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Care Planning Meetings: Issues for Policy, Multidisciplinary Practice and Patient Participation

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Key Words: Older People, Care Planning Meeting, Social Work, Multi-disciplinary Teamwork, Decision-Making, Discharge Planning

Running Head: Multidisciplinary Care Planning Meetings for Older People

Abstract

Although Care-Planning Meetings (CPMs) are an increasingly common part of the practice of social work with older people and multidisciplinary teamwork(MDT), it is uncertain how and by whom the voice and wishes of older people, including those with a cognitive impairment, are given due priority. In addition, there is little professional guidance as to how to best plan and facilitate CPMs for older patients with cognitive and communication deficits and other often complex needs. An added challenge is the wide, often diverse, and conflicting range of perspectives held by health and social care professionals and other family members who may be involved. This scoping review article on CPMs for older people, considers the facilitators and barriers to effective participation as identified in the literature and proposes suggestions for best practices in CPMs which could help promote an individualised approach to participation that best reflects the older patient's wishes.

Key Words: Older People, Care Planning Meeting, Social Work, Multi-disciplinary Teamwork, Decision-Making

Introduction

CPMs have been described as a key process associated with health and social care services for frail older people (Milte et al 2013). Despite the growing importance of CPMs in policy and social work practice, a number of questions remain unanswered about definition and efficacy. It is uncertain whether the voice and wishes of older people, including those with a cognitive impairment, are given due priority and if active participation is realised when CPMs are used. In addition, there is little professional guidance as to how to best plan and facilitate CPMs. An added challenge is the competing agendas of the wide range of health and social care professionals and other family members often involved in CPMs. Part one of this article reviews the literature on CPMs and outlines the facilitators and barriers to effective participation. Based on a synthesis and review of the literature, the second part of the article then proposes guidelines that could help promote an individualised approach to participation that best reflects the older patient's wishes.

Methods

A scoping review approach was adopted as part of the first author's PhD study, in order to identify, summarise and critically reflect on studies relating to care planning with older people including those with a cognitive impairment in order to inform and develop research questions. Scoping reviews are a relatively new approach for which there is not yet universal agreement about definition or procedure (Arksey and O'Malley 2005; Davis, Drey and Gould

2009; Levac, Colquhoun and O'Brien 2010) As a result, an iterative approach to this issue is often recommended in the literature (Pham et al 2014). It is argued that researchers should combine a broad research question with a clearly articulated scope of inquiry. This includes defining the concept, target population, and health outcomes of interest to clarify the focus of the scoping study and establish an effective search strategy (Levac et al 2010.) As this scoping review was part of a PhD study, data was extracted only by the first author which is atypical of scoping reviews (Pham et al 2014) however identified studies were discussed, interpreted and critically appraised in conjunction with the second and third author. The third author was also a stakeholder in the research study and was consulted as part of the literature review, a method also recommended by a number of other authors (Arksey and O'Malley 2005).

