University of BRISTOL

Interprofessional and Interagency Working and Interprofessional Education

Prof. John Carpenter

Rabbie Burns (1759-96)

"O wad some Power the giftie gie **us**, to **see** oursels as ithers **see us**!"

"Oh would some Power the gift give **us**,
to **see ourselves** as **others see us**."

Professional Stereotypes

- **Heterostereotypes** *(held by one profession about another)*
- **Autostereotypes** *(of your own profession)*
- **Perceived Heterostereotypes** *(what you believe another profession thinks about your profession)*

Perceived heterotypes

Doctors

- ✓ Detached
- ✓ Uncaring#
- ✓ Dedicated*
- ✓ Poor communicators
- ✓ Confident*
- ✓ Arrogant*

Nurses

- ✓ Caring*
- ✓ Dedicated*
- ✓ Good communicators*
- ✓ ‘Do gooders’

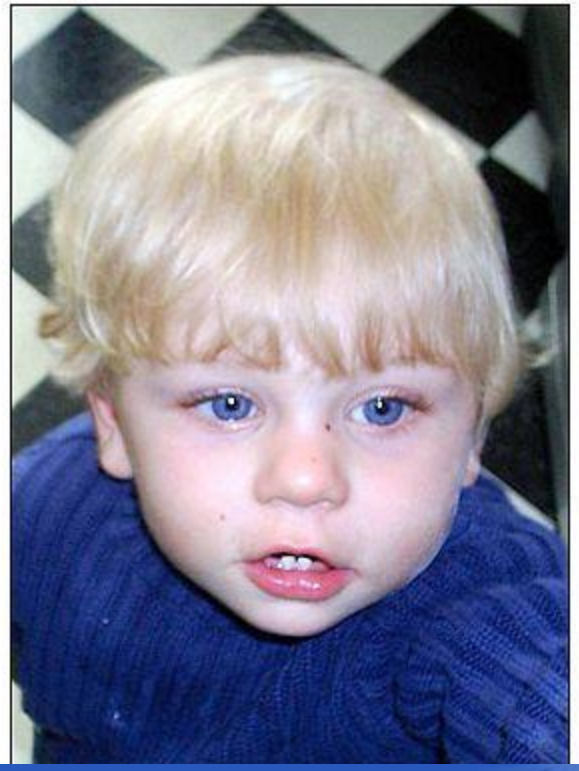
(Carpenter, 1995)

NEWS

Shaming of the Baby P bunglers

By KEVIN SCHOFIELD, Political Correspondent

Published: 11 Jun 2010



A DAMNING report into the failings that led to the death of Baby P will finally be published in full, it was confirmed yesterday.

Families minister Tim Loughton said the findings of the serious case review will help prevent similar tragedies.

Baby Peter Connelly died aged 17 months after bungling Haringey Council social workers in North London missed numerous signs of abuse from his mum, her boyfriend and their lodger.

Haringey children's social services chief Sharon

Who were the “bunglers”?

- The social workers
- The paediatricians
- The police
- The health visitors
- The hospital (Health trust)
- The local authority (Harringay)

Also in Harringay

25th February 2000

Death of Victoria Climbiè

"The suffering and death of Victoria was a gross failure of the system and was inexcusable."

Report of the Inquiry (Laming Report)

"I remain amazed that nobody in any of the key agencies had the presence of mind to follow what are relatively straightforward procedures on how to respond to a child about whom there is concern of deliberate harm."

Why?

- '…the principal failure to protect her was the result of *widespread organisational malaise*.
- A Failure of Management
- 'Sloppy and unprofessional performance'
- Failure to communicate with other agencies
- Failure to take responsibility

A Failure of management

"…the greatest failure rests with the managers and senior members of the authorities whose task it was to ensure that services for children, like Victoria, were properly financed, staffed, and able to deliver good quality support to children and families."

Management across boundaries

"The future lies with those managers who can demonstrate the capacity to work effectively across organisational boundaries. Such boundaries will always exist."

"The safeguarding of children must not be placed in jeopardy by individual preference. The joint training of staff and the sharing of budgets are likely to ensure an equality of desire and effort to make them work effectively."

Laming wrote:

Multi-agency training* is important in helping professionals understand the respective roles and responsibilities and the procedures of each agency involved in child protection, in developing a joint understanding of assessment and decision making practices, and in learning from Serious Case Reviews.

