Local Authority involvement in social care services as a result of the 1959 Mental Health Act continued to remain separate and occupational therapy input was confined to workshops notoriously associated with basket weaving or work-based schemes concerned with menial tasks. Despite the emergence of a more psychologically oriented discourse within psychiatry

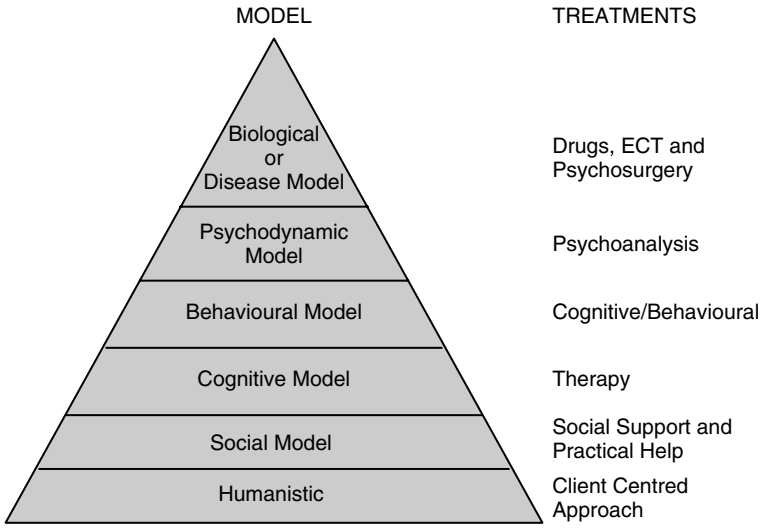

Figure 1.1 Hierarchy models of mental distress in mid 1900s

with the work of Freud, Jung and Skinner giving rise to a mix of psychodynamic and behavioural theories of mental distress, psychologists were still rarely involved in treatment plans. Patients were passive recipients of a regime of containment and medical interventions imposed in 'their best interests' in the absence of consultation and discussion.

The disease model of mental illness dominated the continuation of the institutional era supported by advances in psychotropic medication and medical treatments such as Electro Convulsive Therapy (ECT) and psychosurgery. According to Bond and Lader (1996, p. 4) 'The notion of an illness implies that there is a fundamental difference from normal, and a categorical rather than a dimensional approach is therefore preferred'. This approach rests on the premise that once the illness is medically treated this will negate the need for other forms of intervention as the signs and symptoms will improve. Thus even where other professional groups made a contribution to this uniprofessional approach, each one was bounded by their own codes of conduct, philosophies and models for understanding mental illness that were subsumed within the disease model reflecting the differential status of the other professions relative to psychiatry.

The Introduction of a Multiprofessional Approach

From the 1980s onwards, the configuration of mental health services reflected the developments that had occurred in the previous 30 years and a separation of care between services for people with acute presentations of mental

illness and more chronic conditions. Financial infrastructures were revisited to redress the balance of care between the National Health Service (NHS) and Local Authorities (DHSS, 1981).

There was therefore a mix of old, unclosed, large psychiatric hospitals, purpose-built units for acute care in new general hospitals and designated psychiatric wards in older general hospitals. In addition provision included community residential services, such as hostels, group homes and therapeutic communities, Community Mental Health Centres and day centres run by the NHS and Local Authorities. For individuals at high risk with offending histories in addition to their mental health needs treatment was provided in regional secure units and the special hospitals.

Against this backdrop, the introduction of the 1983 Mental Health Act (MHA) reflected a concern with how mental disorder was defined and sought to clarify under what conditions people should be compulsorily detained. This piece of legislation influenced a move from *uniprofessional* to *multiprofessional* working characterized by 'many' sharing the care of the mentally ill because as (Pilgrim and Rogers, 1996, p. 88) point out its main accomplishment seemed to be 'the formal codification of existing professional roles and practice in relation to compulsory detention of patients'. This was achieved in a number of ways.

Firstly, the 1983 MHA introduced the right for patients to apply for representation by a lay or legal advocate at a Mental Health Review Tribunal that would review the legality of their detention. Tribunal panels established by the 1983 MHA included representatives from lay professionals as well as legal advocates and doctors. This gave a clear mandate to a multiprofessional panel of individuals to combine their expertise from different backgrounds to ensure the safeguard of patients' rights.

Secondly the delineation of professional roles, both within and between disciplines was made more apparent by the 1983 MHA. Under section 5 registered mental nurses in addition to doctors were given new 'holding powers' in order to prevent patients detained informally from leaving hospital. These orders allowed for compulsory detention for short periods of time (up to 72 hours) so that further assessments to explore whether compulsory admission was deemed necessary, could be undertaken.

