TEAMWORK
WITHIN MENTAL HEALTH SERVICES IN IRELAND

MENTAL HEALTH COMMISSION

MHC

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Mental Health
Commission
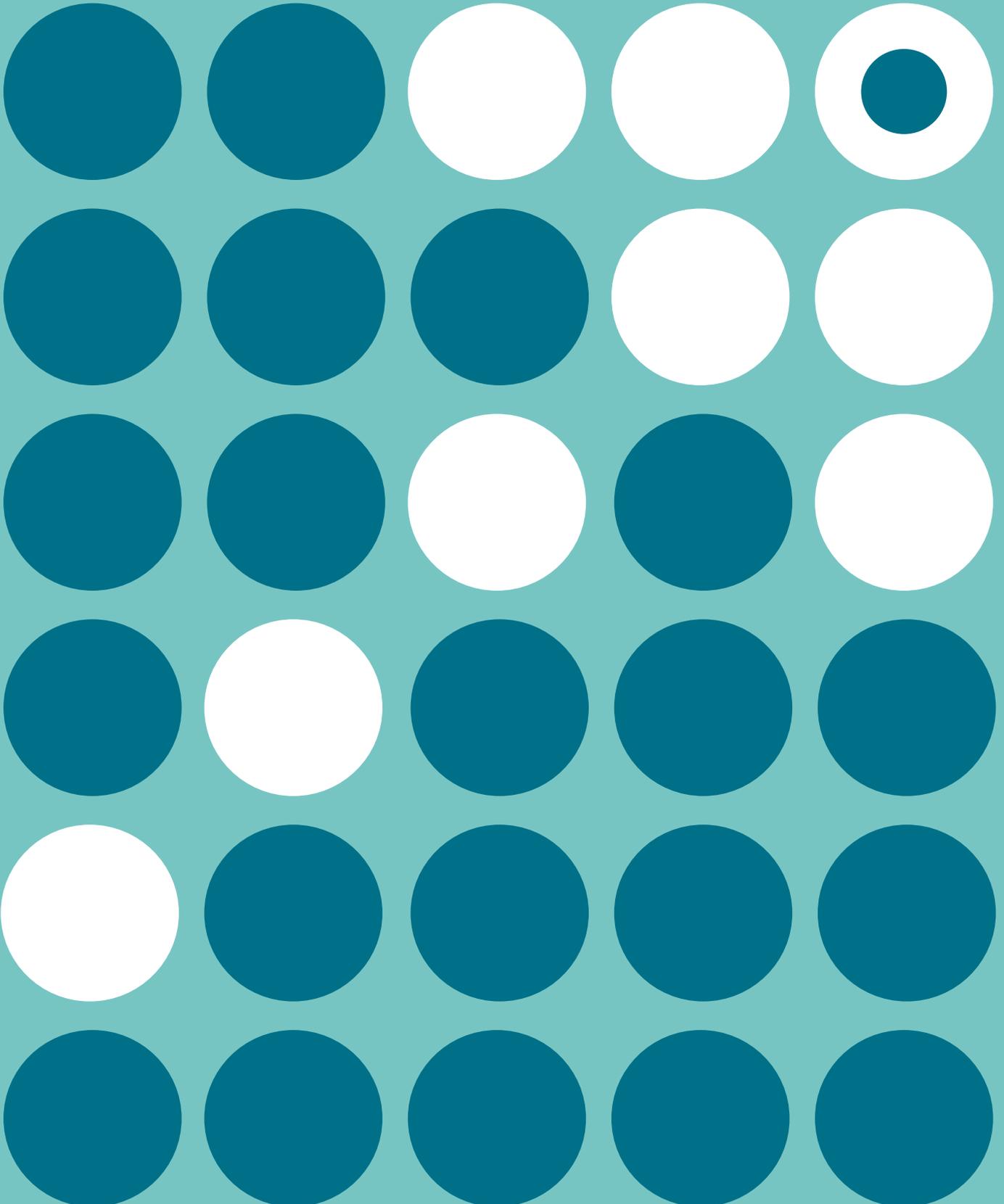
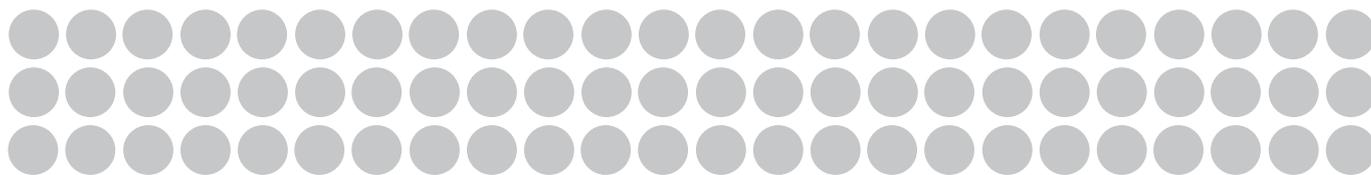# TEAMWORK WITHIN MENTAL HEALTH SERVICES IN IRELAND

RESOURCE PAPER

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on behalf of the Mental Health Commission.**

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CONTENTS

EXECUTIVE SUMMARY

Given its potential benefits for service users, the development of more effective teamworking within mental health services in Ireland remains a prime concern for the Mental Health Commission. This resource paper aims to equip you and your mental health team to:

- Understand what contributes to successful teamworking and some of the pitfalls, and to
- Develop creative solutions for more effective teamworking.

Effective teamwork does not just happen. From the outset teamworking needs to be fostered through good design and effective processes aimed at achieving a service user-centred recovery-based approach to service provision.

A variety of environmental, structural, procedural and individual characteristics constantly interact with each other to produce varying levels of teamworking. Teams can be thought of as travelling through a variety of developmental stages, that they can be helped progress through, by using particular work behaviours and processes.

Service users and carers are best served by team members who have strong professional cultures, work from a recovery orientation and who promote the user's involvement with a variety of external agencies. Robust organisational supports (including provision of adequate resources) are necessary to make this happen.

Mental health teams need clearly defined goals, the minimum number of members (both professional and non-professional) required to complete their work tasks, and the right skill-mix. There is also a need for a robust governance structure, and agreement regarding the model of clinical responsibility employed and the roles of team members.

Teams need to implement an agreed referral pathway, a process of work, and a system to manage workload fairly. They also need to cultivate a healthy communication culture by having policies regarding how decisions are made, and detailing how clinical meetings and confidentiality are managed. While there is a need for a conflict resolution mechanism, it is preferable to prevent conflict. Along with practice supervision and development guidelines, teams and their members also require training.

All these operational requirements need to be clearly captured in an operational policy that is constantly amenable to review as teams remain alert to changes in demand and other key local developments.

This paper presents a resource for continuous improvement, including an audit tool to enable your mental health team to assess whether your teamworking practices are promoting quality of care standards that not only meet stakeholder expectations, but also offer the sort of service that you can be proud of – a service that you and service users are well served by.

Figure 1. Mindmap of this resource paper.

TEAMWORK WITHIN MENTAL HEALTH SERVICES IN IRELAND

Created using the iMindMap software, www.ThinkBuzan.com
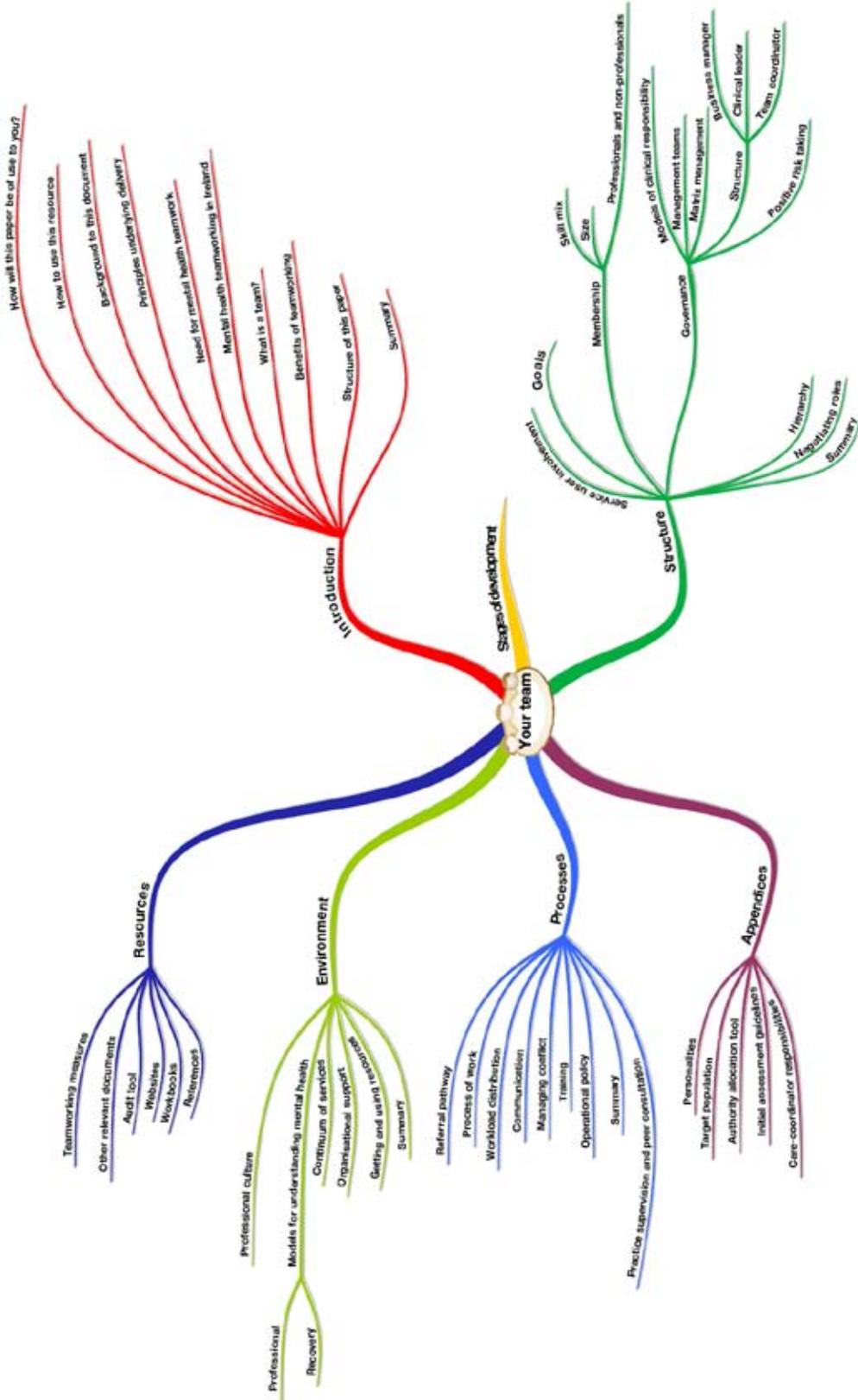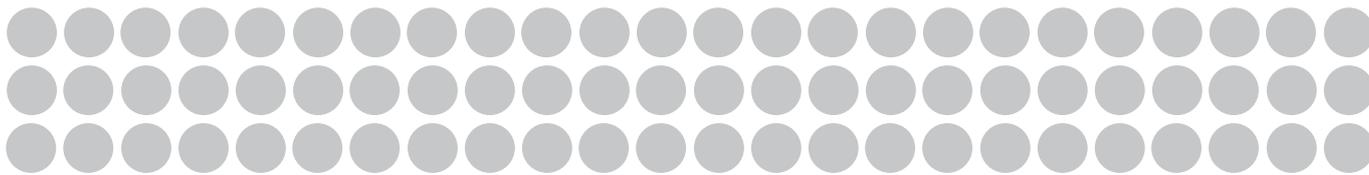
CHAPTER 1: INTRODUCTION

1.1 How will this paper be of use to you?

Targeted at all stakeholders who have an interest in understanding and working through the task of team development, and while more specific to Community Mental Health Teams (CMHTs), this evidence-based resource paper applies to all types of mental health teams. Teams vary greatly, and so they should. You should be responding to the needs of your local community and building on the existing strengths that you have locally. We hope this document will guide your thinking on how to empower your mental health team to develop creative solutions for more effective teamworking. However, the story does not end here. We want to learn from your experience. Feedback would be welcomed from your team regarding how this paper could be further developed to further enhance your service user-centred teamworking.

1.2 How to use this resource

Your team will maximise its learning by reading this resource paper in its entirety. However, as an alternative navigational tool and dependent on your needs, you can use the mindmap (Figure 1) on the Mental Health Commission's website www.mhcirl.ie to 'dip into' relevant sections of this paper.

1.3 Background

A statutory function of the Mental Health Commission is to foster and promote high standards of care and best practice in the delivery of mental health services. A working group was established to work towards this goal by developing a position statement on teamworking to guide mental health service provision in Ireland. Their discussion paper[1] was circulated to a wide variety of stakeholders and associated responses (49 in all) were qualitatively analysed.[2] Along with best-practice guidelines derived from the academic literature, these submissions form the basis of this resource paper.

1.4 Principles underpinning service delivery

The establishment of multidisciplinary teams was proposed in *Planning for the Future*[3] as a central element in the process of deinstitutionalisation or transformation from a bed- to a community-based model of care. *A Vision for Change*[4] further prioritised the development of well-functioning mental health teams. As with broader policy documents such as the Health Strategy *Quality and Fairness*,[5] these documents and *Quality Framework – Mental Health Services in Ireland*[6] highlight the need for service planning and delivery to be underpinned by a variety of key principles (Table 1).

1.5 Need for mental health teamwork

The multiple needs of individuals with severe mental health problems cannot be addressed by any one existing profession. Such problems can be acute, relapsing-remitting and/or chronic. Co-ordinated team-based individualised care that integrates with other health services and with generic, social and community services, is necessary to promote service users' recovery, a good quality of life and community re-integration.[7] Mental health teams need to help achieve continuity of care for these individuals. They also need to address unmet clinical and social need. They can do this by working to increase individuals' effective engagement with services and minimising the effects of social inequality.[8]
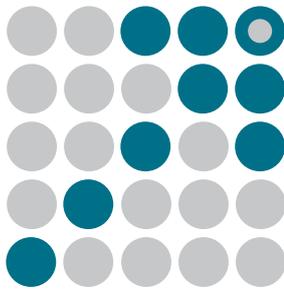
1.6 What is a team?

Teams consist of a group of individuals, who ideally have complementary skills and share a communal physical base. Team members should share a focus on achieving common goals.[9] Health care teams need both individual and mutual accountability whereby members work in an *inter*-dependent manner to meet service user care needs.[a] Ideally, there is agreement on objectives and the processes by which they are achieved. This helps reduce wasted effort, and members understand and appropriately use each others' competencies. These processes are helped by establishing robust and respectful relationships within the team.[12]

Table 1 Key principles for mental health services	
Principle	
Accessibility	Services are accessible where and when required
Accountability	Services are answerable to service users, carers and the wider public
Autonomy	Services recognise the right and ability of service users to make decisions and choices for themselves
Comprehensiveness	Services address all those areas of an individual's life that are important to him / her (e.g. occupation / work, leisure, finance, housing, community life and spiritual needs)
Continuity	Services work with other health services, and with generic, social and community services to ensure delivery of a seamless continuum of care
Co-ordination	There are individualised care plans with clear goals and co-ordinated interventions to meet the full range of service user and carer needs
Effectiveness	Services meet the needs of service users and carers by delivering the intended benefits of evidenced-based interventions
Equity	Resources are distributed in proportion to service user and carer need
Inclusive	Services promote users' access to resources that they have a right to enjoy as citizens included as members of their local communities
Non-discriminatory	Services respond in a way that shows awareness of the potential negative effects of social inequality (e.g. arising from race, gender, sexual preference, poverty, disability) and seek to minimise these in all that they do
Recovery	Services are underpinned by a recovery approach to mental health
Respect	Service users and carers are treated with respect and dignity
Service user-centred	Services are centred primarily on providing the best possible support to service users and carers
Timely	Services are provided as soon as possible in order to minimise dependency on services and ensure that opportunities to work with issues in context are fully realised

Teams benefit from sincere friendliness amongst members. Such cohesion acknowledges members' personal attraction to both the task and the team. Highly cohesive teams have an identifiable team spirit and shared pride in their achievements. Yet, this must be balanced against the potential for 'groupthink',[13] where through pressure for unanimity, members may suppress dissenting opinions in order to maintain team cohesion.[14] Doing so loses all the advantages of multiple perspectives and expanded information, and can result in poor decisions.

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a   The prefix 'multi-' connotes team members who operate 'out of their disciplinary bases' and 'work parallel to each other, their primary objective being that of co-ordination.'[10](p263) 'Inter'-disciplinary teamworking implies a greater degree of collaboration such that team goals are a product of both individual and interdependent (or collective) outputs.[10] Capable of servicing in a more integrated and seamless manner the needs of users with mental health problems, the focus of this resource paper is on inter-disciplinary teamworking.
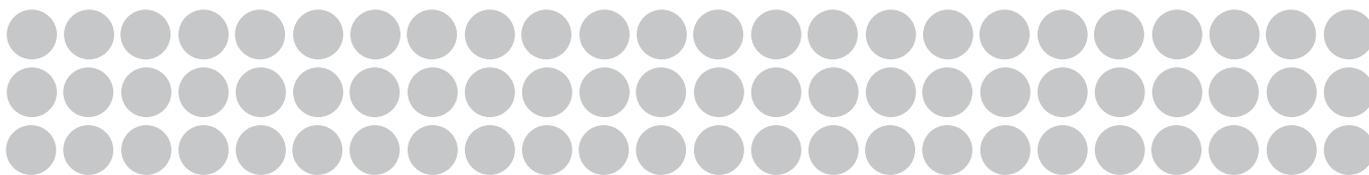
To adapt effectively to the changing landscape of mental health care provision, teams also require flexibility, creativity and innovative practice. They need to introduce and apply improved ways of working or ways of tackling familiar problems. Such innovation is a core criterion for both the definition and survival of teams.[15] It can be achieved if vision (see Section 4.2), safety in participation (see Section 5.4.1), commitment to excellence (of quality of task performance), and (both verbal and practical) support for innovation are present.

1.7 Benefits of mental health teamwork

Effective teamwork is as important to high quality care as other aspects of clinical governance such as risk management and clinical effectiveness.[16] While often difficult to quantify, there are many potential benefits to effective mental health teamworking (Table 2). The 'synergy' of recognising, utilising and integrating the diverse knowledge, skills and experience of team members (and those from external agencies) in a goal-directed manner can result in enhanced creativity and diversity in problem solving, care that is more holistic, and improved co-ordination and continuity of care.[17] As a result, we can predict improved service user (and care giver) engagement, satisfaction and adherence to interventions.

There may also be improved health outcomes such as fewer unanticipated admissions.[18] Effective teamworking is cost-effective,[19] and positively evaluated by referrers.[20] These positive outcomes may be due, at least in part, to the psychological health-inducing effects of effective teamwork on staff such as greater role clarity, lower stress, and enhanced job satisfaction and well-being.[21]

However, bringing a group of staff together and telling them they are a team does not guarantee these teamworking benefits. Indeed, working in a poorly-designed and / or run team may be worse for both staff and service users than not being in a team at all. Teamworking benefits will only be achieved by skilled design, effective implementation, a supportive context and opportunities for continued review and adaptation. This is what this resource paper is all about.

