Working in a Multi-disciplinary Setting

in

Northern Ireland

Curriculum Guidance

for

Diploma in Social Work Programmes

Central Council for Education and Training in Social Work (NI)

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Foreword

This publication has resulted from the outcomes of consultation on the Diploma in Social Work, led by the Department of Health and Social Services in 1998, as part of the Stage II review of CCETSW. During the consultation meetings, representatives of social services agencies consistently indicated that social work students needed additional preparation for work in multi-disciplinary settings. They felt that students lacked sufficient knowledge and skills to enable them to participate in multi-disciplinary and inter-agency work. CCETSW (NI) undertook to provide guidance material to assist DipSW Partnerships in developing a curriculum that reflects the reality of social work today.

The Government is reforming the way in which services are being delivered. They have developed a strategy that places users of services and carers at the centre of decision-making and promotes Empowerment, Partnership and Social Inclusion as key drivers. Social workers will be increasingly required to work in partnership with other disciplines, agencies, users and carers, and local communities to deliver an appropriate, effective and "seamless" service. Students must be provided with the necessary knowledge and skills to enable them to identify and articulate the role of social work in multi-disciplinary settings.

Mary Stewart
Head of CCETSW (NI)

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Introduction

In the preface to the 1989 CCETSW publication *Multi-disciplinary Teamwork: Models of Good Practice* (1:4) the author makes reference to students who may be 'intending' to work in a multi-disciplinary setting. More than a decade later the concepts of multi-disciplinary and inter-agency working in social and health care have progressed to the extent that it is practically guaranteed that the new generation of social workers will be members of teams, perhaps several teams, which encompass not only their similarly qualified colleagues but also a wide range of other professionals with different qualifications, experiences and practices.

Government initiatives abound with policies and targets aimed at an integrated approach to social care; the buzzwords of the era are 'joined-up' thinking and 'joined up' working. Applying such policies and meeting such targets requires the breaking down of the traditional barriers between professionals, the dismantling of bureaucracies and a radical reappraisal of the relationship between individuals who require services and those who provide services. Acquiring and developing the skills to work effectively with, and for the greatest benefit of, service users in such a setting is one of the major challenges for future generations of social workers.

The vision of a fully integrated, multi-disciplinary approach to social care encompasses all aspects from planning and budgeting to service delivery and evaluation across all areas of need. In this guidance document we look, within the context of integrated working in Northern Ireland, at the current policy and structures, the nature of multi-disciplinary working and the implications for social workers in terms of the values, knowledge, skills and competences required. We will look at examples of good practice within Northern Ireland and in other jurisdictions and suggest study exercises to examine the core aspects of multi-disciplinary work.

The material is structured so that the main text covers issues likely to be most relevant to a social work student or practitioner while the text highlighted in boxes provides snapshots of more general interest with regard to multi-disciplinary working across the wider spectrum of social and health care.

Chapter 1

The context of multi-disciplinary work in Northern Ireland

Chapter 1

The context of multi-disciplinary work in Northern Ireland

Since the 1970s the structure for the delivery of social care has been integrated with that of health in Northern Ireland. As such, this context represents a unique opportunity to develop multi-disciplinary approaches, in contrast to other parts of the United Kingdom. Indeed structured integration of these services is still not mandated in other parts of the UK, although government policies have increasingly urged the health and social care agencies to employ "joined up thinking" at the strategic, tactical and operational levels. Hence Community Care Plans, Children's Services Plans and Health Improvement Plans all countenance shared objectives across the health and social care arena, with multi-disciplinary strategies being at the heart of service delivery.

While the structures in Northern Ireland prima facie facilitate multi-disciplinary working, some commentators have questioned whether the potential for integrated service planning and delivery has been maximised. Three issues are frequently cited in reaching this conclusion:

The hegemony of health

Several commentators have noted that placing health and social care agencies together, either in a commissioning or providing capacity, has not been a marriage of equal partners. As Campbell notes:

> *".....there are many more opportunities for multi-disciplinary working than is the case in the rest of the UK. These circumstances, however, are not without problems, particularly because the medical profession and its ideological perspective on social and health care problems tend to dominate those organisations" (2:11)*

The hegemony of health has two fundamental implications in practice:

(i) In the arena of resource allocation, frequently priority is given to health care needs, particularly acute health care needs, over social care needs. Such resource allocation bias not only reflects upon the differential between the professions on the empirical verifiability of interventions (i.e.: the evidence base of what works), but also upon the continuing influence of less eligibility criteria when choices have to be made between the deserving and undeserving.

(ii) The "medical model" of need identification and response is highly influential. Such an ideology tends to pathologise need as problem behaviour, identifying individuals who may be at risk or in need of treatment. This contrasts with an approach of empowering

individuals, their families and their communities and encouraging people to seek their own creative solutions to issues that confront them.

These two pressures, in turn, have led to a second criticism of the present approach to social care delivery.

Technocratisation of social care

Here commentators observe that social workers have frequently adopted a detached, professionalised or technocratic approach to their work. This detachment is particularly marked in separating health and social care workers from the communities they seek to serve. Such an approach minimises community partnerships and empowerment and maximises the importance of eligibility criteria, assessment and treatment processes and programmes of intervention. Such an approach, in turn, is influenced by the third factor frequently identified as a restraint to multi-disciplinary working within Northern Ireland.

Living with the trauma of the 'Troubles'

The 30 years of civil unrest, which has only recently concluded in Northern Ireland, has had a significant effect on the way in which communities, of whichever persuasion, view state agencies and their employees. As the SSI report on "*Living With The Trauma of the Troubles*" comments:

> *"Some of the groups representing those most affected by the "Troubles" were critical of the past response by health and social services. They suggested that the statutory organisations had failed to recognise the specific needs of those affected. Services offered have not been sensitively tailored but have been perceived as incidental to the general services provided" (3:4.6)*

In such an environment, communities and other self-help groups rather than being seen as a catalyst for multi-disciplinary work have been seen as an alternative care network. This has led to a detachment of professionals from communities and with it a marginalisation of their role and remit.

If these factors have been the constraints to the development of multi-disciplinary work in Northern Ireland in the recent past, then the implementation of the Good Friday Agreement facilitates three factors that provide the opportunity to refocus the approach.

Community empowerment and capacity building

Current government policy is to promote the social inclusion agenda, particularly through the use of community development initiatives to involve and empower people to participate in the planning and delivery of services. This policy approach urges professionals to work in multi-disciplinary alliances, engaging with communities in analysing local need, evaluating strengths and weaknesses and building the capacities they require to meet those needs within a community setting.

The social care agenda

As in other parts of the UK, Northern Ireland is being asked to address a social care agenda, which has multi-disciplinary planning and service delivery at its foundation. Among key policy initiatives are:

> **Well Into 2000 - A positive agenda for health and well-being (1997)** which emphasises community-based services for health promotion and illness prevention and the development of closer partnerships between the statutory, community and voluntary sectors in providing community health and social care.
>
> **The Children (NI) Order (1995)** requires HSS Boards, Trusts and partner agencies to develop Children's Services plans and establish multi-disciplinary approaches to identify and provide for children in need.

Structural changes to the governance of HPSS

Currently fundamental structural changes are being proposed to the way in which HPSS are managed and delivered within Northern Ireland. *"Fit for the Future"* (4) contains four key policy proposals which, if implemented, will have a radical impact on the way in which health and social care is delivered:

- Control of HPSS by the Northern Ireland Assembly;
- Primary care professionals to drive how services should be planned, delivered and funded;
- Strengthened integration of health and social services;
- Elimination of unnecessary bureaucracy in HPSS organisations.

All of this highlights the significance with which multi-disciplinary approaches are perceived - as critical in the planning, commissioning and delivery of services which are seen by local communities as relevant to their needs and wishes.

Summary to Chapter 1

- **Government policies of 'joined-up thinking' reflect the integrated HPSS which already operate in Northern Ireland**

- **There is evidence that where integrated social and health care services exist, health services tend to be prioritised which has implications for social care funding and the holistic identification of need**

- **Social workers have faced criticism that a technocratic approach to their work detaches them from the communities they serve, evidenced in Northern Ireland by the public perception that there has been a failure to adequately address the needs of people who have suffered trauma during the 'Troubles'**

- **Current government policy and initiatives promote social inclusion through community initiatives which encompass multi-disciplinary working**

- **There are proposals to radically change the way that HPSS is delivered in Northern Ireland**

Chapter 2

The nature of multi-disciplinary working

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The nature of multi-disciplinary working

The concept of multi-disciplinary working in health and social care is not new. As far back as the 1920's commentators were advocating the co-ordination of community-based services through a single body. The debate continued into the 1940's, but the introduction of the NHS through legislation such as the National Health Service Act 1946 and the National Assistance Act 1948, effectively separated the social and health care functions.

Northern Ireland's integrated system of Health and Personal Social Services, co-ordinated and delivered through four area Boards and the Hospital and Community Trusts, is unique in the United Kingdom.

Definitions

Most social care and health professionals will have experience of working with people from a number of agencies and professions, but the distinctions between different types of interaction are frequently blurred. The terms multi-disciplinary, multi-agency and inter-agency tend to be used interchangeably to describe a variety of working relationships. A multi-disciplinary team, for example, may define itself as such in terms of the various skills required to meet the complex needs of a service user, but the team members and services may be provided by the staff of one agency, such as social services (multi-disciplinary) or by staff from several agencies including health, community services and the voluntary sector (multi-agency). Equally, the planning, funding and commissioning of services may be the result of joint initiatives by a number of agencies (inter-agency) with the provision of such services requiring the skills base of a number of disciplines and from a variety of agencies.

In developing a definition of what is meant by multi-disciplinary working it may be helpful, therefore, to consider it in terms of levels or modes of **co-operation** between professionals and agencies providing social and health care services. (5:43)

Co-operative working can be identified within five modes of interaction:

- **Communication**
- **Consultation**
- **Collaboration**
- **Bilateral working**
- **Joint working**

Communication is defined as co-operation at its most basic level, involving one discipline or agency informing another of its actions or intentions.

Consultation involves activities where one discipline or agency approaches others for their opinions, information and advice on a proposed course of action.

Collaboration involves a degree of mutual activity between disciplines or agencies with adjustments and agreement on the scope and level of participation in that activity but usually with the expectation that each agency or discipline will operate independently in the provision of services.

Bilateral working implies the recognition of an overlap in service provision between disciplines or agencies, which can give rise to both individual and collective operational planning and service delivery.

Joint working implies agencies working together to plan and operate a mutual course of action.

Investigations into organised child abuse led by the Foyle Community Unit of Management (Western Health and Social Services Board) involved setting up an inter-agency advisory group of senior management of the agencies involved, to facilitate communications.

The assessment for and the provision of services and their monitoring and review may involve the practitioner in co-operative working with any number of agencies and patterns of interaction in which a variety of modes may operate. The extent and mode of interaction between agencies should be informed by the needs of the individual service user (or group of service users) and their carers and families.

Throughout this guidance document practical examples will be provided of multi-disciplinary working relationships in the UK in general and Northern Ireland in particular, and measured against the five modes of co-operation defined above. However, before doing so, it is essential to establish the role of service users and their families and informal carers in the co-operative processes.

Service user and carer participation

The holistic approach to personal social services and health care requires the skills, knowledge and expertise of a range of practitioners to meet the needs of individual service users. In a holistic, needs-led model the service user is perceived as a 'whole person' with often complex needs requiring the provision of a 'seamless' range of services tailored to his or her individual needs.

Example: An older person leaving hospital may require a number of services to enable her to return home safely. She may require assistance from the hospital social worker to co-ordinate her return home, medical assistance from her GP, community nursing services and hospital services, personal care such as bathing and dressing from a community care agency, meals-on-wheels, and visiting services from a voluntary agency. The suitability and safety of the service user's home may require assessment and services from an occupational therapist and the housing authority and her financial circumstances may entitle her to assistance from the benefits agencies. Additionally, support may be required for her husband, who is himself entitled to an assessment for services as his wife's informal carer.

The invaluable role played by informal carers within the concept of community based rather than institutionalised care, has received official recognition in recent years. The principle of separate assessment for carers, formalised by the Carers (Recognition and Services) Act 1995 in England and Wales, applies under HSS Guidance in Northern Ireland.

Providing such a range of services requires a high degree of co-operation and co-ordination from the professionals involved, but central to the whole process should be the needs and wishes of the individual service user. The care 'team' consists not only of the professionals, but most crucially the service user herself, her family and carers. Throughout this guide, therefore, service user involvement and participation in all aspects of social and health care provision is taken to be fundamental. The basis of all interaction from the social work perspective should be the outcome for the service user.

The *Well into 2000* document states that a major factor in the successful provision of care services is the *'more meaningful and active involvement of users and carers in the assessment and planning of services'*. (8:10)

The social worker's role

It is one of the basic tenets of multi-disciplinary working that it seeks to address the waste of money and resources caused by the duplication of services. To be successful and effective, multi-disciplinary working requires a high level of professional integration, to the extent that one of the recurring features of multi-disciplinary teamwork is the blurring of distinctions between specialisms.

