City, University of London Institutional Repository

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: http://openaccess.city.ac.uk/7249/

Link to published version:

Working in Partnership

1. Introduction

Developing and sustaining a positive therapeutic relationship with the service user, their family and other carers, is central to the role of the mental health nurse. This is emphasised in England with the CNO review of mental health nursing (DH 2006a), in Wales within standard 8 of "Raising the Standard: the Revised Adult Mental Health National Service Framework and an Action Plan for Wales" (WAG 2005), in Scotland within Key Aim No. 4 - Promoting and Supporting Recovery, of the Scottish Executive National Programme for Improving Mental Health and Well-Being Action Plan (Scottish Executive 2003). In addition, The Northern Irish Executive commissioned an independent review of services and the resultant strategy contains this statement from its Service User Reference group:

> "One element must be changed and that is the attitudes of the professionals and all those who engage with us. Essential to empowerment and recovery is a person centred approach. Understanding the person on their own terms and placing them at the centre of the process." (Bamford Review of Mental Health and Learning Disabilities (Northern Ireland), 2005: p7)

In brief, all these document highlight that the relationship between the mental health nurse and service user needs to be positive, trusting, meaningful and therapeutic. Modern mental health nursing requires the nurse to build on that positive therapeutic relationship and take things to another level by **working in partnership** with the service user. Working in partnership is a collaborative, more empowering way of helping the service user and is a key feature of the **Recovery** approach (see Figure 1).

Insert Figure 1 here:

The key principles and values of the Recovery approach should inform mental health nursing practice in all areas of care and underpin service structures, individual practice and educational preparation (DH 2006a). Nurses need to:

• value the aims of service users;

• work in partnership and offer meaningful choice;

• be optimistic and offer hope about the possibilities of positive change; and

• value the social inclusion of people with mental health problems.

In working collaboratively, the mental health nurse recognises the unique knowledge and expertise the service user has about their own life and experiences. At the same time, the nurse offers to draw on their own skills and professional understanding to jointly develop and agree strategies aimed at helping the person move forward and regain control over their health and life.

As nurses working in partnership, we offer our expertise and knowledge to help the person recognise and understand the choices they have and to resolve problems in a way that is beneficial and acceptable to them. This can be empowering for the service user as the nurse is trying to help the user find their own solutions and build on their own strengths and resources, rather than disempowering and even infantilising the user by taking over and making decisions for them.

Working in partnership is not necessarily easy for either the nurse or the service user. We all tend to carry age-old ideas about nurses caring *for* the patient, doing things *for* the patient – and sometimes that is still exactly what is required. But the challenge for the effective mental health nurse is to recognise and build on the numerous opportunities available within a positive therapeutic relationship to encourage and enable the service user to find their own ways

forward. The nurse can then help the user develop and draw on these skills to deal with other challenges along their personal journey to recovery.

In this chapter, we will outline some of the skills and approaches that the mental health nurse will require in order to work in partnership. Obviously, in one chapter we can only provide a limited number of examples and illustrations of the skills required but we shall aim to consider these across the various life stages the nurse is likely to encounter in their work. One highly important aspect of partnership working we will not cover in this chapter is working with family members and others in caring roles. Working with families and carers requires more detailed exploration than could be allowed here so the reader is directed to useful information at the end of the chapter. We will, though, aim to show some of the challenges and difficulties that may be encountered in trying to work in partnership and how these might be reframed and resolved. In particular, we hope to demonstrate some of the very real challenges that may exist when trying to implement these skills in the 'real world' of mental health services, in which staff often face seemingly impossible demands and insufficient resources (Brennan et al 2006).

2. LEARNING OUTCOMES

By the end of this chapter you should be better able to:

1.   Demonstrate an understanding of skills required to work in partnership with service users;
2.   Describe the potential areas of conflict in working collaboratively with users and how to resolve them;
3.   Identify some of the theories and approaches that underpin these skills;
4.   Use the partnership working skills in practice.

3. EVIDENCE BASE

Best practice in mental health nursing is underpinned by a number of frameworks that shape and inform the outcomes of mental health education and training (DH 2006b, p5). In particular, working in partnership is contained within the very first of The Ten Essential Shared Capabilities (see Figure 2) and is then threaded throughout the rest of the core capabilities for mental health staff. Partnership working is an essential aspect in respecting the user's diversity; in providing care and treatment; in challenging inequality, stigma and discrimination; in promoting recovery; in identifying people's needs and strengths; in providing person-centred care and in promoting safety and positive risk-taking. In other words, partnership working is an absolutely central component of mental health nursing – and arguably the cornerstone of good mental health nursing.

Insert Figure 2 here:

In most modern mental health services, mental health care is also provided within a framework of **case management** in which the users' needs are assessed and addressed by a case manager working as part of a **multidisciplinary team**. In the UK, case management is known as the Care Programme Approach (CPA) (DH 1999; 2008) and the case manager is known as a **care co-ordinator,** a role most often carried out by mental health nurses.