Table 2. Potential benefits of mental health teamwork.	
	Potential benefit
Organisational	• More effective (service user-centred) goal setting • Improved co-ordination and continuity of care
Team level	• Pooled knowledge, skills and experience to inform improved decision making • Increased risk-taking and enhanced flexibility • More efficient use of resources
Service user	• Improved access to and communication with all team members and the resources they embody • Improved clinical and social outcomes, such as fewer unanticipated admissions
Team member	• Increased social affiliation and mutual support • Greater role clarity (and associated lower stress levels) • Cross fertilisation of values, knowledge, experience and skills
Referrers	• Improved interface and communication with mental health services

1.8 Mental health teamworking in Ireland

CMHTs are considered the standard service configuration in both Irish adult mental health services and Child and Adolescent Mental Health Services (CAMHS), the latter catering for children aged up to 18 years.[4] However, adequately staffed mental health teams are a relatively recent phenomena in Ireland. Where teams do exist and while there are many examples of good practice, as reflected in the submissions[2] regarding the Mental Health Commission's teamworking discussion paper,[1] mental health teamworking in Ireland may currently be more rhetoric than reality.[22]

1.9 Structure of this paper

The structure of this resource paper is illustrated by the mind map (Figure 1). The paper first considers the stages of team development. The characteristics that promote mental health teamworking are then described, using the Healthy Teams Model.[23] This model provides a loose framework for categorising teamworking characteristics across four over-lapping themes. Chapters 3 through 5 consider team environment, team structure, and team process characteristics, many of which are recommended in the *Commission on Patient Safety and Quality Assurance Report*.[24] Individual contribution refers to the technical skills that individuals bring to their team (see Section 5.7.3) but also what they bring in terms of their personalities (see Appendix A).

While this framework is not specific to mental health care, it is adapted here to categorise the characteristics identified in submissions[2] relating to the Mental Health Commission's teamworking discussion paper[1] and the academic literature on what influences CMHT working (Table 3). As teams are dynamic, there is often a degree of circularity between team structures and processes, such that the former can partially determine the latter and vice versa. Finally, to assist readers in monitoring the progress of teamworking in mental health teams, we provide an audit tool for use by all stakeholders, along with other resources.

| Table 3: Framework for categorising team characteristics.			
Team Environment	**Team Structure**	**Team Processes**	**Individual Contribution**
• Professional cultures • Models of mental health • Continuum of services • Organisational support • Getting and using resources	• Service user involvement • Team goals • Relevant membership • Governance • Hierarchy • Negotiated roles	• Referral pathway • Process of work • Workload distribution • Communication • Conflict • Practice supervision and peer consultation • Training • Operational policy document	• Acknowledges distress • Seeks help • Has realistic teamwork expectations • Is committed to team • Is emotionally mature • Is socially competent • Demonstrates flexibility

1.10 Summary

This resource paper will assist in understanding and working through the task of team development. It is based on both submissions[2] to the Mental Health Commission's teamworking discussion paper[1] and best practice guidelines highlighted in the academic literature. While more specific to CMHTs, it is relevant to all types of mental health teams. Mental health services need to be underpinned by a variety of key principles including accountability, effectiveness, recovery, respect and service user-centredness. Service users' mental health needs can only be met by mental health team members working together and with other health services and with generic, social and community services.
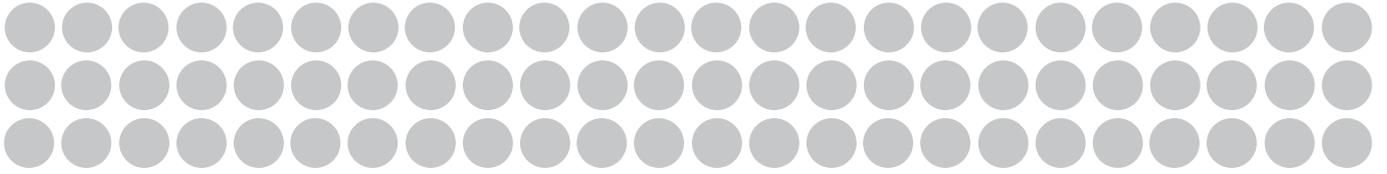
Mental health teams ideally consist of a small number of staff with complementary skills who are committed to a common purpose, clear goals, and high standards, and are interdependent on each other to get the job done. As such, they require appropriately designed team structures and processes, and a supportive context. They also need opportunities to review their performance and how this can be improved. Without these features, the potential benefits of teamworking may not be realised.
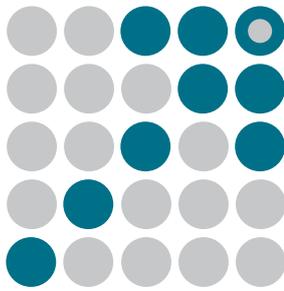
CHAPTER 2: STAGES OF TEAM DEVELOPMENT

The question 'Is our team working as a team?' has to be answered by considering where the team is in its life cycle. Tuckman's group development model[25] describes progression through four stages: forming, storming, norming and performing. As a starting point, awareness of team developmental patterns of change (i.e. what to expect at different stages) can assist teams in assessing their progress towards optimum teamworking.

2.1 Forming
Initially new team members try to replace their stereotypes with realistic perceptions of others' personal and professional characteristics. During this initial forming stage, individual identities and roles partially crystallise. As it is not yet socially acceptable to openly discuss potentially conflictual tensions, communication can be artificial or superficial. Ultimately provisional ground rules regarding the purpose and nature of the team are established. Teams in this stage may be perceived as wasteful of resources (e.g. time).

Your team can move on from this stage if you:
- Spend time getting to know each other as whole people.
- Create space where members can safely and openly discuss team goals and processes, and their roles and aspirations. Outside facilitation might help this process.
- Allow ways of working to emerge in a way that promotes ownership of how the team does business.

2.2 Storming
A period of 'jockeying for position' follows whereby team members gradually reveal their personal goals to force a reconsideration of the nature of the team's task and how to achieve this. This 'conflict' stage is thus characterised by 'turf' conflicts regarding who does what, what power certain members have over others, and potential role overload. Conflicts are initially avoided, but tensions are expressed indirectly via passive resistance, and backstage complaining.[26]

Your team may move on from this stage if you:
- Have spent some time in the forming stage describing the team's primary task, the values that underpin it and how this chimes with the personal values of team members. Doing so makes constructive conflict easier. It also provides opportunities for both the team leader and co-ordinator to model acknowledging and affirming positive values and behaviours. These members can also model disagreement in a way that is not personalised or persecutory.
- Manage conflict appropriately. Doing so can create a more trusting and psychologically safer team environment.
- Encourage team members to abstain from 'backstage complaining' and instead to communicate in an open manner.
- Engage in constructive controversy. Doing so produces a more realistic consensus regarding core issues such as the team's mission and the division of labour. This also creates greater clarity of roles.

2.3 Norming
During this norming or 'cohesion' (or 'setting the rules') stage, team members commit to further improving their teamworking by reviewing their formal and informal ways of collaborating. They seek further consensus on a variety of processes including the model of clinical responsibility adopted, decision making, referral pathways, role definitions, caseload sizes and how to interface with external agencies. Through using a conflict resolution mechanism, members actively formulate solutions to recurrent service delivery difficulties.[26]

In addition to increased mutual respect of others' roles, sincere friendliness develops and social affiliation needs begin to be met. An increasing sense of 'we-ness' and more effective relationships mean that (inevitable)
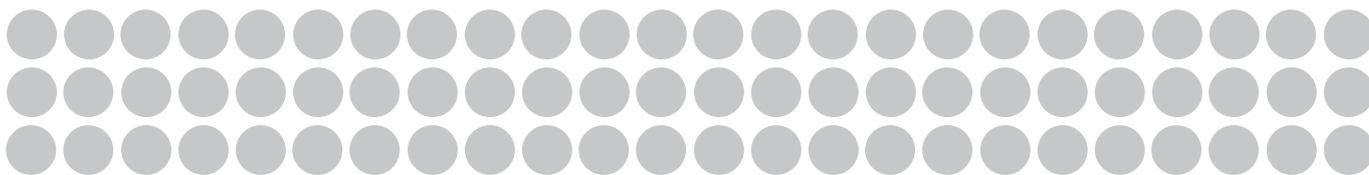
differences are managed well that further builds team commitment. However, overly-cohesive and excessively inwardly-focused teams can deflect attention from both core issues and appropriate connections with external agencies.

Your team may move on from this stage if you:
- Create space for the above-mentioned characteristics to develop.
- Particularly focus on removing any barriers to communication and help everyone find their voice.
- Organise a social event, and perhaps involve other people from parts of the local service that you need to work with to meet the needs of your target population.
- Capture the ways of working in written form and share widely, including with referrers, but to be prepared to continue to evolve. Operational policies should never be in 'final draft'.

2.4 Performing
Once effective team structures and processes have been established, a team can move towards something like a position of equilibrium and focus on 'getting the job done'. As communication is characterised by a willingness to discuss any difficult issues, and as behaviour is regulated by the shared team culture (or set of norms and values), tensions are less likely, team goals are pursued in an interdependent manner, roles are assigned based on competencies and expertise, and work burden is distributed equitably. While levels of sociability (or sincere friendliness) and solidarity (i.e. ability to pursue shared goals) are at their highest during this developmental stage, the team is not so cohesiveness that (task-oriented) members feel compelled to be compulsively nice to each other.[26]

Your team may continue to perform if you:
- Remain aware that unless you continue to develop you will degrade.
- Scan the horizon for what might be coming next.
- Expect things to change and remain aware that roles and practices will continue to evolve, as may your target population (dependent on other local developments).
- Maintain effective relationships with all your key stakeholders and in particular make effective use of feedback.
- Continue to devote space and time to doing what worked to move you forward through the earlier phases of team development.
- Build in supports for the better new ways of working and remove anything that supports unhelpful ways of working.
- Expect setbacks and make good use of your experience to get yourselves back on track.

2.5 Summary
Understanding that teams typically progress through at least four developmental stages, although not necessarily in a linear sequence, can assist in formulating developmentally-appropriate interventions to improve teamworking. Teams can move on from the initial forming stage by creating a safe space for open discussion of goals, structures, processes and individual roles and aspirations. Doing so will help members to own how the team does business. As members come to know each other more, they will reveal their personal goals and values so that differences become apparent. To progress from this storming stage, members need to be supported to engage in open, honest and constructive controversy, thereby resulting in more practical team goals and processes.

During the norming stage, these goals and processes will be further refined and documented. Having established an agreed but evolving operational policy document and a sufficient degree of sociability, teams in the performing stage can focus on 'getting the job done'. Less distracted by internal team dynamics, it is only at this stage that teams can truly focus on meeting service user and carer needs by working in a fully integrated manner with external agencies.

CHAPTER 3: THE TEAM ENVIRONMENT

Environmental characteristics such as professional cultures, models of mental health, organisational support, the available range of services, and how you obtain and use resources can all impact on mental health teamworking.

3.1 Professional cultures

A significant influence on mental health teamworking is the uni-disciplinary and segregated nature of educational programmes. This is despite the fact that most work is done in teams where you need to understand something of how other professionals work.[27] Inter-professional (or joint) education and teamwork-related educational activities remain, at best, peripheral concerns for professional bodies and the programmes that they accredit. The resulting lack of exposure to other disciplines promotes 'tribalism'[28] or excessively strong professional (and uni-disciplinary departmental) identities (or loyalties). This can hinder how much of themselves team members commit to the team and the way it works, and how much they personally invest in the team (i.e. their 'identification' – how much of their identity they put into the team).

Professional training can also predispose individuals towards considering in-group attributes (i.e. of one's own profession) as being superior to those of out-groups (i.e. other professions).[13] Hence, professionals may not only interact on the basis of (poorly-informed) stereotypes, but may also tend to devalue, under-utilise and alienate team members from other professions.[29]

While understandably protective of their respective power bases, professional bodies need to challenge traditional demarcation lines and facilitate enhanced relationships by engaging in joint projects (e.g. developing common foundation educational programmes) where different professions get pre-qualification experience of joint problem-solving with their peers from other disciplines. They could formulate joint statements on matters of mutual concern e.g. the description of the roles of various mental health team members.[30] Additionally, they could give credit for teamwork-related developmental and educational activities.[31]

3.2 Models of mental health

Possibly the most disputed territory in teamworking is professionals asserting the primacy of their theoretical model of mental health and the superiority of the associated interventions.[32] While diversity within teams is to be prized, such conflicts are probably self-indulgent. Service user need requires models that encompass a wide variety of approaches and that, most importantly, have explanatory (rather than merely descriptive) power for users and their supports. A recovery model of mental health rejects a one-model-fits-all approach and helps to build service responses around the users own aspirations and experience of what works (and doesn't work) for them.

3.2.1 Professional models

Purely 'biomedical' models (that emphasise illness, diagnosis and medical treatment) may be charged with being too biologically reductionist.[33] The individualised nature of psychological models (and associated talking therapies) can be criticised for ignoring social, cultural and political aspects.[34] 'Social' or ecological models that emphasise the need for a contextual understanding of the person's social environment are also relevant but risk de-emphasising individual differences and the individual's role in shaping his / her own destiny.

Even the broad and holistic 'biopsychosocial' model (an amalgam of the physical, the social, the psychological, the environment and the organism) presented by Anthony Clare[35] is viewed with some suspicion. Does this model still champion the biological causation and the efficacy of physical treatments?[33] Is this model an example of the expansionist ideology of psychiatry in medicalising and diagnosing increased areas of human behaviour?[36] Yet, with its focus on interactions in various domains, this (collaborative) model offers a viable alternative to the 'medical' versus 'psycho-social' ideological divide.[37]
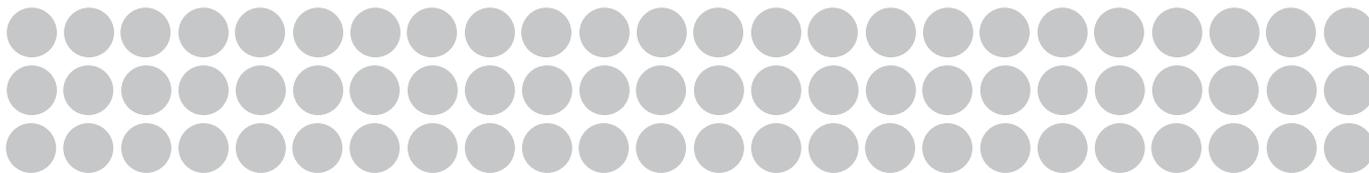
Another alternative to this divide is 'formulation' or a detailed description of why a service user comes to experience life as s/he does, including the inter-relationships of past and present events in connected physical, behavioural, social and cognitive domains. However, it is not an unproblematic solution to the issue of competing models of care. The degree of influence of biological events can still be presented in a way that borders on biological reductionism. More commonly though, in drawing on a range of psychological models, formulation can shift the culture of a team towards more psychosocial perspectives.[38] Critically though, formulations are unique to each service user and can provide an up-to-date direction to appropriate interventions, one that is open to revision in light of new experience.[39]

3.2.2 Recovery model

The profession-centred debate regarding what model of mental health a team adopts distracts teams from the advantages of embracing a recovery model of mental health.[7] Such a model fits with an affirming, aspirational, and solution-focused approach based on integrating models. Rather than asking whether 'a single dominant model or theory of mental distress' or 'a babble of multiple theoretical perspectives' will be effective, this model recognises the need to 'develop a tight bundle of relevant responses congruent' with those of the service user.[40(p258)] Moving beyond the one-model-fits-all approach to a service user-centred approach recognises that this bundle will vary from service user to service user.

As such, teams need to reflect on the values and experience that each team member brings to the team and to align their models and theories on a case-by-case basis to those that have explanatory and problem-solving power for individual users. Taking a recovery approach is partly about supporting service users to reclaim ownership of their own life story.[41] Mental health team members need to remember that whether a model is 'true' in a demonstrably scientific way is probably not as important as its 'heuristic' value – the extent to which it serves to resolve problems and underpins a meaningful working hypothesis for service users that empowers them to take action.[42]

The recovery model of mental health also rejects the throughput model of health care provision that emphasises a cycle of vigorous intervention and expected remission until the next acute episode. While the latter model may help to ration resources and discourage dependency (if only in the short term), a continuing care model is more appropriate to the needs of service users with a chronic course or a relapsing-remitting pattern. This model, of which there are many formulations,[43] defines recovery not as total remission of symptoms or cure, but as supporting service users in valuing their experience of taking control of their lives as socially included citizens with ambitions and aspirations. It highlights the necessity of ongoing therapeutic input and the need for a significant degree of mental health teamworking and collaboration between different agencies so that the totality of service users' needs is addressed.[8] It also rejects the 'sick role' of service users, instead valuing their voice and expertise.[41]

3.3 Continuum of services

Figure 2 illustrates the way in which the different systems within which service users live are nested one within another. Mental health teams are only one element in the continuum of care that service users need.[6] While protecting direct service user care time (that is based predominantly on individual transactions) is a priority, care co-ordinators[b] need to continuously integrate the clinical model of their teams with a broader community-based public health model that 'values individuals for the contribution they make and enables individuals, families and communities to shape their destiny.'[44(p1295)] It also recognises that without nurturing and safeguarding proactive, responsive and integrated community supports, mental health service users may lead impoverished and aimless lives in the community.[45] They have a right to access these supports as citizens on an equal basis with other community members.