Many tasks, such as assessment of need, are common to all areas of service provision and integration is clearly enhanced by shared working and a knowledge and understanding of different perspectives and imperatives. But it is equally important that the participants in multi-disciplinary

working retain their professional identity and an awareness of their specific role and remit within the team; it is the very diversity of professional skills, knowledge and experience that enhances the value of multi-disciplinary working in the provision of holistic services.

The specific role of the social worker in a multi-disciplinary setting includes:

- Knowledge and promotion of the specific responsibilities of statutory social work agencies, e.g.: in relation to child abuse and the abuse of vulnerable adults
- Knowledge of and adherence to the legislation relevant to the provision of social care
- Promotion of the values of social inclusion through the ethos of equal opportunity and anti-discriminatory practice
- Empowerment and enablement of service users, their families and informal carers
- Promotion of service user and carer participation and involvement in all areas of social care provision
- Undertaking the role of advocate

Working in a multi-disciplinary team

The concept of the needs-led, holistic model of social and health care is central to the development of an integrated service. Providing a 'seamless' service which meets all the needs of the service user may involve not only input from social workers but from health professionals, teachers and other specialists in education, the staff of housing departments, the benefits agencies, police, probation and court officers, independent providers and workers in voluntary agencies, support and self-help groups in the community and advocacy services.

The Social Services Inspectorate undertakes multi-disciplinary inspections of services. Inspections of arrangements for the discharge of older people from hospital, for example, are undertaken by teams led by SSI, which include medical and nursing professionals, other professionals allied to medicine (PAMS), social workers and lay representatives.

The concept of joint working is applicable to all service users, adults, children and young people, and to all areas of need. Indeed, it is in the areas of greatest need, such as learning, physical and sensory disabilities, mental health and youth offending, that integrated services can have the best outcomes for service users and their families and carers.

Child and Adolescent Mental Health Services (CAMHS) have been prioritised to meet the mental health needs of looked after children and young people in recognition of the high prevalence of such needs and their consequences in terms of educational under-achievement, youth offending and placement disruption. The concept behind CAMHS is the provision of a comprehensive range of care packages from primary care through to specialist services. Providing such services requires partnership working between social workers, teachers, health professionals and CAMHS specialists.

The working environment

The integration of services may take place in a variety of different environments. Multi-disciplinary working does not necessarily involve working in the same office or setting as colleagues or even the same building. Clearly the concept of a multi-disciplinary team requires some elements of mutual experience in which members can be identified as having a shared goal or purpose, but a social worker may have membership of a number of different modes of multi-disciplinary co-operation relative to the needs of a particular service user or the community to be served. Thus a social worker specialising in adult mental health, for example, may have membership of a HPSS Adult Services Team, of a network supporting the return of a young adult with mental health needs to the community and of a learning set tackling medication compliance in rural areas. The social worker's working environment might therefore, encompass a variety of locations, such as an Area Office, a day care centre, a GP's surgery, a community centre and, of course, the service user's home.

The nature of social work dictates that its practitioners are likely to spend much of their working day in the homes of clients or in the community. New developments in working practices in social and health care are likely to erode even further the traditional concept of the office-based working environment. Developing and maintaining 'intra' and 'inter- disciplinary' working relationships within new and, as yet, largely untested structures will be one of the many challenges facing practitioners.

The enormous advances in computer technology and communications are having a significant impact on where people conduct their working lives. The future for social workers, as for many other professionals, may well encompass the development of 'virtual' workplaces where team members work from home or IT centres, linked to service users and colleagues through electronic communications and the Internet.

There are a number of innovative pilots and systems in operation in the United Kingdom. Surrey County Council has piloted a Telecentre for the use of its employees with positive results on the time spent travelling. Recognition that the telephone is the preferred means of communication for the majority of people has encouraged the development of call centres, such

as Social Services Direct in Enfield and 'one-stop shops', for example, in the London Boroughs of Brent and Harringey and in Leeds.

Summary to Chapter 2

- **Multi-disciplinary working can be most clearly defined in terms of levels or modes of co-operation**

- **The extent or level of multi-disciplinary working should be governed by the needs of service users**

- **Provision of holistic, needs-led services requires a high level of co-operation and co-ordination between professionals**

- **Service user and carer involvement and participation should be fundamental in all aspects of social and health care provision**

- **Multi-disciplinary working encompasses practitioners from a wide range of disciplines in the provision of services to address all areas of need for both children and adults**

- **Social workers engaged in multi-disciplinary working may have membership of several teams or groups and work in a number of different environments**

- **New working practices and developments in information technology may radically change the way that social workers interact with service users and other professionals in the future**

Chapter 3

Examples of co-operative working

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Examples of co-operative working

In this chapter we look at examples of how the needs of service users can be met by multi-disciplinary working. The needs of people who require assistance from social and health care services are often complex. Indeed, one of the guiding principles of the concept of multi-disciplinary working is the recognition that there may be many contributory factors to the difficulties experienced by an individual and that having one identifiable need does not preclude that person from having other needs; the person with a learning difficulty may also have mental health needs, the young offender may also be an abused child. It is often in the more complex areas of need that multi-disciplinary working can be most effective.

In including these examples, the authors have attempted to provide a realistic view of the types of multi-disciplinary working in which a social worker is likely to engage. The exemplars specific to Northern Ireland have been provided by representatives of the multi-disciplinary teams, which assisted and advised on the production of this guidance, all of whom are practising social and health care workers or involved in the training and education of social workers. In each example we examine the modes of co-operation, which occur or are likely to occur in such working relationships.

Young offenders

Example: In the late 1990s in England and Wales, as part of its strategy regarding children and young people who offend, the government instigated the formation of Youth Offending Teams (YOTs). The teams have their own management structure and administration with dedicated funding and staff drawn from social services, the police, probation, education and health. The teams are answerable to the Local Authority Chief Executive.

At the time of writing, YOTs are in the process of becoming operationally active in terms of replacing the former Youth Justice teams in providing services for young offenders in most local authorities. The vision for the YOT is that they will provide a multi-disciplinary service in which practitioners from all the major providers are integrated on either a full or part-time basis. Given the range of disciplines involved, developing effective working relationships is likely to require considerable adjustments in work ethos and practices for all concerned.

Mode of co-operation : Theoretically, the model YOT as a fully integrated team would appear to present an excellent example of the joint working mode. In practice, however, it is likely that all modes of co-operation are likely to be experienced by team members, depending upon whether they are perceived as 'core' or 'peripheral' to the team's role and remit.

Example: The Probation Board for Northern Ireland (PBNI) Youth Justice Unit demonstrates a number of co-operative initiatives including the Juvenile Liaison Panels Bureau, which comprises a

probation officer, police officer, social workers and an education welfare officer. The focus of the panel is to discuss young people at risk of offending and look at ways to divert them from custody.

Mode of co-operation: Bilateral working

Adults with learning difficulties

Example: Mr X and Miss Y have learning difficulties. They had developed a strong friendship and complained they lacked privacy and were "never allowed to be on their own" in the home where they were residents. They requested a move away from the home. Meeting their needs involved establishing a Core Group, co-ordinated by Social Services, consisting of social workers, nurses, residential and day care services staff and an occupational therapist. A psychologist, staff from statutory and voluntary domiciliary care services, housing and benefits agencies were also involved at various stages. All the staff involved worked very closely with the service users and their carers.

The outcome for the service users was the move to a flat supplied by the Housing Executive and furnished through a Community Care Grant. Support services were commissioned from the residential home and from the Statutory and Voluntary domiciliary care agencies. Monitoring, evaluation and review are undertaken by Social Services.

Mode of co-operation: Collaboration

People who misuse drugs

Example: The Eastern Drugs Co-ordination Team, established as part of Northern Ireland's national campaign against the growing misuse of illegal drugs, includes staff from Health and Social Service Boards, the Probation Board, the Police, the Health Promotion Forum and the Independent Sector Forum. The aims of the Team include a joint approach to information and research and the development of networks, communication strategies and training.

Mode of co-operation: Communication; Collaboration

Older people

The emphasis upon community care for older people with social and health care needs has necessitated a high level of multi-disciplinary and inter-agency co-operation to provide the service user with a 'seamless' package of care. One of the best-established areas of co-operative working is in hospital discharge. Hospital-based social workers work closely with medical and nursing professionals, occupational therapists, community care agencies, service users, their families and carers to enable the safe return of an older person to their own home or to take up residence in a residential or nursing home.

Research has indicated that the majority of older people prefer the independence of living in their own homes to residential care. Enabling service users to retain their independence in a supported environment requires a holistic assessment of their needs in terms not only of their social and medical care but also with regard to housing and financial matters. The improvement of housing conditions is one of the main thrusts behind the development of 'Staying Put' schemes in a number of areas in the UK, usually run by voluntary organisations with funding, at least in part, from social and health service budgets.

Example: In Swansea the Elderly Care Staying at Home Scheme is managed by a partnership of Social Services, the Health Authority, the local Housing Authority, Housing Associations and Age Concern.

Mode of co-operation: Bilateral Planning

Example: Mr and Mrs M are estranged. Mrs M is suffering from a degenerative illness with short-term memory loss. Her husband has a history of alcohol abuse and domestic violence. The main carer, a family member, is under severe stress and there is considerable conflict within the family. There is concern that Mr M's return to the family was motivated by the financial and housing opportunities which were likely to arise from his wife's health problems.

The multi-disciplinary strategy to meet the needs of Mr and Mrs M involved their separate social workers working collaboratively with community health workers, the Housing Executive and respite care providers to assess and provide services to meet their mental and physical health needs. Collaboration with the HSS Trust's legal advisers and Mrs M's solicitor was also necessary to safeguard her financial interests.

Mode of co-operation : Consultation; Collaboration

One of the greatest stumbling blocks to independent living and a good quality of life for older people is poverty. Providing a service, which addresses the needs of the service user increasingly, involves the social worker in often complex form filling and negotiation with benefits agencies to obtain financial assistance for the client through allowances, grants and income support. At the time of writing, there are indications that the Direct Payment Scheme will be developed to include older people. The scheme, which allows money to be paid by Boards and Trusts direct to the service user, rather than the service provider, to purchase their own services, has implications for social workers who may be required to assist and advise the service user in purchasing services.

Adults with mental health needs

Community care reforms also have wide reaching implications for people with mental health needs. The provision of supportive services to meet the needs of individual service users may involve input from social workers, the GP, a community psychiatric nurse and other specialist health professionals, housing officers, benefits agencies, and voluntary and self-help groups. The public perceptions of mental illness, particularly in the light of such tragic cases as the killing of

Jonathan Zito by the diagnosed schizophrenic Christopher Clunis, means that social workers may be confronted with the need to deal effectively with members of the wider community.

Example: Mr A is an elderly man suspected of child abuse who had been intimidated from his own home and had been admitted to hospital. Social workers had the dual role of protecting the service user and also the potential victims of his alleged activities. The multi-disciplinary approach to the case involved social workers from the hospital, community and family and child care teams, Mr A's GP, a district nurse, a senior house officer and nursing staff, an occupational therapist, the Housing Executive, the Police Care Unit and legal advisers, and Mr A and his family. There were also links with social workers and housing agency staff in England where Mr A had been resident for a short time and had received elder care services.

An initial multi-disciplinary assessment of Mr A's needs was co-ordinated during his hospitalisation by the hospital social worker. A multi-agency case conference considered the housing problems already experienced by Mr A in terms of intimidation and personal injury, his mental health and expressions of suicidal thoughts, and the potential risks to children of his return to the community.

The outcome for Mr A is a continuing placement in a residential home. His social worker sought funding for the placement, works with staff from the Home on supervision, monitoring and case review requirements, and is liaising with Mr A's GP on a potential referral to a psychiatrist.

Mode of co-operation: Collaboration

Example: Bromley User Group (BUG) is involved in multi-disciplinary working with social services and mental health services and the local authority. The group monitor mental health services, provide information and education on mental health issues and are themselves service providers through consultancy, advocacy and health promotion.

Mode of co-operation: Collaboration; Bilateral planning

Children with disabilities

Example: The manager of a family day centre and crèche facility responded to an increasing number of referrals by health visitors of children under three years old with significant disabilities and syndromes by developing a service to provide stimulation and therapy for the children and support and respite for their parents.

Developing the service required multi-disciplinary working between social workers, nurses, occupational therapists, physiotherapists and specialists in education. Applications for funding and resources required negotiation with managers in childcare, health and disability and learning disability programmes of care as well as eliciting and presenting the views of service users. Liaison with HSS Trust estate managers was also required to survey and prepare plans and submit specifications and costs for a workspace adapted to the needs of disabled children. The outcome

for the client group was a service which provided five days full care with dedicated staff, a workspace and a separate budget.