The care co-ordinator is required to work in partnership with the service user to assess the strengths and health and social care needs of the user, to write a care plan in collaboration with the user and then ensure the care plan is implemented and reviewed by members of the multidisciplinary team and other agencies. Members of the users' family and other informal carers may also be consulted when appropriate and should be provided with a copy of the plan.

The CPA has been often been dismissed as a bureaucratic measure that produces copious paper work but with insufficient resources to ensure care plans are fully implemented (Simpson et al 2003). But at heart, the care co-ordinator role is a genuine attempt to formalise and encourage partnership working between clinicians and the service user (Simpson 2005).

However, a systematic review of the literature on service users and carers' views on mental health nursing suggests that mental health nurses too often fail to ensure that partnership working takes place (CNO 2006, p56). The review reported that whilst service users tend to place a positive value on mental health nurses and hold their listening skills in high regard, nurses do not provide them with sufficient information to make informed choices and tend not to provide suitable opportunities for collaborating in their own care.

When aiming to explore the evidence base for partnership working it is difficult, even impossible, to simply search for clinical trials or systematic reviews of partnership working. Working in partnership or collaboratively with someone tends to emerge or grow out of a therapeutic relationship built on empathic understanding, warmth or positive regard, and genuineness or congruence (see previous chapter). These are the three conditions that Carl Rogers identified through research and practice as 'necessary and sufficient' in any person trying to help another achieve personal growth or therapeutic change (Rogers 1961). Consequently, it is difficult and arguably futile to tease out or unpack those aspects of such a relationship most associated with 'partnership working' and subject them to a randomised controlled trial.

It is also difficult to measure and regulate components of a partnership relationship which necessarily involves participants' personalities, personal styles and culture. Similarly, it would be difficult to control for the influences of personal histories, experiences and current contextual factors such as age, gender and ethnicity. Neither could you deliberately allocate groups of

people to no or abusive partnership working and measure against good partnership working. This is clearly unethical.

This does not mean that there has been no analysis of partnership working, but we should be aware that 'gold standards' of research are very difficult to apply in such complex contexts (Repper & Brooker 1997). We are though, able to identify some of the specific skills associated with partnership working and consider the evidence base for them. In this, we have to look at other knowledge streams to extend our understanding. Concepts such as individual reflective analysis, case studies and learning through experience may be equally useful. Often the most useful sources are key texts which directly deal with the formulation of partnership working and what that is like for the worker. These tend to be derived from many years of experience in working with users, supervising workers and often come from practitioners with counselling and psychotherapeutic skills, as well as mental health nursing. We can also draw on studies that have collated and analysed the accounts and perspectives of the patient or service user, including studies designed and conducted by service users (Rose 2001).

There is a growing body of research into the effectiveness of various interpersonal, psychotherapeutic or conversational approaches (Roth & Fonagy 1996). Many of these are being adapted and employed in mainstream mental health and psychiatric settings (Parry 1996). In particular, **Cognitive-Behavioural Therapy (CBT)** is considered effective for a range of conditions (Newell & Gournay 2000) with variable evidence available as to effectiveness in routine practice (Durham et al 2000).

CBT helps people talk about how they think about themselves and the people around them and how what they do affects their thoughts and feelings. It can help people change how they think (cognitive) and what they do (behaviour), which can help them feel better and in more control. CBT focuses on 'here and now' problems and difficulties, rather than search for the causes of distress or symptoms in the past, and can help to make sense of overwhelming problems by

breaking them down into smaller parts. **Psychosocial Interventions** have been developed for people with psychosis which take many of the principles and techniques of CBT and use them alongside family work and case management to assist the person with psychotic experiences (Healy et al 2006). Within substance misuse services**, Motivational Interviewing** techniques serve a similar function in assisting the service user to understand their motivation to change and take them through the difficulties of change (Rollnick and Miller 1995).

Service users can become stuck in a cycle of disempowerment and despair as they respond to life situations over which they feel they have no influence or control. Deegan (1992) has argued that this **'learned helplessness'** develops when service users and too often mental health staff, buy into the idea that psychiatric illness or vulnerability necessarily means that the user has limited capacity for reasoned thought and even less capability to take sensible, meaningful actions.

Understandably, service users may initially feel overwhelmed and powerless in the face of mental distress and experiences that are frightening, depressing and disorientating. That powerlessness can then be reinforced by the stigmatised and discriminatory attitudes frequently shown in society towards people with mental illness. Where such beliefs are then further reinforced by health care staff perhaps influenced by a limiting, medicalised view of mental distress, nurses and others start to take responsibility *for* users – whether it is necessary or not.