Finally the Act specified in detail how professional roles and responsibilities should be exercised. For example Approved Social Workers (ASWs) were required to make the application for admission under section whilst two medical doctors had to provide a recommendation that this course of action was in the best interests of the patient. ASWs were required to interview people being assessed under the Act in a suitable manner to ensure that detention was the most appropriate way of providing the care and treatment which they needed. By specifying professional responsibilities in this way the 1983 MHA

provided a much clearer demarcation of skills and roles of the professional groups than previously and contributions from viewpoints other than from the medical perspective were acknowledged.

Not only did the 1983 MHA influence multiprofessional contributions on a one-to-one and team level it also set out to change multi-agency working primarily between health and social services. According to Hudson (1987) agencies do not naturally collaborate, striving instead to maximize their level of autonomy. However the Act introduced in section 117 the provision of 'aftercare' for patients being discharged from compulsory treatment in hospital. Providing this type of aftercare was identified as a joint responsibility between health and social services who were required to contribute to coordinated packages of care on discharge. Similar messages regarding multi-agency working were reinforced by the subsequent National Health Service and Community Care Act (Great Britain, National Health Service and Community Care Act, 1990) that changed the traditional territory of psychiatric services, setting out more clearly the responsibilities of Local Authorities for providing community mental health care.

These changes should be viewed as developments in multiprofessional and multi-agency working as they perpetuated the status quo of professional groups working together albeit in ways they had not done previously. The professionalization of mental health care was still clearly demarked from a more inclusive approach that sought contributions from people who were using mental health services, to their care and treatment. As Perkins and Repper (1998, p. 3) point out, service users were excluded from service planning meetings and were 'only invited to ward rounds to demonstrate their symptoms and hear the doctor's prescription'. Thus whilst joint working between professionals could be deemed to have moved on a stage, the involvement of service users remained at an impasse. It is this crucial dimension of service user involvement that marks the difference between multiprofessional and multidisciplinary working.

Multidisciplinary Working in the 1990s

According to Rogers and Pilgrim (1996) the 1983 MHA was 'flimsy' in its impact on service development because of the focus on improving the rights of forcibly detained patients at the expense of promoting a more community oriented response to care delivery generally. It was not until the introduction of community care policies in the late 1980s that this balance was redressed.

Community Care, Agenda for Action (DHSS, 1988) and Caring for People (DH, 1989a) embodied the principles of care in the community that were enacted through the 1990 National Health Service and Community Care Act

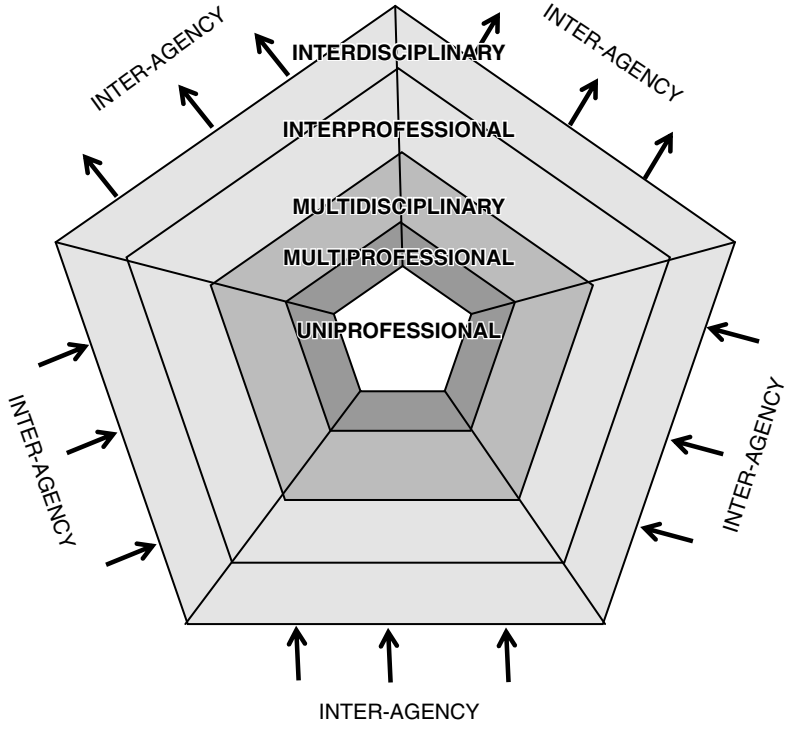

Figure 1.2 Stages of multidisciplinary working

(NHSCCA) and the subsequent Care Programme Approach (CPA) guidance in mental health (DH, 1990).