Mode of co-operation: Consultation; Collaboration

Summary to Chapter 3

- **The needs of people who require assistance from social and health care services are often complex**

- **Co-operative multi-disciplinary and inter-agency methods of working are effective in providing integrated and seamless services to users**

Chapter 4

The value of co-operative working

Chapter 4

The value of co-operative working

There is a clear mandate from Government that multi-disciplinary and inter-agency modes of working are integral to the modernisation of social and health services. It is a virtually universal requirement of service plans that references are made to developments in integrated working practices. These need to be accompanied by stated outcomes, measures or targets and the performance indicators to be used to evaluate them. Complying with such requirements is an often complex and time-consuming task, but current and future participants in multi-disciplinary working have a key role in contributing to such plans.

The value of shared information in co-operative working is reflected in the SSI Annual Report 1999, which states "*Services should be located on a 'continuum of need', graded to provide appropriate levels of service to meet varying levels of need. It is essential that each service is aware of the other services on that continuum so as to allow an individual's needs to be optimally met'. (6:8)*

In this chapter we examine the advantages and disadvantages of integrated services for those involved in the processes of social and health care.

Social Services

Co-operative working requires a considerable investment in time and resources if it is to be implemented effectively for the benefit of service users. Most social workers would concur with the comment of one Social Services Team Manager that developmental work had in the past:

> *"...inevitably a lower priority than my day to day team management work. My job is to manage the Adult Care Team, a complex enough activity in itself without trying to reinvent the local health and social care system at the same time!" (7:21)*

The impetus to provide integrated, user-centred, needs-led services has, however, necessitated the development of strategies to break down the traditional barriers between the various agencies of social care and health provision. Such strategies are hardly new to Northern Ireland which has had a level of integrated social and health care services since 1973. A few of the many benefits of co-operative working are:

- At the planning and commissioning level, co-operative working with other agencies provides the opportunity to pool funding and resources

- The breaking down of barriers between professionals at all levels leads to better working relationships based on mutual understanding and respect

- Improvements in communication lead to earlier intervention thus reducing the need for crisis intervention

- Greater understanding of procedures and eligibility criteria lead to improvement in referral processes and fewer inappropriate referrals

- Opportunities become available to increase the skills base of social work professionals and to share knowledge and information

- Social workers have the opportunity to promote and disseminate values of social inclusion, such as equal opportunities and anti-sectarianism among other professionals

- Better and more consistent outcomes for service users

Health services

Northern Ireland's Health and Personal Social Services have enjoyed a degree of integration for nearly three decades with no legal separation between acute, community health and social work budgets, although GP and primary care services are funded separately. In practice, however, services have often become fragmented, in no small part as a result of the adherence to the principles of the internal market, which has encouraged competition rather than co-operation between HPSS planners and providers.

Initiatives in the late 1990s to abolish the internal market and GP Fundholding in favour of local, primary care centred commissioning arrangements and to remove the barriers to integrated services caused by bureaucracy should have the effect of permitting greater multi-disciplinary working.

Many of the advantages to social work professionals of multi-disciplinary working are of equal value to their colleagues in health services; the advantages specific to health service providers include:

- Focus on community-based services is likely to reduce waiting lists for hospital beds

- Better co-ordination of services to assist the early return of service users to the community

- Influence over the planning and provision of social as well as health care services

- Common structures, planning cycles and geographical boundaries which provide cost-effective services and reduce administrative costs

- GPs and other primary care providers have the opportunity to learn about community and secondary health care services

Service users

On the face of it, there can be few disadvantages to service users and their carers and families in the co-operative approach to the identification and provision of their social and health care needs. However, the concept of user-centred services and the emphasis on user participation carries with it responsibilities for the service user; to be part of the care 'team' implies an understanding of issues surrounding services and the making of choices which may be especially difficult for people at a time of particular stress or for those with severe disabilities or complex health needs.

In England, Easington District Council initiated a project to enable 'fast track' joint assessments of elderly, physically disabled people with terminal illnesses. Social Care, Health and Housing professionals worked on the project, with particular emphasis on home adaptations.

There is much research, debate and literature on the theme of empowerment which is outside the scope of this guidance. However, one of the many strengths that the social worker can bring to multi-disciplinary and inter-agency working is an appreciation of the issues surrounding empowerment and a commitment to the involvement of service users at all levels of service planning, provision and monitoring.

The advantages to service users of co-operative working include:

- A more 'seamless' and co-ordinated service

- Fewer assessments needed to achieve a holistic package of care

- The likelihood of more needs being identified and met through a mixed economy of care

- More flexibility and choice in the type of services and of service providers

- Better opportunities for involvement in the processes of planning, receiving and monitoring of services

- Better protection for vulnerable service users where there is transparency of service provision and the involvement of a range of people and organisations

- Reduction in the stigma often felt by people in approaching social services for help by being able to access services through, for example, their GP's surgery or community networks.

Belle Isle Elderly Winter Aid (Leeds) community project was co-ordinated between statutory and voluntary agencies and residents to provide services, such as a handy person scheme and physical health checks.

The Community

One of the major thrusts in the present Labour government's modernisation plans for social and health care services is the emphasis placed upon services which promote inclusion. Social and health care professionals are enjoined to work co-operatively with voluntary agencies and community groups to develop and deliver strategies to improve the health and well being of all members of the community. In Northern Ireland, this aim is encapsulated in the strategic document, *Well into 2000. (8)*

One of the responses of the social and health care agencies has been to establish inter-agency groups, such as Health Action Zones (HAZ), to look at ways of developing community based strategies to combat the effects of poverty and poor health care involving not only statutory agencies but voluntary and community groups.

The Creggan Day Centre is a focus for community based services including support services for families and day care for adults with mental health needs. Initiatives include training local mothers to support others in need of help or advice.

One of the ways in which statutory social service and health agencies have countered the difficulties caused by diminishing resources and the requirement to establish the 'Best Value' ethos has been to rely increasingly upon voluntary and charitable organisations to provide a wide range of services. Increasingly, such organisations receive funding from social and health care agencies and are usually the first point of call in the development of user involvement strategies. Voluntary and self-help groups in the community have, therefore, become major players in the arena of social and health care, both as the representatives of service users and as service providers. Thus, it is highly likely that co-operative working will bring social work practitioners more routinely into contact with such agencies.

Northern Ireland, in the aftermath of the 'Troubles,' faces particular challenges as a community. The Social Services Inspectorate report *Living with the Trauma of the 'Troubles'*(3) made a number of recommendations regarding services for individuals who have suffered physical, social and psychological trauma. Health and Social Services Trusts are required by the DHSSPS to implement the recommendations and the recognition of the need for services has led to a number

of initiatives from both the statutory and voluntary sectors, such as a regional Trauma Unit for young people and families.

CCETSW (NI) and the Community Relations Council collaborated on the publication of *'Getting Off the Fence'*, which provides a framework for PSS agencies to *'move forward in the collective process of societal reconstruction'*.

The advantages to the community of multi-disciplinary working include:

- The opportunity for individuals and groups in the community to have a say in the services provided for them
- The development of services which are relevant to the particular needs of the community
- The creation of an enhanced sense of community through greater local ownership and control

Summary to Chapter 4

- **Multi-disciplinary working is central to the Government's modernising agendas for health and social services and can no longer be perceived as optional**

- **Commitment to multi-disciplinary working requires a considerable investment in time and resources but the disadvantages are outweighed by the advantages to all participants**

- **Social and health services benefit from pooled resources and funding and the opportunity to develop 'best value' services, based on shared information, knowledge and experience, which provide better outcomes for service users**

- **The multi-disciplinary approach gives service users and carers both rights and responsibilities and they may require the particular skills of social workers to empower and enable them to exercise such rights and responsibilities**

- **The advantages to service users of multi-disciplinary working include a 'seamless' provision of service by which more of their needs are met, a greater assurance of quality and greater protection for the most vulnerable**

- **For communities, the advantages of multi-disciplinary working include a greater say in the provision of locally relevant services and fewer people socially excluded**

- **Voluntary agencies are now important providers of services in the community**

Chapter 5

Establishing multi-disciplinary teams

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Establishing multi-disciplinary teams

Meeting the needs of service users has always required a degree of co-operative working between professionals, even if at only the most basic level of the five modes of co-operation previously described - communication. Often co-operation has been informal in nature, built upon networking between individuals in different agencies with little attempt at or commitment to establishing shared protocols and procedures to formalise the process. The lack of established mechanisms, or their inconsistent use, has inevitably led to inconsistencies in the standard of care afforded to service users, sometimes with dire consequences for the most vulnerable.

In 1998, DHSS/SSI published a report on the suicide of an elderly man, Frederick Joseph McLernon, which recommended that communication, shared information and the involvement of all the relevant disciplines, agencies and individuals is of prime importance in the comprehensive assessment of need. (9)

The recognition in recent years of the value of multi-disciplinary working at all levels of social and health care provision, and the commitment of government to its application, has given rise to the requirement for agencies to adopt a structured and proactive approach to the development of inter-agency working relationships.

In this chapter we examine the main stages of development in building multi-disciplinary and inter-agency teams.

The needs analysis

The establishment of any multi-disciplinary or inter-agency relationship must be relevant to the needs of an individual service user, group of service users or the community as a whole. Identification of need requires analysis of information from a number of sources. The three primary sources of information are:

- Data from the existing information systems of the agencies involved, such as referral rates, caseloads and needs and services met and not met

- Information and expert opinion from professionals in the statutory, voluntary and private sectors

- The views, wishes and expectations of existing or potential service users, their carers and their communities

Evaluation of the extent to which multi-disciplinary working is meeting its objectives requires ongoing analysis of information from these key informants. For example, evaluating the needs of looked after children would include:

- Data from the census and the agencies involved in working with looked after children on the known or prospective need for services, including comparative data from other authorities

- Information and advice from social service and health managers and practitioners with expertise in children's services, such as child protection teams and the staff of residential units

- Information and advice from other organisations, such as the Police, Education, and voluntary agencies, such as Barnardo's and the NSPCC

- Consultation with children in residential and foster care and recent care leavers, including those with physical, sensory and learning disabilities, those with mental health needs and ethnic minorities, on their experiences of being looked after

- Consultation with the families and carers of looked after children.

In practice, the gathering and analysis of information is often fraught with difficulty. Existing information may be inaccurate because of poor, non-existent or under-used case recording systems; the census is conducted only at ten year intervals. There may be poor working relationships, political issues or traditional barriers between professional agencies which will need to be addressed before any meaningful dialogue can begin. The consultation and involvement of service users and carers requires skill in empowering their meaningful participation in the processes.

Additionally, despite the emphasis placed on computer technology in the workplace, social and health care agencies frequently lack the systems or expertise to collate and evaluate the mass of data which is generated by surveys and other consultation exercises and turn it into useful information.(10)

Planning and purchasing

Establishing the social and health care needs of individual service users, groups of service users and the community is an ongoing process which goes hand in hand with the planning, commissioning and purchasing of services. There is no point along this continuum where the analysis of need stops and the planning and purchasing of services begins. The processes of planning and purchasing can be identified in terms of:

Assessment

Consideration of the methods for assessment is crucial to effective multi-disciplinary working. A frequent complaint from service users is that they are required to undergo a number of assessments to obtain the services they need with endless repetition of the same information to staff of the various agencies involved in their care. Professionals, while recognising the waste in time and resources of multiple assessments, have concerns that their colleagues in other disciplines may lack sufficient specialist knowledge to assess the needs of the service user, leading to the purchase of inappropriate services. The tightening of eligibility criteria can also generate tension between professionals, leading to a reluctance to undertake the joint assessments which would, ironically, result in less duplication of effort and more cost effective services.

Overcoming these difficulties requires the implementation of joint assessment procedures and documentation and training in multi-disciplinary skills.

Service providers

One of the perceived aims of co-operative working between agencies is to reduce the duplication of services. However, diminishing financial resources and strict eligibility criteria can result in services being reduced or discontinued, leaving a gap in service provision. While agencies may be keen to protect their professional boundaries, they may also have to face the fact that they no longer have the resources to provide the services required. This has had the unfortunate consequence of professional wrangling between agencies about who should provide services, often to the considerable detriment of the service user, particularly in cases of complex need. Such matters need to be addressed in multi-disciplinary working to ensure that service users do not suffer delay in the provision of essential services or fail to have their needs met.

Establishing who is to provide services requires clear policies and good communication between agencies, which may also include independent providers and voluntary organisations. There will clearly be agenda, policy and cultural differences between the statutory agencies and, for example, providers of services on a commercial basis or volunteers who also act in the capacity of advocate for the service user. Ensuring that there are protocols and procedures in place to provide equality of opportunity and to protect vulnerable service users is an important element of multi-disciplinary working which most often falls to statutory agencies.

DHSS, in conjunction with Child Care (NI), have published an information pack for voluntary agencies, *"Our Duty to Care"*, on good practice for the protection of children.

Information about the range and availability of services is also essential. Specialised services must be properly 'marketed' to the professionals who make referrals to ensure they are used effectively and appropriately to meet the needs of the service user.