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b   The term 'care co-ordinator' is used in preference to 'keyworker' as it better describes the care co-ordinating nature of this role, including co-ordinating care across a range of services (as opposed to within just one service as typifies the role of keyworker).
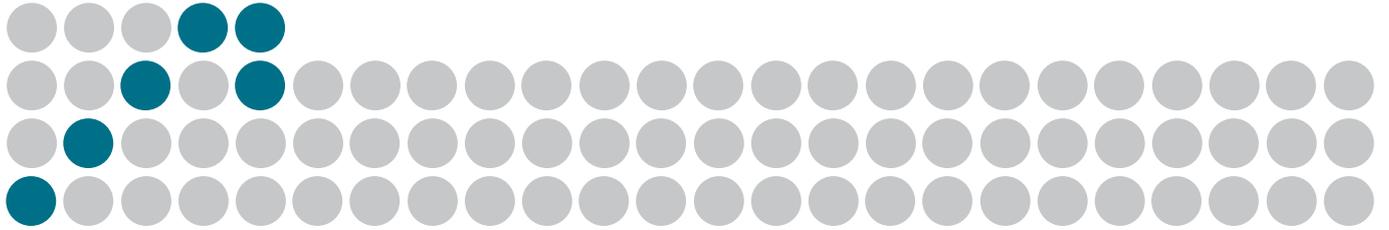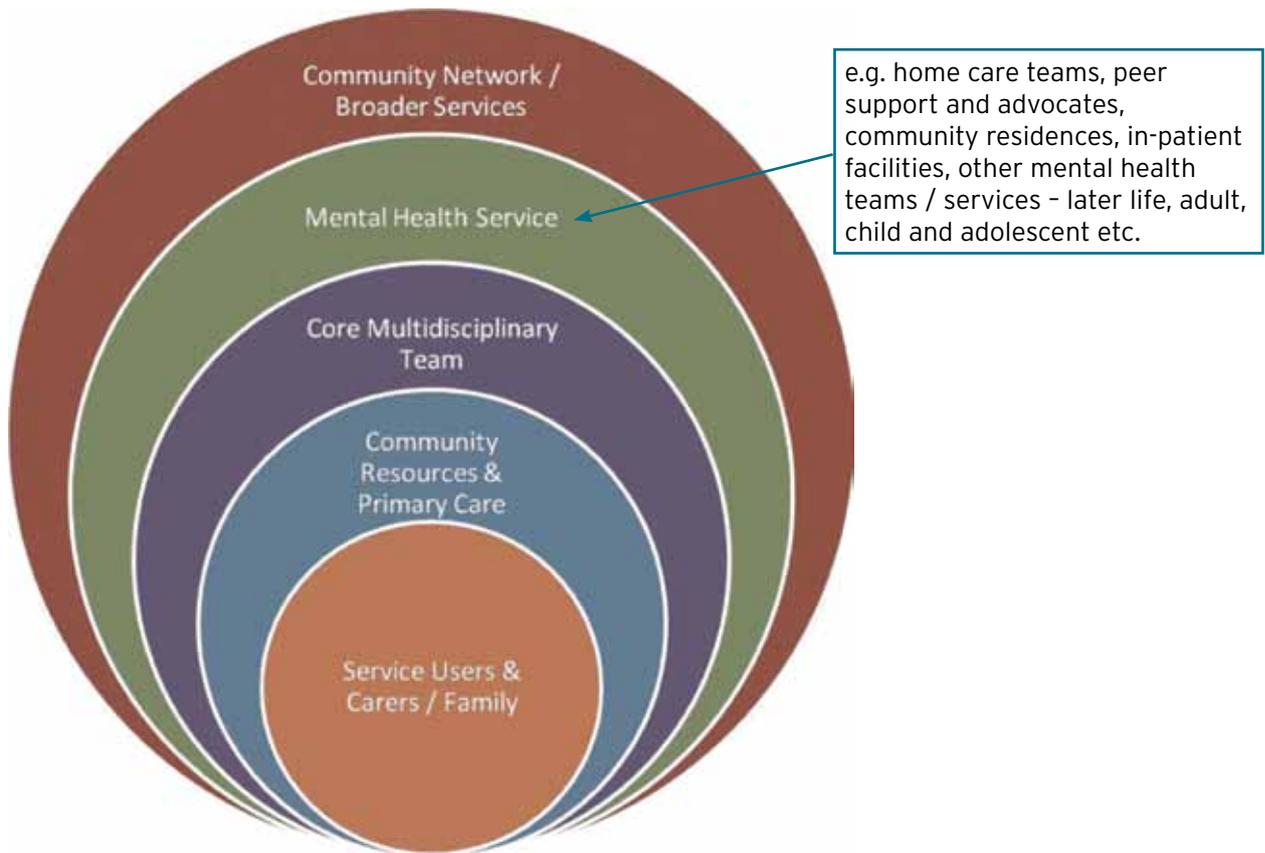
Figure 2. Service users' expanded environment.

e.g. home care teams, peer support and advocates, community residences, in-patient facilities, other mental health teams / services – later life, adult, child and adolescent etc.

3.3.1 Carers

The term 'carer' no longer equates to just the families of service users. This term can also describe other significant social supports (e.g. a friend, the local newsagent). Many carers are often ill-equipped and poorly supported to meet the needs of loved ones with mental health needs, whether they live with them or not.[46] The burden of unpaid informal care and intensive support may lead to many negative consequences including disrupted employment, and poor physical and mental health. If consented to by service users, their carers can be supported by facilitating (carer-centred) input into their care plans that recognises and meets carer needs.

As such, mental health teams need to proactively provide ongoing (emotional) support to at-risk care-givers, respite care when necessary, support in accessing other services, and (home-based) psycho-education specific to the needs of their loved ones.[47] Carer interventions (e.g. psychotherapy, parenting skills, stress management) can assist in reducing service users' relapse rates and improve their quality of life.[8] Carers must also be empowered to work collaboratively with mental health teams in formulating solutions to problems.[48] This can help to support more positive expectations among carers of the potential for improvement within the individuals concerned.

3.3.2 Community resources and primary care services

Typically the first port of call, general practitioners (GPs) deal with both 90% of mental health morbidity and up to 30% of individuals with severe mental health problems independent of secondary care services.[49] The high volume and varied case-mix of mental health problems and the sometimes complex nature of mild-to-moderate mental health problems continue to stretch the capacity and competence base of most GPs in Ireland.[50] To
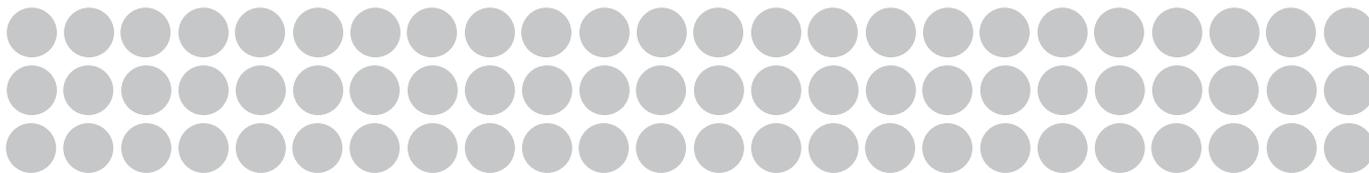
improve primary care service capacity, various models of primary and secondary care liaison have been proposed, none of which appear to be more effective than others.[51] However, it is anticipated that the consultation-liaison model will be rolled out,[4] whereby secondary care mental health team members will enter into ongoing educational and supportive relationships with primary care clinicians. In allowing cases to be discussed without formal (onward) referral by primary care, regular on-site liaison has the potential to reduce the number of inappropriate referrals to secondary services and to develop capacity in primary care.

While all mental health team members provide this primary care liaison function, elements of other models of primary and secondary care liaison can also be adopted.[51] Provision of information or more intensive practice-based education and treatment seminars on the identification of mental health presentations,[52] along with agreed referral guidelines (see Section 5.1.1), may also increase primary care capacity. In making better use of available capacity, the 'Stepped' care approach can increase throughput and the appropriateness of service provision. This involves skilled assessment in order to direct service users to the most appropriate and least intensive level of alternative and community-based care. If needed, service users can then either 'step up' or 'down' to more or less intensive forms of intervention. In doing so, the numbers of inappropriate referrals to secondary care mental health services can be reduced.[53]

While it does not guarantee co-operation, geographical proximity of mental health team members, preferably in a shared premise with primary care staff and communal areas (e.g. a coffee area) can act as a highly effective co-ordination mechanism.[54] Mental health teams also need to facilitate service users and carers linking up with a range of more informal services including advocacy organisations, volunteer workers, community self-help support groups, sport and leisure facilities and faith communities.

3.3.3 Other services
Service user problems may worsen if mental health teams fail to provide the right services and / or engage them. Where appropriate, CMHTs need to liaise with specialist mental health teams in a manner similar to liaising with primary care services, ensuring that they appropriately manage service user transitions.[6] Factors exacerbating service users' problems may also include lack of stable housing, poverty, poor physical health, lack of gainful employment and social networks that are restricted to a circle of providers and service users of mental health services.[45] In order to access the services required by service users (to meet their complex needs), these teams need to integrate with, and co-ordinate the activities of many different agencies including health, social services, housing, education, transport, leisure, criminal justice and employment.[6,8] In relation to the latter, the more proactive 'place and train' model needs to supersede the traditional 'train and place' model so that service users receive on-going support while working in meaningful jobs.[55]

3.4 Organisational support
Another influence on mental health teams is their organisation's culture and the degree to which practical supports are made available (Table 4). Most organisations are mechanistic in that they strive to create certainty by centralising authority, and putting work into some regular pattern.[56] If professional work is perceived as too diverse or unpredictable, managerial pressure may urge professionals to conform to excessive specification (as manifest in a top-down operational policy) that is experienced as oppressive.[57]

An organisational climate that is characterised by bureaucratic pressures (e.g. to contain costs) can further increase preoccupation with control and efficiency, and eclipse mental health team clinical priorities.[58] Such over control clashes with the professional ethos that maintains that controlling uncertainty is the expert's forte.[59] Hence, a significant organisational support involves tolerating the uncertainty and lack of predictability associated with granting teams sufficient autonomy to formulate and implement their own operational policies in pursuit of desired outcomes. Sometimes the best support involves just being clear about outcomes but then leaving space for teams to develop their own ways of getting there.

Organisations need to also ensure adequate resources including responding quickly in filling core team member vacancies and, if necessary, reconfiguring posts to meet emerging clinical needs. Evidence of adhering to best-practice guidelines (e.g. weekly team meetings, open communication), of efficiencies (e.g. realisation of team goals, improved levels of stakeholder satisfaction) and of innovative practices need to be reinforced by team-based incentives that are contingent on the whole team's performance.[60]

Table 4. Examples of organisational supports.

- Allow teams to formulate and implement their own operational policy documents
- Ensure adequate administrative support
- Respond quickly in filling core team member vacancies
- Provide flexible and responsive workforce development opportunities
- Provide opportunities for time-protected and facilitated team training or building
- Educate team leaders to adopt effective leadership styles
- Make available opportunities for practice supervision and in-service training
- Listen and respond to team members' risk management concerns
- For innovative or efficient teamworking provide team-based incentives such as
  - Greater levels of earned autonomy (e.g. less frequent external monitoring)
  - Acting as pilot sites for new initiatives
  - Improved access to capital, training or performance improvement funds

3.5 Getting and using resources

There will never be enough mental health resources. Demand will always increase to outstrip supply. It is no surprise then that teams are preoccupied with perceived under-funding. Individual disciplines have traditionally worked from a 'them and us' paradigm when trying to secure resources. While doing so will dilute their power base for getting resources, they need to adopt a team-based model for bidding for resources to best meet the collective demands on the team.

To date, resource management in Irish mental health teams has been poor given the 'failure' to transfer the 'considerable staff and capital resources available in the declining institutional model to support new community developments.'[22(p46)] The utilisation of resources has often merely reflected historical circumstances and provider priorities rather than clinical need. Teams have to prioritise the use of their resources to meet the clinical needs of those with severe and enduring mental health presentations using needs assessments, robust gate-keeping practices and explicit effectiveness criteria. It behoves managers to engage in radical reorganisation of staff deployment, especially during times of economic rationalisation where new revenue funding is limited. It is also important that any new investment or reconfiguration of resources is accompanied by evidence of service improvement with clearly articulated benefits.[61]

3.6 Summary

Service users are best served by team members having strong professional cultures to ensure good team diversity – yet not so rigid that they believe their contribution to be superior to those of others or that they are reluctant to work collaboratively. Championing a recovery model of mental health, as opposed to engaging in a profession-centred debate regarding what professional model is superior, also serves users and carers well. In recognising that they are only one element in the continuum of care that service users need, teams also need to work in an intrinsically integrated manner with carers, community resources, primary care services, and broader services.

To work well, teams also need a variety of organisational supports including the freedom to formulate and implement their own operational policy documents (within clearly specified parameters), human resources
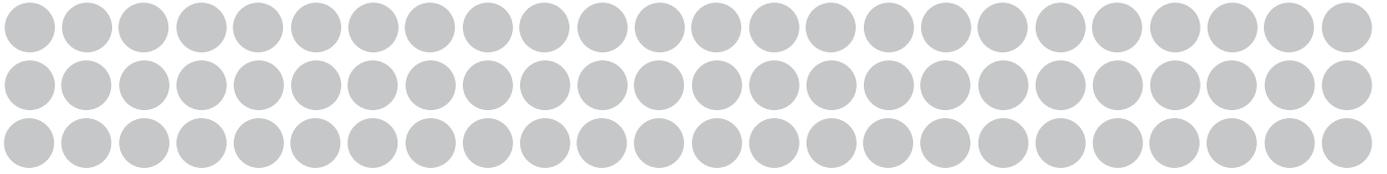
support in filling core vacancies quickly and providing adequate workforce development opportunities, making available opportunities for practice supervision and in-service training, and providing team-based incentives. Teams need to adopt a team-based model for bidding for resources to meet the collective demands on the team. They also need to ensure that resources are used in an effective manner, including engaging in radical reorganisation of staff deployment where necessary.

CHAPTER 4: TEAM STRUCTURES

The framework for team processes is provided by team structures. These include a structural ethos that prioritises service user involvement, performance goals, the right membership, governance structures, hierarchy, and negotiated roles. As in clinical work, the over-riding principle in developing teams is on building from existing strengths in the local system (rather than undermining them). This includes respecting that each team has its own personality, history and set of ideologies, all of which may have contributed to good teamworking. Hence, it is important to accommodate existing strengths and not to coerce all mental health teams to be the same.[62]

4.1 Service user involvement

First and foremost, service users need to be recognised as experts by experience and/or by training.[41] Their involvement (and that of care givers) may manifest at one end as the provision of relevant information, through to health education, consultation, satisfaction audits, and participation in improvement.[44] However, they ultimately need to take on active roles as contributors to their own care, care givers, service designers, leaders and improvers. While their involvement may also manifest as different approaches to clinical decision making, ranging from 'professional choice' (i.e. the clinician decides and the service user consents) to 'shared decision making' (i.e. information is shared and both decide together), service user choice needs to be cultivated (i.e. the clinician informs and the service user makes the decision[63]). Doing so appears to increase their engagement,[64] as does offering them what they want (see Section 5.4.2).

Working from the principle that service user need comes first, they must be recognised as part of, and true partners in, mental health teams.[65] Their traditional passive recipient role must give way to that of active influential participant in achieving physical and mental well-being.[66] As such, self-advocacy must involve working in partnership with one's chosen care co-ordinator in formulating a comprehensive care plan.[6] If self-advocacy is proving difficult, service users should have access to a service user advocate (e.g. accessible via the Irish Advocacy Network). The advocate is a peer who has had occasion to either use the mental health services themselves or had some relevant involvement with them, as well as having had recognised training in peer advocacy.

### 4.2 From values through vision to goals

As a pre-requisite for successful and sustained teamwork, teams need a well-defined, forward-looking and collective vision or purpose to provide focus and direction to team members' energy.[67] From such a vision, teams need to derive clearly defined, aspirational but attainable performance goals and outcome criteria that speak to basic human values. These team goals need to be drawn up in such a way that stakeholders can evaluate team member behaviours against them to judge whether they support the stated values of the team. For this reason, they need to be made explicit in an operational policy document (see Section 5.8). A wide base of ownership of these service user-centred team goals encourages commitment to the collective and interdependent action necessary for their realisation and helps team members to transcend narrow professional goals and immediate self-interest.

4.3 Relevant membership

While typically built up in an incremental manner, frequent mental health team member changes can trigger partial regression to earlier stages of team development (e.g. members may no longer have shared goals). Given that it is an essentially interpersonal process, personality traits such as emotional stability, extroversion, openness to experience, agreeableness and conscientiousness can promote teamworking (see Appendix A). More specifically, team composition needs to reflect local clinical needs and have the minimum number of members required to complete the work at hand. Ideally, both professionals and non-professionals will make up the team.

4.3.1 Skill mix according to clinical needs

The skill mix of a mental health team has to have the capacity to meet local clinical and social needs, principally of those with severe mental health problems (see Appendix B), rather than merely reflecting norms of professional
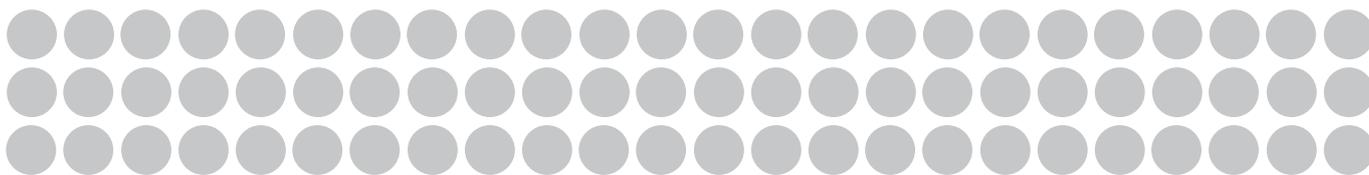
representation and the (sometimes indiscriminate) redeployment of staff. However, the required skill mix may vary. For example, a CMHT will have less of a focus on people with severe mental health problems if locally there are other specialised secondary care teams (e.g. Crisis, Home-based or Early Intervention Teams or Rehabilitation CMHTs). Alternatively, in the absence of these specialised teams, if CMHTs are sufficiently large, sub-teams can be developed (within these CMHTs) to perform each of these specialised functions.[4] Where this happens the need for the sub-teams to form part of the larger unit (and the time taken serving it) needs to be critically reviewed. In a context of high-demand, it is likely that such team configurations will struggle to retain focus on their specific population without clear commitment, monitoring and effective leadership and management.

4.3.2 Team size
Small team size (e.g. six to eight members) may facilitate more effective complex decision making. However, this is more of a guide than an absolute necessity for success. Rather, effective teams have only the minimum number of team members required to complete their work tasks.[68]

While the large mental health teams proposed in *Vision for Change*[4] can facilitate creation of functional sub-teams, other (non-functional) sub-groups may also develop (e.g. medical versus non-medical or decision-making versus non-decision-making). Large teams may also tend toward functioning less like a team with all the interdependency and shared focus that this requires, and more like an expanded work group. This can result in an unhealthy dependence on an (over-functioning) team leader, information transfer problems, ineffective team meetings, and reduced compliance with team policies, possibly because contributions are less identifiable.[69] Associated centralised decision making (see Sections 4.4.1 and 5.4.2) may also work against processing and integrating the diverse perspectives of team members that otherwise may facilitate increased levels of innovation. To guard against such outcomes, a robust governance system is required (see Section 4.4).

4.3.3 Professional and non-professional affiliated staff
Research is needed to establish the optimal skill-mix within CMHTs in specific contexts. However, most teams are likely to include representation from administration, clinical psychology, nursing, occupational therapy, psychiatry, social work and support workers. Along with vocational and benefit advisers, such input can be augmented via input from assistant grade professionals who can engage in a specific range of tasks under supervision. There may also be a need for the technical expertise of other professionals including addiction counsellors, psychotherapists, and speech and language therapists to fulfil team goals. All this needs to be informed by local needs assessments[6] and by what other services are available locally (see Section 3.3).

Some teams may struggle to recruit and retain qualified staff,[22] especially rural teams. The instability of unfilled posts can lead to discontinuity of care, critical skill gaps and disproportionate numbers of inexperienced or temporary staff..[70] It also means that teams have to continually renew themselves, draining energy and emotional strength, thus compromising teamworking. It therefore behoves senior managers to provide, at a minimum, responsive workforce development opportunities[71] informed by an equitable career structure for all professional and non-professionally affiliated team members.

The populating of mental health teams solely with professionals may represent misguided professional expansionism[72] and the imposition of substantial costs without commensurate benefits.[47] Mental health support or recovery workers can perform fundamental caring duties and spend dedicated time with service users and/or their care givers and are cost-effective.[55] With a diverse range of educational backgrounds and personal life experiences, these workers may be service users, carers, nursing assistants or retired staff.[4] Peer support specialists, a role where personal experience of mental health problems is a job requirement, can also work as team members.[41] Likewise, health care assistants can undertake the more labour-intensive and time-consuming tasks that (over-loaded) professional team members cannot attend to.[73]
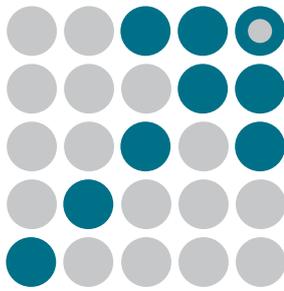
4.4 Governance

Conducive to the safety of service users,[24] governance refers to the 'the procedures associated with the decision-making, performance and control of organisations, with providing structures to give overall direction to the organisation and to satisfy reasonable expectations of accountability to those outside it.'[74(p7)] As such, governance broadly consists of structures and processes (see Chapter 5), both of which require an understanding of the concepts of responsibility and accountability. With regard to structures, mental health teams are governed by an inter-disciplinary Area Mental Health Management Team.