Another approach that provides a very useful, collaborative and empowering framework for working in partnership with users is Egan's (1994) skilled helper model. Originally developed in psychological counselling, this person-centred, problem-solving approach to helping has been adapted by many people working in psychiatric settings. Egan argued that people are often poor at solving problems and mental distress develops when people try to ignore or deny problems, or get stuck repeatedly attempting the same unsuccessful solutions. The nurse's task within this

approach is to help the user become more able to manage the problems they are faced with. To achieve this, Egan identifies three stages:

- Help the person identify and clarify their difficulties, needs and problems, but also the things that are going well;

- Help the person identify what they would like to do and achieve – to help them construct a better future; and

- Help the person create strategies to move towards those goals.

The nurse aims to engage the user in a process that moves through the three stages, whilst acknowledging that the person brings a unique knowledge and understanding of their life story and particular situation. The nurse offers to share knowledge of the helping process so that people can become more resourceful and self-supporting (Watkins 2001). We shall look at these approaches in more detail later.

In helping the person develop better problem-solving or coping strategies, it is important to recognise that many people will already be using strategies they have found helpful themselves. Research studies conducted with people diagnosed with schizophrenia (Barrowclough & Tarrier 1997) and bi-polar disorder (Lam et al 1999) found that the majority of people employed various coping techniques with varying levels of success.

By enquiring about and acknowledging the user's own attempts to manage distressful or challenging experiences and situations, the nurse actively demonstrates a commitment to partnership working and can reinforce the person's determination to self-manage. Nurses can then draw on their knowledge and experience to discuss and suggest additional coping mechanisms to help the user broaden and strengthen their repertoire of coping skills. Watkins (2001) suggests that a number of interventions drawn from solution-focused therapy can be

effective in helping people find strategies to move forward in their recovery. The nurse asks solution-focused questions that help the user identify strategies that are already employing and to encourage them to develop new ones.

However, it is also important that nurses consider how best to adapt and integrate such skills within a conversational, collaborative style of working that recognises the nurses' unique role within clinical settings (Perkins & Repper 1996, Gamble & Brennan 2006). Such an approach helps normalise the application of these complex skills (Brandon 1996), which makes their use more acceptable.

Finally, we need to consider that in working in partnership to provide people with more choice sometimes involves an element of risk.

> The possibility of risk is an inevitable consequence of empowered people taking decisions about their own lives. (DH 2007, p8).

Whilst there is insufficient space in this chapter to explore these issues in detail it is worth directing readers to recent guidance that aims to support the principle of empowerment through managing choice and risk in a responsible, considered way. The guidance encourages multidisciplinary teams and health and social care organisations to foster a common, agreed approach to risk and to share the responsibility for risk in a transparent and constructive way (DH 2007).

4. **STEP BY STEP DESCRIPTION**

1. Why form a partnership?

Why do nurses form partnerships with users? The simple answer to this question is that partnerships are formed to help the user to get better. But then we must ask, what does "better" mean? Well, "better" means helping a user create a healthier future, with more chance of a good quality of life, and a higher chance of mental and physical health, combined with social opportunities in the form of meaningful relationships, housing, employment and education. All these are aspects of what has already been referred to as the recovery approach. In essence then, we form partnerships with users to facilitate recovery.

We are still left with questions, however, as recovery has different meaning for people with different issues. Many aspects of "recovery"- quality of life, health, relationships, and employment - are dependant on individual characteristics, cultural norms, and stage of life. Take a look at the table below and ask yourself if you agree with the broad statements about recovery as applied to different user groups.

Insert Table 1 here:

Therefore recovery needs to be defined for any given client with any given problem. This makes it virtually impossible to discuss recovery in any more than general terms unless related to a given individual. It should also be remembered that recovery came from the user movement and that nurses "borrow" the term when they use it (Davidson 2005). It does not belong to nurses or other professionals. In addition, within specific services such as those dealing with people with dementia, there is considerable debate as to the appropriateness of the word "recovery", as there

is concern that the word may be read as "cure" or a return of full function (Adams 2007). In general, therefore, whilst we may all agree with the principles of the personal focus and respect for personhood in the concept of recovery, we may have to find careful ways to communicate these ideals within specific services.

[box starts]

Case Example: Life Story Work

Life Story Work is a specific intervention designed for people with dementia. It is designed to assist in retaining a sense of self and personhood in the face of memory loss (Clark et al 2003).

On Jasmine Ward in Prospect Park Hospital, Reading, England, the ward team offer life story work to inpatients like Bob. In this, Bob is engaged in relating the important aspects of his life in terms of relationships, significant events, work experiences, personal preferences and anything else that has meaning for Bob. His family were also asked to assist in providing information and material such as photographs and other memorabilia. This was all collated together using a book-like template designed by Central and North West London NHS Trust and the dementia charity "For Dementia" (Thompson 2007). The end product becomes Bob's property. Staff on the ward report that the work helps them to see the person behind the condition and appreciate Bob's uniqueness.

