The Open University

Communication in health and social care

Relationships in two settings

Commentary:
On this you'll hear health and social care workers and service users at two locations in the West Midlands of England talking about the interpersonal communication and personal relationships that are part of their everyday experience. In the first section you'll hear from Martin, Wendy and Tony, three members of the community mental health team, and from Gill, a user of the community mental health services in Droitwich. First, Martin Leeder.

Martin Leeder:
My name's Martin Leeder. My official title is Locality Manager for Wychavon which is one of the six localities in Worcestershire for the provision of mental health services. It's the only community mental health team in Worcestershire which is fully integrated in terms of a multidisciplinary team so we have a single base for all disciplines providing mental health services so that's arranged from consultant psychiatrists and the other medics, psychology, social workers, community psychiatric nurses, community OTs, and admin staff. I directly manage the social workers, CPNs, the OTs and the admin staff. The other staff, the medical staff and the psychologists, I have a role of co-ordinating the work of the whole team but I don't, not directly responsible for day-to-day management of their work.

Commentary:
How do they ensure good communication within the mental health team?

Martin Leeder:
In terms of day-to-day communication for the team that's relatively easy as long as you've got the systems in place. So, for example, we always start the day with whoever is actually in on that day getting together for, even if it's just five minutes at the beginning of the day, just to run through basic things that are happening, where people are going to be, what is actually happening through the day. We have a weekly team meeting on a Wednesday which is the only day that all members of the team work, so that at least there's one point of the week when the team regularly comes together, so that's a crucial way of communicating really, but all members of the team have access to mobile phones so that's, I suppose that's a crucial thing in a sense because when we didn't have that you wouldn't always be able to contact somebody, and certainly in terms of needing to contact a manager you would have to be very clear about where you were and when you were going to be there. Now with mobile phones you can just say you can contact me on that number so that, that obviously improves things.

Commentary:
What is Martin's relationship with service users, and how does this reflect the approach taken by the team as a whole?

Martin Leeder:
The contact I have with service users tends to be much more on a kind of an equal footing, I suppose, in the sense that they would be party to service development groups that we might have, for example we have a locality planning group for Droitwich, and service users are represented on that. So I tend to meet service users on planning meetings and service development type projects rather than as a professional providing a service, so in that sense it's more of an equal relationship really. The locality planning groups were set up when we first went into the integrated teams. The basic role or purpose of those groups is to actually get everybody together who's involved in providing mental health services, or has an interest in mental health services, to look at what the current needs are, current needs and future needs, and to be actively involved in planning new services, providing services and developing the service in the way that we want it to go. So we did a service review for

Droitwich which was very, very, very heavily involved service users and carers, and they were involved in providing all the information in terms of what was needed within the locality. The whole approach is very much client-centred so that the individual who's referred will be at the centre of any assessment that took place, and their needs. It wouldn't be a case of professionals making an assessment saying well, we think you need 'a', 'b' and 'c', it's more done in a partnership way really so that individuals, certainly within the mental health service, are very, very much involved in their own assessment and devising their own care plan.

Commentary:
What kinds of relationships does the mental health team have with other local agencies, and what contributes to good communication between agencies?

Martin Leeder:
We deal with a whole variety of other agencies which is crucial in us achieving our aims in terms of integrating people in the community. I think we have very close relationships now with the local housing department and housing providers, the housing associations that most of our service users will be tenants of. We have a bi-monthly housing liaison meeting. In terms of good communication that is a really good example of how we've moved things on and actually sitting round a table with people, on a regular basis, discussing individual cases and beginning to understand from both sides the problems that housing have, that's actually fostered a very close working relationship and better understanding, which means that the outcomes for the service users are better, and people are much more likely to get a good service. Probably somewhere around 90-95% of referrals that we get will come directly from primary care, from GPs, sometimes from health visitors, but it's mainly GPs, and communications there can be very different at times. We have some GPs who, because they understand more about the service that we provide, their referrals will be much more appropriate and there's good rapport and understanding, but there are quite a number of GPs who probably don't fully understand where we're coming from in terms of our priorities with people with more severe problems, so we're not really geared up to working with people that have moderate, well certainly mild mental health problems. Some communication can fall down because of different expectations from different people.

Commentary:
Next we hear from Wendy Monks who explains her role in the team and her relationship with service users.

Wendy Monks:
I'm Wendy Monks and I'm an approved social worker in the community mental health team here. Our main role is to work with people with severe and enduring mental illness. I carry a caseload of people with long term mental health problems, and some with more short term, more sort of solvable mental health problems, if you like. At two o'clock in the afternoon you might be talking to somebody who's lost their Giro, and then at three o'clock in the afternoon you might be getting involved with somebody who is very ill and you may be saying to them that you're going to do, you know take them into hospital, or do something fairly controlling that they absolutely don't want and don't like, and aren't willing to go along with, so there's a huge amount of variation. And often we're working with people in a kind of helping and partnership sort of relationship, but then every now and again have to kind of shift that role and shift the balance, and perhaps go into a phase where we're being quite controlling and exerting power over them which feels very odd, you know, you have this kind of equal relationship as far as possible, and then it suddenly becomes very unequal for a while, and it can feel quite uncomfortable. But what's interesting, I think, is that once people get over these acute phases usually the relationship settles back down again and you're not often left with kind of resentment and mistrust, and whatever you can, you know, you can retrieve that balance again which is good.

Commentary:
The role of social worker involves quite complex relationships with service users, but Wendy also works as a member of a multidisciplinary team, and these ups and downs are what Wendy talks about next.