### 4.4.1 Model of clinical responsibility

Responsibility can be defined as 'a set of tasks that an employing authority, professional body or court of law can legitimately demand of a practitioner.'[75(p281)] Accountability describes the relationship between a practitioner and the authority in question. So practitioners are responsible for certain tasks or functions and are accountable to an authority for those responsibilities.[76]

The subject of much debate but fundamental to optimum teamworking,[77] members of each mental health team have to agree on a particular model of clinical responsibility, of which there are several. Whatever model a team adopts, team members need to assume enough autonomy to work effectively and ethically yet not so much that it impedes the everyday operation of the team or realisation of team goals.[76] The fact that team members should be interdependent on their team colleagues to realise team goals inevitably decreases their clinical autonomy, regardless of what model is adopted. If there is not that level of interdependence, it might be necessary to consider whether a team is the best model for service delivery.

Not in keeping with current models of practice, it is inappropriate to interpret that consultant psychiatrists carry overall responsibility if they are involved, however peripherally, in the care of service users,[78] or for all referrals received. Such a centralised or 'star' model of responsibility[79] can be perceived as crossing professional boundaries and forcing team members into 'devalued, disempowered, hand-maiden' roles.[80(p136)]

There is the model of 'direct' responsibility that holds that a team member is only responsible if there is direct clinical involvement with a service user. Then there is the 'delegated' model of responsibility. According to their current contractual arrangements, if they delegate aspects of service users' care to other team members, consultant psychiatrists retain 'clinical primacy' or a 'continuing overall responsibility' for the care of these service users. This model also provides for every team member remaining responsible for the quality of their care and accountable (to their professional body) if it falls below acceptable standards (i.e. negligence).[78] The latter includes not challenging decisions that appear to be wrong and following instructions that are 'manifestly wrong.'[76] Such negligence coexists with vicarious liability that offers no protection for individual practitioners, whereby the employer may be liable for staff negligence when acting in the normal course of their duties.

Possibly more appropriate to 'performing' teams where there is a climate of internal trust,[77] the 'distributed' model of responsibility holds that responsibility is distributed among the involved team members according to their role and contribution. Hence, if things go wrong, accountability may be divided up (e.g. 20% my fault, 20% your fault, 60% her fault) and not diffused. This 'spider web' type model[79] emphasises mutual accountability and the notion of 'being in the boat together' with regard to achieving team goals. With this model the consultant psychiatrist remains responsible for their own direct clinical involvement, including the quality of advice and assessment given. They also retain 'clinical primacy' in selected and specified cases, and work in a consultative fashion with other team members. These members also retain responsibility for their own caseloads, and for service provision in accordance with advice given and accepted.[78]
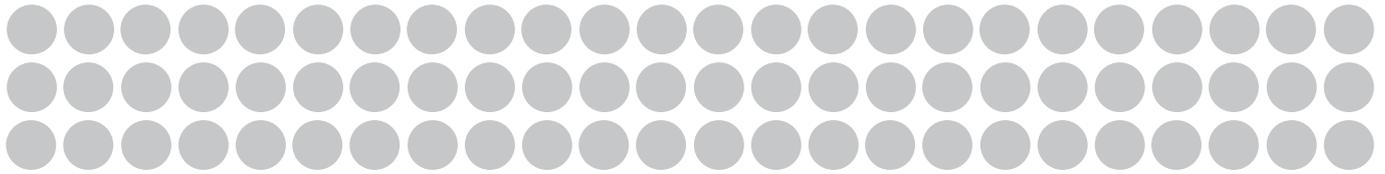
4.4.2 Management teams

A multidisciplinary Area Mental Health Management Team provides both strategic and high-level operational management (e.g. performance monitoring) of all mental health teams in its defined geographical area. While service planning and development is prioritised, this management team also over-sees relevant resource management (e.g. recruitment) and the implementation of quality assurance programs. It is important to transfer the substantial staff and capital resources available in the declining institutional model of care to promote a community-based public health model of service provision.[8]

While endeavouring to keep team sizes small, members of these teams include a management or administration representative, a consultant psychiatrist or (executive) clinical director, a director of nursing, discipline heads (e.g. occupational therapy, clinical psychology and social work), a (trained) service user (or advocate) and possibly others (e.g. primary care or health promotion representatives).

4.4.3 Matrix management

Mental health teams are 'co-ordinated' in that team members are contracted in from their (profession-specific) departments so that there is dual accountability: operationally to the team co-ordinator and professionally to their (same-discipline) line manager. Accordingly, the professional line manager ensures adherence to acknowledged professional standards or codes of conduct via peer consultation (see Section 5.6). S/he also facilitates maintenance of these professional standards of care by co-ordinating (profession-specific) continuing professional development and associated budgets (see Section 5.7.3).

4.4.4 Team governance structure

To facilitate their effective day-to-day operation, mental health teams have a shared governance structure of business manager, clinical leader and team co-ordinator.[4] While there is some overlap between their defined responsibilities, these are presented in Table 5. For example, both the clinical leader and team co-ordinator have a shared responsibility in providing vision and direction for service development (both internal and external to the team), and they have to motivate team members to contribute to and buy into this vision and associated team goals. In enabling members to lead individual working groups aligned to their specialist areas of interest and expertise,[81] they can motivate team members to transcend professional self-interests for the (greater) good of realising team goals.[82]

A more comprehensive template for allocating authority for key decision-making responsibilities is presented in Table 15 (see Appendix C). These three post holders need to work in a cohesive, collaborative and co-ordinated manner in order to avoid role confusion and conflict and maintain positive internal relations among all team members.[75] However, they also need to retain their independence. For example, the team co-ordinator 'cannot afford to be seen merely as the psychiatrist's proxy and needs to signal a degree of detachment from the consultant psychiatrist's judgements.'[36(p69)]

4.4.4.1 Business manager

The two primary responsibilities of the business manager are to manage the mental health team's day-to-day budget and any office functions. S/he manages budget-related administrative functions, maintains a system for registration of service users, and prepares information in various media. S/he also needs to ensure that support functions are put in place (e.g. information technology systems and administrative support staff). While this post is open to all professionals, the post holder must be a (mental health) clinician who has got some administration (e.g. financial) or management training, or a manager or administrator who has knowledge of mental health services.[83]

Table 5. Team governance structure and responsibilities.

Business Manager	Clinical Leader	Team Co-ordinator
Manage day-to-day budgets Manage budget-related administrative functions Manage office functions Ensure that support functions are in place Prepare information in various media Maintain system for registration of service users	Provide vision and direction for service development Where appropriate, lead on clinical decisions Where appropriate, delegate clinical responsibility Motivate members to work towards team goals Solve recurrent care delivery problems Nurture a psychologically safe environment	Provide vision and direction for service development Achieve optimum levels of performance Co-ordinate processing of referrals Organise team meetings Liaise with external agencies Profile critical skill gaps Co-ordinate clinical inputs Monitor members' workloads Facilitate equitable work-burden distribution Co-ordinate members' leave Ensure clinical records are adequately maintained Profile need for, and organise, teamwork training Promote evidence-based teamworking practices Facilitate internal and external conflict resolution Lead in formulating operational policy Organise team reviews of practice / clinical audit Lead in assessment of local clinical need Communicate relevant clinical matters and team activities

4.4.4.2 Clinical leader

Leadership is the process of 'influencing others to engage in the work behaviours necessary to reach organisational goals' that includes the process of transforming loose groups of individuals into effective teams.[84(p7)] It is a process that is best partly distributed throughout teams.[85] As goals are achieved through team members, there is a mutual interdependence of leader and led.[86] While the shared governance structure of mental health teams frees the clinical leader of many managerial responsibilities (e.g. clinical co-ordination, clinical audit), s/he has many challenging leadership responsibilities.

The acceptability of the 'clinical primacy' afforded to consultant psychiatrists under their current contracts must be discussed within mental health teams. For example, it needs to be recognised that such a model of clinical responsibility is 'perfectly compatible with a high degree of clinical autonomy (and responsibility) in whoever is directly treating' the service user, 'irrespective of disciplines.'[69(p59)]

On a social dimension, through investing time team building a network of one-to-one and trust-based relationships with team members (e.g. by remaining accessible and open, listening actively, giving feedback, adhering to procedural fairness), the clinical leader can build a community of trust[85] that is also characterised by personal support (for the leader) from team members. Such an environment of trust can lead to improved cohesion and morale, safety in participation and meaningful two-way communication (see Section 5.4). The clinical leader needs
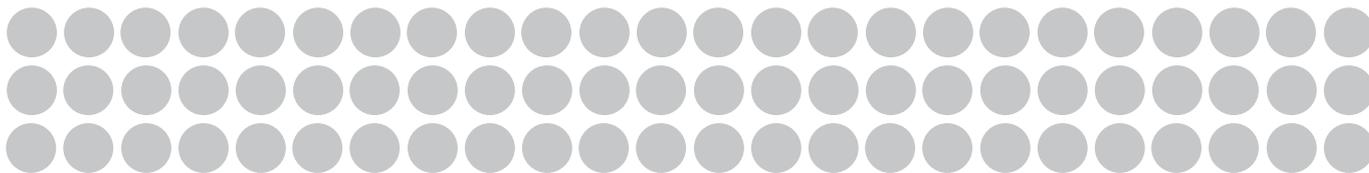
to understand the basis of, and model how to manage, potential conflicts and work with members in formulating solutions to recurrent care delivery problems.[26] Such effective problem solving requires the clinical leader to nurture a culture of respect for diversity and tolerance for different, often conflicting but creative viewpoints.

The clinical leader needs to work from a broad and recovery-oriented model of mental health (see Section 3.2.2). As his/her leadership style and adopted model of clinical responsibility (see Section 4.4.1) are significant influences on team characteristics and outputs,[77] both need to evolve over time to accommodate a team's developmental stage.[87] As such, the clinical leader needs to understand the principles of group dynamics and team development, and the influence of different team design characteristics.

In summary, mental health team clinical leaders need to combine advanced technical proficiency with strong interpersonal qualities.[88] While a significant number of respondents to the Mental Health Commission discussion paper[1] indicated that this role should not be based on privilege of profession without due regard to the competencies required,[2] current contractual arrangements allocate this demanding role to the consultant psychiatrist or psychiatrists in the team. Where there is more than one psychiatrist, agreement is needed regarding division of role responsibilities (e.g. geographical, clinical interests).

4.4.4.3 Team co-ordinator
The team co-ordinator takes the lead in formulating the team's operational policy document, monitoring whether it is implemented in an orderly and results-oriented manner, and periodically evaluating it. The latter is particularly important at critical developmental points (e.g. team membership changes), as well as clarifying respective roles and responsibilities (see Section 4.6). In order to profile potential critical skill gaps, the team co-ordinator also takes a lead role in assessing both local mental health service needs and the existing skills mix within his/her team. This can result in a recommendation to the Area Mental Health Management Team of targeted recruitment and/or the provision of team training.

S/he 'co-ordinates' intra-team clinical activities (e.g. team pooling, discussion and allocation of referrals)[4] and team members inputs to realise decisions made by the care co-ordinators but informed by the team. However, with the support of the clinical leader, the team co-ordinator is likely to have a significant (although non-determinant) input into how these decisions are made. S/he also monitors members' workloads to both inform equitable work burden distribution[32] and to protect team capacity for new referrals (see Section 5.3).

At a service level, the team co-ordinator organises team meetings and keeps team members informed of relevant clinical matters and team activities. S/he also liaises with both external stakeholders (e.g. primary care practitioners) and agencies (e.g. local community and self-help groups) regarding how relationships with these services can be made and developed. At an administrative level, s/he co-ordinates members' leave and signs their leave and expense forms as agreed with their respective line managers. S/he also ensures that clinical records are adequately maintained,[89] and carries a (reduced) clinical caseload to retain his/her credibility within the team.

While this post is also discipline non-specific, the post holder must be an experienced mental health professional who possesses the requisite organisational and interpersonal skills to co-ordinate the team's activities.

4.4.5 Positive risk taking
While needing to avoid professional paternalism (i.e. professionals know best and decide the nature of intervention), mental health teams have an obligation to guard against risk of service user or carer demoralisation from repeated failure by engaging in good teamworking and clinical practices. This requires respect for service users' autonomy (i.e. freedom from external control and right to self-determination) and facilitating their engaging in positive risk taking whereby they can make mistakes and learn from them.[41] Staff need to feel that the risk management regime within which they work is explicit and supports such learning, as well as not leaving them vulnerable to blame when events do not go as planned.

4.5 Hierarchy

The above team governance structure recognises that differences in the exercise of power are inevitable and necessary if the full benefits of the diverse talents within a mental health team are to be realised.[90] Leaving a team to work out internal operational structures without external support may result in poor teamworking and a sense of inadequacy among team members.[91] Team members who strive for participatory and egalitarian relationships with service users may also emphasise intra-team equality and a 'flat hierarchy.'[31] In practice this often merely serves to mask the power relations in play, making it more difficult to challenge their legitimacy and thus risking making them more oppressive and unhelpful.[92] Hence, mental health teams need to honestly discuss the exercise of power and hierarchy.[93]

Governance structures can only be judged in terms of what they achieve. Have they facilitated adequate discussion and agreement on the model of clinical responsibility (see Section 4.4.1), the process for decision making (see Section 5.4.2) and on team member roles (see Section 4.6)? Are legitimate sources of power (e.g. different levels of knowledge, skills and experience) differentiated from illegitimate sources (e.g. personality, education, or verbal skill)?[93] To discourage team members from both jockeying for positions and resorting to covert coalition building, are measures employed to actively empower them in the interests of team effectiveness? Is there a remedial plan for those who exercise power by acting autonomously or by distancing themselves from team processes (e.g. different referral pathways, partial team membership)?

To avoid team member non-participation, alienation and the creation of unnecessary risk,[94] are there safeguards to minimise excessive power differentials (e.g. a dominant professional culture overwhelming a recovery-based approach)?[80] Do such safeguards also promote a positive experience for both service users and care-givers[95] and their participation in decision-making, both at management and clinical levels?[96]

4.6 Negotiated roles

According to social psychological theory, 'role' is defined as recurring activities of an individual, appropriately interrelated with the repetitive activities of others so as to yield a predictable outcome.[97] Roles are integral to the professional persona, and in attempting to retain their identity, team members will seek to differentiate their roles.[30] Differentiation in the interests of providing a rich and varied skills mix is to be welcomed. Working at the edge of 'comfort zones' promotes creativity and change. However, team members may adopt excessively inflexible role boundaries in response to unmanageable stress (Table 6). Subsequent failure to work outside narrow and rigid role definitions may slice service users' mental health needs into portions, thus fragmenting their care.[98]

Table 6. Role stressors.	
Type of stress	**Potential causes**
Role uncertainty or ambiguity	• Poor role definition
Role conflict	• When overlapping roles go unacknowledged • Poor role definition • When members compete for exclusive ownership of certain roles
Role blurring	• Poor role definition • The pressure to work generically so as to minimise the number of team members involved with individual service users
Role strain	• Demands of role exceed members' maximum capacity output • Role not adequately challenging
Role de-specialisation	• Resorting to generic monitoring or support due to large caseloads
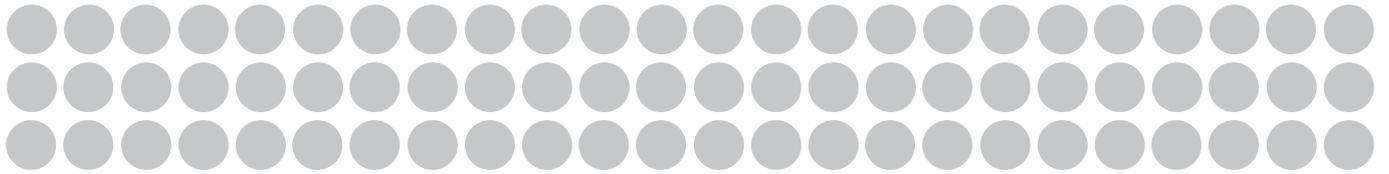
Such negative outcomes are likely given that formalised job descriptions map only loosely onto job content with roles being assigned on the basis of local custom and practice.[99] Lack of discussion also results in ignorance, competition and jealousy that reinforce inaccurate professional stereotypes. Team member roles need to be openly negotiated and periodically reviewed. Who has the skills to do what, when and with what resources and support?[100] Agreeing on retaining differentiated disciplinary roles (but balancing these with some shared core tasks) promotes a flexible, diverse, informed and efficient team response to the varying needs of service users. It is only when distinct discipline-specific and individual-specific contributions are mutually understood and highly valued, and strong professional links are maintained, that members will feel sufficiently contained to adopt more flexible role boundaries and produce service user-centred outcomes.[58]

4.7 Summary

As in any design process, form needs to follow function, and the primary function here is the achievement of a service user-centred recovery-based approach to provision. Mental health teams need to prioritise service user involvement. They need a collective vision and associated goals and clarity about the outcomes to be achieved. Effective teams have only the minimum number of team members required to complete their work tasks, ideally consisting of professionals and non-professionals with a skill-mix reflective of local clinical need. They also need a robust governance structure consisting of a clinical leader, a team co-ordinator and a business manager, agreement on the model of clinical responsibility to be employed, and promotion of positive risk taking.

While much good work can be done to shape respective roles and practices on paper, in practice individuals will need to work collectively to create a context where roles are clear but not so rigidly defined as to create a situation where the team's whole is less than the sum of its parts. This requires that individuals conduct themselves with respect and maturity in the interests of building mutual trust and effective relationships.

It is only in such a safe context that the important issue of differentiating the legitimate from the illegitimate sources of power in the team can take place as an ongoing process. The overall aim is that everyone in the team, and particularly those in leadership or management positions, share responsibility for creating an environment where everyone can exercise their legitimate power to be creative, resourceful, compassionate and skilled in the interests of better outcomes both for users and their supports, and colleagues within the team.

CHAPTER 5: TEAM PROCESSES

Team processes 'reflect the way that teams handle tasks and interpersonal dynamics' and how teams transform inputs into outputs.[23(p365)] These designed processes need to have greater influence on what happens within teams than the more random interplay of personalities within teams (see Appendix A). They include agreement on the referral pathway, the process of work, workload distribution, communication, conflict, management, practice supervision and peer consultation, and training, all of which must be described in a team operational policy document.

5.1 Referral pathway
To simplify service user journeys, the referral pathway to mental health teams (Figure 3) needs to be clear, integrated, and easily navigated.[101] Teams need to rigorously apply inclusion criteria and agree on the extent of the referral net and how the team is accessed.

5.1.1 Definition of target population
The clinical need that CMHTs have to meet is influenced by the existence, and stage of development, of other local more specialised secondary care teams (e.g. Crisis, Home-based or Early Intervention Teams, or Rehabilitation CMHTs) whose respective and more easily defined target populations may lead to having more of a common focus and higher teamwork levels.[102] It is crucial that in any given locality there exists the local whole system leadership and management to ensure that when all the definitions (and associated referral criteria) of target service user populations that teams are using are brought together, they represent a coherent whole that will serve the needs of the entire population. Otherwise localities will create contexts where too many team resources are taken up in fighting turf disputes and service users and their supporters experience being bounced around the local service system creating delays, further distress and sometimes falling through the cracks in local service provision entirely.[61]

CMHTs ideally need to consider both the 'old' and 'new' populations of individuals with severe mental health problems (see Appendix B). A working definition of such problems is 'a level of distress or disturbance that could normally result in a diagnosis of psychosis, psychiatric admission, or community-based interventions to prevent admission.'[103(p177)] It is not ideal however to define service user groups locally in terms of the service responses that they invoke as this will be subject to a range of influences beyond the subjective distress and disturbance that they experience. This is why the team needs ongoing mechanisms for caseload profiling and monitoring to maintain a more qualitative perspective on who is being served and how.