Scoping Review Strategy

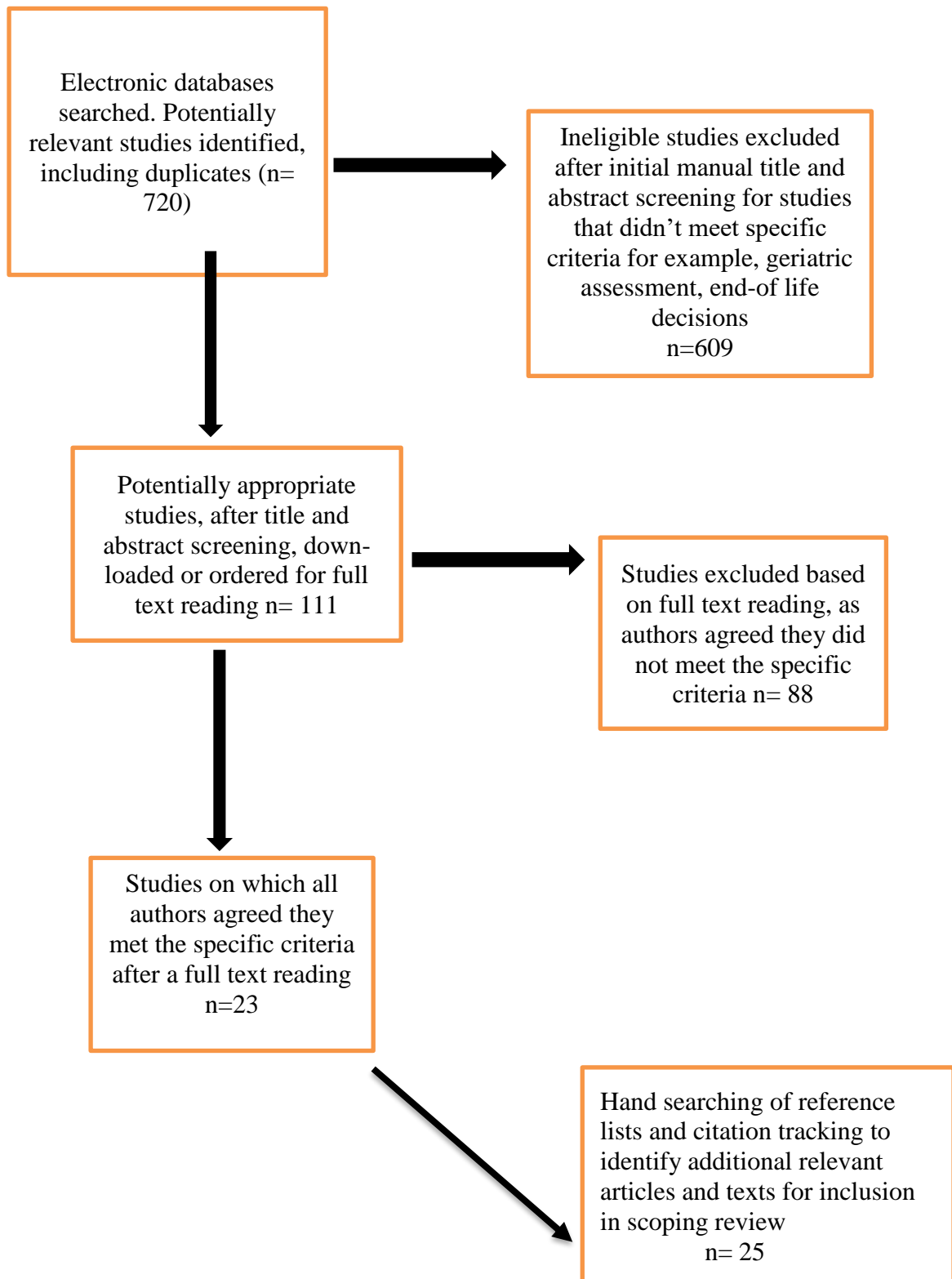
The research question used to carry out the scoping review was as follows:

'What does the existing literature tell us about older people and their participation in multidisciplinary CPMs?'

Two key concepts, firstly 'care planning meetings' and synonyms related to this term and secondly, 'older people's participation in care planning or decision-making' were used in the search. A range of databases were searched, including Pubmed, Medline, CINAHL, PsychINFO and JSTOR using the following MESH headings singularly and in combination: 'meetings/group meetings', 'family meetings', 'care planning meetings'

'discharge planning conferences' 'patient participation', 'multidisciplinary team', 'aged', 'older' 'family', 'family caregivers' 'discharge planning'. As this search strategy identified only a limited number of articles (see Figure 1) an alternative strategy was adopted accepting no limitations on publication types and involving hand-searching bibliographies of articles and books to uncover other relevant materials. Because this initial trawl revealed a paucity of literature relating to CPMs with older people, available literature relating to CPMs with other client groups was also examined, including Australian studies in palliative care and rehabilitation settings.

Figure 1 Literature Review Search Strategy



A broad inclusion criteria was followed namely, any literature related to the two key concepts outlined above: care planning meetings or synonyms of this term as well as literature relating to older patient's participation in care planning and decision-making.

Data Analysis

An interpretivist inductionist approach (IIA) where the researcher tackles a problem from the perspective of theoretical sensitivity to existing concepts, ideas and the theory was used to develop the analysis framework for this study. With an IIA, the researcher plays an active and deliberate role in organising and assigning meaning to the data as a way of constructing higher-order categories and theories (Kuczynski and Daly 2002). Analysis of the information from reviewed articles followed an iterative data reduction method (Crabtree and Miller 1999; Creswell 2003; Kvale 1997). Information was extracted and data grouped for identifiable similarities and trends. Convergent themes were noted and developed and supportive literature identified (Crabtree and Miller 1999; Kvale 1997).

The origins and purpose of CPMs

The original impetus for CPMs arose from policy drivers who in the last two decades, have become increasingly focused on human rights, autonomy, self-determination, independence, patient participation and discharge planning, particularly for older hospital patients. In a climate where there has been an increased focus on the human rights of disadvantaged groups such as children, migrant workers, persons with disabilities and women, increasingly it has been argued that older people including people with dementia deserve

special care and attention in relation to their human rights (Shakespeare, Zeilig and Mittler 2017).