* Also understood as interprofessional education.

HM Government

Working Together to Safeguard Children

A guide to inter-agency working to safeguard and promote the welfare of children.

"Safeguarding children is everyone's business."

Interprofessional education (IPE)

- Definition: “occasions when two or more professionals learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 1997)

  - As part of qualifying professional programmes
  - Postqualifying (Continuing Professional Development - CDP)

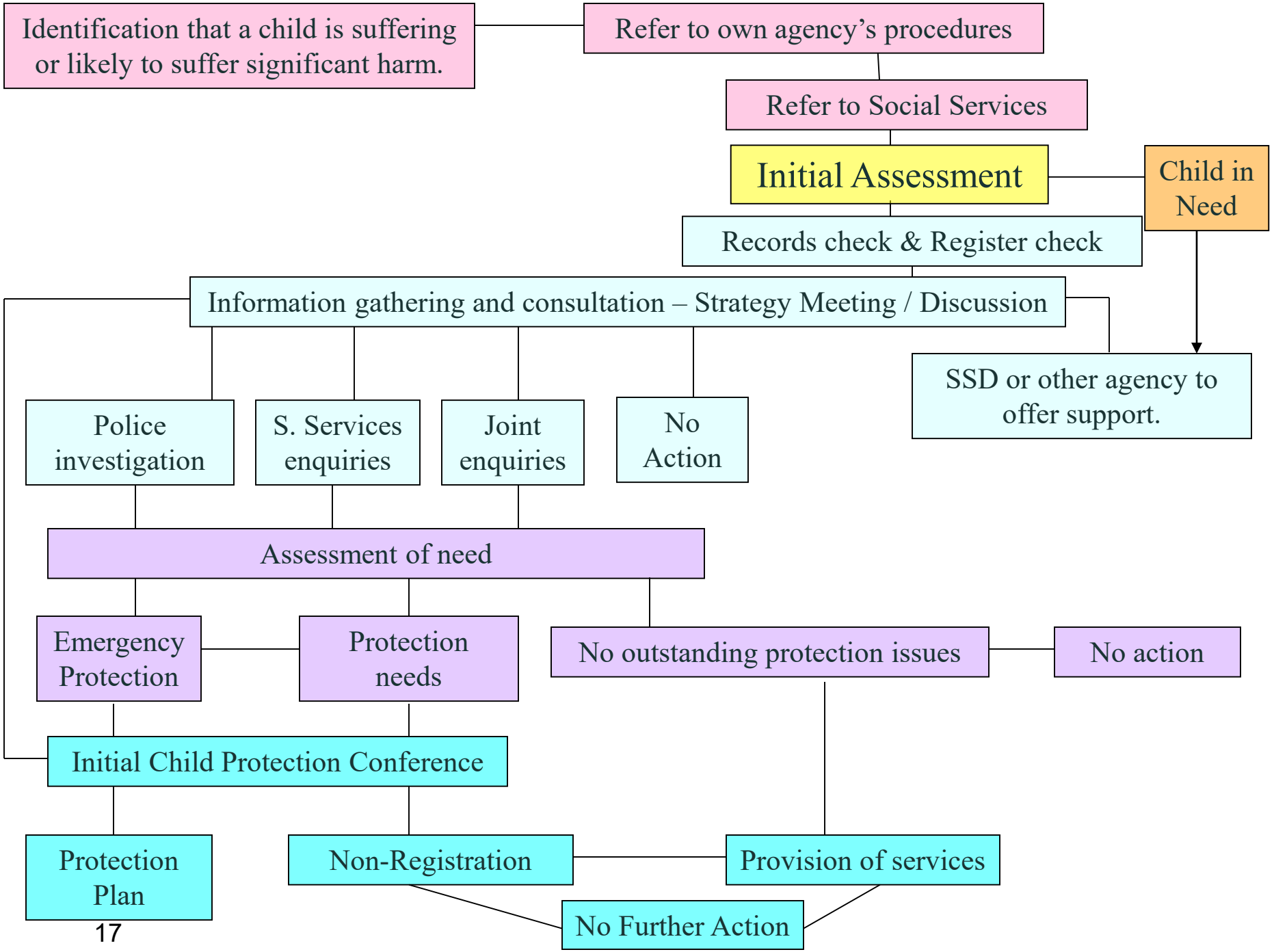
Evidence: two examples

- Short courses on safeguarding children: evidence of effectiveness for professionals
- Longer programmes on community mental health with evidence of their impact on service users (clients).