Also, there are those individuals with mild-to-moderate problems who do not meet a working definition yet whose problems are of such intensity and so severely disabling that they do not respond to primary care interventions. There is a particularly heightened risk that these individuals may fall through all the nets.

Hence, there is a need for an expanded definition of severe mental health problems. While teams can use available caseload profiling tools, serving as the eligibility or inclusion criterion for receipt of services, an expanded definition could be a composite index of referral 'severity'. Such an index (with higher weightings for factors that better discriminate between mild-to-moderate and severe mental health problems) could include diagnostic group, co-morbidity, chronicity, number and length of previous hospitalisations, associated functional impairment, previous deliberate self-harm and immediate safety, history and maturity of coping mechanisms, access to natural supports, and need for formal or informal care.[104] Consistent application of such a tool can shape appropriate referral behaviour over time, support caseload profiling for the purpose of ongoing peer consultation, and contribute to local needs assessment.
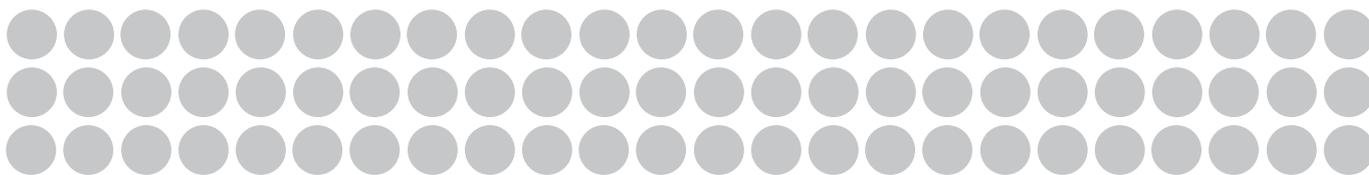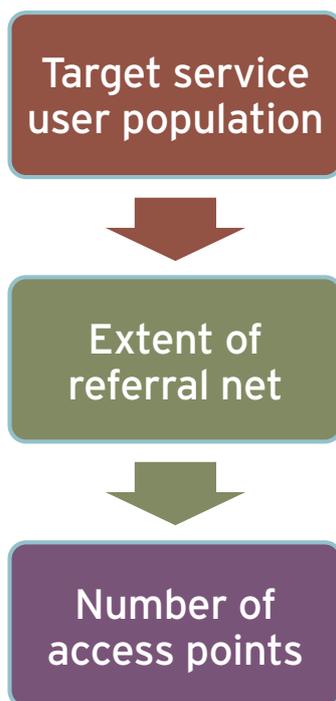
Figure 3. Referral pathway.

5.1.2 Extent of referral net

On the condition that they rigorously apply eligibility criteria, mental health teams can accept referrals from a variety of selected sources (e.g. primary care and other health care practitioners, social services, voluntary organisations; housing agencies).[103] Re-referrals can also be accepted via care co-ordinators from service users and care givers. Such practices facilitate easier access to services and sensitivity to the clinical need of service users who may experience difficulties gaining access to services.[47]

5.1.3 Number of access points

Referrals are typically accepted via the team co-ordinator. If they are 'urgent' referrals, possibly defined as those where the referrer believes the individual needs to be seen on the day of referral or the following day, they are sometimes allocated (for emergency assessment) outside team meetings. However, once established, crisis appointments may become used by referrers to expedite the assessment of non-urgent cases[69] and so vigilant monitoring of this facility is needed. The co-ordinator brings all new 'routine' referrals to the weekly meeting for discussion and team-based allocation.[4] This single point and clear route of access improves service accessibility[103] and facilitates monitoring of the level of workload strain on the team and any imbalances in the system.[69]

5.2 The process of work

The process of work pertains to the internal processing of referrals. This is an iterative cycle whereby, using initial assessment findings, the mental health team initially decides whether to assign a care co-ordinator, refer back to the referral source with advice or refer on. The team reviews clinical progress after intervention has started to review progress, update the care plan or recommend closure (Figure 4).[89(p182)]
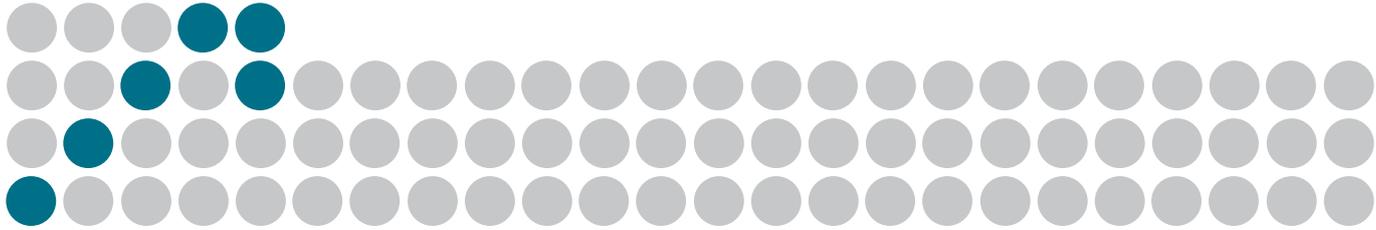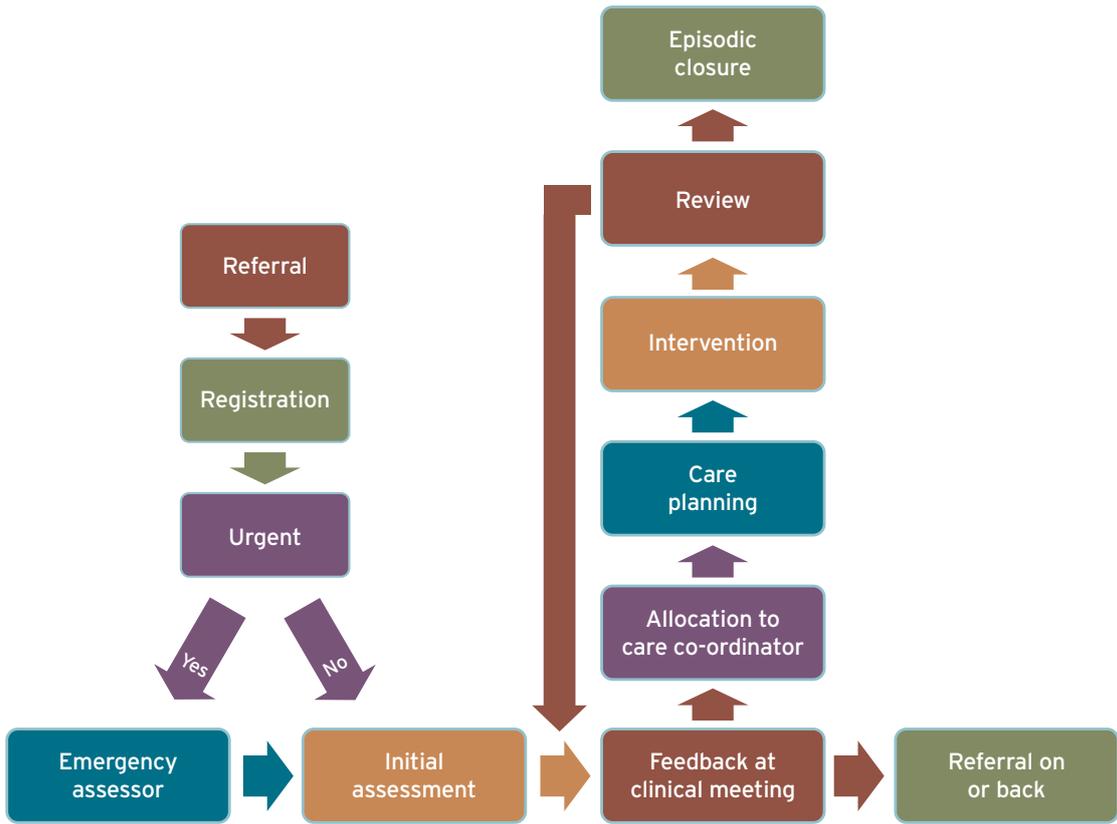
Figure 4. The process of work.


5.2.1 Registration
A skilled clerical officer (or administrator) can systematically record information at registration, screening out referrals using objective demographic criteria such as living out of catchment area. As well as improving accessibility, taking referrals over the telephone can assist the process of planning the most effective assessment process.[89]

5.2.2 Allocation for assessment
All referrals are preferably pooled and allocated for assessment at a team meeting (see Section 5.4.3). The establishment of relationships and the potential commencement of some therapeutic work make it desirable for the initial assessor to be assigned as the care co-ordinator if the individual is taken on for further work.[105] Hence, initial allocation needs to be on the basis of information captured at registration and 'matched' with team member skill-set, experience, ethnic origin, gender and specialist interests, and on the basis of any known service user preferences (that may change over time). It is important to guard against random or arbitrary allocation merely on the basis of available capacity (i.e. who has 'space in their diary') or perceived imbalances in work burden distribution (see Section 5.3).

5.2.3 Initial assessment
While service users may be easy to engage,[106] mental health teams need to take steps to make accessing services easier. To enhance capacity, all team members need to be available to undertake initial assessments. Teams need to agree on an assessment format that is brief enough to engage users yet detailed enough to adequately profile
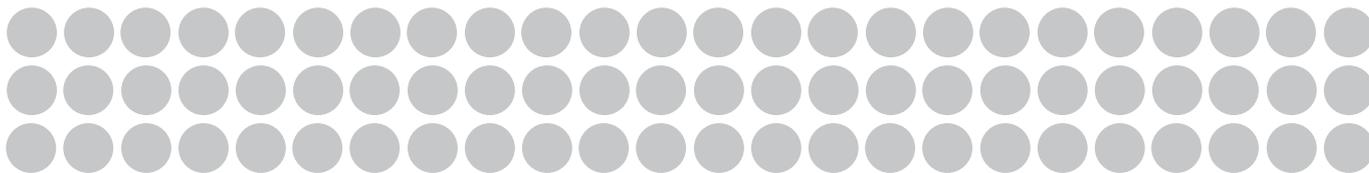
their problems and strengths (see Appendix D). Users should also be provided with a leaflet outlining the format of assessment, including clarifying that there is confidentiality within the team and on a strictly 'need to know' basis with services outside the team, and that reporting of suspected child abuse is mandatory.[107] Towards the end of the assessment, the assessor and service user formulate an interim care plan. As an initial or wait-list intervention, service users may be supplied with some relevant educational leaflets and/or biblio-therapy.

The need for routine joint assessments needs to be kept under review, as it reduces the resources available for other team functions and typically leads to access problems and waiting lists.[61] They are also based on the unproven assumption that two or more heads are better than one.[108] However, some potentially difficult assessments (e.g. where risk management and reduction are primary concerns) may warrant input from more than one team member.

5.2.4 Re-allocation or redirection according to need
Initial assessment findings are discussed at the next mental health team meeting. The team decision[4] may be to refer onward to a more appropriate service (e.g. less intensive treatment options) or to refer back to the referral source with advice.[89] It is important that decisions are made on the basis of need rather than to avoid workload pressures.[109] Where those pressures become intolerable in the face of legitimate need, a wider local whole system response is needed (see Section 3.5). It is also important that processes concerned with gatekeeping the team do not come to dominate, taking valuable time away from the important task of actually supporting service users.[61] This is another context where leadership and management that span the whole local service system are both required to ensure that good information on the pressure on the system as a whole informs decisions about the allocation of capacity. It also requires that teams operate flexibly and maturely, recognising that they are part of a bigger whole serving the needs of their local community.

If a team's profile among local referrers is right and the whole system management is such that the team is appropriately resourced, it is reasonable to expect that the most usual outcome is that referrals will be accepted and a care co-ordinator assigned from among the team members. While this team member ideally is the initial assessor, if assessment data indicate clinical need (or service user preference) more suited to the skill-set, life experience (including gender and race) and specialist interests of other team members, the service user needs to be re-allocated. This minimises the possibility of negative therapeutic experiences and disengagement.

All team members engage in the multi-faceted care co-ordinator role (see Appendix E for a list of responsibilities). The primary goal of this role[110] is that of co-ordinating service users' care and varying needs during the different phases of their mental health problems and to ensure that the work with them is monitored at an appropriate level and frequency.[111]

5.2.5 Care planning
Working from the interim care plan, a care co-ordinator's first task is to formulate a comprehensive recovery care plan[6] that includes a 'time frame, goals and aims' and 'strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and user satisfaction.'[4(p81)] Such a plan needs to outline achievable short-, medium- and long-term goals across all relevant life domains, the content of which will evolve over time (see Table 7). These goals need to be reviewed at least every six weeks.

5.2.6 Review
Reviews provide an opportunity for care co-ordinators, and where possible service users and carers, to take more time and space to present how their work together is progressing. As an adjunct to clinical observation, this process can be enhanced by using valid and reliable instruments (e.g. HoNOS[112]). Care co-ordinators need to regularly assess if recovery outcomes (across a variety of life domains; Table 7) are being achieved and bring this data to team meetings to inform structured team (or peer) reviews of service user progress. Until such time that teams are resourced with web-based information technology systems to manage clinical records, it is likely

that information will remain hard to locate in increasingly voluminous case notes. Hence, there is a need for an accessible and current summary of team input in such case notes. A team review can also monitor if clinical care has drifted. It also provides a safeguard against therapeutic complacency or apathy – 'long association can lead to over-familiarity' so that 'changes in mental state or side effects of drugs are overlooked.'[69(p67)] Service users' preferences and goals may also change as time progresses and these need to be reflected in updated care plans.

Table 7. Service user life domains.

Life domain

1. Signs and symptoms
2. Neighbourhood and families
3. Sports and leisure
4. Volunteering
5. Arts and culture
6. Faith communities
7. Education
8. Employment
9. Services

5.2.7 Episodic closure
As a guide, mental health teams need to retain 10-15% of their capacity to accommodate new or urgent referrals, and/or other emergencies.[69] Lack of throughput can result from members' retaining, and failing to discharge, their fixed case-loads of chronic, stable and familiar cases, and their reluctance to take on potentially complex cases.[32] This again underlines the need for teams to stay outward looking, continually fostering links with other more socially inclusive forms of support. Excessive workloads can also predispose to generic monitoring and support, thus rendering team members' specialist skill-sets redundant.[29]

When selected cases have sufficiently stabilised and found alternative support in the community to the extent that they no longer need interdependent inputs from mental health team members, as discussed at team meetings, care co-ordinators need to episodically phase down their involvement and discharge these cases to primary care services. For each closed case, there is an agreed ongoing care plan that includes those circumstances where the mental health team might resume work with the service user. Hence the 'episodic' nature of closure. Local health communities ought never feel that a team has 'washed its hands' of a service user who has relevant presenting issues.

5.3 Workload distribution
Profiling workload distribution in teams is often based solely on the measurement of the readily available 'currency' that is caseload volume statistics. However, such a method of determination neglects factors such as diagnostic case-mix or complexity (and associated clinical risk), report writing responsibilities and travel commitments.[113] Such factors form part of available caseload profiling tools and that may place varying work burdens on different team members. Teams need to get this process right as inequitable caseloads can lead to intra-team anger, envy and, ultimately, to team member burnout.[105]

As detailed in Table 8, these factors can yield a continuum of low- to medium- to high-dependency needs and variable levels of clinical support required.[109] The limited nature of some professionals' input (to each case) can also lead to relatively greater service user throughput.[36] If the clinical need for particular competencies
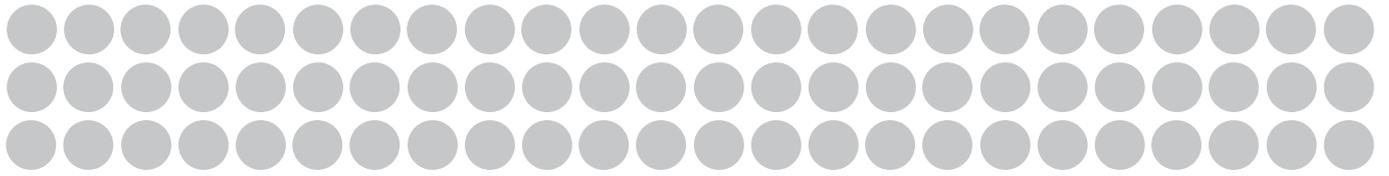
consistently exceeds what is available within teams, the team co-ordinator needs to inform the local Area Mental Health Management Team with a view to further recruitment of individuals with these competencies.

Table 8. Levels of clinical support required by service users.

Level of support	Example of input
Low	Regular injections at clinics (but no home visits or other support)
Medium	Weekly anxiety management and relaxation classes
High	Regular home visits and/or talking therapy and other support

5.4 Communication

As reflected in the submissions[2] to the Mental Health Commission's teamworking discussion paper,[1] teams need to nurture an open and honest communication culture (Table 9). Indeed, communication is the glue that links together all of the other teamwork processes together.[114] While clinical meetings are the primary forum for communication and decision-making, it is important not to neglect the importance of the more informal communication that takes place in all the other social spaces in the team's life. It is also important not to neglect where communication will not take place, through an agreed policy on confidentiality.[6]

5.4.1 Desired communication behaviours

Mental health teams must ensure that information is communicated in such a way that it is easily understood by service users and carers.[6] The latter must also feel free to disclose personal information or concerns without fear of rebuke or judgement. Team members must also be open to (appropriate) challenge from service users and carers.

The potential teamworking advantage of bringing together members' multiple perspectives and generating more effective decisions is dependent on the development of a climate of internal trust and safety in participation. Such a climate of psychological safety exists when there is a shared belief that the team is safe for interpersonal risk taking and that ideas can be proffered tentatively without fear of abuse or ridicule. Such a climate contrasts with 'blame cultures' that can trigger defensive clinical practice and stifle creativity and innovation. A psychologically safer environment can lower the threshold for admitting professional limitations and seeking help from team colleagues, and can reduce potential clinical risk.[94] Accepting that some errors will be made and acting on learning from adverse events or near misses[24] also builds psychological safety, as does discussing new ideas and improved ways of working. In turn, the latter can elicit further free expression of thoughts, including questioning of decisions or highlighting safety or risk management concerns.[67]

Lack of psychological or participative safety can manifest in a reluctance to speak out against the perceived dominant view. This leads to a culture of conformity. It can also lead to service users functioning as the communication link between team members (creating a non-containing and fragmented experience for them), excessive use of professional jargon or cynical humour, avoidance of substantive discussion of simmering resentments, backstage complaining, and a distribution of interaction that is skewed toward the more educated high status members.[92,115,116] This can result in team meetings that are characterised by a series of one-on-one dialogues between a dominant (and socially distant) leader and each member in turn,[26] especially in the 'forming' stage of team development (see Section 2.1). This is particularly problematic at that stage in that as members need to re-orientate themselves to the dynamics of a new peer group, the need for open communication is more pronounced in new or re-constituting teams.

Table 9. How to cultivate a healthy communication culture.