[box ends]

2. How do we form a partnership?

There are basic behaviours that any nurse should adhere to in all interactions. These are that the nurse should:

- be respectful;

- keep promises;

- be honest (e.g. about availability); and

- pay attention to privacy and dignity.

While these have been covered in previous chapters, it is worth reminding ourselves that partnerships are based in the bedrock of mutual respect. Nurses signal this respect in the first instance by paying attention to the basic common courtesies.

Once a respectful relationship has been established (and there are users - and indeed some nurses - who find it very difficult to build a respectful relationship) partnership working can be defined by two basic features. These two features are engagement and problem solving.

3. Engagement

Astute readers may be asking; "what is the difference between a respectful relationship and engagement?" The difference is that you enter into a respectful relationship, but once in it you engage with each other towards a specific goal. We can have respectful relationships with anyone. Engagement means making an active commitment to do some joint work.

Nurses engage with users to facilitate problem solving. This is the work of the partnership. At first glance this statement can seem quite cold and clinical, but it is not.

4. Problem Solving

If users and professionals engage to achieve goals, problem solving is the vehicle that gets them there. Problem solving can be broken down into distinct steps and builds on Egan's (1994) model identified earlier:

a) Helping users identify and clarify needs and problems

- Helping them tell their story ("Why are you here?")

- Helping them unload

- Avoiding assumptions, interpretations, OUR solutions

- Establishing and agreeing shared understanding of what the situation is and what needs to change

- Measure the need or problem and how it affects the user

- Identifying how we can help them

b) Develop an intervention or set of interventions designed to satisfy the need or alleviate the problem

- Bring in prior knowledge or find knowledge about the evidence base for that particular problem or need.

- Negotiate areas of responsibility in carrying out the intervention.

- Describe, in terms the user can understand, who will do what within a time frame.

- Record this, again in ways understood by the user of the service. This is the basis of good care planning under the CPA.

c) Evaluate the intervention

- We do this simply by measuring the outcome against our previous measurement (Quantitative, e.g. a recognised measurement of anxiety or depression) and asking the user "did it work?!" (Qualitative).

- If it didn't achieve the required outcome, change. It is important in this that nurses avoid blaming the user or themselves. If the attempt was honest we have learnt a valuable lesson. It is important to know what does not work at a given time. It gets us nearer to what will work.

- Few interventions are completely successful in all departments right away. We learn what we can from each attempt.

[box starts]

Case example: Erratic sleep

Jane is on an acute ward recovering from an acute psychotic relapse. She is well enough to undertake a mental state examination with Jack, the nurse. In this she has no ongoing psychotic symptoms but an erratic and distressing sleep pattern. Jane and Jack agree to work on this. They use a sleep diary and an anxiety scale to measure the problem.

Jane believes in the power of crystals and meditation. Jack gets some information on sleep hygiene. After looking at Jane's nighttimes routine they agree to changes which include bits from Jane (using crystals and practicing yoga in the evening) and bits from Jack (reduction in caffeine, advice on the use of hypnotics). Although this has limited success at first in terms of hours sleep, Jane feels less anxious. The intervention is changed to include listening to soothing music on MP3 as she gets into bed. Over time the intervention is felt to be working by Jane. There is a reduction in her anxiety score and she states she is less anxious. Hours slept does not improve.

[box ends]

5. Difficulties

In many ways the case study above is an ideal position in that two capable people put their expertise together and aim to problem-solve a difficulty. In mental health working there can be other factors which can negatively impact on the formation of a partnership between the user and the nurse (see Table 2).

Insert Table 2 here:

For some people being in a partnership and agreeing a plan can be extremely difficult and challenging. Being able to trust another person and work with them so closely can in itself be very frightening. In good partnership working, the nurse will encourage sensitive discussion of the challenging emotions this arouses. Sometimes you will need to temporarily stop the problem-solving to re-assure, re-negotiate and re-establish the partnership.

[box starts]

Case Study: Absconding research

Absconding is an emotive and difficult issue in many acute inpatient environments. Recent research has allowed a deeper understanding of why some clients actively run away from partnerships. Different types of client profiles have been identified which indicate why people go missing or abscond (Bowers et al 2003). Often, service users have domestic concerns they wish to attend to or are upset or disturbed by events on the ward. The evidence-based effective interventions recommended for these clients reflect many of the qualities in this chapter. For example, nurses are advised to spend more time with patients who are actively disengaging, to elicit and respect their concerns and be sensitive in the breaking of bad news or negotiations around leave and access to the community (Bowers et al 2005). Working in partnership with the

service users, their family and members of the multidisciplinary team is the key to

implementing all of these solutions. See the website at the end of the chapter for more details.