Working Together Chapter 4: Interagency Training is compulsory

1. Jointly funded by social services, health, police through Local Safeguarding Boards
2. Aims to produce:
   1. Shared understanding of roles and responsibilities
   2. Improved communication
   3. More effective case and team working
3. For all those working with children (including librarians, fire offices, social workers, nurses).

Procedures are complicated, see next slide….


Identification that a child is suffering or likely to suffer significant harm.
Refer to own agency's procedures
Refer to Social Services
Initial Assessment
Child in Need
Records check & Register check
Information gathering and consultation – Strategy Meeting / Discussion
SSD or other agency to offer support.
Police investigation
S. Services enquiries
Joint enquiries
No Action
Assessment of need
Emergency Protection
Protection needs
No outstanding protection issues
No action
Initial Child Protection Conference
Protection Plan
Non-Registration
Provision of services
No Further Action

The Research

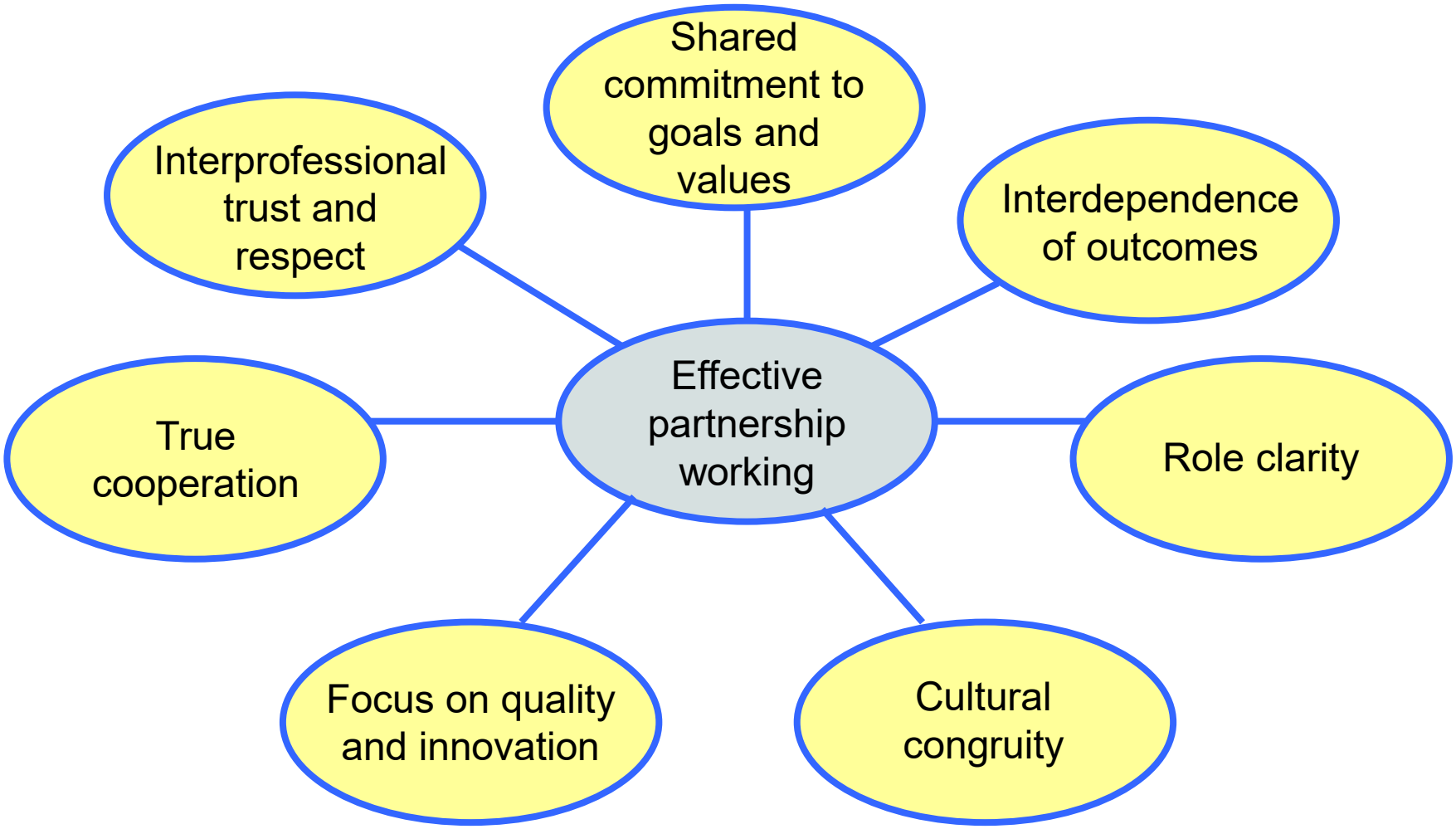
Commissioned by English government Department of Children, Schools and Families and Department of Health.