Action

- Listen to, acknowledge, respect and respond to the input of all team members and service users
- Model asking for help, admitting mistakes, and acknowledging job-related distress
- Nurture various forms of communication (e.g. formal / informal, verbal / written)
- Encourage creativity, innovation and free expression of opinions
- Prioritise care co-ordinators communicating with service users / carers
- Commit team members to attend regular, goal-focused and well-managed team meetings
- Engage all team members in organised information-sharing meetings
- Take positive steps to ensure that all team members are kept informed
- Agree and implement a team operational policy
- Ensure service users / carers have maximum opportunities for meaningful input into formal decision-making procedures
- Normalise the reality of the challenges of teamworking
- Encourage a tolerance for diversity and a degree of conflict
- Respond collaboratively and work out mutually acceptable solutions to problems
- Agree and implement a conflict resolution mechanism

5.4.2 Decision making

Individual mental health teams need to discuss and agree on formal decision-making procedures. These procedures have to ensure that team members' multiple perspectives and their broad range of knowledge and skills contribute expanded information and generate more effective decisions.[23] If many people in the team are involved in a decision making process, the wider ownership leads to a greater perceived legitimacy of decisions and increased support for their implementation.[117]

However, it is also important to make sure that, in common with the principles described earlier regarding team size (see Section 4.3.2), there are the minimum number of people involved to achieve an effective outcome. There needs to be some discretion for 'practitioner-only' decisions, otherwise the team is likely to become mired in protracted meetings around minutiae.[9] These pertain to decisions made without reference to the team meeting or a team policy and typically pertain to decisions relating to professional responsibilities or professional-specific casework. At the same time, 'practitioner-after consultation' decisions recognise that it is good practice to use the team as a source of support in decision making (e.g. through feedback and discussion in team meetings).

Despite the intuitive appeal of using 'majority voting' to come to team decisions, the numerical strength of some professions makes this method redundant. As it is unlikely to consistently find everyone agreeing, the need for team members to be clear about the authority they have under the responsibilities and accountabilities defined for team members is crucially important (see Section 4.4.1). Teams rarely proceed on the basis of achieving consensus[20] and relying on it is a hostage to fortune. In some cases, team members may have to 'agree to disagree' and formally record their objections. In other cases, people may just feel they have to abstain from decision making on the grounds, for example, of inadequate experience or information. For the more routine and practical decisions that drive teams day-to-day, Table 15 (in Appendix C) provides a comprehensive template for allocating authority for key decision-making responsibilities.

Partnership working needs to be nurtured such that service users and their carers have maximum opportunities for meaningful input into formal decision-making procedures (see Section 4.1). This can occur on at least two levels. They need to not only input on decisions about their own care and support, but lead such decision making provided staff are not asked to behave unethically or collude in damaging acts.[41] By making the best use of their
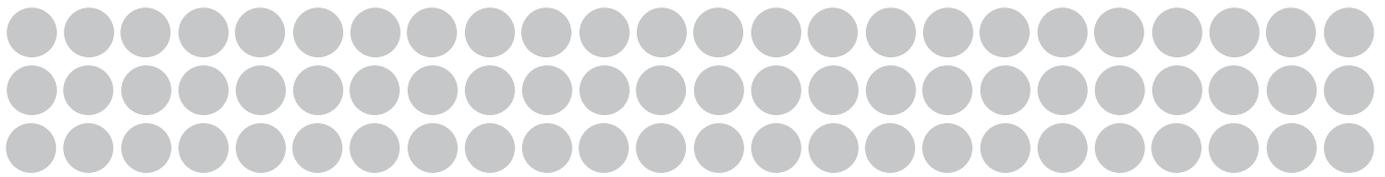
unique experience, the former results in improved decision making and increases personal responsibility and empowerment. Second, while national policies may determine local practice, service users can also input on local policy and management decisions rather than relying on particular professions to advocate on their behalf.

Clinical priorities can be eclipsed by bureaucratic pressures (e.g. to reduce costs, implement cost neutral changes), especially during times of financial constraint.[58] Hence, mental health teams need to continually debate whether decisions actually maintain (or improve) service user-centred clinical standards[118] and ensure the implications are effectively communicated to those with the authority to ensure the highest quality provision.

An adequate degree of participative safety (or a shared belief that the team is safe for interpersonal risk taking; see Section 5.4.1) is required to minimise the potential of 'groupthink' (see Section 1.6). Such safety reaps the benefits of access to multiple perspectives and expanded information. Formal decision-making procedures also need to guard against 'analysis paralysis' whereby a team may avoid making decisions due to feeling overwhelmed by constantly seeking out and/or analysing new information to inform.

5.4.3 Clinical meeting

Teams that do not have at least weekly, well-attended and highly participative clinical team meetings do not warrant the title of 'team.'[119] While some teams may have problems with their timing and venues, meetings need to be based in the same location and be time-protected. To ensure that they are productive and to guard against their becoming a chore, the (potentially rotating) chair needs to rigorously adhere to a structured agenda (Table 10).[89(p188)] While their primary business is that of processing clinical cases, throughout such meetings teams should be thinking about how they are working as a team. To facilitate more formal discussion of teamwork concerns including team strategies, processes and performance, it is usually necessary to schedule additional stand-alone meetings, possibly on a monthly basis.

To be productive, team meetings need to be skilfully managed. Numerically larger sub-groups (within teams) can displace the 'voice' of other minority professions. Complex decision making in larger meetings is particularly difficult. There is also the danger of a 'looking at your feet syndrome' during discussion of new referrals – a clear sign that team members may be feeling overwhelmed by the volume or nature of their work. Additionally, it is important to appreciate that some individuals may be relatively broad and narrative in describing clinical presentations, in contrast to the conciseness of others who get into the 'headlines' quite quickly.[94] Clarifying team expectations in this regard with respect to what level of detail team members find optimal for decision making can be usefully clarified. Use of complementary, informal communication can also support the more formal communication of team meetings but cannot substitute for it or for inadequate written communication (e.g. recovery care plans, updating team decisions in file notes, recording action points regarding new referrals or allocations at team meetings). Therefore, several forms of communication need to be nurtured.

Table 10. Structure of team clinical meetings.

Standing agenda item

1. Pool all referrals
2. Discuss new referrals or re-referrals, and allocate for initial assessment
3. Feed back on assessments and allocate cases to care co-ordinators
4. Discuss cases awaiting assessment
5. Provide brief updates on ongoing cases
6. Conduct in-depth reviews of selected cases

5.4.4 Confidentiality

As discussed with service users at their initial assessment (see Section 5.2.3), confidentiality is team-based and only on a strictly 'need to know' basis when communicating with other agencies. The confidentiality policy of mental health teams has to also describe how disclosures of suspected child abuse and plans to self-harm or harm others will be reported onwards (e.g. to care givers, general practitioners, social work departments).

5.5 Conflict

High levels of intra-team conflict can result in fragmented clinical care (e.g. members working as solo practitioners towards discipline-related goals, poor integration with external agencies), the pretence of cooperation, and teamwork that is only nominal. At best, mental health teams may fail to develop their best level of teamworking, at worst, they may 'self-destruct.'[40] There may be many reasons for such outcomes including the discipline-based nature of professional training that focuses on individual productivity (see Section 3.1). In the absence of inter-professional training (see Section 5.7.4), team members may not have acquired adequate teamworking knowledge and skills.

While a degree of (intra-team) task conflict is inevitable, preventative measures, based on understanding how it emerges, can be taken to minimise it. When conflict does erupt, teams need to implement proactive measures to ensure that it is constructive and results in positive change.[81]

5.5.1 Preventing conflict

Pressures to succeed, and the unrealistic expectation that there should be no differences and conflict in teams makes conflict more likely, and all the more challenging when it does occur. Various personality traits (e.g. a lack of tolerance for diversity and conflict; see Appendix A) can lead to an accumulation of hostile and ambivalent feelings or 'unfinished business' among team members[120] that can, in turn, lead to more conflict. Team members need to appreciate that a multi-disciplinary team without differences is a contradiction in terms[9] and that absence of conflict cannot be construed as an index of team cohesion or stability of relationships.[119] Highlighting and normalising the reality of teamworking challenges can create new-found acceptance that differences need to be openly acknowledged and negotiated around.

The process of formulating a team operational policy document (see Section 5.8) can also lead to taboo subjects (e.g. the distribution of power or clinical responsibility) becoming less personal and more amenable to discussion.[121] This process includes clarifying team member roles, responsibilities and team goals, and agreeing on referral eligibility criteria, service user pathways, the process of clinical work, the team governance structure and mechanisms to manage conflict.[101] It is important that this process emphasises a solutions-focused, strengths-based approach to team development that builds from existing strengths and assets.[122]

5.5.2 Managing conflict

There are at least three ways to respond to conflict. First, *responding collaboratively* involves engaging in 'constructive controversy' – the open-minded discussion of opposing stances – and trying to work out a mutually acceptable solution. Doing so can build mutual respect and facilitate resolution of differences.[123] Second, *contending* is trying to impose one's will, wishes and perspectives on others. This can easily lock individuals into a 'conflict spiral'. Research indicates that contending behaviours are quickly reciprocated by even stronger contending responses from others. In the process, the benevolent views of opposing parties can be dismantled.[124] Third, *avoidance* might also be used[125] leaving issues of substance unresolved, thereby creating the context for further conflict in the future.

If 'task' conflict is avoided or contended with and not resolved, 'relationship' conflict (Table 11) may develop.[126] Task conflicts are often misconstrued as relationship conflicts and vice versa. Contrary to popular wisdom, avoiding responding to 'relationship' conflict may sometimes be beneficial in facilitating teamworking – while ignoring interpersonal annoyances, collaboratively managing new task conflicts over time may create an improved team
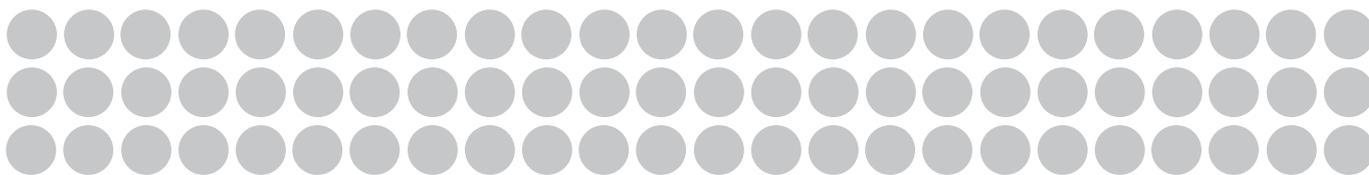
climate.[127] The desire to do good work with service users is usually at least one important shared value that transcends interpersonal differences.

Table 11. Task and relationship conflict.		
Conflict type	**Description**	**Effects**
Task	Related to team tasks as detailed in team operational policy or clinical judgements	• May motivate team members to look for optimal judgements and decisions
Relationship	Ego-centric or personality-based conflict that concerns insights and information that are unrelated to the task at hand, and involves negative emotions	• May threaten members' personal identity and feelings of self-worth • May hinder pro-social behaviour, damage team climate and predispose to team failure

The appropriateness of how conflict is managed is also dependent on the stage of team development (see Chapter 2). Ideally, process difficulties are addressed early in team formation or re-constitution.[114] However, during the initial stages of team development, the prospect of teamworking may engender feelings of anxiety and stress, and team cohesion may be fragile such that there are norms of maintaining pleasant and unruffled contacts that avoid challenge. Associated conflicts may be initially dealt with by avoidance, and tension may be expressed indirectly through humour, passive resistance or backstage complaining.[26] It may only be in the later stages of team development when there is an adequate degree of intra-team trust that members may engage in frequent conflicts.

Mental health teams need to establish and recognise formal 'stepped' mechanisms for conflict resolution. As a first step, efforts should be made to manage intra-team conflicts in-house in an informal manner, if necessary by including the team co-ordinator. This can be facilitated by supporting individual team members' communication when conflict does occur. If not resolved via informal means, the next step should involve the team co-ordinator consulting with the appropriate professional line manager(s). If doing so still does not achieve resolution, both should refer the matter to the local general manager with overall responsibility. Having such clear mechanisms may in and of itself lead to less conflict meaning that the mechanisms never actually have to be used – it is merely important that they are there.[91]

5.6 Practice supervision and peer consultation
Along with operational management exercised at team level through the team co-ordinator, both 'practice' (or clinical) supervision and peer consultation shape the practice of team members. The purpose of supervision is to provide support and a safe place for learning based upon evidence-based practice[128] but in some contexts it also has a control and monitoring function. In teams where most of the staff are fully qualified practitioners, this narrow definition of supervision is comparatively unusual. Such 'practice supervision' can only operate in the context of a formal accountability relationship between a line manager and a same-discipline staff member in training who has yet to achieve the status of independent practitioner. This relationship requires that the supervisee act in accordance with directives given. The supervisor also needs to be trained in the area of work (being supervised) so that s/he can be held accountable for that work. Hence, supervision typically does not span disciplines.[76]

Once qualified, team members are personally accountable to their professional bodies and the courts for the exercise of their professional responsibilities. Hence, the important receipt of advice and support (i.e. what is

often perhaps unhelpfully labelled as 'supervision') either within or across disciplines may be more accurately described as 'mentoring' or 'peer consultation'. This peer consultation process is perhaps the core rationale for operating in a team and values the team as a resource.[39] This can occur when cases are being reviewed in team meetings or on a one-to-one basis. It behoves senior managers to ensure that resources (e.g. time and funds) are made available to provide other opportunities for such peer consultation as well as, where necessary, more focused training and consultation in a specific approach (e.g. a particular form of therapy) outside of the team.

5.7 Training

While time and patience are important parameters to be considered when building a team, as highlighted in the submissions[2] to the Mental Health Commission's teamworking discussion paper,[1] different types of (pre- and post-qualification) training are required to prevent critical skill gaps both at an individual and team level. Service users and carers should be involved in designing and delivering such training, particularly if this can happen at a local level.[24]

5.7.1 Service user and carer needs

As it is often overlooked in both under-graduate and post-graduate programmes, team members need (formal) ongoing (and preferably team-based) education regarding the needs of both service users and carers (see Sections 3.3.1, 4.1, 5.1.1 and Appendix B), and how these needs remain at the heart of care and service planning. The specialised needs of some service users also necessitate some team members undertaking specialist training (e.g. presentation-specific assessment protocols and/or therapeutic models). By focusing on providing (albeit evidence-based) clinical interventions, some team members may lose sight of the necessity to put service users first and listen to their preferences.

5.7.2 Shared skills

The importance of positive, supportive, empathetic and respectful service user-provider relationships cannot be overstated.[24] In addition to technical proficiency (see Section 5.7.3), all team members need to have a service user-centred ethos and advanced relationship-building skills. Inter-professional training is needed to develop skills such as the ability to respect diversity, retain objectivity, employ active and empathic listening, generate trust, and more generally, the ability to interact therapeutically with service users.

As mental health teams need to guard against transplanting institutional care practices into community settings, members need to embrace a recovery orientation (see Section 3.2.2) and a broader community-based public health model of service delivery (see Section 3.3). Along with training on the Mental Health Act,[129] another suitable topic for team workshops (or induction) is developing knowledge of the mental health, health and wider services available (see Sections 3.3.2 and 3.3.3). Training also needs to promote familiarity with the values, skill sets and responsibilities of other team members, crisis intervention methods, conflict resolution strategies, teamworking principles and the team's operational policy document.[31] Other training topics may include cultural awareness, managing case-loads and associated administrative tasks, conducting intake or risk assessments, formulating care plans, and understanding care co-ordinator responsibilities (see Appendix E).

5.7.3 Profession-specific needs

While no profession has a monopoly on 'comprehensive' training, assessment or intervention,[80] each team member brings to the team an in-depth knowledge of, and advanced competence in, a particular model of mental health care that needs to be maintained by continuing professional development.[24] Informed by annual one-to-one appraisals, each professional line manager can collaboratively formulate a professional development plan that identifies the training needs of same-discipline team members.[130] Having identified training needs, teams need to underpin their commitment to staff development by allocating study leave and requisite resources in an equitable manner for all team members.
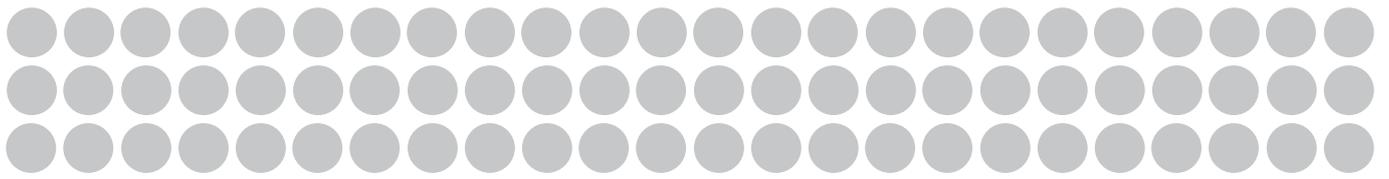
Specialist competencies such as service evaluation, service planning and development, audit, research, community development, training, teaching, education, and research need to be maintained. Such skills are at risk of being lost or deprioritised because of their 'invisibility.'[131] Likewise, specific competency frameworks may serve as training templates for certain team positions, including that of clinical leader.[88]

5.7.4 Team training

The continued segregated nature of professional training, the relative neglect of teamworking principles in the training programme syllabi, and the exposure of professionals to predominantly uni-disciplinary practices (albeit in 'team' settings) remain problematic. These have predisposed to poor teamworking skills among team members, different attitudes to teamwork and relating to others on the basis of ill-informed stereotypes and defensive interpersonal styles (see Section 3.1). Rather than hope that members will spontaneously work together effectively, mental health teams need teamwork training or opportunities for team building to nurture a shared mental model of teamworking, as embodied in a collaboratively constructed operational policy document. It is important that such training avoids utopian descriptions of teamwork. It needs to be aspirational and informed by existing strengths, but also mindful of where the team is now and the journey it needs to travel. Otherwise, the gap between ideal and real practice may foster cynicism and blame.[132]

While team outcomes (or outputs) are typically used to evaluate team effectiveness (see Chapter 6), team development and training can follow a four-stage process of envisioning a preferred future, looking at where the team is now in terms of those highest aspirations, and then harvesting all the assets that got the team to where it is to inform the next small steps for improvement.[122] Research has not yet established whether teams characterised by poor teamworking respond more positively to team structure improvements or to process interventions. As teams are dynamic, there is often a degree of circularity between team structures and processes, such that the former can partially determine the latter. Yet, as teams evolve, team processes often shape the structures within which they function best.[133] Hence, teams may need both structural and process interventions to maximise individuals' contributions and the efficacy of teamworking.

Regular opportunities for reflection (e.g. Table 12)[23] can enable mental health teams to understand how they learn and develop, to refine and correct their knowledge and practice, to develop a shared team culture, and to ensure the integrity of their internal ways of working. For example, Edmondson's model of team learning[134] highlights how psychological safety (see Section 5.4.1) contributes to a culture of learning and a variety of team learning behaviours such as sharing information, experimenting and asking for help.

Table 12. Guide for reflective analysis and team development.	
Stage	**Task**
1.	Reflect on current teamwork
2.	Comparatively appraise team performance
3.	Plan team improvement strategies
4.	Implement and evaluate change

It is positive practice for mental health teams, even when they are working well, to use external mediation or facilitation. As many teams can become trapped in a vicious cycle of clinical work overload, team training needs to be delivered in protected time. While this is particularly true of teams in the early stages of development (see Chapter 2), even established teams need to be supported and encouraged to provide such training. International experience suggests that as soon as teams stop developing and moving forward they begin to decline.[135]

5.8 Operational policy document

Unless all of the aforementioned team structures and processes are discussed, agreed (as manifest in an operational policy), and implemented, a mental health team will function poorly. Likewise, an overly-prescriptive operational policy document may impose a stifling uniformity and result in poor teamwork.[136] There is a middle ground where policy provides clear but minimum specification of how such a team needs to work. This balance ideally affords team members every opportunity to exercise their profession-specific skills.[91] Hence, an operational policy document provides clear direction of how to do what, yet sufficient space to develop creative working methods.[137] To ensure a wide base of ownership and commitment to implementation, time needs to be set aside for all team members to collaboratively formulate and regularly review their team's operational policy document.