In many European countries in a climate of austerity and cuts to health and social care budgets, population ageing is creating particular challenges for social care and social work services. Continuing financial cut backs have led to an unprecedented assault on the resources needed to maintain older people within the community (Lymbery 2014). Ironically, legislative developments (the Mental Capacity Act 2005) and rights as enshrined in the Convention on the Rights of Disabled People (CRPD, UN 2006) have brought attention to how people even those with impaired capacity still have legal capacity and therefore have rights to be supported to choose where and with whom they wish to live. In line with the CRPD (UN 2006) they also have rights to home based community supports although most older people and indeed health service professionals may be unaware of this. It has been argued certainly in England that the absence of adequate social care services means that governments are failing in their commitment to promote the human rights of older people (Boyle 2010). In other jurisdictions such as Sweden, specific legislation has been developed to ensure participation of older people in care planning. Self-government and integrity is central in the Swedish Social Services Act (2001, 453), and even if the applicant is diagnosed with dementia he or she has the legal right to make the final decision about the use of supportive services (Larsson and Olsterholm 2014).

This emphasis on the needs of older people is partly a consequence of increasing numbers of hospital patients with disabilities and cognitive impairment, and the involvement of third party decision-makers such as family

members (Milte et al 2013). As a consequence, arrangements for Multidisciplinary Team (MDT) collaboration between professional care providers, older people and their family/caregivers became mainstreamed in many services (Jones et al 1997). Although their original function was to respond to crisis situations (Loupis and Faux 2013), CPMs are now routinely used in a more anticipatory manner and, when carried out well, are thought to build important organisational bridges between hospital and community care (Griffith et al 2004). CPMs represent an opportunity for the expression and exploration of the lifeworld of both the older person and their families: however, this fragile space can be vulnerable to manipulation or colonisation by healthcare professionals' systems world (Donnelly et al 2013). CPMs may serve different functions depending upon the specialism or service. For example, in rehabilitation services, CPMs tend to offer patient, family members and MDTs an opportunity to ask, 'where to from here?' (Neville 2006) with a view to assist older patients and their family members to reach mutually agreed goals in an inclusive, supportive and positive environment.

Despite early optimism about the potential of CPMs, the aspirations for active participation and the empowerment of older people and their families in decision-making are often not met in practice contexts where there are resource demands and organisational difficulties (Efrainsson et al 2003,2004,2006; Hedberg, Johanson, and Cederborg 2007). Concerns have been expressed about the inadequacy of the knowledge base about *how* the participation of patients in CPMs is best accomplished (Bangsbo, Duner and Liden 2014). The rights of older people with cognitive impairment and other communication/comprehension deficits are particularly important to keep in

mind given their vulnerability and often lack of engagement in clinical decision-making processes which tend to be driven by MDT discourses and the views of family members (Abramson 1998). As a consequence, the older person with a cognitive impairment or communication difficulty is often silenced or their views may be subordinated, dismissed as not valid or neglected (Donnelly et al 2013). CPMs are restricted by the structure and process of meetings which often do not accommodate the needs of the older adult (Milte et al 2013). CPMs also generally require a significant amount of clinician time (Hannon et al 2012) and it can be difficult to coordinate the needs and views of different professionals and family members. It is not surprising to learn therefore, that CPMs require high-level interpersonal skills in the areas of facilitation, negotiation and goal-setting (Reed and Harding 2015) and that this task in practice often falls to social workers.

Defining CPMs

CPMs play a significant role in an older patient's hospital journey. Their usefulness has been particularly highlighted in palliative care settings, where family support for treatment, planning and continuing care is vital (Gueguen et al 2009). Internationally, CPMs are an integral part of social work in hospital settings, yet there is no universal understanding or definition of the concept. A range of different terms can describe the same or similar processes including: family meetings (Griffith et al 2004); family conferences (Hansen, Cornish and Kayser 1998; Duffy and Healy 2013); discharge planning conferences (Efrainsson et al 2003); and, more recently, care planning meetings (Hedberg Johanson, and Cederborg 2007,2008). The move towards the more neutral term of 'care planning meetings' replaces older, more paternalistic notions,

such as ‘family meetings’ or ‘family conferences’ (Crisp 1989). One of the most widely cited definitions in this field describes a CPM as *“involving a number of family members, the patient and hospital personnel in discussions concerning the patient’s illness, treatment and plans for their discharge or care outside the hospital”* (Hansen, Cornish and Kayser 1998,58). The fact that family members appear to take preference before the patient reflects this sense of paternalism and is in contrast to more recent approaches that seek to recover and highlight the voice of the older person (Osterholm and Hayden 2014).