In 8 areas in England.

Research Questions

- How is interagency training organised? Is the system robust?
- What kind of training is delivered and by whom?
- Does it work? i.e. do participants develop a shared understanding of their respective roles and responsibilities?
- Is it value for money?

Seven dimensions of effective partnership working



Source: West and Markiewicz (2006)

LSCB training: what kind of Partnership?

- Mandated: (but no ring fenced funding).
  - Often previous history of collaboration.
  - Shared commitment – small group (education, health, children's social services, police)
- Responsibilities delineated (in *Working Together*).
- Clear objectives (but outputs (courses) rather than outcomes (learning)).
- Accountability to LSCB.

The Safeguarding Courses (n= 131)

- Responding to Child Protection Concerns (Level 1) (31)
- Working Together (Level 2) (33)
- Domestic abuse (22)
- Parental mental health (8)
- Drug using parents (8)
- Disabled children (11)
- Female genital mutilation (2)
- Children and Young People with sexually harmful behaviour (10)

What are the courses like?

- Length: 1, sometimes 2, days.
- Mixed professional groups of 15-25
- 'Internal' (local agency staff) and external trainers
- Presentations of research, legislation, local policy and procedures
- Highly interactive: small groups, case based, focus on roles and responsibilities, communication exercises.
- Informal contacts and networking

Does it work?

- Development of self-report measures of outcomes (knowledge, self-efficacy and attitudes)
- Participants assessed in a times-series design at:
  - Registration (T0)
  - Start of Course (T1)
  - End of course (T2)
  - Follow-up after 3 months (T3)

Responding to CP concerns (Level 1)

Jade is an eighteen month old child. The health visitor has noticed a bald patch on the back of her head. She is worried and feels that her development is delayed because she isn't stimulated sufficiently.

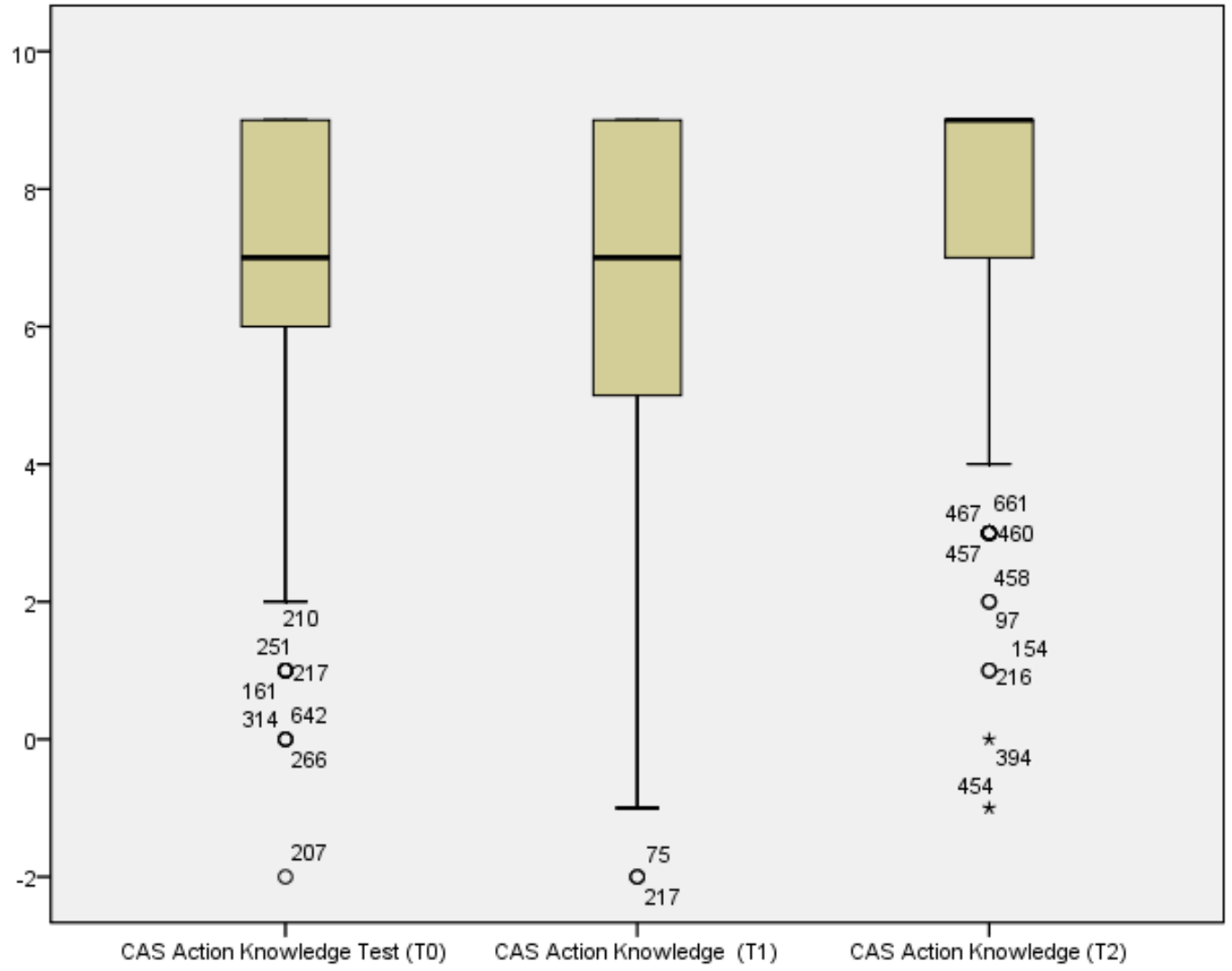
1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: ……