In addition to articulating essential service standards such as level of service provision, frequency of clinical contact or clinical and non-clinical time,[61] a team's operational policy document serves a variety of functions (Table 13), and, at a minimum it describes a variety of team structures and processes (Table 14).[89(p174-175)]

Table 13. Functions of an operational policy document.

	Function
1.	Provide a reference for team members on essential service standards
2.	Provide a reference for team members on how the team's work is to be conducted
3.	Act as a central source for inducting new members into the team
4.	Act as an aid to better liaison through providing a description of the way the team relates to external agencies
5.	Provide a clear account of internal structures and processes on which to base continuous team building
6.	Act as a reference for senior management and those concerned with the appraisal of team performance
7.	Provide the basis for further team development
8.	Provide a highly specific description of the team that can be used for public relations work and informing others interested in establishing similar teams

5.9 Summary

Mental health teams need to implement an agreed referral pathway, a process of work, and a system to equalise work burden. These teams need to cultivate a healthy communication culture by having policies regarding how decisions are made, and detailing how clinical meetings and confidentiality are managed. While there is a need for a conflict resolution mechanism, it is preferable to prevent conflict by employing a number of measures (e.g. education of teamwork challenges). Along with practice supervision and peer consultation guidelines, teams also require training for both shared and profession-specific needs, and a focus on learning to work effectively as a team (e.g. reflective practice). All these effective ways of working should be captured in an evolving team operational policy document.

	Heading	Sub-headings
1.	Introduction	
2.	Team aims	• Overall purpose • A statement of values and principles • Essential service standards • Specific team goals
3.	Team membership	
4.	Governance structure	
5.	Model of clinical responsibility	
6.	Referral pathway	• Target service users / threshold eligibility • Extent of referral net • How to access the team
7.	Processing of referrals	• Registration • Assessment • Allocation
8.	Care co-ordination	• Care planning • Review • Episodic closure • In-patient admission • Record keeping and data collection • Taking leave
9.	Integrated working	
10.	Communication	• Decision making • Clinical meetings • Confidentiality
11.	Conflict management	
12.	Practice supervision and peer consultation	
13.	Training	• Individual • Team
14.	Team audit	
15.	Appendices	• Job / role descriptions • Sample forms (e.g. assessment, care plans) • Teamworking audit tool

Table 14. Sample headings for a team operational policy document.

CHAPTER 6: RESOURCE TOOL KIT

Quality mental health care will be realised only if teams are successful in implementing best-practice teamworking principles to meet local clinical need. To inform this process, in addition to the extensive list of references provided in this document, this chapter presents a (yet-to-be-validated) audit tool that was formulated (by the authors of this paper) on the basis of the teamworking characteristics highlighted both in the submissions[2] relating to the Mental Health Commission teamworking discussion paper[1] and in the academic literature. Also included are websites on teamworking, workbooks and other related documents.

6.1 Teamworking audit tool
Having collaboratively established quality of care standards, relevant stakeholders need to audit if the teamworking practices of mental health teams are promoting their meeting these standards. Audit involves critically analysing the quality of 'not only clinical care but the way in which care is delivered and the resulting outcome' for service users and carers.[138(p80)] Hence, an audit tool needs to profile both *what* a team does and *how* it does things (e.g. what procedures are followed), in addition to structural characteristics and outcomes, as reflected in service users' mental health status and quality of life.

As 'quality of performance often loses out to quantification,'[139] an effort has been made in developing this audit tool to also consider criteria beyond those that are easily measured or administratively convenient. We are attempting to measure what counts, not just what is countable.

Different stakeholders prioritise different things and the implications of pursuing one thing has knock on effects with another. For example, a preoccupation with reducing waiting times can lead to distortion of clinical priorities, while service users may prioritise interpersonal skills and maintenance of clinical competence without regard for concerns of maximum throughput at minimum cost. For this reason we advocate assessing quality of care using a constituency approach where characteristics that might be given different weight by different stakeholders are all included.[140] The measure therefore does not aim to be a definitive statement of your teamworking, as the outcome of the evaluation will depend on who does it. However if you use it several times with the same range of stakeholders, it will generate a useful sense of direction and range of priorities for you all to consider and an opportunity (assuming you use the same range of stakeholders) to measure how things have improved.

In employing a Likert scale and score-based ratings for various teamworking characteristics, it is hoped that stakeholders will move away from describing teams as simply 'good' or 'bad' teams. The concern is to be 'better' no matter what your team's developmental stage. This tool may complement current quality or audit initiatives for mental health teams.

This teamworking audit tool consists of 25 statements. A 4-point Likert scale is provided.

1	2	3	4
Strongly disagree	**Mostly disagree**	**Mostly agree**	**Strongly agree**

Using this scale, please rate your team on each listed item. For items that you rank your team as '1' or '2' on, please include the rationale for your ranking under the 'comments' section.

The maximum possible score is 100. Lower scores represent a less positive rating, and higher scores a more positive rating.

		1	2	3	4
1.	Team members agree on and pursue team goals.				
2.	Service users are encouraged to take on challenges that lead to personal growth and development (e.g. progress new interests, try something new, take on new roles).				
3.	Team members feel safe to voice their opinions, readily seek help with clinical work, and acknowledge work-related stress and mistakes.				
4.	Service users work in partnership with their care co-ordinator, are enabled to make informed choices and input into service planning.				
5.	Care co-ordinators work well with multiple agencies (e.g. service users, carers, local community services, other mental health and health services) to facilitate care co-ordination that meets the full range of users' needs.				
6.	The team uses resources efficiently (e.g. members operate to their strengths, have full caseloads, link effectively with external agencies, practise in an evidence-based manner).				
7.	Team members have shared views about the lines of accountability.				
8.	Service users meet their goals across multiple domains (e.g. control symptoms, maintain employment and good physical health).				
9.	Team members understand and adhere to the adopted model of clinical responsibility.				
10.	Service users can readily access the team when in crisis.				
11.	Team members readily accept and work within the team's governance structure of business manager, clinical leader and team co-ordinator.				
12.	Team members understand and value the roles of their team colleagues that are openly negotiated and periodically reviewed.				
13.	There are low absence and turnover rates of team members facilitated by various supports (e.g. peer consultation, appropriate skill mix, workforce development opportunities, equal opportunities for continuing professional development).				
14.	Team members adhere to an agreed team operational policy.				
15.	There are regular opportunities for teamwork training (e.g. education, reflective practice).				
16.	Team members use an agreed referral pathway (e.g. eligibility criteria, referral source, number of access points).				
17.	Team members use an agreed work process (e.g. registration, allocation, initial assessment, re-allocation, care planning, review, episodic closure).				
18.	There is a culture of good communication (e.g. access to respectful team members who listen to service users' concerns, well-attended structured team meetings, respect for contributions, regular review of written care plans, communal files, and discussion of work burden, conflictual tensions, the exercise of power and hierarchy).				
19.	Team members expect differences between them and manage these in a constructive manner in the pursuit of meeting service user needs.				
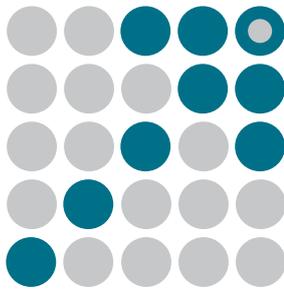
		1	2	3	4
20.	While all relevant team members are involved in decision making, service users are the ultimate decision-makers.				
21.	Team members provide practical support for new ideas and their application.				
22.	Each service user has at least one close reciprocal relationship and is involved in the larger community.				
23.	While recognised as only a last resort, in-patient services are seldom used.				
24.	Team members depend on and make good use of each others knowledge, skills and experience to meet local clinical needs.				
25.	The team makes changes on the basis of regular evaluation findings (e.g. referrer or service user monitoring and feedback, team performance or goal attainment review)				

Comments:

6.2 Websites on teamworking policy and practices
Bristol Mind – While this provides and promotes service user-focused services in the UK, it is a good source of reports on user-focused monitoring and user-led research. **http://www.bristolmind.org.uk/**

Care Networks – This is especially good for personalisation tools **www.dhcarenetworks.org.uk**

Improving Access to Psychological Therapies – This is a good resource for mild-to-moderate mental health problems **www.iapt.nhs.uk**

Integrated Team Monitoring and Assessment (ITMA) **http://www.readiness-tools.com/tool-full. aspx?toolguid=0d6382ad-f017-4623-8d10-93f2f314e346**

Mental Health First Aid **www.mhfaengland.org.uk**
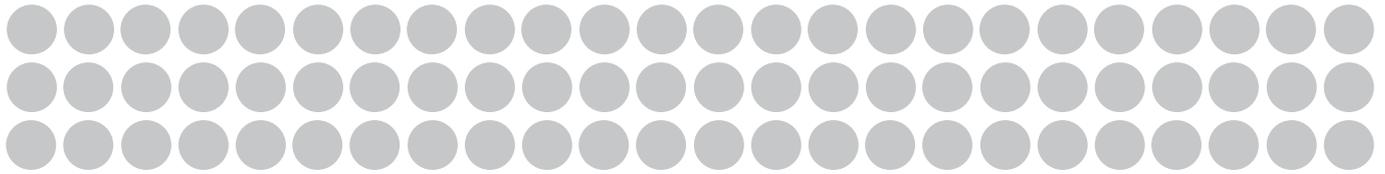
National Mental Health Development Unit – Refer especially to the page on care pathways **www.nmhdu.org.uk**

National Social Inclusion Programme **http://www.socialinclusion.org.uk**

New Ways of Working – This is a rich resource for mental health services including a Positive Practice Guide on the Creating Capable Teams Approach (CCTA) **http://www.newwaysofworking.org.uk**

The Royal College of Psychiatrists 360 Degree Assessment for Consultant Psychiatrists **http://www.rspsych. ac.uk/crtu/centreforqualityimprovement/acp360.aspx**

Sainsbury Centre for Mental Health – This has many briefing papers on relevant aspects (e.g. supported employment, welfare advice, prison interface) **http://www.scmh.org.uk/**

South West Development Centre – Refers especially to leadership and teamwork development mindmaps **www.swdc.org.uk**

Training and Development for Health – This is a service development support for teams with a useful Capacity Framework **http://www.td4h.co.uk/index.php**

6.3 Workbooks
The Creating Capable Teams Approach (CCTA) **http://www.newwaysofworking.org.uk**

6.4 Teamworking measures
The Aston Team Performance Inventory (ATPI) **http://www.astonod.com/atpiView.php?page=1**

The Community Mental Health Team Effectiveness Questionnaire (CMHTEQ)[140]

ITMA (as referenced above) – Like other measures, it is recommended that this is not used outside of an affirming solution-focused development process. Otherwise people may merely assess their team as poor and become demoralised.

The Productivity Measurement and Enhancement System (ProMES).

6.5 Other relevant documents
Working Psychologically in Teams[39]
http://www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/new_ways_of_ working_for_applied_psychologists.cfm

Moving On: From New Ways of Working to a Creative Capable Workforce – Guidance on Responsibility and Accountability[141] **http://www.newwaysofworking.org.uk/pdf/0330_randaguidanceconf.pdf**

New Horizons – The new Department of Health strategy that builds on build on the National Service Framework for mental health **http://www.dh.gov.uk/en/News/Recentstories/DH_097701**

Doing What Works: Individual Placement and Support into Employment[142]

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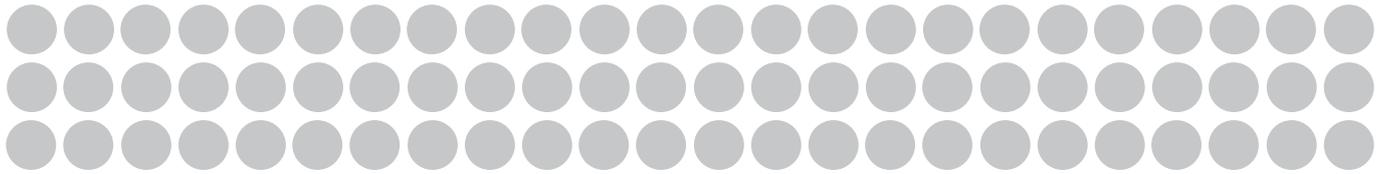
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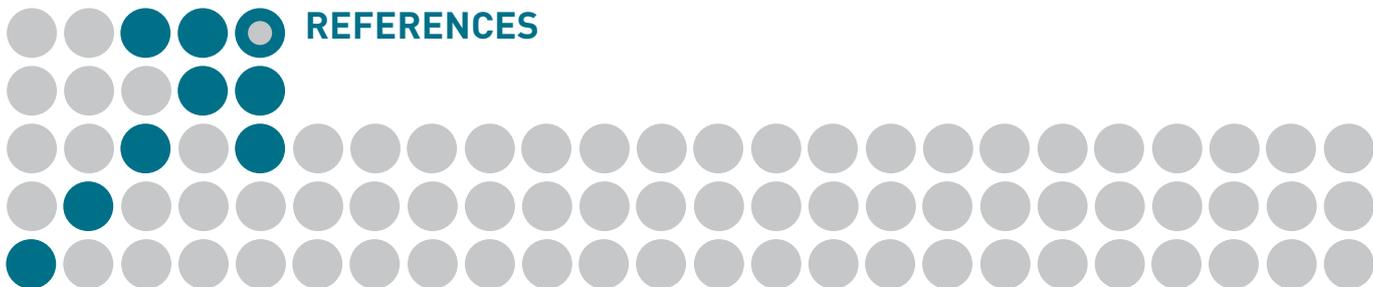
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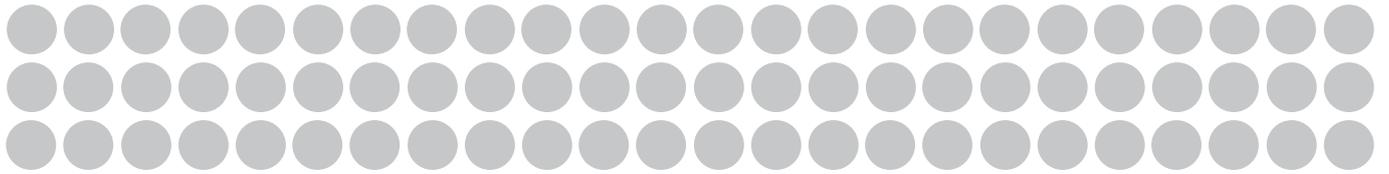
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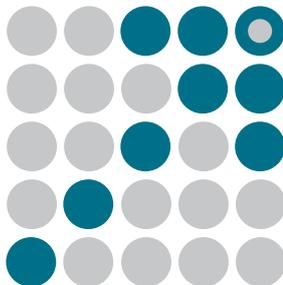
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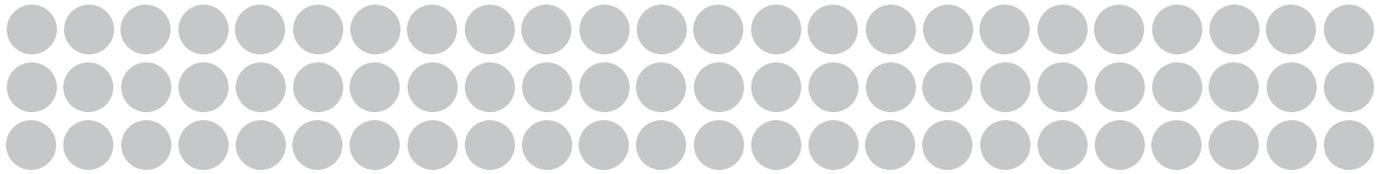
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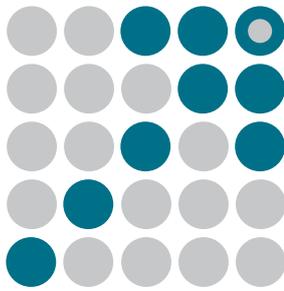
Appendix A: Team member personalities

Personality is the combination of psychological traits that we use to classify people. Overlooked to a large degree in the submissions[2] to the Mental Health Commission's teamworking discussion paper, the degree to which the personalities of individual members mesh can influence the nature of teamworking in mental health teams. Indeed, it is not unusual to hear of team members with 'overly-strong' personalities or 'personality clashes' diminishing the nature of teamworking.[29] But such explanations are overly simplistic and can mask how personalities 'only intensify structural conflicts that would, over time, produce an intolerable and impossible situation for anyone.'[9(p43)]

Hence, ongoing intra-team difficulties often indicate that teams have not yet developed the means to deal with internal problems (e.g. role conflicts) that are inherent in trying to accomplish interdependent team tasks.[119] While it is unhelpful to leave the discussion of teamworking problems at the level of the individual, categorised here using the 'Big Five' model of personality,[143] certain dimensions of personality can facilitate greater levels of teamworking and quality service provision.

1. Emotional stability
In order to feel 'contained' and safe, service users and carers need team members who are emotionally stable and tolerant.[69] Such individuals, often described as 'mature', tend to have a resilience to cope with the varied challenges of teamwork and the potential threat to their professional identity.[144] They tend to be calm, self-confident in their role as a professional and secure, such that they respond appropriately to challenges from team colleagues. They are open to recognising and discussing their limits of professional competence, to admitting mistakes (rather than seeking to attribute blame), and to asking for help without suffering a loss of self-esteem.[119]

2. Extroversion
While not all team members can be so, gregarious, assertive and sociable members can promote the use of humour, appropriately challenge majority views, and increase intra-team social affiliation and job satisfaction. Their social competence and connection with others can enable service user engagement and resolution of differences or conflict. However, if a member is dominant, his/her opinions can inhibit discussion and consideration of issues. Such personalities can be contained by a structure that values each contribution equally.[145]

3. Openness to experience
It benefits mental health teams that at least some members are creative, curious and open to learning. The strength of narrow profession-specific beliefs and values can be reduced if members remain open to the potential inter-professional re-socialisation in their team. For example, rather than interpreting differences as deficiencies in the training of team members, they learn to overcome their attitudinal biases and come to value their team members' skill-mix. They also come to replace a primary allegiance to their professional group with a dual loyalty or commitment to their profession and to their team.[146] They also are more inclined to learn from colleagues and develop new skills, take calculated risks, and re-adjust their teamworking expectations to reflect the realities of teamworking. Importantly, their creativity empowers teams to seek out new and improved ways of working.