This variety of terms for CPMs also appear to reflect the number of functions associated with the meeting process, including: education (Gueguen et al 2009); rehabilitation planning (Griffith et al 2004; Froenck 2005; Neville 2006); information sharing and treatment planning (Griffith et al; 2004; Hudson et al 2009; Gueguen et al 2009) and discharge planning (Efrainsson et al 2006; Hedberg, Johanson, and Cederborg 2007,2008). In early analyses of CPMs it was argued that such processes work well together when the older person, carers and MDT are satisfied with the amount and quality of information exchange (Griffith et al 2004). This clarity of decision making can enable older patients to experience a level of control about their care planning and treatment (Ever 1981).

Increased calls for greater empowerment and involvement of older people and their family carers in discharge planning has led to a renewed focus on models and processes of shared decision-making (Bangsbo, Duner and Liden 2014). More recently policy makers have recognised the need for a shift from the paradigm of the older person as a passive recipient of care to one of more

active citizen (Bartlett and O'Connor 2007), yet it would appear that such aspirations fail, as the voice of the service user is marginalised and the process often experienced as disempowering (Stacey et al 2016).

To date, the voice of the patient in CPM decision-making seems largely unconsidered in the literature (Reed and Harding 2015). A number of studies from Sweden appear to be the exception in this case. Efraimsson et al. (2003,2004,2006) observed discharge planning conferences involving eight older women in Sweden. Although legislation exists in Sweden to support the older people's right to participate in decision-making related to their care, this study found that the majority of woman were relatively powerless during their discharge planning conference. In a later study, they asserted that the basic ethical principles of democracy, autonomy and patient participation were compromised because the patient was not alert enough to participate in a meaningful way (Efraimsson et al 2006).

In contrast, another larger study which examined 33 discharge planning conferences which also took place in the Swedish hospital system showed that, in six out of ten cases, the patient was the main decision-maker (Lundh and Williams 1997). Interestingly however, 55% of patients did not believe that they had adequate information to authentically participate in their discharge planning conference. In conclusion, these studies suggest that, even where systems appear to be in place that facilitate patient decision-making, older patients are not always adequately prepared or enabled to participate in an effective manner (Lundh and Williams 1997; Efraimsson et al 2006).

Knowing the person and the quality of the therapeutic relationship

Jarrett and Payne (1995) observed that an increased awareness of how non-verbal signals, such as body movements, can reflect a persons' wish to talk about an important issue in their lives, and that these types of signals should be supported and acted on to enhance notions of personhood (Kitwood 1997). The question must be posed however about whether social workers and MDT members are actively aware of such cues during decision making processes in CPMs? The literature suggests that a fundamental antecedent to meaningful participation by the patient in CPMs is the nourishing of a therapeutic relationship by professionals (Cahill 1996; Tutton 2005). A therapeutic relationship with older people necessitates a collaborative relationship between service users and social workers (Duffy and Healy 2013). This form of participation is implicitly related to the concept of social worker and MDT members 'knowing the patient' (Florin., Ehrenberg and Endfors 2008) and the patient understanding, consciously or unconsciously, that this relationship can enable a greater opportunity for participation and decision-making (Tutton 2005). For genuine therapeutic alliances to develop with older patients, trust and respect are vital and an emotionally secure environment must exist, if participation is to take place (Ashworth, Longmate and Morrison 1992). If participation in CPMs is to be more than a superficial consultation, it must be treated as an extension of this therapeutic relationship alongside a realistic appreciation of the obstacles to this participation (Hedberg, Johanson, and Cederborg 2007,2008), as described below.

Knowledge of group decision-making processes

It is apparent that social worker's knowledge of group decision making processes in the clinical context tends to be neither well developed nor articulated when compared, for example, to extensive research on the use of family group conferencing in child welfare contexts (Connolly 2006).

Information exchange and decision making is sometimes considered by social workers and MDTs as routine and not demanding a high level of skill (Hansen et al 1998). Despite the promotion of CPMs as an essential tool for information sharing and goal clarification, sparse evidence exists to demonstrate the process for training staff to conduct or participate in them (Gueguen et al 2009). Many MDT members report they do not receive sufficient skills training on how to interact with CPM processes (Fineberg 2005) and other professionals (Goldman et al 2016).

It is important, however, that multidisciplinary group dynamics are attended to in these contexts. It can be challenging and demanding to involve older people in the communication about their care (Hedberg, Johanson, and Cederborg 2007) and how the creation of meaning is achieved in CPMs relies predominantly on the ability of the other participants to involve and help support the older person (Sundin and Jansson 2002). Some professional groups such as social workers or doctors, are expected to take leads in facilitating CPM processes yet surprisingly, this is often not a routine part of their formal professional education (Hudson et al 2009).

The notion of greater participation by older patients is championed on the grounds of increased satisfaction, better disease management and opportunities for citizens to take greater control of their health (Collins et al

2007). These objectives, however, are necessarily subject to contextual circumstances. For example, some older people appear to favour a shared decision-making approach over a passive or autonomous style (Foss,2011). Others, although offered the opportunity to participate, often continue to allow MDT members to act on their behalf, in particular reverting to 'expert opinion' for final decisions relating to discharge (Roberts 2002).