[box ends]

The nurse's good intentions to work respectfully and collaboratively can also be frustrated as we

repeatedly encounter people that are weary, suspicious, mistrustful, ambivalent and angry – or

who appear to undermine, manipulate or 'sabotage' genuine attempts at partnership (Bowers

2003). Compassion and emotional energy are not inexhaustible commodities and continually

stressful encounters can cause intense anxiety and lead nurses to withdraw psychologically and

physically from the user for self-protection (Menzies 1960, Bray 1999). We often hear

complaints of nurses spending too much time in the office, rather than engaging with patients.

In order to consistently make use of one's self, to apply subtle interactive skills and to work

collaboratively with enthusiasm and empathy, mental health nurses need to be enabled and

encouraged make use of personal reflection, supportive colleagues, teamwork and clinical

supervision.

6. Endings.

Partnership between a client and a nurse will inevitably end. It is important for both nurse and

client to recognise that ending is important. Given that partnership working involves the

investment of emotional energy, the ending of the partnership should be as healthy as possible

for both parties. What we mean by this is that nurses will, inevitably, form many partnerships in

the course of their career. Some of these partnerships will adhere to the positive principles

outlined in this chapter. Some will be stymied by the difficulties outlined in this chapter. In

order to remain optimistic and giving of one self, all partnerships need to be reflected upon, as

indicated above. In our experience many nurses are able to remain optimistic and giving

because they experience both positive partnerships with clients and positive support from colleagues when difficulties arise.

If it is possible to end the partnership in a healthy manner, it is important for nurses and clients to meet and evaluate. In this both parties can learn valuable lessons as to what helped and what hindered the partnership. This meeting should be structured to allow the exchange of experiences and, if appropriate, a reflection on difficulties. If it is not possible to meet the client, nurses should use supervision to reflect on the partnership and any feelings they are left with. While it is sometimes appropriate to communicate these reflections to the client via a letter or phone call, the nurse should always be clear that the client is able to receive these communications in the spirit they are given. In other words, nurses should ensure that their motives for communicating are not to lecture, blame or punish, but a genuine attempt at reconciliation of the partnership. It is important to remember that many clients will continue to use services and form other partnerships and the nurse has a responsibility beyond their own interaction with clients in allowing them to believe that the services are aimed at truly assisting them in spite of any difficulties.

5. CONCLUSION

All services are now signed up to the *principles* of recovery, even if it is difficult to use the word "recovery" for all service areas. This commitment is enshrined in many of the policy documents of the last decade. At the core of recovery is a new focus for the relationship between clients and mental health professionals, including nurses. In this there has been an active shift towards collaborative work aimed at assisting clients to solve the effects of mental health problems rather than prescriptive interventions that do not take into account personal preferences. This collaborative work is what partnership working is all about. Nurses need to actively attend to the principles of partnership working, in spite of the many difficulties.

Further reading and URLs

Watkins, P. (2001) Mental Health Nursing: The Art of Compassionate Care. London,

Butterworth-Heinemann.

- A very helpful, accessible book for students and qualified mental health nurses that

    includes several chapters on aspects of partnership or the working alliance.

Absconding:

http://www.citypsych.com/

Cognitive Behavioural Therapy (CBT):

http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/cognitivebehaviouraltherapy.aspx

Mental health of older people:

http://www.scie.org.uk/publications/elearning/mentalhealth/index.asp

Mental Capacity Act and related issues:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidanc

e/DH_074491

Motivational Interviewing:

http://www.motivationalinterview.org/

Psychosocial Interventions (CBT for psychosis) :

http://www.hearingvoices.org.uk/info_carersleaflet3.htm

http://www.sign.ac.uk/guidelines/fulltext/30/index.html

Recovery, self-management and related themes:

http://www.rethink.org/living_with_mental_illness/recovery_and_self_management/

http://www.samh.org.uk/assets/files/113.pdf

http://www.scottishrecovery.net/content/

Service user involvement

http://www.voxscotland.org.uk/sitebuildercontent/sitebuilderfiles/voxguidanceongoodpracticein

serviceuserinvolvement1.doc

The 10 Essential Capabilities and Involving users and carers (Modules 2 & 3):

http://visit.lincoln.ac.uk/C6/C12/CCAWI/default.aspx

Working with families and carers:

http://www.citypsych.com/docs/Carersfinal.pdf

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidanc

e/DH_4009233

http://www.rethink.org/how_we_can_help/research/our_research/carers.html

References

Adams, T. (2007) *Dementia Care Nursing: Promoting Well-being in People with Dementia and their Families.* London: Palgrave.

Bamford Review of Mental Health and Learning Disabilities (Northern Ireland) (2005) *A Strategic Framework for Adult Mental Health Services.*
http://www.rmhldni.gov.uk/adult_mental_health_report.pdf Accessed 30.03.2008.