Strategy

The agencies involved in multi-disciplinary working will each have their own operational strategies which will need to be brought together to achieve a seamless and integrated service. Typically, a joint strategy will require a statement of shared vision or intention with clear objectives and priorities, a realistic plan for implementation, a financial framework (including identification of existing and future resources) and structures for monitoring and review (which should include user and carer involvement).

At senior management level, a joint strategy would be contained in a plan, such as a Children's Services Plan or (in England) a Quality Protects Management Action Plan, which is a public document. At practitioner level, the elements of the joint strategy should be evidenced in the personal Care Plan of the service user.

Co-operation and Working Together for Health Gain and Social Well Being (CAWT) **is a cross border initiative which involves the participation of the Boards, Trusts and social and health care agencies from both Northern Ireland and the Republic of Ireland in working together to identify common areas of need, irrespective of political boundaries, and to develop services to meet such need. Some of the projects in which CAWT is engaged include initiatives in child accident prevention, the improvement of parenting skills, youth intervention and the protection of children with disabilities.**

Technical

The capacity to share information across boundaries is a desirable element of inter-agency working, but it is rare indeed that even the statutory agencies have compatible case management or recording procedures and systems. Concerns about the accuracy of case recording and issues of confidentiality are reasons often cited for failing to address the development of integrated systems.

Government departments are placing increasing pressure on social and health service agencies to use computerised information systems and to improve the technical competency of managers and practitioners. However, the cost of purchasing equipment, implementing systems and training staff, added to traditional 'techno-phobia' among social and health care professionals, has meant that progress is slow.

In implementing YOTs in England and Wales, the Youth Justice Board allocated sums, per capita of local youth population, for the purchase of computerised case recording and management information systems, compatible with those of the Board.

In practice, multi-disciplinary working will often require the establishment of systems and procedures to ensure the generation of accurate and reliable information among and between professionals and the sharing of such information with service users.

The Ulster Hospital and Community Health and Social Services Trust Adult Mental Health Programme, is currently developing a pilot scheme to provide cross-professional computerised records to include information from social workers, community psychiatric nurses, consultants and other medical and nursing staff. Those who will be able to access information include GPs, Accident and Emergency and Outpatient units. The establishment of several layers of security to ensure confidentiality and the control of information being accessed is of particular importance to the pilot scheme.

Financial considerations

Establishing multi-disciplinary working requires considerable attention to budgetary issues. Finance for multi-disciplinary initiatives and services is provided in a number of ways:

- Identifiable contributions from the participating agencies' mainstream budgets
- Pooled budgets
- Joint funding
- Grants
- Other sources such as Lottery money and European funding
- Service user contributions to the cost of services

Budgeting issues are inevitably complex. Agencies have changing and competing priorities, often imposed upon them by central or local government, which may or may not be shared by their partner agencies. All agencies face severe financial pressures, with restrictions placed upon the statutory sector by 'ring-fenced' money which must be spent on particular areas of need. Additionally, different financial planning cycles make the co-ordination of funding difficult.

In April 1997, the North Down 'Total Purchasing' pilot was initiated. It involved GPs in four surgeries and the Eastern Health and Social Services Board. It gave GPs' power to purchase a wide range of services for their patients, equivalent to the purchasing power of the Health and Social Services Boards. The Primary Health Care Team, including GPs, worked with senior social service and health managers on the pilot which involved the management of a single social and health care budget and the strategic development of social and health care services.

Service users may be required to make contributions to many services, such as home care and residential care, which can involve applications for benefits. Complexities frequently arise from the distinction between social services, which may involve a financial contribution, and health services,

which are free at the point of delivery. Home improvements to allow the service user to remain at home may involve lengthy applications for grants from the Housing Executive. The situation where individuals are denied essential services because of inter-agency wrangling about who should pay for them is unfortunately not uncommon.

For the voluntary agencies, funding may come from a variety of sources, including the statutory sector, and bids for this and other forms of funding, such as Lottery grants, are a common feature of voluntary sector management. Most funding is time-limited, with an inevitable impact on the ability of voluntary agencies to make long-term commitments to provide services.

Financial considerations pervade social and health care services at all levels. In a multi-disciplinary setting, the practitioner is likely to face a complexity of financial issues surrounding social service budgetary restrictions, cross-agency funding and individual service user's personal income in negotiating services to meet the needs of the service user.

Management

Multi-disciplinary working involves co-operation between professionals who may have radically different management structures and cultures of accountability. Management of multi-disciplinary working requires the consideration of issues regarding whether separate lines of management should remain or whether management should be devolved or otherwise co-ordinated. Devolved management requires the development of structures which may have to reflect or provide alternatives to a wide range of professional management styles, such as supervision in social work, clinical audit for medical practitioners and training for police officers.

One of the strengths of a multi-disciplinary team is the diversity of professional experience and skills which can be brought to delivering holistic services. However, practitioners may have difficulty sustaining their professional identity when their working environment is remote from their colleagues in the same discipline, particularly on a full-time or long-term basis. Consideration needs to be given to the mentoring arrangements that need to be put in place to shadow the formal devolved management practices.

Management of a multi-disciplinary team, therefore, requires attention to individual and team training and development.

Training and staff development

In multi-disciplinary working, training and staff development needs to be considered. This might include:

- An audit of skills within the multi-disciplinary group
- Identification of additional areas of expertise required to meet the aims of the initiative

- Identification of training needs for individuals and the professionals involved as a whole
- Consideration of how professional skills will be maintained
- Consideration of how professional knowledge might be shared
- The role of service users and representative groups in the training and development process.

Summary to Chapter 5

- **Multi-disciplinary working requires the establishment of shared protocols and formalised procedures to help ensure consistent standards of care**

- **Developing an effective multi-disciplinary team requires the setting of clear objectives through the identification of need and the planning, purchasing and financing of services appropriate to such needs**

- **Identification of the needs of service users requires analysis of data and consultation with the appropriate professionals and with existing and potential service users and carers**

- **Effective planning and purchasing of services should be informed by a holistic assessment of need, knowledge of the existence and availability of services and consideration of how diverse strategic and technical factors may impact on the ability of providers to deliver services**

- **Consideration of how services are to be financed encompasses not only the budgetary procedures and constraints of statutory and voluntary providers but also the cost to service users and how they may be enabled to meet such costs**

- **Management of a multi-disciplinary team requires procedures to address the professional, training and developmental needs of individual team members, who may be from very diverse working cultures, and of the team as a whole**

Chapter 6

Values, knowledge and competences

Chapter 6

Values, knowledge and competences

As we have seen, contemporary social work practice increasingly involves the practitioner in co-operative working with a wide range of individuals and organisations. The experience of many social workers in the multi-disciplinary setting has been positive, with the establishment of effective working practices, good working relationships and excellent outcomes for service users. However, for the social work practitioner to work effectively within a multi-disciplinary setting, an understanding of the dynamics between team members and an appreciation of different professional cultures and practices is required.

Equally, the values which underpin and are integral to social work may not be fully understood or shared by colleagues from other disciplines and tensions may arise which may impact upon the effectiveness and cohesion of the team. It may be incumbent upon the social work practitioner, therefore, to disseminate and promote such values within the multi-disciplinary team.

This section discusses the values, knowledge and competences required of social workers in multi-disciplinary settings. It should be read in conjunction with Assuring Quality in the Diploma in Social Work - 1 (CCETSW second revision 1996) which sets out in full the values, knowledge and competences required of qualifying social workers.

Values

Social Work values require that practitioners:

- identify and question their own values and prejudices, and their implications for practice
- respect and value uniqueness and diversity, and recognise and build on strengths
- promote people's rights to choice, privacy, confidentiality and protection, while recognising and addressing the complexities of competing rights and demands
- assist people to increase control of and improve the quality of their lives, while recognising that control of behaviour will be required at times in order to protect children and adults from harm
- identify, analyse and take action to counter discrimination, racism, disadvantage, inequality and injustice, using strategies appropriate to role and context
- practise in a manner that does not stigmatise or disadvantage either individuals, groups or communities

In a multi-disciplinary environment, social workers may be working with colleagues with differing value sets who exhibit, through their language or actions, bias or discrimination towards other members of the team or to service users and their families and carers. Equally, there may be a lack of understanding or commitment to the rights of individuals to be treated with dignity and respect and to participate in making the decisions which affect their lives. The dilemmas and conflicts which arise from such issues and the resolution of such difficulties is likely to be part of the day to day experience of workers in a multi-disciplinary environment.

Knowledge

The experience of some practitioners in a multi-disciplinary setting is that they can sometimes feel isolated, undervalued or marginalised. The comments of one practitioner who worked as the lone social worker in a GP's surgery indicates that multi-disciplinary working can be intimidating:

> *'I must admit that I joined the group with all my presumptions, assumptions and stereotypes intact. My personal attitude towards GPs hovered between subservience and downright obsequiousness. If directed by my GP to stand on my head in a corner, my probable response would have been "which corner?"'(7:7)*

However, social work practitioners have an invaluable role to play in a multi-disciplinary team providing social and health care. In particular social workers can bring knowledge and understanding of:

- the statutory and legal obligations in the provision of social care services
- ethics and values and their implications for social work practice and multi-disciplinary and interagency work
- the role of social work and other professions in multi-disciplinary work
- work in specialist areas of practice which can be of benefit to the team as a whole in its delivery of services
- sociological and psychological theories and their application to social work practice
- how organisations work and the potential for conflict between organisational, professional and individual values
- models and methods of social work interventions; their application and appropriateness in a range of circumstances and settings

- access to resources
- interpersonal and communication skills, enabling social work practitioners to interact effectively with other professionals and service users

Competences

The Core Competences required of a student undertaking the Diploma in Social Work are an indication not only of the skills fundamental to all social work but also of the relevance of multi-disciplinary working in the provision of social care. The six core competences outlined below are integral to the five models of co-operative working identified in Chapter 2.

Communicate and Engage: The ability to 'form and develop working relationships' with individuals and organisations is an essential skill with particular relevance to multi-disciplinary working. The identification and evaluation of key factors concerning the community and the roles played within it by the various agencies, and an ability to recognise and acknowledge different perspectives, values and aims, provides a basis from which to develop and sustain working relationships with colleagues and service users alike. Social workers need to be competent in networking effectively.

Promote and Enable: The user-focused, needs-led model of social and health care requires that service user involvement is fundamental in all aspects of service delivery. The promotion and enabling of individuals to 'meet responsibilities, secure rights and achieve change' requires social workers to provide information and advice so that individuals can make informed choices, and to encourage and assist them to have their voice heard. In a multi-disciplinary setting, the social work practitioner is often the most appropriate and skilled team member to ensure that even the most disadvantaged service user remains the focus of co-operative working.

Assess and Plan: Working in partnership to assess an individual's circumstances and plan an appropriate response requires skills in identification, negotiation, evaluation and review of need and of the resources available or required to meet that need. In a multi-disciplinary environment, the social work practitioner is likely to have the greatest skills and experience in identifying and analysing risk of harm, abuse and failure to protect; and is likely to have responsibility for ensuring adherence to social services policies and legal requirements.

Intervene and Provide Services: Social work practitioners are required to have the skills to contribute to the provision of services following assessment of need as well as having a central part to play in the co-ordination, monitoring and evaluation of agreed programmes. An understanding of resource issues is often required in terms of budget and eligibility criteria and the ability to evaluate the efficiency and effectiveness of services. In ensuring the involvement of the service user in all aspects of service delivery, the practitioner will be in a position to assist and enable users and their family and carers to participate fully in making the decisions which affect their lives.

Working in Organisations: The Core Competences equip the social work practitioner with many of the skills required to participate fully in a multi-disciplinary team. To work effectively within the team, a practitioner is required to retain his or her professional identity while contributing to its development in terms of policies and procedures and the planning and allocation of work. However, multi-disciplinary working is not without its tensions and difficulties. Social workers must also be able to identify and understand the roles and responsibilities of the other professions within the team and maintain effective, collaborative working relationships. They must be able to acknowledge and analyse professional dilemmas and conflicts and take appropriate action to resolve them.

Develop Professional Competence: Social workers are required to develop their skills in terms of effective working practices, such as the ability to organise their workload, communicate effectively with colleagues, other professionals and service users and carers, and contribute to meetings, discussions and decision making. All such skills have relevance in a multi-disciplinary setting where there is a requirement to establish joint protocols, procedures and practices. The skills of identification, analysis and evaluation also required of social workers have particular value in terms of assessment and decision making.

The importance of research in Personal Social Services is emphasised in the Report of the Social Services Inspectorate (1999) which states that it should:

> *'...help to promote best practice through identifying particular components of practice or service delivery that enhance the health and well being of the recipients of that service.' (6:30)*

In terms of multi-disciplinary working, the social work practitioner who continues to review and appraise current research throughout their practice can make a considerable contribution to the knowledge and development of the team and promote the integration of creative and well-tested practices and services.