Creating a context that encourages participation is dependent on a range of factors including the number of participants, communication processes and level of consensus and conflict (Donnelly et al.2013). Time pressures, limited choices, the stress associated with critical decisions, and conflicting agendas (Coulton et al 1982) are additional influencing factors. Crucially, effective communication and decision-making between patients, families and MDTs requires time, training and higher clinician competency in shared-decision-making has been evidenced in CPMs of longer duration (Milte et al 2013).

Pre-Meeting Preparation

For CPMs to be effective, it has been argued that a set of planned arrangements and processes need to be in place (Milte et al 2013; Bangsbo., Duner and Liden 2014). Firstly, consideration should be given to the number of people in attendance because if there are too many participants the concept of 'parallel talk' is likely to occur (Berglund et al 2012) or that the older person is at risk of being passive at the meeting (Bangsbo., Duner and Liden 2014). Unfortunately, it is often the case that older people, family members and MDT members believe that the aims and outcomes of CPMs are not always apparent, clear or consistent (Loupis and Faux 2013). It is

imperative therefore that the function and purpose of the CPM has been fully explained to the older person and their family (Bangsbo., Duner and Liden 2014). A pre-requisite for effective participation by the older person is a coherent approach to agenda setting. Studies have shown the need to align the perceived needs of all participants and to make explicit the purpose of CPMs in advance (Donnelly et al 2013).

Whilst the literature emphasises the importance of pre-meeting preparation for older patients and family members as an essential stage in CPMs, in practice this is rarely addressed or implemented (Griffith et al 2004; Efrainsson et al. 2006; Donnelly et al.2013; Loupis and Faux 2013; Bangsbo, Duner and Liden 2014). Older people tend not to be prepared for meetings and often lack essential knowledge about the CPM decision-making process and future care options, contributing to reduced opportunities for participation (Efrainsson et al 2006). In the absence of agenda setting, and when MDT members position themselves as expert, or the older person or family's opinion falls secondary to this alleged expert opinion, the older person's input into the discussion may be discouraged and their wishes may not be given full credence (Opie 1998). It has been argued that, in order to promote the voice of the older person within their CPM, assistance should be provided to the older person to prepare questions (Bangsbo., Duner and Liden 2014) or a question prompt list should be drawn up (Milte et al 2013).

Communication

CPMs are clearly not an example of everyday discourse but rather an institutional conversation. In ordinary talking participants engage on fairly

equitable grounds (Drew and Heritage 1992; Sarangai and Roberts 1999; Efraimsson et al. 2006) but in institutional conversations there are significant power differentials and in the context of older hospital patients, often differences based on age, gender and social class. While this emphasis on information-giving and communication is of central importance (Donnelly et al 2013), the management of the subsequent process is also crucial. In particular, formal rules and the overuse of technical language tend to confound and prevent opportunities for dialogue and empowerment (Efraimsson et al 2006; Agar 1985; Satterlund Larsson 1989; Efraimsson et al 2004). Powerful MDT discourses tend to crowd decision-making spaces; one study found that professional opinions outweighed those of the patient and their family members combined (Hedberg, Johanson, and Cederborg 2007,2008). Given the asymmetries in the relationship, MDT members tend to control discussions and steer the focus of the CPM to their own, or the institutional agendas (Opie 1998).

This unequal distribution of power then become exaggerated, depending on the cognitive impairment and or communication difficulties of the patient (Osterholm and Hayden 2014). and the ability of family members and carers to influence events. Davis and Pope (2010) use the metaphor of 'conversational ghosts' to express this important phenomena. This issue can be addressed by communicating through the use of everyday language and pronouns such as 'you' and 'we' to support older people in taking more positive positioning in these meetings (Leppanen and Lindstrom 1999).

The way that decisions are framed, and by whom, may also have a significant impact on how such information is processed and used by

decision-makers (Hedberg, Johanson, and Cederborg 2007). In some instances, it is not uncommon for older patients to be talked *about*, in the third person, rather than talked *to* during their CPM (Hedberg, Johanson, and Cederborg 2007; Donnelly et al 2013). The institutional setting therefore serves as a purposeful structure, or at worst, acts to confine the participation of older patients. MDT members and family members therefore have a critical role to facilitate and enable the older person to actively participate in their CPM (Bangsbo, Duner and Liden 2014). It has been suggested that the more positive outcome for CPMs is contingent upon explicit organisational guidelines and the upskilling of MDTs (Donnelly et al 2013; Bangsbo, Duner and Liden 2014) which may help heighten awareness of power differentials and what factors hinder and encourage older patients' participation in CPMs.