Barrowclough, C. & Tarrier, N. (1997) *Families of schizophrenic patients: cognitive behavioural interventions.* London: Thornes.

Bowers, L. (2003) Manipulation: searching for an understanding. *Journal of Psychiatric and Mental Health Nursing, 10*: 329-334.

Bowers, L. Simpson, A. & Alexander, J. (2003) Patient-staff conflict: results of a survey on acute psychiatric wards. *Social Psychiatry and Psychiatric Epidemiology, 38*(7), 402-408.

Bowers, L., Simpson, A., & Alexander, J. (2005). Real world application of an intervention to reduce absconding. *Journal of Psychiatric and Mental Health Nursing, 12*(5), 598-602.

Brandon, D. (1996) Normalising professional skills. In Heller, T., Reynolds, J., Gomm, R., Muston, R. & Pattison, S. (eds) *Mental Health Matters*. Basingstoke, McMillan/Open University Press.

Bray, J. (1999) An ethnographic study of psychiatric nursing. *Journal of Psychiatric & Mental Health Nursing, 6(*4), 297-305.

Brennan, G., Flood, C. and Bowers, L. (2006) Constraints and blocks to change and improvement on acute psychiatric wards – lessons from the City Nurses project. *Journal of Psychiatric and Mental Health Nursing, 13*, 475-482.

Clarke A., Hanson E. & Ross H. (2003) Seeing the person behind the patient; enhancing the care of older people using a biographical approach. *Journal of Clinical Nursing; 12*(5), 697-706

Davidson, L. (2005) Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective. *Journal of Mental Health, 14*(1), 25-35.

Deegan, P. (1992) The independent living movement and people with psychiatric disabilities: taking back control over our own lives. *Psychosocial Rehabilitation Journal, 15*(3), 4-19.

DH (1999) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. A Policy Booklet*. London: HMSO.

DH (2006b) Best practice competencies and capabilities for pre-registration mental health nurses in England: The Chief Nursing Officer's review of mental health. London, Department of Health.

DH (2006a) From values to action: The Chief Nursing Officer's review of mental health nursing. London, Department of Health.

DH (2007) Independence, choice and risk: a guide to best practice in supported decision making. London, Department of Health.

DH (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*. London: Department of Health.

Durham, R.C., Swan, J.S. & Fisher, P.L. (2000) Complexity and collaboration in routine practice of CBT: What doesn't work with whom and how might it work better? Journal of Mental Health, 9, 4, 429-444.

Egan, G. (1994) The skilled helper: a problem-management approach to helping. 5th Edition. Pacific Grove, California, Brooks/Cole Publishing.

Frak, D. (2005) Recovery Learning: A Report on the Work of the Recovery Learning Sites and other Recovery-orientated activities and its incorporation into The Rethink Plan 2004-08. London, Rethink.
http://www.rethink.org/living_with_mental_illness/recovery_and_self_management/recovery/
Accessed 16.12.2007.

Gamble, C. & Brennan, G. (Eds) (2006) Working with Serious Mental Illness: A Manual for Clinical Practice. Second Edition. London, Elsevier.

Healey, H., Reader, D. & Midence, K. (2006) An introduction to and rationale for psychosocial interventions, in Gamble, C. & Brennan, G. (Eds): Working with Serious Mental Illness: A Manual for Clinical Practice. Second Edition. London, Elsevier

Lam DH, Jones S, Hayward P, Bright J, (1999). Cognitive therapy for bipolar disorders: a therapist's guide to concepts, methods, and practice. Chichester: Wiley and Sons.

Menzies, I. (1960) Social systems as a structured defence against anxiety. Human Relations 13, 95-121.

Newell, M. & Gournay, K. (2000) Mental Health Nursing: An Evidence-based Approach. Edinburgh, Churchill Livingstone.

Prochaska, J. O., Norcross, J. C., & Diclemente, C. C. (1994) *Changing for good; A revolutionary six-stage program for overcoming bad habits and moving your life positively forward*. New York: Avon Books.

Parry, G. (1996) NHS Psychotherapy Services in England: Review of Strategic Policy. London: Department of Health.

Repper, J. & Brooker, C. (1997) Difficulties in the measurement of outcome in people who have serious mental health problems. Journal of Advanced Nursing, 27, 75-82.

Repper, J. & Perkins, R. (1996) Working alongside people with long term mental health problems. London, Chapman & Hall.

Rogers, C. (1961) On Becoming a Person. A therapists' view of psychotherapy. London: Constable.

Roth, A. & Fonagy, P. (1996) What works for whom? A critical review of psychotherapy research. London: Guilford Press.