Summary to Chapter 6

- **Social work increasingly involves practitioners in co-operation with a wide range of individuals and organisations**

- **Successful multi-disciplinary working requires an understanding of different professional cultures and recognition that not all workers will share the values which underpin social work**

- **The values, knowledge and competences expected of social workers can ensure that they are particularly well equipped to work effectively in a multi-disciplinary environment**

- **Social work practitioners can make a major contribution to the promotion and development of anti-discriminatory practices within a multi-disciplinary group**

- **Social workers should be aware of the value of their role in a multi-disciplinary environment**

- **The practitioner should continue to review and appraise current research and promote new developments in the provision of social and health care**

Chapter 7

Exercises

Chapter 7

Exercises

Chapters 1-6 have explored the context of multi-disciplinary working and discussed the opportunities and dilemmas for social workers. To enable social work students to consolidate and develop their knowledge and understanding of work in a multi-disciplinary setting, this chapter provides seven exercises which draw on the content of the preceding chapters. The exercises explore the opportunities, dilemmas and tensions in working alongside other disciplines, analysing and assessing service user needs and delivering 'joined-up' services:

Exercise 1 - Needs analysis

Exercise 2 - Identifying multi-disciplinary relationships

Exercise 3 - Sharing information in multi-disciplinary work

Exercise 4 - Assessment of Service User need (case study)

Exercise 5 - The value of multi-disciplinary work

Exercise 6 - Co-operative working - barriers and tensions

Exercise 7 - Multi-disciplinary working in Northern Ireland (case study)

Exercise 1

Needs analysis

Aim: The establishment of any multi-disciplinary or inter-agency relationship must be relevant to the needs of a service user, group of service users or the community as a whole. The purpose of this exercise is to examine methods of identifying need through the gathering and analysis of information from the primary sources of existing data, professional expertise and user experience to inform the planning and strategic processes. The key aspects of assessment of need are illustrated on the Needs Analysis Pyramid. This exercise links to the discussion on needs analysis in Chapter 5.

Resources:	Facilitator(s)	Flip chart and paper
	Marker pens	Copies of the Pyramid Diagram

Method:

(1) Decide upon an area of service delivery to be the focus for the exercise, for example:
- Looked after children
- Adult mental health
- Learning difficulties

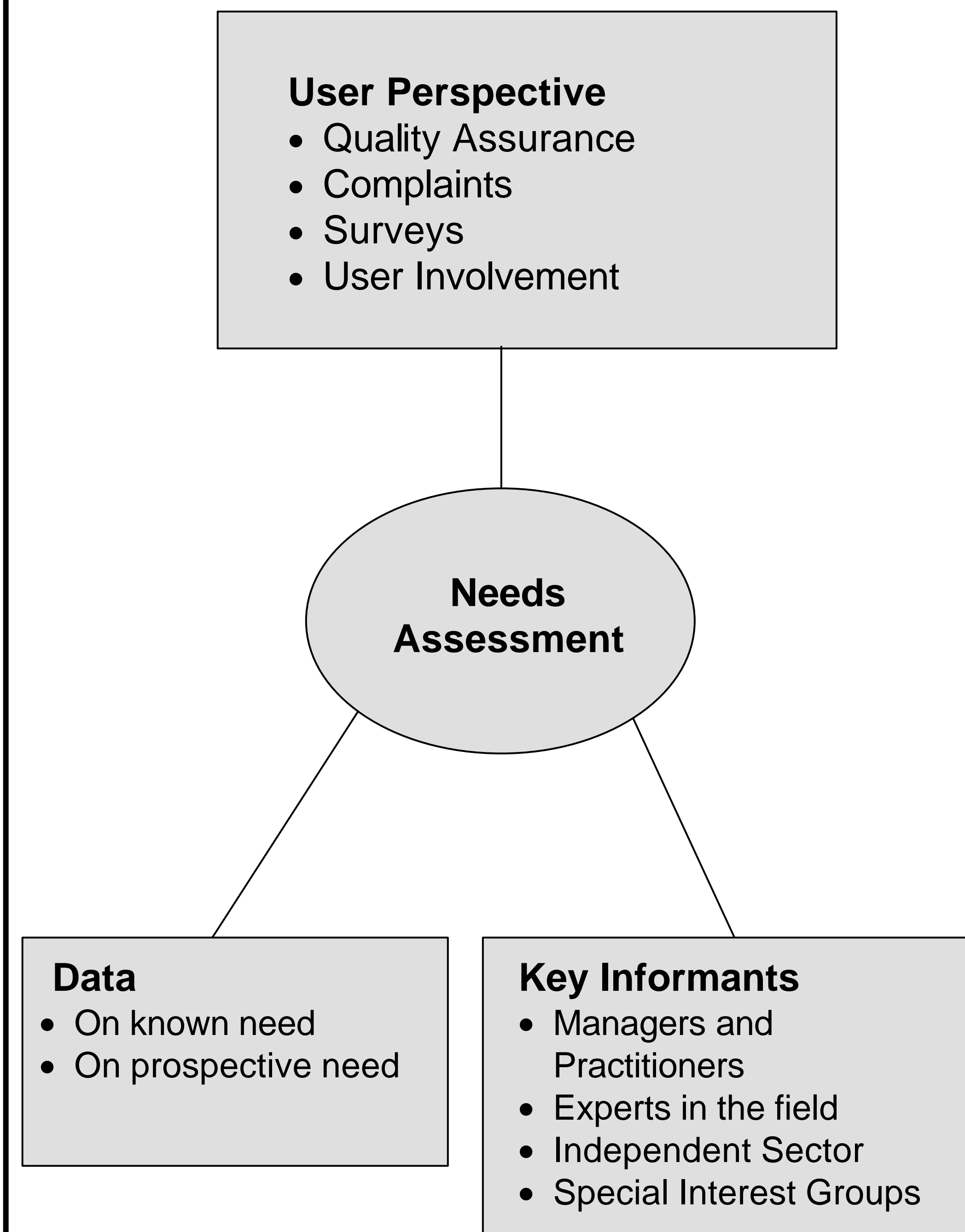
(2) The exercise can be undertaken as a group or in smaller groups or pairs who record their views and report back to the main group

(3) Identify the information you require to evaluate the nature of the needs to be met, for example:
- Current referrals and caseloads
- Needs currently met
- Needs currently not met

(4) Identify key informants and the information you require from each of them on how work and services should be developed, for example:
- Social service managers and practitioners
- Service providers
- Voluntary groups
- Service users and carers

(5) Identify means of obtaining the information from each of the key informants, for example:
- Surveys
- Quality assurance systems
- Complaints

(6) Identify the possible constraints and challenges which may have to be addressed in the process. How might these be negotiated?


Needs Analysis Pyramid
User Perspective
• Quality Assurance
• Complaints
• Surveys
• User Involvement
Needs Assessment
Data
• On known need
• On prospective need
Key Informants
• Managers and Practitioners
• Experts in the field
• Independent Sector
• Special Interest Groups

Key Points from Exercise 1

The key points which should arise from this exercise include:

- Ways in which the need for a particular service is evidenced. E.g.: through user feedback, statistical evidence

- Processes of evaluating the extent of the need for services. E.g.: statistical evidence, caseloads, surveys

- Identification of the providers of services. E.g.: statutory agencies, voluntary agencies, informal carers

- Consideration of how the current provision of services might be evaluated. E.g.: user consultation, quality assurance processes

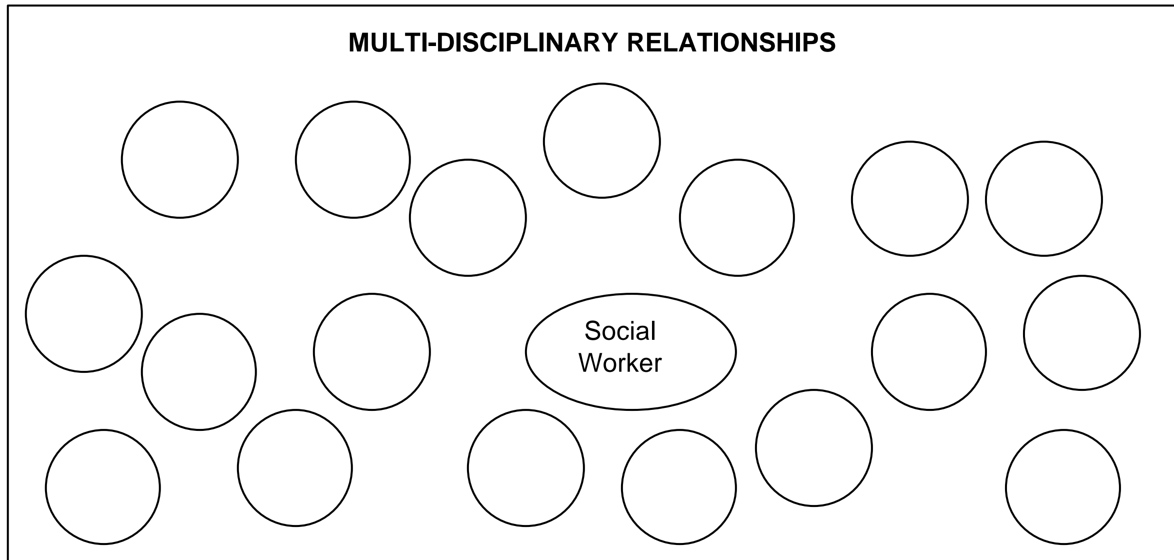
- Consideration of how the means of meeting unmet needs might be identified. E.g.: consultation with other professionals, user involvement

- Discussion of the role of the social worker in the multi-disciplinary assessment of need

- Consideration of how the competences required of a social worker relate to that role

Exercise 2

Identifying multi-disciplinary relationships



Aim: Five modes of co-operation in multi-disciplinary working are identified in Chapter 2. The aim of this exercise is to identify the modes which are likely to operate in a multi-disciplinary approach to service provision. Participants should be encouraged to take a holistic, multi-disciplinary approach in identifying the people and agencies that might co-operate in meeting the needs of the service user.

Resources: Facilitator(s)
Copies of blank Bubble Graphs
Copies of Example
Pens

Method:

(1) Identify an area of service provision, for example:
- Youth offending
- Teenage pregnancy
- Drug misuse

(2) Identify the professionals, agencies, service users and their informal carers who might be involved in a multi-disciplinary provision of services, for example:
- Police

- Education
- Health

(3) Map the likely modes of co-operation in each case by entering the names of the various agencies in the blank circles and joining them using different lines to indicate the different modes. For example:

....	Communication
- - - - - - - -	Consultation
___________	Collaboration
=========	Bilateral Working
+++++++++	Joint Working

The definitions of the modes are as follows:

Communication is defined as co-operation at its most basic level, involving one discipline or agency informing another of its actions.

Consultation involves activities where one discipline or agency approaches others for their opinions, information and advice on a proposed course of action.

Collaboration involves a degree of mutual activity between disciplines or agencies with adjustments and agreement on the scope and level of participation in that activity but usually with the expectation that each agency or discipline will operate independently in provision of services.

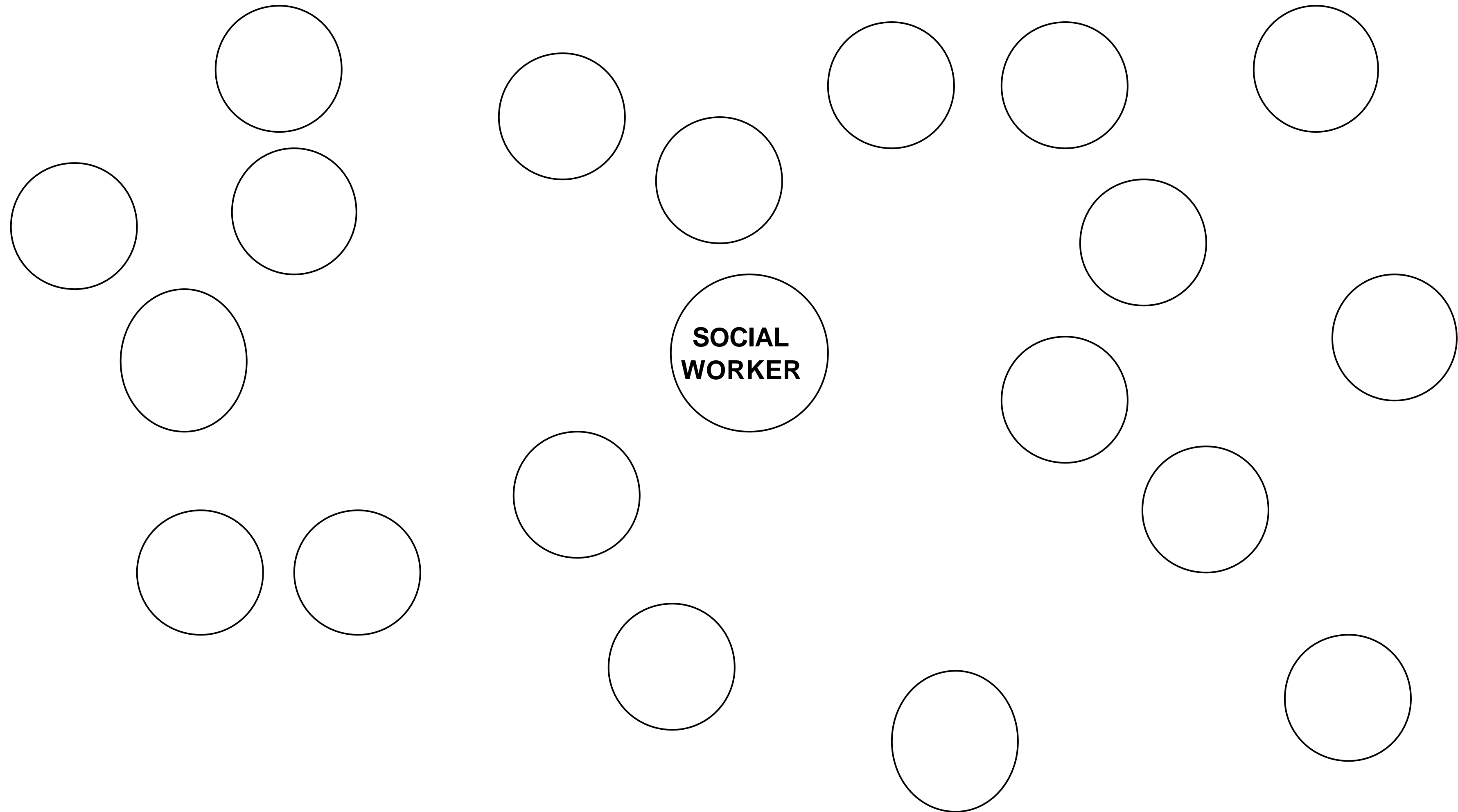
Bilateral working implies the recognition of an overlap in service provision between disciplines or agencies which can give rise to both individual and collective operational planning and service delivery.