The impact of family members

In these contexts, preferences of older people and family members can often diverge. Past events and contemporary family dynamics may impact on how family members interact with the older person during discharge planning discussions (Griffith et al 2004). It is often the case that MDTs may place excessive demands on family caregivers resulting in the older person feeling like a burden (Bangsbo, Duner and Liden 2014). In an early discussion of the use of CPMs, Hansen, Cornish and Kayser (1998) suggest that more time should be spent discussing discharge planning with family members rather than with the patient themselves. Such narratives tend to prevail in health and social care services. As a consequence, older patients have less influence and may be only minimally involved or even excluded.

This problem is often compounded by the actions of MDT members who often attribute higher status to family members than patients in the decision-making process (Hedberg, Johanson, and Cederborg 2007,2008). It has been noted that, for many older patients, there is an inverse relationship between patient and family member participation; where family participation is high, patient participation tends to be low (Abramson 1998). A number of questions are then raised about the role and function of CPMs that suggest ethical concerns (Donnelly et al 2013). If the purpose of the CPM is to arrive at a rational decision about discharge, it is of concern that the patient's voice and opinion might not be included in this process, particularly where the more powerful discourses of family members and MDTs hold sway (Abramson 1998).

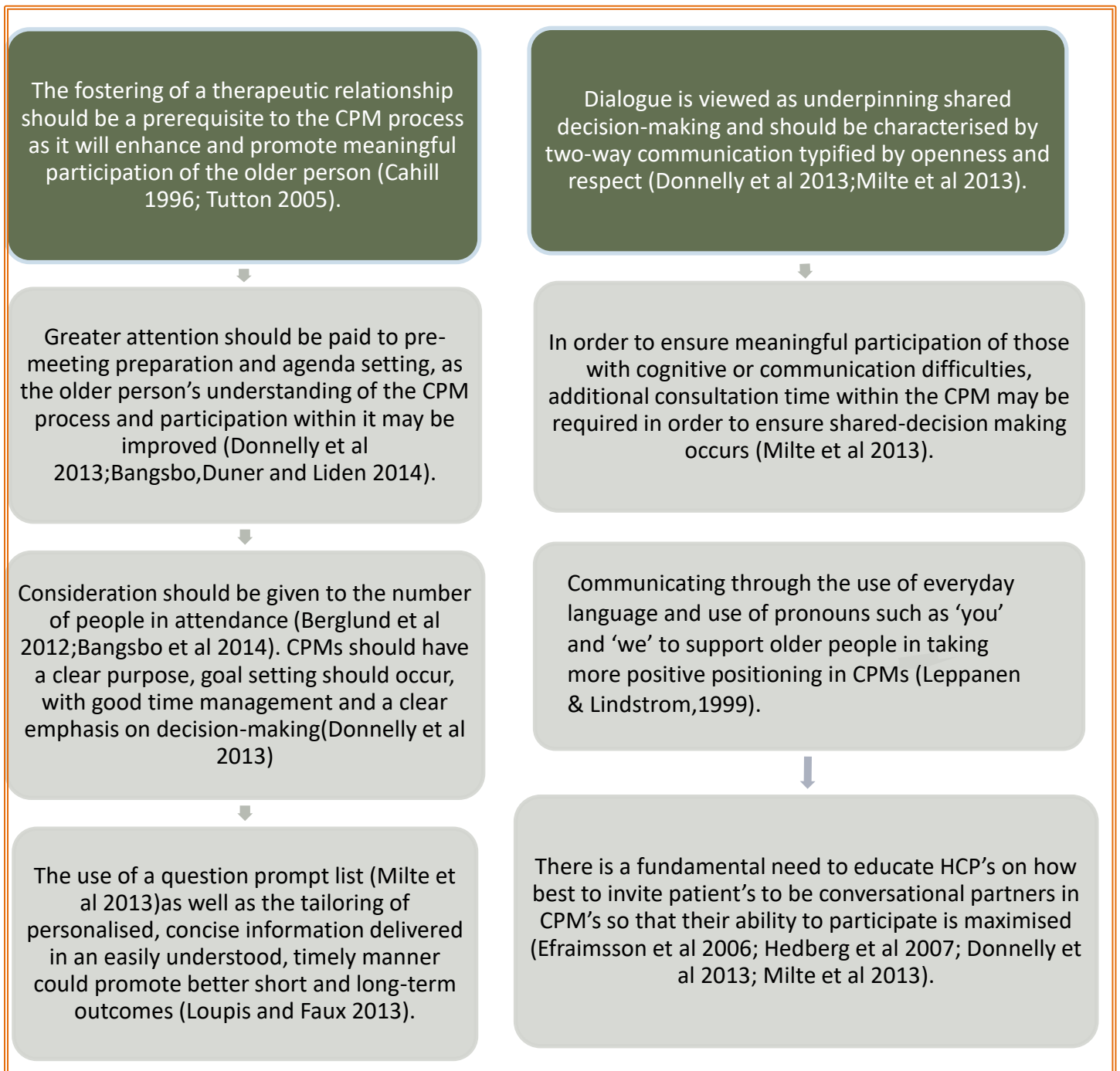
Tokenism in patient participation

If, and when, these more influential discourses occupy the decision-making spaces, concerns arise, not just about the absence of the older person's views (Efraimsson et al. 2006), but how this situation can be squared with policy makers' expectations about consumer driven services, citizenship and empowerment. It has been suggested that a number of misperceptions exist about CPMs in this respect. It may be that they represent more of an 'institutional conversation' than a more empowering forum that allows participants engage on fairly equal grounds (Drew and Heritage 1992). This contradiction is reinforced by environmental factors. Creating opportunities for participation in a hospital environment is a challenging and complex process and older people appear to be particularly vulnerable in this setting (Tutton 2005). Shorter inpatient stays and the working conditions of MDTs often result

in planning *for* rather than planning *with* the patient (Perry, Hudson and Ardis 2011; Connelly et al 2009). Divergent opinions occur between the intentions of MDTs to promote patient autonomy and some older patients' reports of being unable to express their opinions. Efraimsson et al (2004) for example, reached the worrying conclusion that older participants were actually 'fooling themselves' into believing that their participation played any role in the ultimate outcome of the discharge planning process