No abuse □

Foundation: *Knowing what to do*

range of scores (-9 to +9) (N = 466)



Working Together to Safeguard Children

(Level 2) 1-2 days

"Provides opportunity for participants who have already received basic child protection training to improve understanding and knowledge of their own and other's responsibilities.

Provides opportunity to explore with colleagues from other agencies challenges related to working together."

Professional and Interprofessional Relationships in Safeguarding (changes)

- ↑ "I have a good understanding of the roles of different professionals who engage in work to safeguard children" p***
- ↓ "I lack confidence when I work with people from other professions" p***
- ↑ "I am comfortable working with people from other professions" p***
- ↑ I feel that I am respected by people from other professions." p*** NB

Attitudes to Interprofessional Interaction

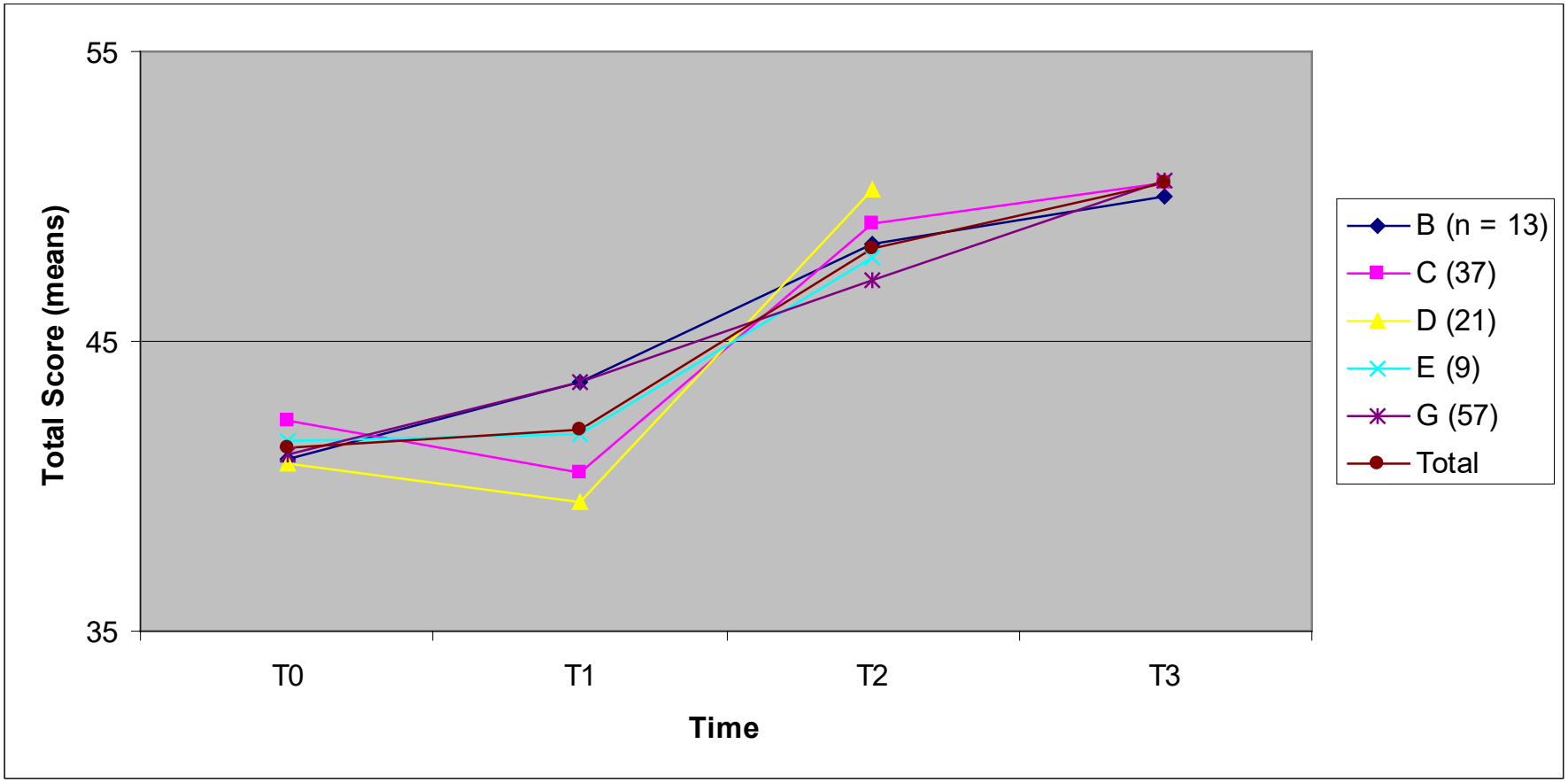
- ↔ "There is a status hierarchy in safeguarding work that affects relationships between professionals"
- ↔ "Professionals who engage in work to safeguard children do not always communicate openly with one another"
- ↑ "It is easy to communicate openly with people from other safeguarding children disciplines" p***

Safeguarding Disabled Children Scale (examples)

1. **Attitudes:** Compared to non-disabled children, disabled children who say they have been abused are less likely to believed by adults.
2. **Confidence:** I would personally feel confident that I could correctly identify a disabled child who had been abused.
3. **Knowledge:** Physically disabled children are over 4 times more likely to be abused than non-disabled peers.
4. **Procedural knowledge:** I am clear about my roles and responsibilities when abuse of a disabled child is alleged or suspected.

Safeguarding Disabled Children

(mean scores)



Headlines

- Interagency training is liked