Joint working implies agencies working together to plan and operate a mutual course of action.

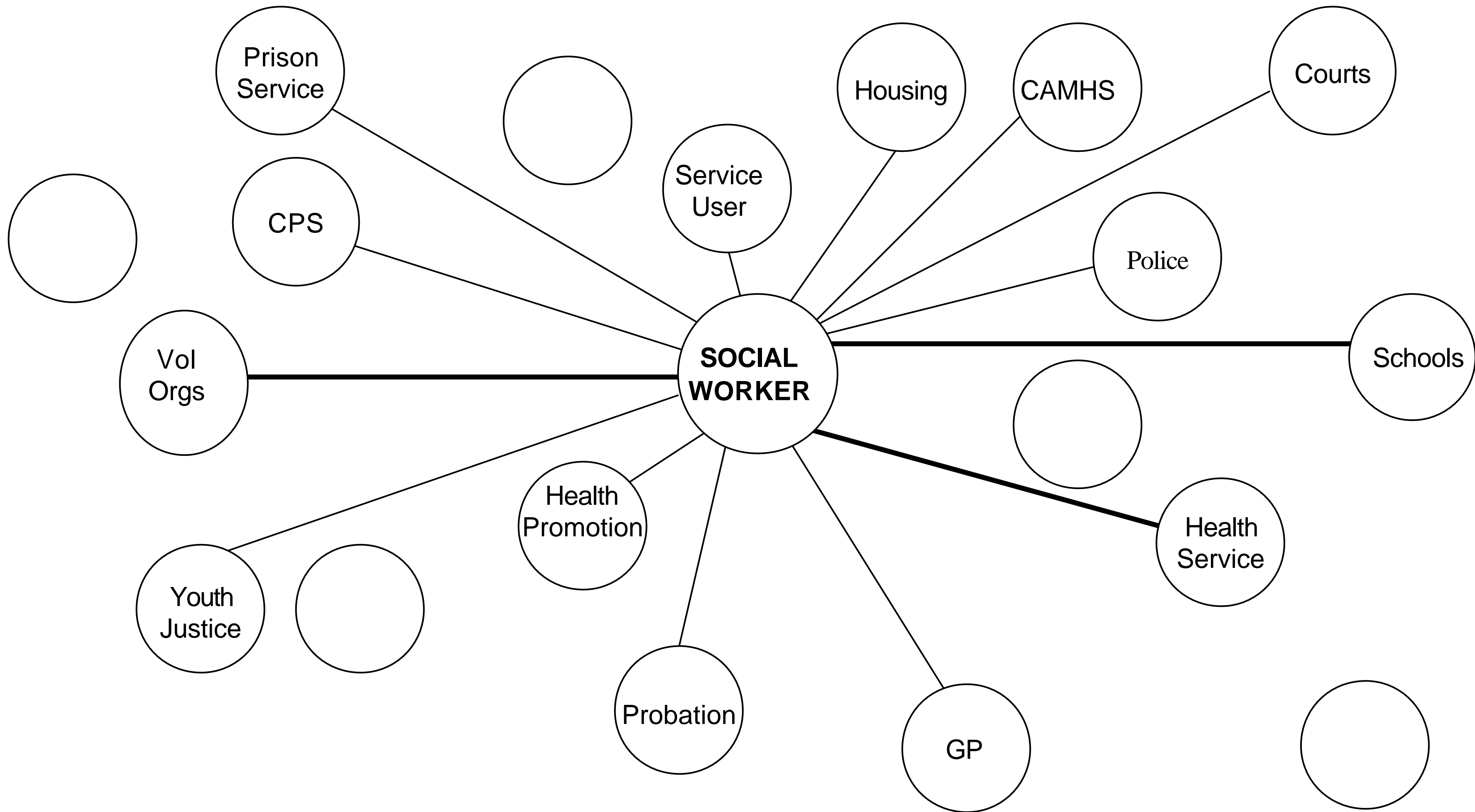
(4) Identify the challenges which might have to be addressed

(5) Consider what skills might be helpful in addressing the challenges

MULTI-DISCIPLINARY RELATIONSHIPS



MULTI-DISCIPLINARY RELATIONSHIPS



EXAMPLE

Services for young people who abuse drugs

Key Points from Exercise 2

The key points which may arise from this exercise include:

- The tensions and conflicts which might arise between partners in co-operative working. E.g.: between the social worker's duty to protect the service user's confidentiality and the legal obligations of police officers

- How such tensions might impact on modes of co-operation. E.g.: the statutory obligations of social service departments in child protection cases might result in communication being the main mode of co-operation

- The need to establish cross-boundary protocols which reflect the nature of the work undertaken

- Reflection that the modes of co-operation may be variable or developmental. E.g.: consultation on a community based service for older people may lead to collaboration in the provision of services

- Consideration of the different perspectives of partners in co-operative working. E.g.: How would the diagram look if a GP or a voluntary group was the central agency?

- Consideration of where service users, their families and informal carers should be placed in the chart and the modes of co-operation which might result

- Discussion of the role of the social worker in multi-disciplinary relationships

- Consideration of the competences required of a social worker in relation to that role

Exercise 3

Sharing information in multi-disciplinary work

Aim: The exchange of information is one of the fundamental requirements of multi-disciplinary working in terms of both the information to be shared between professionals and between the professionals and the service user. The aim of this exercise is to identify the types of information which might be shared between partner agencies and individuals in the process of delivering a service to the individual user and to consider the limitations which might arise in the sharing of information.

Resources: Facilitator(s)
Copies of blank Table
Copies of Example
Pens

Method:

(1) Identify an area of multi-disciplinary working

(2) Identify what information the participants have access to and where it is likely to be held, for example:
- Client record systems
- Card indexes

(3) Consider what information you would exchange between multi-disciplinary partners, for example:

- Individual case histories
- Aggregated information about a group of service users
- Data on services already provided
- Financial information

(4) Consider what limitations exist on exchanging information, for example:

- Confidentiality issues
- Policies and protocols
- Data protection

(5) Map your findings on the attached table or devise one of your own.

INFORMATION TABLE

SERVICE PROVIDER	DATA SOURCE	DATA ITEMS	INFORMATION EXCHANGED

SERVICE PROVIDER	DATA SOURCE	DATA ITEMS	INFORMATION EXCHANGED
Hospital	Computer records Medical notes	Medical history Treatment received Continuing treatment	Medication Specialist nursing Prognosis
GP	Computer records	Medical history Services provided	Primary care services required
Social services	Assessment forms	Home circumstances Informal carers Eligibility criteria Financial details	Services required Services available How costs to be met
Home care agency	Info data base Assessment forms	Previous services supplied Services available	Home services required Cost
Housing Executive	Data base Inspection records	Suitability of housing Improvement grants Eligibility criteria Alternative accommodation	Services required Services available Cost
Voluntary group	Card index	Availability of services Eligibility criteria	Available services
Occupational Therapist	Assessment forms	Aids/adaptations required	Services required Services available
Specialist services	Info data base Assessment forms	Availability of services Services required	Respite care/specialist nursing available
Benefits agency	Data base Computer records	Record of contributions	Benefits available Eligibility criteria

EXAMPLE

Service user requiring palliative care

Key Points from Exercise 3

The key points which may arise from this exercise include:

- Discussion on the desirability of shared information. E.g.: ‘seamless’ provision of services that meet the needs of the individual service user

- Consideration of the difficulties that might arise in obtaining the information. E.g.: poor record keeping, inaccurate information

- Consideration of the requirement for policies and procedures. E.g.: to overcome professional barriers, reduction in inappropriate referrals

- Consideration of confidentiality issues. E.g.: sharing information provided by the service user

- Consideration of the rights of the service user. E.g.: access to personal information

- Discussion of the role of the social worker in the exchange of information

- Consideration of the competences required of a social worker in relation to that role

Exercise 4

Assessment of service user need

Aim: The multi-disciplinary approach to service provision reflects the holistic model of social and health care which aims to provide seamless, needs-led, user-focused services. The purpose of this exercise is to give students the opportunity to assess the needs of a service user and the variety of services required to meet his needs. The example provided is drawn from the case history of a service user.

Resources: Facilitator(s)
Flip chart and paper
Marker pens
Copies of case history

Method:

(1) Read the case history

(2) Identify the needs of this service user

(3) Identify the needs of other people who may be involved, for example, members of his family, other members of the community

(4) Consider who should have membership of the multi-disciplinary group which would meet the identified needs

(5) Consider what challenges or dilemmas might have to be addressed in the course of the assessment process

Case History:

Paul is due to be discharged from the psychiatric ward of the local hospital where he had been admitted under the Mental Health (NI) Order, 1986. Paul had been found wandering around naked, having cut his wrists. He had absconded from the hospital on a number of occasions.

Prior to his admission Paul had led a very transient existence, living at various times with his mother, with girlfriends and in hostels and a homeless shelter. He has a previous history as a drug user and hospital staff describe him as at times hostile, agitated and aggressive. Psychological tests have placed his IQ at 81.

Paul has reported that he fantasises about rape and has threatened to "rape" a female worker at a voluntary centre where he went to ask for counselling about sexual abuse which had been perpetrated against him as a child. He reports he has raped women in the past. He has a daughter aged 9 whom he has not seen for some time.

Paul has been prescribed Clopixol 300mgs every two weeks. He has a previous history of non-compliance with medication.

Key Points from Exercise 4

The key points that may arise from this exercise include:

- Advantages of adopting a holistic approach to the provision of services. E.g.: over an exclusively medical model

- An appreciation of the variety of services required to meet the needs of individual service users

- Consideration of issues relevant to family members and the service user's community and other professional staff. E.g.: child protection, medication compliance, personal safety of staff

- Discussion of the role of the social worker in the case. E.g.: advocate for the service user

- Consideration of the conflicts and dilemmas which might arise for the social worker in a multi-disciplinary setting. E.g.: in protecting the confidentiality of the service user

- Consideration of the competences required of social workers in relation to their role in a multi-disciplinary setting

Exercise 5

The value of multi-disciplinary work

Aim: The experiences of professionals and service users have indicated that there is 'added value' to multi-disciplinary working, that the whole is greater than the sum of the parts. The participants in the multi-disciplinary partnerships should have a clear understanding of the desired outcome and of the ways by which they can be measured. The aim of this exercise is to identify the 'added value' attached to multi-disciplinary working in the assessment process.