and that in most cases decisions had already been made prior to the discharge planning conference taking place. However laudable the desire to include older people in CPMs, often on the basis of person-centred, human rights -based approaches, the literature indicates, at best, piecemeal success in this area. Even where MDT members advocate for change, they may experience conflict and tension between their own professional and perhaps personal values and the external demands placed on them by hospital managers, discharge planners and the institutional agendas (Efraimsson et al 2006).

Based on this scoping exercise and critical analysis of the literature, Figure 1 provides an overview and synthesis of some of the key issues for MDTs, the authors recommend should be considered when participating in multidisciplinary CPM's. It provides a user friendly 'CPM Checklist' summary and offers a synthesis of the literature for best practices in CPM's with older people.

Figure 2: 'CPM Checklist.' Synthesis of the literature on best practice in CPM's with older people.



DISCUSSION

Currently governments and policy makers' expectations that there should be full participation of older people in CPMs, it would appear, can only be partially fulfilled given the complexity of issues at play. Without critically examining 'common-sense' practices which are assumed to be normal, the status quo remains (Biggs 1993). If participation is to involve more than a superficial consultation, it must be treated as a process that is complex, takes time (Wilcox, 1994) and where the development of a therapeutic relationship is viewed to be a fundamental aspect of professional practice (Cahill 1996; Tutton 2005). In addition, there is a need to continually redefine assumptions and decisions for each older person, who should not be a 'silent witness' to the CPM process.

The concept of personhood (Kitwood 1987) and person-centredness presupposes an understanding of group processes that improve older persons' possibilities to participate in institutional conversations (Foss 2011). Based on our scoping review and analysis we would argue that the meaningful participation of older people in CPMs is achievable, but only under certain conditions (Efraimsson et al 2006; Hedberg, Johanson, and Cederborg 2007,2008; Donnelly et al 2013; Milte et al 2013). We would contend that active participation is possible if a supportive and communicative approach is adopted by social workers and MDTs and if the older person is well prepared and advised on the agenda and purpose of the CPM (Donnelly et al 2013; Bangsbo et al 2014). Hospital clinicians need to see beyond the rhetoric of CPMs and the often misjudged assumption made about its democratic credentials. They need to be mindful of the value-laden role they play as agents facilitating the discharge planning agenda of

the hospital. In doing so, there is a need to be cognisant of the inherent asymmetry in power relationships within hospital settings, and the potential conflicts which may arise between organizational, professional and personal goals (Hedberg, Johanson, and Cederborg 2007).