These policy developments encouraged a first phase in *multidisciplinary working* (see Figure 1.2) that continued as the NHSCCA was implemented. Both this legislation and the CPA emphasized the need to involve people who used services in the ways in which they were designed and delivered. The NHSCCA explicitly introduced the requirement for 'needs-led' as opposed to 'service-led' assessments and embodied the principle that people who receive help should have a greater choice in what is done to assist them.

This stage in the evolution of joint working is thus flagged as *multidisciplinary* in contrast to *multiprofessional* because of this more overt involvement of service users and their carers in the planning and development of community-based mental health care. Even though in the 1990s this involvement may have been tokenistic there was an emerging acceptance that service users could no longer be regarded as passive recipients as they had a valid perspective to offer about mental health services, based on their direct experience of using them.

Multidisciplinary Teamworking

According to Woodcock (1989) a team is a group of people who share common objectives and who need to work together to achieve these. From the 1990s onwards, multidisciplinary practice was increasingly delivered through Community Mental Health Teams (CMHTs). However these were configured in very different ways across Britain because of a lack of prescription in government policy.

At one end of the spectrum was the Community Mental Health Centre (CMHC) where all team members from the different disciplinary groups were brought together in one building often with a single 'operational manager'. Referrals to the team were discussed at a team meeting where decisions were made about the most appropriate team member to take on the referral and undertake the individual work with the service user. Service user groups were usually established locally and linked to CMHCs while inpatient beds were generally retained on a hospital site.

At the other extreme CMHTs existed in name only. Community psychiatric nurses (or CPNs) and social workers continued to work from separate uniprofessional team bases and conduct their own referral and assessment procedures. Often CPNs were still based on the hospital site with psychiatrists. Psychology input usually remained scarce and available only via a referral from the CMHT. Occupational therapy also tended to remain within the domain of the hospital provided as therapeutic activities to inpatients. In these kind of teams service user involvement was much less developed and at a tokenistic level.

Table 1.1 The relationship between team communication and collaboration, adapted from Gregson et al. (1992)

Level of communication	Extent of collaboration
1. No direct communication	Team members who never meet, talk or write to each other
2. Formal brief communication	Team members who encounter or correspond but do not interact meaningfully
3. Regular communication and consultation	Team members whose encounters or correspondence include the transfer of information
4. High level of joint working	Team members who act on that information sympathetically, participate in general patterns of joint working, subscribe to the same general objectives as others on a one-to-one basis in the same organization
5. Multidisciplinary working	Involvement of all workers and service users as team members in a mental health setting

Parallels can be drawn between the spectrum of multidisciplinary working that existed in the CMHTs in the mid to late 1990s and Gregson et al's taxonomy (1992) which aimed to explain a link between the level of collaboration between team members and their related patterns of communication (see Table 1.1 above). Where CMHTs existed in name only, communication was non-existent or very brief and formal with little meaningful interaction between team members ensuing (levels 1–2). Where CMHTs adopted the CMHC model communication and collaboration was more akin to levels 3–4 with level 5 being reserved for those exceptional CMHTs where service users were actively involved in teamwork and service planning.

Between the CMHTs at opposite ends of the spectrum were any number of variations with many teams engaging in communication and collaboration characteristic of level 3. As a result the majority of teams had some common elements of joint working that typified *multidisciplinary* as opposed to *interdisciplinary* working. These are outlined in Key concept 1.1 below.

Key concept 1.1: Elements of the first phase of multidisciplinary working in mental health from the early to mid 1990s

- Separate duty systems operated by CPNs and social workers.
- An emerging demarcation between community and hospital provision such that nurses working in inpatient settings were increasingly seen as distinct from their counterparts in the community.
- Alternative philosophies shaped care in the community as different from institutional care to the extent that the mental hospital was not regarded as included in 'community care'.
- The biomedical model of mental illness continued to dominate.
- The mental hospital continued to be regarded as the place for treatment and medical interventions.
- Service users' involvement was tokenistic, often limited to consultation regarding service development and service users were excluded from involvement in key decision making about service planning and delivery.