Rollnick S., & Miller, W.R. (1995) What is motivational interviewing? Behavioural and Cognitive Psychotherapy, 23, 325-334.

http://www.motivationalinterview.org/clinical/whatismi.html Accessed 30.03.2008

Rose, D. (2001) Users' Voices: The perspectives of mental health service users on community and hospital care. London, Sainsbury Centre for Mental Health Care.

Scottish Executive (2003)   National Programme for Improving Mental Health and Well-Being: Action Plan 2003-2006. Edinburgh: Scottish Executive.

Simpson, A. (2005) Community psychiatric nurses and the care co-ordinator role: squeezed to provide 'limited nursing'. Journal of Advanced Nursing, 52(6), 689–699.

Simpson, A. Miller, C. & Bowers, L. (2003) The History of the Care Programme Approach in England: Where did it go wrong? Journal of Mental Health, 12(5), 489-504.

Thompson, R. (2007) Older Peoples mental health services; supporting and developing health care assistants. *Mental Health Practice; 10(10) 34-38.*

Watkins, P. (2001) Mental Health Nursing: The Art of Compassionate Care. London: Butterworth-Heinemann.

WAG (2005) Raising the standard: The Revised Adult Mental Health National Service Framework and an Action Plan for Wales. Cardiff: Welsh Assembly Government. http://wales.nhs.uk/sites3/page.cfm?orgid=438&pid=11071 Accessed 30.03.2008.

Artwork number	Description	Please specify whether (i) Photograph (ii) To be drawn by artist	Permission required? If so, please give details.
1	**Figure 1: Recovery approach and mental health nursing**	ii	No
2	**Figure 2: Working in partnership: first of the Ten Essential Capabilities for mental health practice**	ii	No
3	**Table 1: Recovery for different user groups**	ii	No
4	**Table 2: Difficulties encountered in working in partnership**	ii	No

Biographical notes

Alan Simpson is a postdoctoral research fellow and lecturer in mental health nursing at City University, London.

Geoff Brennan is Nurse Consultant in Psychosocial Interventions (PSI) for Berkshire Healthcare NHS Foundation Trust.

Website materials

Glossary

Term (up to 60 characters)	Definition (up to 500 characters)
Working in partnership	Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflicts of interest or aspiration that may arise between the partners in care.
Recovery approach	A personal process of tackling the adverse impacts of experiencing mental health problems, despite their continuing or long-term presence. It involves personal development and change, including acceptance that there are problems to face; a sense of involvement and control over one's life; and the cultivation of hope and using support from others.
Case management	Known in the UK as the Care Programme Approach (CPA), Case management provides a framework in which the strengths and needs of users are assessed and care plans written, implemented and reviewed in consultation with the user, family and other carers.
Care co-ordinators	The care co-ordinator or case manager co-ordinates and oversees the care plan and often has the closest therapeutic relationship and most contact with the service user.
Multidisciplinary team	Team of workers providing care for service user and support for families and carers. Often includes psychiatrists, mental health nurses, social workers, occupational therapists, psychologists and other support workers.
Cognitive-Behavioural Therapy (CBT)	CBT can help people change how they think (cognitive) and what they do (behaviour), which can make them feel better. CBT focuses on the 'here and now' problems and difficulties. Instead of focussing on the causes of distress or symptoms in the past, it looks for ways to improve your state of mind now.
Motivational Interviewing (MI)	The working principle of MI is that it is the business of the individual to change their life and the business of the therapist to assist this change. Taking the position that any change can be understood as a process, MI allows both parties to understand the stages of change and work collaboratively to support the change process.
Psychosocial Interventions (PSI)	PSIs are specific interventions for people with psychotic experiences. To be a valid PSI, the intervention must be evidence based, person centred, and aimed at reducing the stress of an individual experiencing psychotic symptoms or their carers.
Learned Helplessness	Learned helplessness is a psychological condition in which someone has learned or come to believe that they have little influence or control over a situation, often resulting in them becoming passive, apathetic or withdrawn.

MCQs for Partnership Working book chapter

Type: multiple choice		
Title: Chapter XX - Question 01		
1)		Complete the following sentence: Working in partnership is the first of:
Feedback: Working in partnership is the first of the ten Essential Shared Capabilities for mental health staff. Page reference: XX		
incorrect	a.#	The Ten Capable Shared Essentials
correct	b.#	The Ten Essential Shared Capabilities
incorrect	c.#	The Seven Deadly Sins
incorrect	d.#	The Seven Wonders of the World
END OF QUESTION		

Type: multiple choice		
Title: Chapter XX - Question 02		
1)		In the Recovery approach, whose aims is it most important to consider and value?
Feedback: Working within the Recovery approach, it is essential that you show that you understand and value the aims of the service user. Page reference: xx		
incorrect	a.#	The consultant psychiatrist's aims.
incorrect	b.#	The ward manager's aims.
correct	c.#	The service user's aims.
incorrect	d.#	The Mental Health Act Commission's aims.
END OF QUESTION		