Yet when CPMs are well prepared and carefully structured there are opportunities to tilt the balance of power in favour of the older person, and to help them to maximise control over decisions affecting their lives. The CPM process, when facilitated well, can help gain insights into patient, family and community relationships and problems can be dealt with in transparent and communicative ways (Loupis and Faux 2013). However, where there are contradictions between the ideal of achieving effectiveness and efficiency whilst simultaneously striving towards holistic care, then CPMs will be less successful. In this sense, there may well be considerable discrepancies between the ideological intentions of the CPM -humanistic ideals such as person-centered care, personhood, 'patient perspective', 'autonomy' and 'democracy' evoke expectations - and the institutional goals which may be more reflective of control, cost containment and rational planning (Donnelly et al 2013). The results of such ideological contradictions and tension tend to place social workers at the front-line struggle to meet institutional, patient and family goals simultaneously. The busy social worker may be blithely unaware of these dynamics but the more reflective practitioner may struggle with such moral and ethical dilemmas within their day-to-day clinical practice (Lymbery 2014). We would conclude by arguing that the assumption that striving for participation automatically confers the status of participant to older people must be challenged. We have argued that participation may be construed as

tokenism or manipulation of service users by providers (Donnelly et al 2013). Conflict of interests may also arise as well as the claim that the involvement of more patients as true participants will result in delays and additional costs (Roberts and Chapman 2001).

In many contexts and countries, the state undoubtedly relies on family members to provide care to their older relatives. Family members often have to assume a dominant role as it will be necessary for them to take on the role of carer when the older person returns home. Likewise, it is possible that the MDT direct the majority of the discussion towards family members rather than the older person themselves as they are also reliant on the family members to facilitate discharge arrangements by providing care and support. The literature also suggests that there is some evidence that lack of engagement by patients is a purposive strategy. Huby et al (2004) found that patients' lack of engagement in decision-making was part of active management to get family members to look after them when they returned home. Autonomy is an underlying principle which encourages self-determination and older patients ought to be afforded the opportunity to decide how they want to exercise their autonomy, even if that is by intentionally adopting a passive role (Florin, Ehrenberg and Endfors 2008). Older people therefore should be supported to make decisions based on their own preferences for participation (Efrimsson et al 2006).

If older patients are not addressed directly or asked to confirm, negate or select different options, it can be argued that they are awarded 'passive participant status' (Efrimsson et al 2004). MDT members may be uncomfortable in sharing power and knowledge with patients in practice, even

though they acknowledge this idea in theory (Florin, Ehrenberg and Endfors 2008). On the other hand, it could be asserted that MDT members choose to direct conversation within CPMs to family members as they are operating within the organizational frame and under significant time and discharge planning pressures. It is clear that the effort to involve patients as genuine participants ought to be self-evident to professions widely accepted as having human interpersonal relationships at heart (Ashworth, Longmate and Morrison 1992). However, participation is all too often viewed as straightforward and merely a matter of intent being sufficient instead of ensuring that actual and meaningful participation has taken place. Social workers and MDTs must also have received adequate education and skills training in this area (Gueguen et al 2009).

Contradictions in this field and tensions often exist for social workers which suggest the need to move beyond the descriptive teamwork evaluations to recognize the key professional, social, and political issues that underpin both the barriers and facilitators to multidisciplinary practice. By illuminating the structural factors and process driven nature of multidisciplinary interactions such as CPMs, it is possible to identify alternative directions and interventions to support a multidisciplinary approach to discharge (Goldman et al 2016). In preparation for the role of CPM facilitation, the implementation of education and training programmes for social workers and MDTs is strongly recommended (Hudson et al 2009; Donnelly 2012., Reed and Harding 2015). This type of specialist training should be included in both undergraduate and post-graduate courses. In house training should also take place in workplaces such as at hospitals, Day Care Centres and nursing homes/care homes. The

training should be experiential and interdisciplinary enabling participants learn from one another with role play and videotape recordings. The findings of this review suggest that training in this area should encompass communication skills, education on group decision-making processes, the use of sensitive non patronizing language, as well as the development of skills on how to balance the different agendas of the older person, their family members and institutions/organisations. All training should be underpinned by a person-centred care philosophy and by human rights principles including participation, accountability, non-discrimination, empowerment and legality.

Conclusion

In summary, this scoping review reveals a range of barriers, as well as a number of facilitators, for MDTs to empower older people during CPM processes. It is crucial that improvements to the education and training of healthcare professionals on how best to encourage and support older people are introduced. This will enable a more authentic conversation to take place with older people's participation maximised in CPMs, and social citizenship realised. The management of interactional processes are crucial in terms of an older patient's ability to progress along the participation continuum. Emerging toolkits (Hudson et al 2009; Donnelly 2012; Nelson et al 2009) for preparing MDTs to engage with CPMs can provide a basis for educational programmes for MDT members on preparation, planning, communication and patient participation at CPMs, as well as the promotion of increased awareness of power dynamics and professional organizational goals and outcomes within the CPM process. The enactment of specific legislation

relating to a legal entitlement for older people to be included in decision-making, such as that in Sweden, may offer a more concrete framework for practitioners and ensure a standardised approach to the participation of older people within the CPM process. By working reflexively, and critically analysing work practices, modes of interaction can be identified which seek explicitly to minimize power differentials and maximise meaningful participation for the older person.

Declaration of Interests

The authors report no conflict of interests.

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