- It's effective *in the short term*:
  - Knowledge, self confidence
  - Understanding and respect for those involved in safeguarding
  - (Almost) everyone learns
- (and good value for money).

- But can IPE make a difference to the lives of clients/service users?

IPE for Community mental health

Five year evaluation of a two-year part-time programme (1997-2003).

University of Birmingham.

Replicated at University of Sunderland (2003-5)

Curriculum

1. Principles and values (user-centred)
2. Assessment and care planning
3. Mental Health Law
4. Cognitive Behaviour Therapy
5. Family Intervention
6. Interagency and team working
7. Research methods (for MA)

Outcomes: the Kirkpatrick/Barr Framework

Level	Description
Level 1: Learners' Reactions	What do participants think about their learning experience? Are they satisfied with the programme?
Level 2a: Modification of attitudes/ perceptions	Have these changed? **between participants**; towards patients/ users and their problems, circumstances, care and treatment.
Level 2b: Acquisition of knowledge/ skills	**What have they learnt? What can they now do?**
Level 3: Change in behaviour	Can they transfer what they have learned to the workplace? Changed attitudes, newly acquired knowledge or skills in practice.
Level 4a: Change in organisational practice	Has what they learned changed the organisation and/ or delivery of care?
Level 4b: Benefits to service users	**Does it make any difference to the health and well being of service users?**

Stereotypes (attributes)

High – Moderate - Low

Psychologists	Social Workers	Psych. Nurses
Academic rigour	Academic rigour	Academic rigour
Leadership	Leadership	Leadership
Communication		
Interpersonal	Interpersonal	Interpersonal
Practical skills	Practical skills	Practical skills
Life experience		
Professional competence	Professional competence	Professional competence

No change after one year – Why?