Resources: Facilitator(s)
Copies of blank Grid
Copies of Example
Pens

Method:

(1) Identify an area of service provision to be the focus of the exercise. For example:
- Home based services for older people
- Respite care for children with disabilities
- Community services for adults with mental health needs

(2) Divide the participants in the exercise into two groups to represent:
- Service providers
- Service users

(3) Each group considers and identifies the 'added value' of the multi-disciplinary approach to the assessment process for the group they represent, lists them on flip chart paper and reports back to the whole group

(4) Enter the advantages for each group on a flip chart using the attached grid as a model

(5) Discussion of the issues involved in the measurement of outcomes

Added Value Table

Multi-disciplinary Assessment

Providers	Service users

Added Value Table

Multi-disciplinary Assessment

Providers	Service users
• Better informed of services required; can plan to meet local need • Development of effective procedures and protocols • Development of good practices • Breaking down of professional boundaries • Hospital beds become available sooner • Fewer re-admissions to hospital • Fewer people in long term residential care • Staff better informed of available services • Improved information sharing • Less administration • GPs better informed of services • Integrated services • Reduced costs • Money available to develop services • Healthier community • Improved relationships with the community • Fewer complaints from service users	• Care plan which is appropriate to needs • Fewer assessments • More needs identified and met • More treatable conditions being identified and dealt with • More certainty about who is to provide services • Better informed about services available • More choices and opportunities to exercise choice • Co-ordinated services • Less delay in receiving services • Earlier rehabilitation • Earlier return home • Greater protection for the most vulnerable • Support for informal carers • Safer and more secure home environment • Reduced risk of 'slipping through the net' • Improved access to benefits • Improved health • Satisfaction with services • Confidence in the care system

Example

Multi-disciplinary assessment of older people for home care

Key Points from Exercise 5

The key points, which should arise from this exercise, include:

- Identification of the benefits of multi-disciplinary assessments. E.g.: less duplication of effort, fewer assessments for service users

- Identification of how the benefits can be measured. E.g.: cost effective service provision, less delay for the user in receiving services

- Identification of the 'added value'. E.g.: planning of appropriate local services, better health for members of the community

- Consideration of the conflicts which might arise. E.g.: between the budgetary restraints of service providers and the requirement for tailored specialist services to meet the individual needs of a service user

- Consideration of the requirement for formalised protocols and procedures. E.g.: in terms of confidentiality and access to information about the service user

- Consideration of the means by which a multi-disciplinary assessment might be undertaken. E.g.: joint assessments, multi-skilled assessors

- Consideration of the implications for social workers of the different means of multi-disciplinary assessment. E.g.: training, less specialism

- Identification of the role of the social worker in a multi-disciplinary assessment. E.g.: promotion of the social rather than medical model of social care

- Consideration of the competences required of social workers which are particularly relevant to multi-disciplinary assessments

Exercise 6

Co-operative working - barriers and tensions

Aim: Multi-disciplinary working frequently involves co-operation between people from diverse professional cultures with different working practices and a variety of perspectives on the provision of services. Effective co-operation in such an environment requires understanding and respect for the views and imperatives of others and the establishment of working practices, which allow the full participation of all members of the multi-disciplinary group.

The aim of this exercise is to give students the opportunity to examine their own preconceptions about the providers of services and service users within the multi-disciplinary context, to identify the traditional barriers to co-operative working and to consider ways in which they might be overcome.

Resources: Facilitator(s)
Flip chart and paper
Marker pens

Method:

Ideally, a multi-disciplinary approach should be taken to this exercise by involving actual practitioners of the various disciplines, service users and carers. Alternatively, the various participants of a group may be represented through role-play.

(1) Decide on an area of service to be the focus of the exercise. For example:
- Adults with learning disabilities
- Pregnant teenagers
- Travelling Community

(2) Identify the agencies and individuals who are likely to be included in a multi-disciplinary team to provide services. For example, services to meet the needs of a pregnant teenager may require the involvement of:
- Social workers
- Hospital staff
- GP
- Midwife
- Teachers
- Family care unit
- Service user's parents
- Adoption agency

(3) Identify participating professionals or allocate roles to individuals, pairs or groups of students. For example, one group could represent social services, another education, another a voluntary agency and so on.

(4) Each individual, pair or group has 3 tasks to undertake and write up on flip chart paper:

- To consider the likely perceptions of the person or agency they represent with regard to the service user. For example, a police officer's perception of a family of travellers as potential law breakers; a social worker's perception in terms of the social care needs of individual members of the family

- To identify the role of the person or agency in meeting the needs of the service user. For example, the social worker as advocate or key worker for an adult with a learning difficulty; the housing officer providing suitable accommodation but also dealing with the concerns of other tenants

- To consider ways in which the various professionals can become full members of the care 'team'. For example, through team building, joint training, understanding of each others roles

(5) After each task the groups representing the various individuals and agencies report back to the full group on their findings

(6) Summary of the key points arising from the exercise

Key Points from Exercise 6

The key points which should arise from this exercise include:

- Recognition of the different roles played by the various professionals and agencies involved in providing services
- Consideration of the preconceptions professionals have of their colleagues in other disciplines. E.g.: GPs are ‘only interested in doling out pills’; social workers are ‘woolly-minded liberals’
- Consideration of the constraints placed upon professionals. E.g.: eligibility criteria, budgetary constraints, statutory obligations, protocols and procedures
- Recognition of the professional strengths of each member of the ‘team’
- Identification of ways of overcoming barriers to multi-disciplinary working. E.g.: knowledge and understanding of and respect for the role of individual team members and agencies
- Consideration of the difficulties social workers might face in a multi-disciplinary setting. E.g.: becoming marginalised, dilution of professional knowledge and expertise
- Recognition of the dilemmas and conflicts which may face a social worker. E.g.: in acting as advocate for a service user and also being the employee of an agency providing services
- Consideration of the competences required of a social worker which are particularly relevant to overcoming barriers in a multi-disciplinary environment

Exercise 7

Multi-disciplinary working in Northern Ireland

Aims: The provision of personal social services in Northern Ireland cannot adequately be addressed without consideration of the difficulties for individuals and communities arising from sectarianism and the aftermath of the Troubles. The aim of this exercise is to examine some of the issues surrounding sectarianism in the provision of services and to consider the dilemmas and conflicts which might arise for the social work practitioner in a multi-disciplinary environment.

Clearly, issues of sectarianism are particularly sensitive and consideration should be given to the support participants may require in undertaking the exercise. It is recommended that this exercise is undertaken with reference to the teaching guidance, *Getting Off the Fence. Challenging Sectarianism in the Personal Social Services in Northern Ireland.* Tutors may wish to undergo anti-sectarian training themselves before approaching the subject with students and there is a list of relevant organisations in the above guidance at Appendix 3.

Resources: Facilitator(s)
Flip chart and paper
Marker pens
Copies of *Getting Off the Fence*
Copies of case history

Method:

(1) Participants in the exercise should work in pairs or small groups, record the main points of their discussion on flip chart paper and report back to the full group

(2) Read the case history of Michael C.

(3) Identify the issues of sectarianism that arise from the case history

(4) Consider the dilemmas which might arise for the social work practitioner from such issues

(5) Examine ways in which such dilemmas might be addressed in a multi-disciplinary environment. E.g.: good practice guidelines, policies, training, support systems

(6) Consider the role of the social work practitioner within a multi-disciplinary team in relation to sectarianism. E.g.: promotion of equal opportunity and anti-discriminatory practice

Case history:
Michael C, who is 34 and has learning difficulties, has been referred to social services by his GP. She feels that his elderly parents, who are in poor health, are finding it increasingly difficult to provide the constant care he requires and she is concerned for his welfare. After a multi-disciplinary assessment of Michael and his parents, a decision is made to provide respite care on a regular basis for Michael and help with cleaning and shopping for Mr and Mrs C which will be provided through a voluntary agency.

On his first visit to the residential home, Michael phones his parents crying and upset and asking to be brought home. The residential home is of mixed religion, but had in the past been single denominational. Most of the residents and staff are of that denomination, to which Michael and his parents do not belong. Michael's parents have strong political and religious affiliations that they have passed on to their son, although he has no real understanding of the issues. He feels frightened and threatened by the residents' noisy support of 'the enemy' and their sectarian comments during a television news report. Staff have tried to reassure Michael, but they do not feel they can intervene unless he becomes at risk of harm. The general feeling among the staff is that social services are at fault for placing Michael in the residential home without considering the problems likely to arise from its location and past history.

The volunteer assigned to assist Mr and Mrs C lost a brother during the 'Troubles' when he was the innocent victim of a riot on a housing estate. She finds it very difficult to cope with some of the comments made by Mr and Mrs C, who have assumed she shares their opinions. She lives in an area where families with her own affiliations predominate and she is concerned that Mr and Mrs C will become abusive if they discover where she lives. She has reported her concerns to the organisation for which she is a volunteer, but the manager seems reluctant to discuss the matter and suggests she ignores the comments and just gets on with it. The volunteer is becoming increasingly distressed with the situation and is considering leaving the organisation.

Both Michael's placement and the home support are at risk of breaking down. Mr and Mrs C have made a complaint about Michael being placed in the residential home and say they will manage on their own in future, although they are clearly unable to continue to provide the level of care their son needs. Preliminary investigations by a social work manager indicate that none of the staff from any of the agencies involved in the assessment of the family felt able to address the sectarian issues. Several of them however admit to having had concerns which they felt constrained from discussing with their colleagues for fear of causing offence.

Key Points from Exercise 7

The key points which may arise from this exercise include:

- Recognition that sectarianism has implications for all members of the community, service users and service providers alike

- Appreciation that the holistic model of care requires that the individual needs of service users and their carers which result from sectarianism and the trauma of the Troubles need to be identified and addressed

- Consideration of the identity issues which might arise within a multi-disciplinary team

- Consideration of the protocols, procedures and practices required within the multi-disciplinary team to ensure that the issues are addressed

- Recognition that sectarianism needs to be constantly challenged with sensitivity in the work place

- Recognition of the role of social workers in the promotion of equitable service provision

- Consideration of the competences expected of a social work practitioner which are relevant to this role

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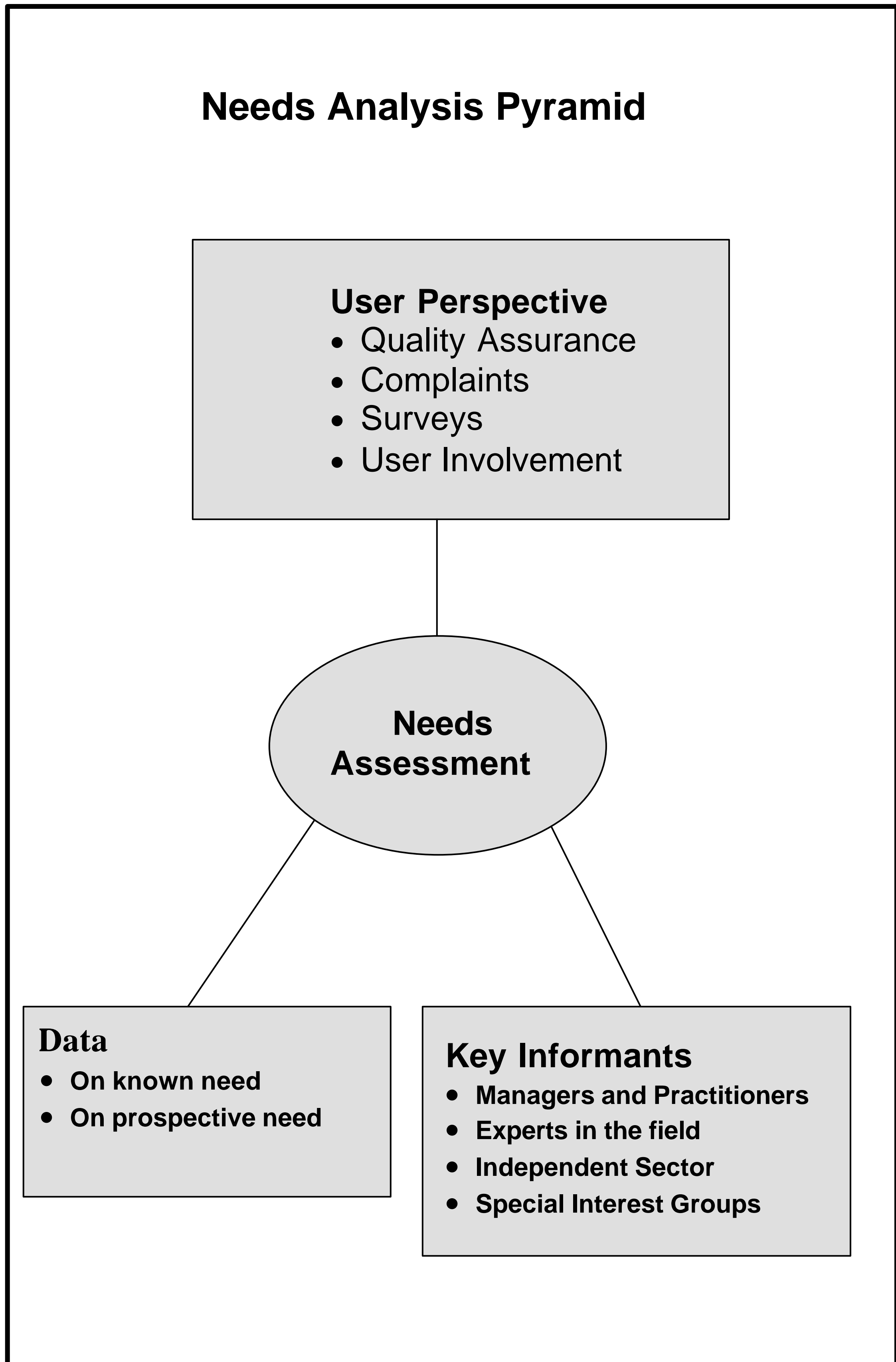
Resource Materials