Throughout the 1990s a number of mental health inquiries began to highlight the flaws in the CMHT approach including the problems with professionals recording and passing information, poor risk management, a lack of bed availability, poor ward environments and management. In an attempt to strengthen discharge arrangements for service users considered most at risk of losing contact with services the *Mental Health (Patients in the Community) Act* (1995) was passed by parliament. This legislation introduced new paragraphs into section 25 of the 1983 MHA in order to provide aftercare under

supervision (or supervised discharge), reserved for individuals who had been compulsorily detained on a section 3 for treatment in hospital and who would receive section 117 aftercare on discharge. Both psychiatrists and ASWs were identified as the professionals who would assess and apply for individuals to become subject to this increased level of multidisciplinary discharge planning.

Alongside this legislation was a renewed emphasis on the Care Programme Approach (CPA) as the mechanism for promoting a more integrated approach to multidisciplinary working (DH, 1995) and several training aids were developed to improve practice in line with policy. In addition, service user involvement in the care planning process began to be more explicitly promoted as an indicator of good practice (Carpenter and Sbaraini, 1996).

As a result many CMHTs did embark on a training programme and implemented strategies to improve integration. Where teams were fragmented across different sites they were brought together into the same building and arrangements for CPA, supervised discharge and existing section 117 aftercare procedures were revised and agreed locally between mental health Trusts and Local Authorities.

Single operational managers for the teams were appointed although as Onyett and Ford (1996) point out these managers were often nurses, social workers or psychologists who had little or no management experience. This resulted in particular tensions between the management of day to day caseloads and staff resources and the delivery of professional supervision where managers were from a different disciplinary background to the worker being supervised. Such issues led to the management of many CMHTs being perceived as weak and a criticism that the focus on individuals with the most severe mental health needs was lacking in some teams.

Whilst there was therefore some evidence that multidisciplinary working in the CMHTs was evolving from the early stages in the mid 1990s in response to the critics, there was a political view that mental health and social care needed more radical modernization (DH, 1998a, 1998b). To this end the National Service Framework (DH, 1999a) and related Mental Health Policy Implementation Guide (DH, 2001) set out the standards for contemporary mental health care and the service models that must be in place. The specialist teams identified in the Policy Implementation Guide are detailed in Table 1.2 overleaf.

Interventions offered by the specialist teams include psychological therapies such as Cognitive Behavioural Therapy in addition to relapse prevention, family work, problem solving and education about signs and symptoms of mental distress. These 'talking' treatments were to be offered alongside the prescribing of medication which focused on the use of newer neuroleptic drugs and antidepressants in line with guidelines from the National Institute of Clinical Excellence (NICE).

Table 1.2 Specialist teams identified in the Mental Health Policy Implementation Guide 2001

Team	Population Covered and Caseload Size	Focus	Disciplinary Composition
Crisis Resolution Teams (CRTs)	150,000 caseload 20–30 service users per worker	Crisis intervention to prevent relapse and hospital admission	Multidisciplinary, named worker plus a team approach
Assertive Outreach (AO)	Caseload 10–12 per worker	A strengths-based approach with individuals with severe and enduring mental health problems who are likely to disengage with services	As above
Early Intervention in Psychosis Teams (EIP)	A population of a million in total served by between 3 and 4 teams with links to respite services	Individuals between 14 and 35 years with their first episode of psychosis or within 3 yrs of symptom onset	Multidisciplinary team integrated with Child and Adolescent Mental Health Services (CAMHs), primary care, education and youth services.

Multidisciplinary Working from 1999 Onwards

The impact of these developments on CMHTs has resulted in several changes that have required a more sophisticated level of multidisciplinary working. Some CMHTs have disbanded completely to form the specialist teams identified above and a team approach is favoured over a single worker being accountable. In other areas CMHTs have retained a gatekeeping role between primary care mental health services for people with more common mental health problems and those who require more specialist interventions.

With the introduction of new non-professionally affiliated staff such as Support Time and Recovery (STR) workers into these teams, the effect of these developments has been to encourage each disciplinary group to 'add' their particular contribution to achieve the objectives of the team. Rawson (1994) would describe this as an example of the 'additive effects model' where multidisciplinary working can be regarded as the sum of the disciplinary

perspectives. Represented mathematically this would look like *2 + 2 + 2 + 2 + 2 = 10*.

However, whilst many of the above developments have been positive, and heralded a further step towards increased integration of mental health care and treatment, they have raised a number of challenges that need to be addressed if interdisciplinary working is to be achieved.