- Intergroup contact limited
- Similarities but not differences emphasised
- Participants did not act as members of their profession
- Lack of attention to different roles and responsibilities
- Participants ‘not typical’

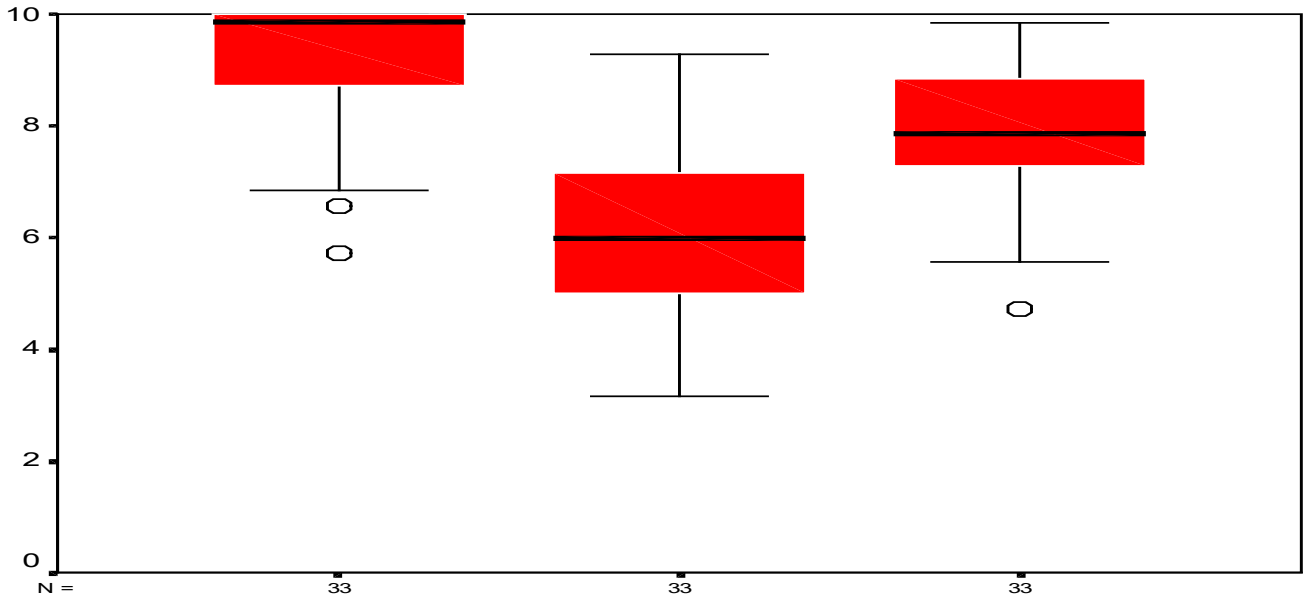
Ratings, Participant observation and Group interviews

Barnes, Carpenter, Dickinson (2000)

Do they learn Multidisciplinary team working?

Students' ratings of importance and self-efficacy (knowledge and skills) at T1 and T3.

Scale: 0=not at all, 5=intermediate, 10=very high/expert.



Outcomes: Service users' views on trainees

- *She makes one feel that what a person thinks matters.*
- *My worker understands me because she is trained to understand. She understands me because she cares about me*.
- *She treats me as how I am, as an individual and not an illness.*

Comparative design

- Service users/clients with severe mental illness randomly selected from the caseloads of students on the course.
- Changes measured over 6 months

- Service users randomly selected from the caseloads of mental health practitioners in two districts where no similar courses were running.

Outcomes for clients

Almost all users believed that the students and comparators treated them with respect and understood them and their experience of mental ill health.

Multi-disciplinary working, 77% (vs. 70% comparators*) considered that the student had worked with other agencies to ensure their needs were met.

Involved them in care planning as much as they wished 81% (vs. 59% comparators ***): asked them whether they wanted a member of their family involved in planning their care.