for

Exercises

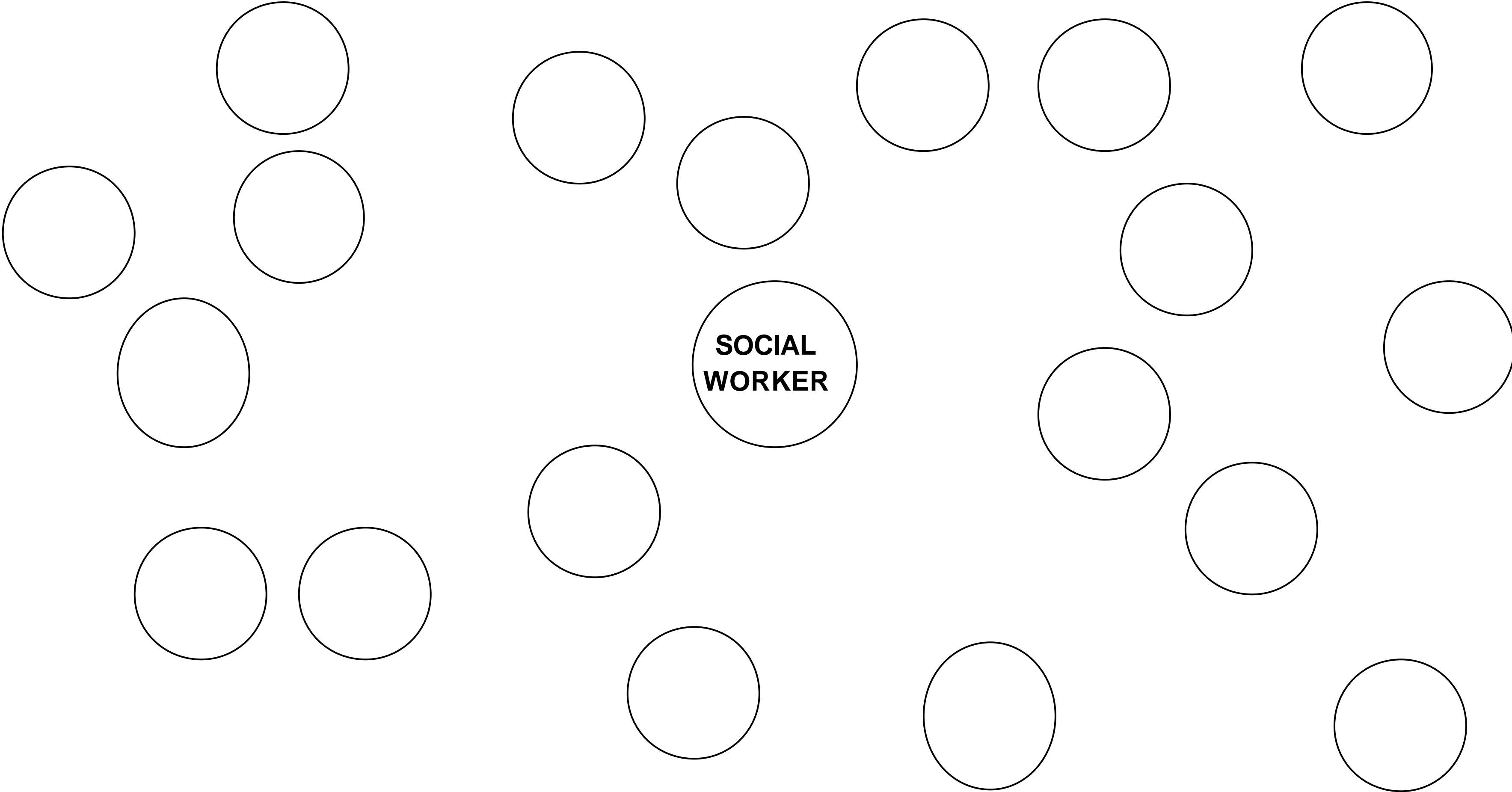
Contains:
Information sheets
Blank grids
Case Studies
Blank Tables

Exercise One
Needs Analysis Pyramid

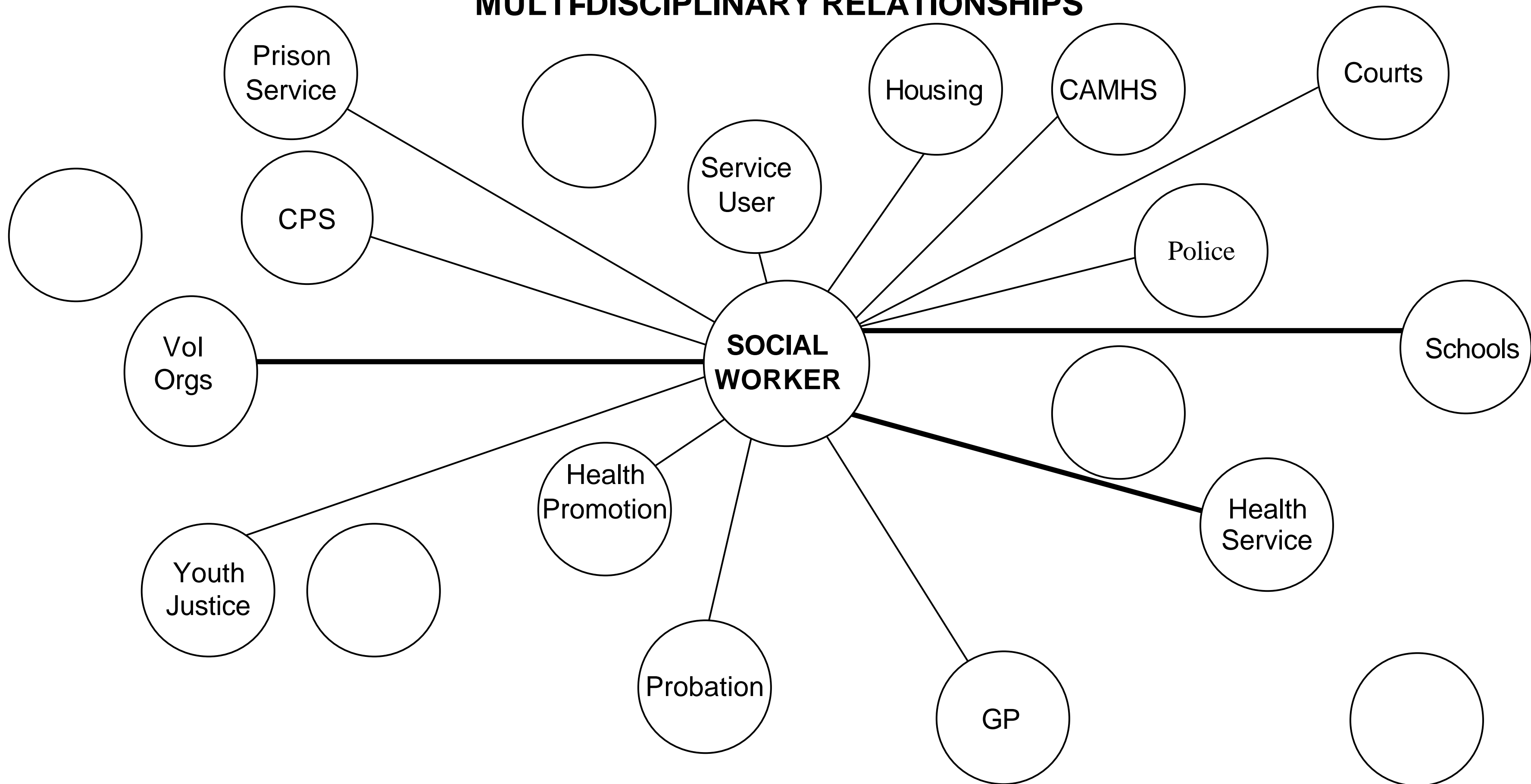


Exercise two
Blank Bubble Graph

MULTI-DISCIPLINARY RELATIONSHIPS



Exercise two
Bubble Graph Example "Services for young people who abuse drugs"



Exercise three
Blank Table

INFORMATION TABLE

SERVICE PROVIDER	DATA SOURCE	DATA ITEMS	INFORMATION EXCHANGED

Exercise three
Example Information Table

Service user requiring palliative care

SERVICE PROVIDER	DATA SOURCE	DATA ITEMS	INFORMATION EXCHANGED
Hospital	Computer records Medical notes	Medical history Treatment received Continuing treatment	Medication Specialist nursing Prognosis
GP	Computer records	Medical history Services provided	Primary care services required
Social services	Assessment forms	Home circumstances Informal carers Eligibility criteria Financial details	Services required Services available How costs to be met
Home care agency	Info data base Assessment forms	Previous services supplied Services available	Home services required Cost
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Voluntary group	Card index	Availability of services Eligibility criteria	Available services
Occupational Therapist	Assessment forms	Aids/adaptations required	Services required Services available
Specialist services	Info data base Assessment forms	Availability of services Services required	Respite care/specialist nursing available
Benefits agency	Data base Computer records	Record of contributions	Benefits available Eligibility criteria

Exercise four
Case History

Paul is due to be discharged from the psychiatric ward of the local hospital where he had been admitted under the Mental Health (NI) Order, 1986. Paul had been found wandering around naked, having cut his wrists. He had absconded from the hospital on a number of occasions.

Prior to his admission Paul had led a very transient existence, living at various times with his mother, with girlfriends and in hostels and a homeless shelter. He has a previous history as a drug user and hospital staff describe him as at times hostile, agitated and aggressive. Psychological tests have placed his IQ at 81.

Paul has reported that he fantasises about rape and has threatened to "rape" a female worker at a voluntary centre where he went to ask for counselling about sexual abuse which had been perpetrated against him as a child. He reports he has raped women in the past. He has a daughter aged 9 whom he has not seen for some time.

Paul has been prescribed Clopixol 300mgs every two weeks. He has a previous history of non-compliance with medication.

Exercise five
Blank Grid

Added Value Table

Multi-disciplinary Assessment

Providers	Service users

Exercise five
Example Grid
Multi-disciplinary assessment of older people for home care

Added Value Table

Multi-disciplinary Assessment

Providers	Service users
• Better informed of services required; can plan to meet local need • Development of effective procedures and protocols • Development of good practices • Breaking down of professional boundaries • Hospital beds become available sooner • Fewer re-admissions to hospital • Fewer people in long term residential care • Staff better informed of available services • Improved information sharing • Less administration • GPs better informed of services • Integrated services • Reduced costs • Money available to develop services • Healthier community • Improved relationships with the community • Fewer complaints from service users	• Care plan which is appropriate to needs • Fewer assessments • More needs identified and met • More treatable conditions being identified and dealt with • More certainty about who is to provide services • Better informed about services available • More choices and opportunities to exercise choice • Co-ordinated services • Less delay in receiving services • Earlier rehabilitation • Earlier return home • Greater protection for the most vulnerable • Support for informal carers • Safer and more secure home environment • Reduced risk of 'slipping through the net' • Improved access to benefits • Improved health • Satisfaction with services • Confidence in the care system

Exercise seven
Case History

Michael C, who is 34 and has learning difficulties, has been referred to social services by his GP. She feels that his elderly parents, who are in poor health, are finding it increasingly difficult to provide the constant care he requires and she is concerned for his welfare. After a multi-disciplinary assessment of Michael and his parents, a decision is made to provide respite care on a regular basis for Michael and help with cleaning and shopping for Mr and Mrs C which will be provided through a voluntary agency.

On his first visit to the residential home, Michael phones his parents crying and upset and asking to be brought home. The residential home is of mixed religion, but had in the past been single denominational. Most of the residents and staff are of that denomination, to which Michael and his parents do not belong. Michael's parents have strong political and religious affiliations that they have passed on to their son, although he has no real understanding of the issues. He feels frightened and threatened by the residents' noisy support of 'the enemy' and their sectarian comments during a television news report. Staff have tried to reassure Michael, but they do not feel they can intervene unless he becomes at risk of harm. The general feeling among the staff is that social services are at fault for placing Michael in the residential home without considering the problems likely to arise from its location and past history.

The volunteer assigned to assist Mr and Mrs C lost a brother during the 'Troubles' when he was the innocent victim of a riot on a housing estate. She finds it very difficult to cope with some of the comments made by Mr and Mrs C, who have assumed she shares their opinions. She lives in an area where families with her own affiliations predominate and she is concerned that Mr and Mrs C will become abusive if they discover where she lives. She has reported her concerns to the organisation for which she is a volunteer, but the manager seems reluctant to discuss the matter and suggests she ignores the comments and just gets on with it. The volunteer is becoming increasingly distressed with the situation and is considering leaving the organisation.

Both Michael's placement and the home support are at risk of breaking down. Mr and Mrs C have made a complaint about Michael being placed in the residential home and say they will manage on their own in future, although they are clearly unable to continue to provide the level of care their son needs. Preliminary investigations by a social work manager indicate that none of the staff from any of the agencies involved in the assessment of the family felt able to address the sectarian issues. Several of them however admit to having had concerns which they felt constrained from discussing with their colleagues for fear of causing offence.