Firstly, the raft of new roles and new ways of working has been introduced simultaneously and at such a pace that services have struggled to keep up with the policy changes. According to Øvretveit (1993, p. 105) formal work-role responsibilities are 'the work expected of a person by his or her employers; the ongoing duties, and the tasks which are delegated by higher management from time to time'. The roles taken on by staff within mental health services have become increasingly blurred as the range of knowledge and skill is spread across traditional professional boundaries and extended to include workers in a more hands on support role.

Secondly, organizational structures have become more complex to accommodate the diversification of teams, a factor which, according to Miller and Freeman (2003), has the potential interfere with effective teamworking. Thirdly, as multidisciplinary team membership diversifies, interpersonal relationships can be hindered by power structures and differences in commitment to teamworking. Finally a whole set of issues, marked by ambivalence, surround attempts to allow service users and carers more influence in the way that services are organized and the choices of treatment available.

Taken together these factors can all detract from the sum of the different disciplinary perspectives as postulated by Rawson. Mathematically this would look like *2 + 2 + (–2) + 2+ (–2) = 6* and would result in mental health care struggling to move beyond multidisciplinary delivery.

Interdisciplinary Working: The Utopia?

For all the above reasons it is important to remain cautious about the extent to which mental health services and teams are working together collaboratively, demonstrating purposive interaction *between* disciplines and teams within the service system. This is reinforced by Miller and Freeman's study in 2003 which found that out of six so-called interdisciplinary teams in a range of settings including community mental health only one was demonstrating effective collaborative working.

This team was characterized by a highly developed vision of teamworking and shared philosophy of care that encouraged a shared responsibility for team actions. Communication was multilayered and all team members were expected to contribute to problem solving and decision making in respect of their service

users. Role understanding was also multilayered with team members knowing what each other's role comprised, how it was performed and the underpinning rationale for action. However, role boundaries were also flexible and team members learned new skills and knowledge to contribute to better continuity of care. Joint practices were therefore evident in the team in respect of joint assessments, monitoring service users and evaluating therapeutic interventions.

While Miller and Freeman didn't consider the actual or potential contribution from service users and carers in the teams they studied, they did find that collaboration was increased by a wide range of knowledge being used on which to base team decisions and a problem solving approach. The greater this level of collaboration, the more frequently practices such as continuity and consistency of care, together with appropriateness and timeliness of referrals were upheld.

Applying this to an Assertive Outreach team provides a case example of what contemporary interdisciplinary working could look like.

Key concept 1.2: Case example of interdisciplinary working in an Assertive Outreach (AO) team

- Clear guidance would be evident about referrals to and from the team and about how the team connects and communicates with other community teams and inpatient services.
- There would be formal and informal arrangements for communicating within the team about day to day care of service users.
- There would be integrated pathways of care across the service with the AO team being clear about their distinctive contribution to the care system in terms of their philosophy of approach.
- The team approach would be rooted in the original model of Stein and Test (1978) that emphasizes working with each individual's strengths to promote engagement and continued participation in psychosocial interventions alongside medication compliance.
- A shared flexible responsibility for working with individuals rather than a single worker, reinforced by a good understanding of each other's role in the team and the specific roles of Care Coordinator and Responsible Medical Officer.
- Service user's awareness of their own signs and symptoms would be encouraged and such knowledge together with carers' perspectives would contribute to the team decision making process re: care planning allowing for a more shared responsibility of care.

According to Gregson et al. (1992) such combined integrated effects of disciplines working together generates new potential and enhances rather than undermines the input of individual team members. The result is a level of 'magic' or synergy within the team such that the whole becomes greater

than the sum of the parts. Gregson refers to this as the multiplicative effects model which he represents mathematically as $2 \times 2 \times 2 \times 2 = 32$.

It is this level of interdisciplinary working for which contemporary service should be striving and which is possible if the policy developments are implemented creatively in practice. This shift ultimately requires a more inclusive approach across individual care, teamworking and organizational service delivery levels.

Summary

This chapter has attempted to define how interdisciplinary working differs from the ways in which mental health professionals have worked together since the early part of the last century.

Over the last 100 years systems and structures in mental health services have evolved to a point where they can support interdisciplinary practice. The Policy Implementation Guides have identified the service elements that are required of a modern mental health system and changes to the mental health workforce mean that services are poised on the brink of greater collaboration in the future.

The difference between interprofessional and interdisciplinary working is the extent to which non-professionally affiliated staff and service users and carers are involved in care planning and delivery alongside the traditional mental health professionals. A truly interdisciplinary approach hinges upon such involvement to respond to the diversity of service users' needs in the twenty-first century and reflect the wider social inclusion agenda in contemporary mental health and social care.

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