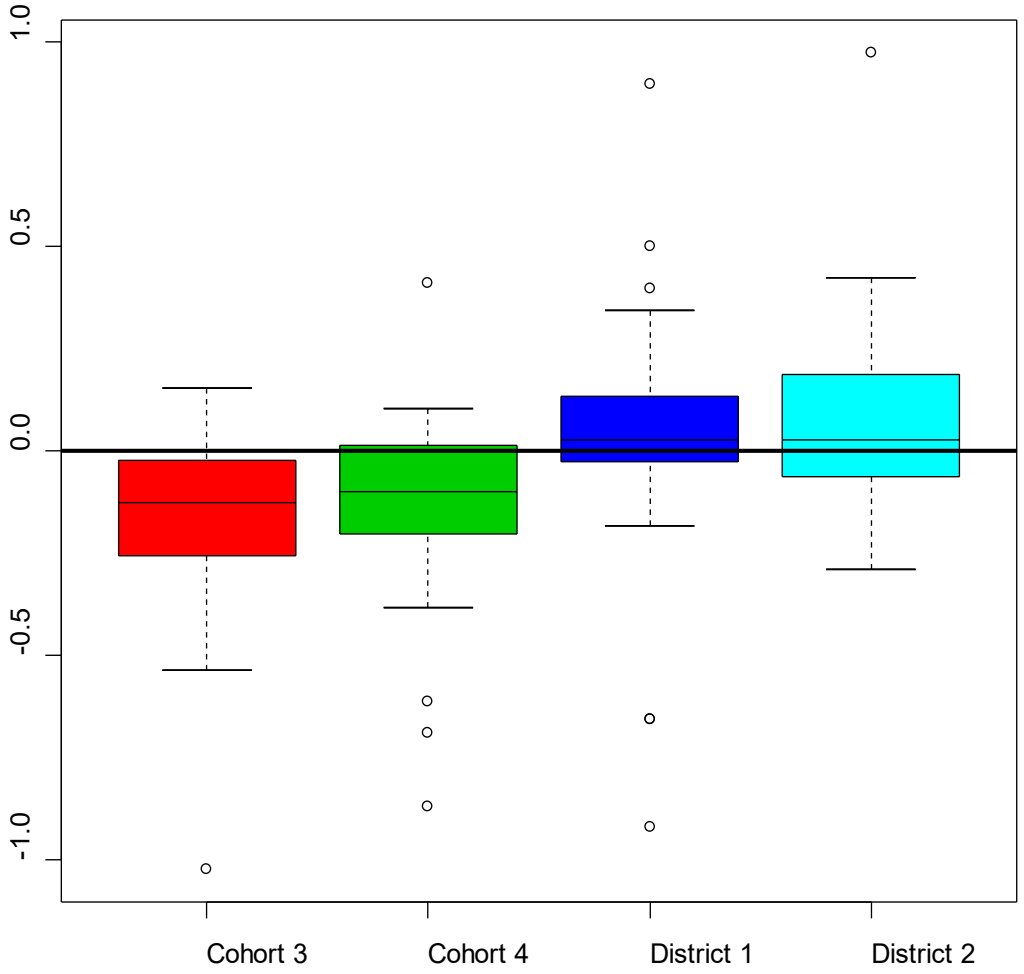
Clinical outcomes for users (6 months)

Statistically significant improvements (t1-t2):

- General social functioning (GAS)
- Reduction in mental health and social problems (HoNOS)
- Decrease in psychiatric symptoms (BPRS)

- But, can this be attributed to the training?
  - Comparison groups results: also tended to improve.
  - Except for life skills: improved for student group but no change for comparators***

Change in Life Skills (LSP total scores)



Other evidence of positive outcomes

- Teamworking and family conferencing in palliate care (USA)
- Services for victims and survivors of interpersonal violence (UK)
- Quality improvement in neonatal intensive care (USA)
- Team training to reduce incidence of adverse incidents in emergency departments (USA)
- Teamworking in stroke rehabilitation units (USA)

Conclusion

- IPE will not solve all problems experienced in interprofessional and interagency working
- Barriers to cooperation are structural and organisational as well as educational and attitudinal
- But we have some evidence that attitudes can be changed, knowledge increased and skills implemented, with beneficial outcomes for service users.

Thank you to my colleagues

- Dr Demi Patsios, Dr Eszter Szilassy, Prof. Simon Hackett.

- Diana Barnes, Dr Claire Dickinson.

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