Wendy Monks:
I share a room with two other social workers and CPNs and an occupational therapist so inevitably, you know, we're talking to each other all the time and we're often doing joint work with clients. I might often be working with somebody with one of the CPNs, or perhaps the OT or whatever, so there's a dialogue that goes on, you know, all day really, we work very closely together. Then we've got the medical staff and the psychologists also based in this building so, again, there's a lot of conversation on a day-to-day basis with both of them, and we'd often stop and have a chat about this person or that person. It makes a big difference being physically together because you can have the conversation informally at an early stage rather than, you know, spending ages trying to get through receptionists and what have you, and turning it into a big deal. You can nip things in the bud. Everybody's got their own personality, everybody's got a different approach. Sometimes there's a clash, you know, we don't all approach our work or our service users in the same way, and we try and be grown up about how we resolve those sorts of differences, and that works reasonably well, but even in this team there's still a certain amount of hierarchy and there's still a certain amount of power imbalance between some staff and other staff groups, particularly the medics, I mean it's much better than it ever used to be, but it's still there to a certain extent. If the consultant psychiatrist feels that something should be done this particular way, and I feel it should be done a different way, it's not always easy to resolve that. We usually get there but it's not necessarily that comfortable. Although things have probably evened out an awful lot over the years, inevitably the medical profession still does have a higher status than, for instance, community psychiatric nurses or social workers, or whatever.

Commentary:
Next we hear from Tony Partridge, another social worker, who also reflects on relationships between professionals from different backgrounds working together.

Tony Partridge:
I'm Tony Partridge. I'm an ASW, which is an Approved Social Worker, under the Mental Health Act. I work in the community mental health team. I carry a caseload of round about 25-30 service users who all suffer with a severe and enduring mental illness. I think being in the same room as nurses, OTs, social workers, who share their troubles, and their worries and concerns about service users, and by the service users that perhaps the nurses have been seeing for years before we came together as a CMHT, and then have a lot more information stored wherever about my service users that I'm working with at the moment, so I depend on them for that, and I find that useful.

Commentary:
How does Tony describe his role and that of the team generally in relation to service users?

Tony Partridge:
I spend a lot of my time trying to empower the service user. Everything I'm doing today we're trying to empower the individual to make choices for their self, to make their own decisions, to help their selves which, in turns, improves their own self esteem and their feelings of self worth, people find it disempowering to be sat there amongst all the professional service users and they struggle with that, and so I have to speak for them, or help them speak, or help them get their point across, help them in trying to impress on professionals who, in the past, and I'm not saying they are now but certainly in the past, they've been unapproachable, unbelievable, you know, and I don't think I'd be far off the mark if I said most consultants years ago were like that. Some of them have changed, not all, but some of them have changed. We in Worcestershire are involved with service users now in job interviews for staff. There's a user forum in the county that has a voice in what goes on in in-service delivery, so there's a great shift towards empowering people to help their selves.

Commentary:
What are the implications for Tony of being one of only two male workers in the team?

Tony Partridge:
Other than the manager I am the only male member of the team. All the nurses, OT, social workers, are all female, so I get certain service users that they wouldn't dream of asking one

of the females to see on their own. I don't get to see many female service users. If I look at my caseload I've got about three or four out of thirty. And it has its disadvantages because I find it hard to relate to them, because I don't deal with them, and then obviously there are a lot of people coming into the service now who have been abused, a lot of women have been abused in the past, and that has brought on their mental health problems and issues, which would seem of little advantage for the service users, but a disadvantage for me because I don't get to experience that sort of work. So when we meet to discuss someone in the team meetings I have no experience, so I just have to sit and listen. Sometimes I can contribute on general issues and general bits of stuff, but not the in depth stuff, and I find that a bit frustrating.

Commentary:
Next we hear from Gill who has been a user of community mental health services for some time. How does she describe her relationship with the service in Droitwich?

Gill:
My name is Gill and I've really had links with mental health services since I was a teenager really. Manic depression is what I have now, told that I suffer from, but it's taken quite a long time to get to that stage of finding out really what was wrong, and why I couldn't function very well at certain times, and at others I was really functioning quite well. I went along to relaxation, and to assertion, and various other groups, and eventually was allowed to run my own group, and that was a very worthwhile experience for me, and I think with a lot of people, had quite a lot from that. And that seemed to be a very good idea, to allow people who are getting better and wanted to do more, to take on a group of their own interest. A few people did that and really got a lot from it.

Commentary:
Gill describes her relationships with professionals, including a social worker that she's known for a number of years.

Gill:
I have a social worker who I've been working with, oh I don't know, twelve years or more, and who really has been wonderful, seen me through a lot of problems and difficulties. Everybody goes through some, but I seem to have had a fair few over the last few years, and that has been a wonderful link, probably on a three-weekly basis, but I know I can always phone in. With this particular lady if I could say mutual respect I feel is very important and empathy. I appreciate the sound common sense approach I get from her. You're treated with dignity and I'm very much on to this one within the mental health service. I think people need to be treated with some dignity. She was the one I felt who gave me the chance to run a group of my own, and that really made a big difference. There are some people in this world who I do feel give such a lot to their jobs that they give beyond, and I have found somebody who's like. When I look back at one or two social workers who just sort of turned up, this makes me realise how good the one I'm talking about is. If I catalogued what we'd been through together, for me really, but equally she was having bereavements, etcetera, and so there was a certain amount of help from either side, which is nice when it can happen like that, as I think it does with quite a few people, and you don't have to be too familiar with people to know when they're in difficulties, and sometimes you can help them as much as they're perhaps helping you. I've known that there's always somebody there who I could count on, and that's helped me tremendously. I also have this similar relationship with my consultant psychiatrist. They both treat people with respect. They seem to me to be very caring people, but not to the point where it's silly. I would always try to keep a line between the professional and me, if you like, because I think you do need to have a line drawn.