Type: multiple choice		
Title: Chapter XX - Question 03		
1)		When writing a care plan, at what stage is it is important to try and involve the service user?
Feedback: The user should be actively involved (wherever possible) in discussing, writing and reviewing the care plan at all stages. Page reference: XX		
incorrect	a.#	When the user is discharged from hospital.
incorrect	b.#	When it is time for the Consultant's ward round.
correct	c.#	Throughout all stages.
incorrect	d.#	When you have completed most of the sections on the form.
END OF QUESTION		

Type: multiple choice		
Title: Chapter XX - Question 04		
1)		What is the name of the person-centred problem-solving approach described in the chapter?
Feedback: Egan's (1994) skilled helper model is a person-centred, problem-solving approach developed in counselling psychology and useful in psychiatric settings. Page reference: XX		
incorrect	a.#	Elgar's skilled helper model
incorrect	b.#	Elgar's helpful skills model
incorrect	c.#	Egan's model skills helper
correct	d.#	Egan's skilled helper model
END OF QUESTION		

Type: multiple choice		
Title: Chapter XX - Question 05		
1)		In partnership working, the nurse should aim to:
Feedback: In partnership working, the nurse should aim to identify and build on coping strategies already successfully employed by the user. They can also discuss and suggest other strategies from relevant literature and expertise within the team. Page reference: XX		
correct	a.#	Build on coping strategies already employed by the user.
incorrect	b.#	Replace the users' own coping strategies with evidence-based strategies.
incorrect	c.#	Design nurse-led strategies in consultation with the multidisciplinary team.
incorrect	d.#	Tell the user to use strategies identified by the Consultant psychiatrist.
END OF QUESTION		

Type: multiple choice		
Title: Chapter XX - Question 06		
1)		To work in partnership with enthusiasm and empathy, mental health nurses need to be enabled and encouraged make use of:
Feedback: The use of clinical supervision and support from colleagues helps staff maintain mental energy and enthusiasm for difficult emotional work and empathy with users. Page reference: XX		
correct	a.#	Clinical supervision
incorrect	b.#	Long breaks in the staff room or office.
incorrect	c.#	The internet.
incorrect	d.#	Refreshing drinks.
END OF QUESTION		

Interactive self assessment information:

Chapter:	
	8
Title:	**Partnership Working Self Assessment**
Scenario description:	In your next clinical placement identify a fellow professional (it does not have to be a nurse – it could be an occupational therapist, doctor, pharmacist, health care assistant, volunteer, advocate, etc) that you think personifies and demonstrates the principles and practices outlined in the chapter on partnership working. Numerous potential situations offer themselves where you may witness examples of good (or not so good) attempts at partnership working. These might include: • direct communication with patient or carer, e.g. someone coming to the ward office; somebody attending an outpatient clinic; or visiting a person in their home. • facilitating a therapeutic intervention, e.g. admitting someone to the ward; giving medication, introducing to ward round/CPA meeting, attending to physical care needs. • maintaining the principles of partnership in the absence of the patient, e.g. when discussing the person with colleagues, when recounting or handing-over information about difficult or challenging incidents. While this is an imposed exercise and may feel artificial, it is very important to realise that many nurses carry out this type of self-assessment in the course of their development. It is therefore intended that you carry it out, at least mentally, more than once as different people can offer you different lessons. Using the questions below, try and list the qualities that the person demonstrates. You can save and print off your answers and include it in your portfolio as evidence of your work towards this competency. You may wish to discuss some or all of these with your mentors and identify how you can develop your skills in partnership working further.

Question information (one of these per question - i.e. you can have several questions per interactive scenario, please copy and paste below as required):

Quality 1)	Behaviours
Suggested author answer: (e.g. offering the patient a cup of tea, saying please and thank you, welcoming a family member on to the ward)	
Page reference: xx	
END OF QUESTION	

Quality 2)	Attitudes
Suggested author answer: (e.g. using un-emotive language, being calm in interactions, demonstrating honesty)	
Page reference: xx	
END OF QUESTION	

Quality 2)	Knowledge
Suggested author answer: (e.g. Awareness of patient personal history, circumstances and preferences, awareness of patients' and carers' wider social networks.)	
Page reference: xx	
END OF QUESTION	

Exercise 2)	The above exercise will allow you to understand what you aspire to. In subsequent reflection it is important to identify; • What you already have • What you need to develop • Awareness of personal limitations and barriers
Suggested author answer: • What you already have (e.g. "I always check with people what they like to be called") • What you need to develop (e.g. "I sometimes use the phrase PD for people with a personality disorder and feel uncomfortable with this." • Awareness of personal limitations and barriers (e.g. "I feel uncomfortable with this particular patient and I think it's MY problem")	
Page reference: xx	
END OF QUESTION	