4. Agreeableness
The human relations approach to staff retention holds that the role of intra-mental health team social processes is the largest motivator of staff.[147] Hence, in contributing to a socially-reinforcing atmosphere where members' social needs are met, the presence of co-operative, warm and trusting team members can reduce turnover and maintain continuity of care. Such individuals also tend to give others the benefit of the doubt. However, overly co-operative members can fail to adequately represent their discipline-specific viewpoint, while at the other extreme, cold, disagreeable and antagonistic members can reduce team cohesion and fragment delivery of care.
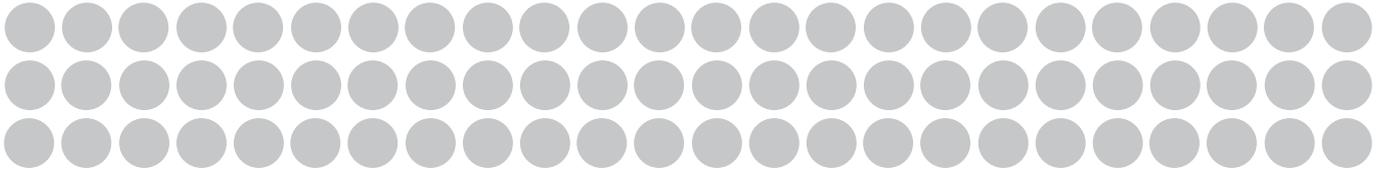
5. Conscientiousness

Reliable team members who are responsible, organised, dependable and persistent contribute to a safe and a 'readiness to support each other' culture. This can reduce engrained individualism, and foster collective orientation, interdependence and a team commitment such that self-concept and esteem become dependent on team success.[146] In enhancing continuity of care, the presence of such members can enable service users to feel a greater degree of containment.
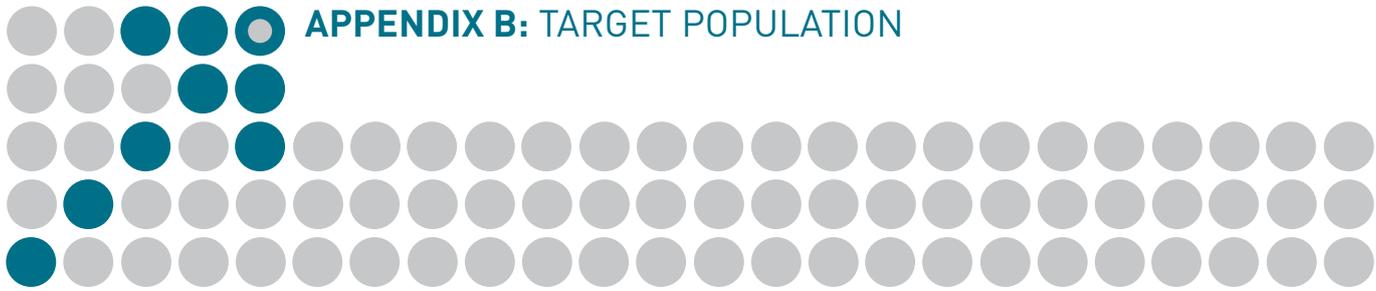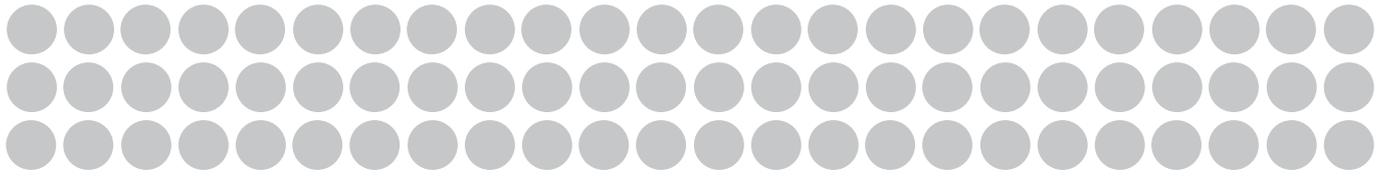
Appendix B: Target population

CMHTs need to prioritise both the 'old' and 'new' populations of individuals with severe mental health presentations. They have to first cater for the needs of discharged long-stay (typically geriatric) individuals. The prolonged hospital stays of these individuals ordinarily predisposes to a progressive deterioration of community living skills, social and cognitive deficits, and varying degrees of 'institutionalism'. The latter is a syndrome that includes 'lack of initiative, apathy, withdrawal, submissiveness to authority, and excessive dependence on the institution.'[148(p6)] The associated passivity of these individuals promotes their acceptance of mental health team interventions but teams need to be active on their behalf to nurture community supports in order to promote integration. Some commentators highlight the variability in the degree to which this dwindling population can tolerate stress and unpredictability that predisposes to acute psychotic breaks and repeated hospitalisations.[148] However, evidence indicates that as long as sufficient resources are available to provide a good quality of care, long-stay service users function well in the community.[149]

Ongoing de-institutionalisation has created a pressing concern to meet the needs of the 'new long stay'[150] who have severe mental health difficulties (e.g. psychosis). Their typically more difficult-to-treat profiles are due to a variety of factors including exacerbation of symptoms and problematic behaviours brought about by easy access to alcohol and other illicit drugs, and a high degree of co-morbidity.[151] While only a small minority, these individuals can find it challenging to sustain themselves in the community and can experience frequent and often involuntary admission for lengthy periods of time.[152] Due to their need for long-term specialised care, they are difficult to manage in community facilities.[153] Many will also have experienced homelessness. Hence, mental health teams have to provide assertive outreach-type services to this population, with a strong emphasis on engagement through reliable and committed relationship building.

Appendix C. Framework for allocating authority for key decision-making Responsibilities[154]

This framework is aimed at achieving the maximum possible clarity over the allocation of authority for key decision-making responsibilities among the main stakeholders in mental health teams.

The broad headings have been designed to reflect a cyclical process of strategy development, implementation, management, monitoring and review. Such cyclical processes will be familiar to practitioners involved in individual service planning. It also includes the management of project-based innovations. The broad headings are therefore described below but can be adapted to represent the responsibilities in question and how you categorise them:

- Planning/Strategy development- super-ordinate to specific care group interests
- Planning/Strategy development for specific care groups
- Implementation of plans/strategies
- Project-based innovation
- Steady-state operation
- Quality assurance/risk management

The framework can be extended downwards to include those key tasks concerned with work with individual service users:

- Within the service user-staff member relationship decisions about work with an individual user.
- Care co-ordination decisions concerning an individual service user e.g. which workers should be involved, and how.

Three levels of authority can be allocated for each decision-making responsibility.[9] The three levels and their codes are:

D. The right to *decide*, whereby one party has ultimate decision making responsibility and can overrule the views of others. This party is ultimately responsible for the task.
J. *Joint* decision-making power, whereby each party has power of veto. Lead roles can be specified.
C. The right to be *consulted* and kept informed of developments.

Table 15 is a template that teams can use to guide debate regarding how authority for key decision-making responsibilities is allocated. Two worked examples are provided to illustrate how this template can be completed.

Table 15: Allocating authority matrix for key decision-making responsibilities							
	Team member	**Business manager**	**Clinical leader**	**Team co-ordinator**	**Professional line manager**	**Area Mental Health Management Team**	**Service user**
Strategy development							
Deciding overarching mission / values	C	C	C	C	C	D	C
Deciding financial & other parameters		J (Lead)	J	J		D	
Deciding team training strategy							
Deciding individual performance review systems							
Decisions concerning development of information systems							
Decisions concerning personnel policies							
Decisions concerning development & monitoring of team information & communications strategy							
Decisions concerning development & monitoring of team research & development strategy							
Decisions concerning development of review system for monitoring outcome of change in team							
Decisions concerning development of methods for effective user participation							
Decisions concerning development of methods for effective carer participation							
Deciding processes for needs assessment							
Implementation of plan							
Decisions concerning clinical & social care activity levels							
Deciding operational policy							
Agreeing business cases for new appointments							

	Team member	Business manager	Clinical leader	Team co-ordinator	Professional line manager	Area Mental Health Management Team	Service user
Table 15: Allocating authority matrix for key decision-making responsibilities (continued)							
Implementation of plan							
Deciding job descriptions & specifications							
Deciding service user group							
Determining case-load size (weighing up experience, casemix, etc.) & other quantitative parameters of activity							
Deciding levels of non-clinical & non-social care activity (e.g. own training, training others, research, etc.)							
Steady-state operation							
Decisions concerning the provision of effective support to teams							
Allocation of routine cases							
Deciding appointments							
Deciding support / peer consultation for individual team members							
Deciding training for individual team members							
Deciding content of annual appraisal re. objectives & achievements for individual team members							
Deciding on disciplinary action							
Approving annual leave							
Signing off expenses							
Decisions concerning trainee placements							
Determining specific clinical &/or social care intervention on the basis of assessment (to include the no. & frequency of sessions offered & when cases are to be closed)							

Table 15: Allocating authority matrix for key decision-making responsibilities (continued)							
	Team member	**Business manager**	**Clinical leader**	**Team co-ordinator**	**Professional line manager**	**Area Mental Health Management Team**	**Service user**
Quality assurance / risk management							
Decisions regarding the monitoring of compliance with operational policy (e.g. attendance at team meeting, use of record keeping forms, provision of care data-sets, etc.)							
Decisions concerning obstacles to safe & effective interventions, including overwhelming of personal competence / resources							
Decisions concerning methods of evaluation / audit for service developments (inc. participation of users & carers).							

Appendix D. Initial assessment guidelines.

Table 16. Guidelines for structure of initial assessment.[155]

Orientation to service
Demographic details
Reason for seeking help
Description of presenting problems
Suicidality & deliberate self-harm
Mental health history
Medical history
Current medication
Involvement with other services
Family-of-origin
Family-of-creation
Relationship history
School / vocational history
Living arrangements
Social support network
Faith beliefs (e.g. religious)
Personal strengths and assets
Insight into own problems
Addiction
Mental state examination
Psychometric questionnaire findings
Forensic history
Collateral from family / significant others
Motivation for seeking help
Ambitions
Other relevant information
Initial formulation
Brief summary
Interim care plan (i.e. care needs & actions)
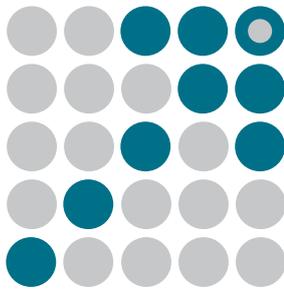
Appendix E. Care co-ordinator responsibilities[45(p22-23),89(p185-186)]

Comprehensive needs assessment

1. Seek out any further information needed following initial assessment. This may be via old notes, communication with the referrer, or others involved.

2. Send a letter or report to the referrer describing the outcome of the assessment.

3. Arrange any further assessments (e.g. intra-team by the consultant psychiatrist or occupational therapist).

4. Report any relevant information regarding assessments and subsequent developments to the other team members at weekly team meetings, the referrer, the service user's general practitioner and any other workers involved.

5. Inform the weekly team meetings of any delays or refusals in gaining assessments, information or interventions.

Risk assessment and management

6. Develop risk management plans to support service users' independence and daily living within their accommodation.

7. Assess service users' needs and circumstances and evaluate the risk of abuse, failure to protect and harm to self and others.

8. Assess the need for intervention and present assessments of service users' needs and related risks.

9. Inform the team co-ordinator, the relevant line manager or the team as a whole of any concerns about finding oneself unable to cope with any aspect of the work, including personal difficulties, unrealistic demands on experience and knowledge, or sheer volume of work. There is always a danger of the team assuming a 'macho' culture in which care co-ordinators suffer in silence for fear of being thought inadequate. Since everyone has a unique but finite range of skills, knowledge and experience, care co-ordinators need to be applauded for acknowledging any limitations.

Assessing and responding to carers' needs

10. Assess the needs of carers and families of service users.

11. With service user consent, develop, implement and review programmes of support for carers and families.

Care planning and review

12. Establish with the service user a collaborative approach aimed at achieving the outcomes that they have identified. It is sometimes useful to negotiate a contract with the service user.

13. Organise clinical reviews. The first review occurs within six weeks after allocation and other people involved with the case are invited. Subsequent reviews occur not more than six weeks later. Extra reviews are organised as necessary and for some complex and difficult cases, this happens frequently.
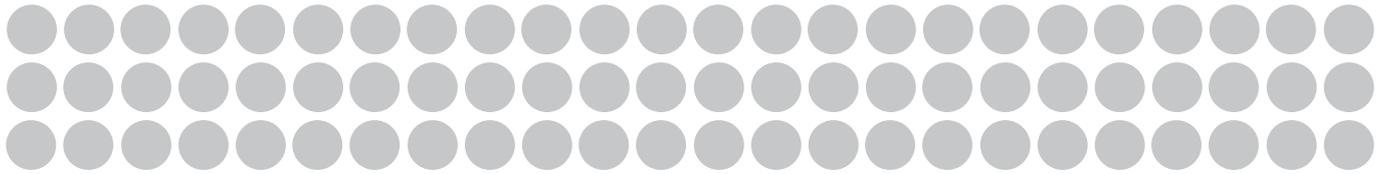
14. Actively seek the involvement of other workers or agencies in helping to meet any of the various needs that the service user identifies. This includes drawing on resources both within and outside the team.

15. Hand over and liaise with relevant staff during service user transitions e.g. when admitted to hospital or upon engagement with another agency.[6] If the case is to remain open, reviews and case conferences are attended, links with relatives and friends are maintained, and the care co-ordinator remains available to help transfer the service user back to a less sheltered environment.

16. Unless the mental health team has an explicit out-of-hours function, arrange all appointments and room bookings to end before 5.30pm. This helps team members to maintain boundaries around their working hours.[c]

17. Ensure that the communal record is kept up to date.

18. Ensure that data for evaluation are clearly communicated to the team co-ordinator for entry into computer.

19. When taking leave, legibly summarise work to date in the communal file,[6] including any necessary contingency plans should the service user encounter difficulties in the care co-ordinator's absence.

    If another team member needs to be involved, this is made explicit in the summary and agreed with the care co-ordinator concerned. Cases are also summarised verbally at the weekly clinical team meeting.

Transfer of care and discharge

20. Phase down involvement when approaching (episodic) closure on a case, maintaining contact with a service user until they have found alternative support (e.g. facilitated support from carers, community resources, primary care services). Where a service user is being referred back to the original referrer or another agency, the care co-ordinator liaises with them in order to decide how to respond to any early warning signs of relapse or other difficulties. This stage particularly involves unpaid carers and stresses that the mental health team can be called on again at any time (unless it was agreed that this would not be appropriate).

21. Ensure that the original referrer (and the general practitioner) has a written record stating that the case is closed and including any contingency planning.

Generic

22. Carry an ID card on all home visits and produce it on demand.

23. Remain as the named contact person for particular service users (and carers).

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c   Given the likelihood of unforeseen and unexpected crises concerning service users with mental health needs, ideally each CMHT will provide an out-of-hours crisis intervention service component. For example, for homeless people, this may take the form of an outreach service provided on an extended hours basis (08.00 to 23.00 daily).[4]
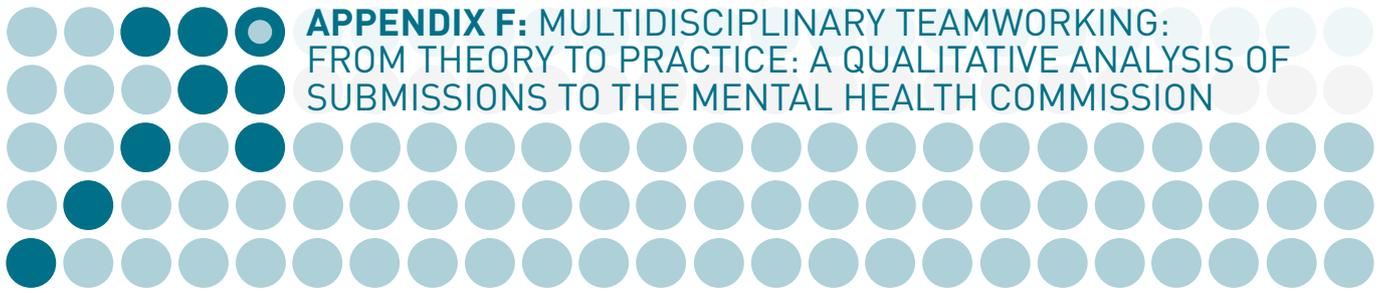
MULTIDISCIPLINARY TEAMWORKING: FROM THEORY TO PRACTICE

A QUALITATIVE ANALYSIS OF SUBMISSIONS TO THE MENTAL HEALTH COMMISSION

Mental Health Commission (2006)

CONTENTS

LIST OF TABLES

AIM AND CONTEXT

A Mental Health Commission discussion paper entitled 'Multidisciplinary Team Working: From Theory to Practice' was circulated in early 2006 to various stakeholders throughout Ireland. The purpose of this paper was to encourage and inform debate on the issue of multidisciplinary team (MDT) working in mental health services. Stakeholders were invited to consider the issues that were raised in the document and to share their views with the Mental Health Commission. Specifically, stakeholders were asked to respond to 22 specific questions. The aim of this discrete report is to provide a qualitative analysis of these submissions.
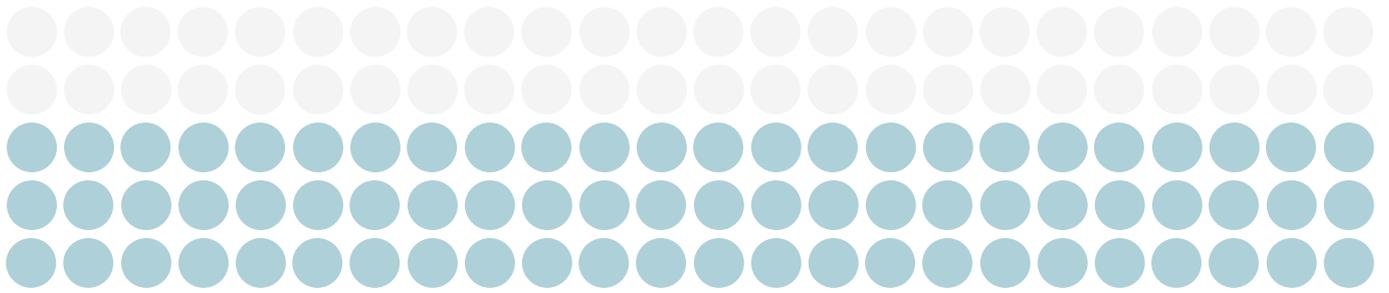
METHOD

Participants

A total of 49 responses to the discussion paper were submitted by various stakeholders to the Mental Health Commission. A breakdown of the type of respondents by number of responses is displayed in Table 1 below.

**Table 1. Number of respondents by type of respondent (% in parentheses).**

Professional Grouping	No. of Individual Responses	No. of Group Responses	Total No. of Responses
HSE / Independent	12 (24)	(24) (43)	21 (67)
Professional Body	-	4 (8)	4 (8)
Advocacy / Voluntary Organisation	2 (4)	2 (4)	4 (8)
Academic / Research Organisation	2 (4)	2 (4)	4 (8)
Specialist Health Services	-	1 (2)	1 (2)
Individual Responses	3 (6)	-	3 (6)
Total	19 (39)	30 (61)	49 (100)

General Approach to Analysis

Content analysis was used to identify the key themes evident in the submissions for each question. This involved reviewing the transcripts to identify common threads, which were then sorted into mutually exclusive themes. Using these themes as a framework, a frequency analysis was carried out on the transcripts as a whole to determine how many stakeholders referred to each theme in their submission. In order to highlight these themes, for some questions, quotes were selected and included to reflect the nature of the perspectives around each theme. As it is not possible to include all quotes relating to a specific theme, samples are selected to offer the reader an insight into the discussions.

In addition to the thematic analysis for each question posed by the Mental Health Commission, the analysis also set out to identify any major criticisms or suggestions for improvement in the transcripts made by respondents, which were not addressed in the analysis of each question.

Given that there are a higher number of both individual and group submissions by the HSE/Independent Provider (see Table 1), the responses for these two subcategories will be considered separately in the analysis. That is, the submissions from the HSE/Independent Provider will be separated into the sub-categories; HSE/Independent Provider Group and HSE/Independent Provider Individual. The individual and group responses will be considered as one single category for each of the remaining types of respondents.
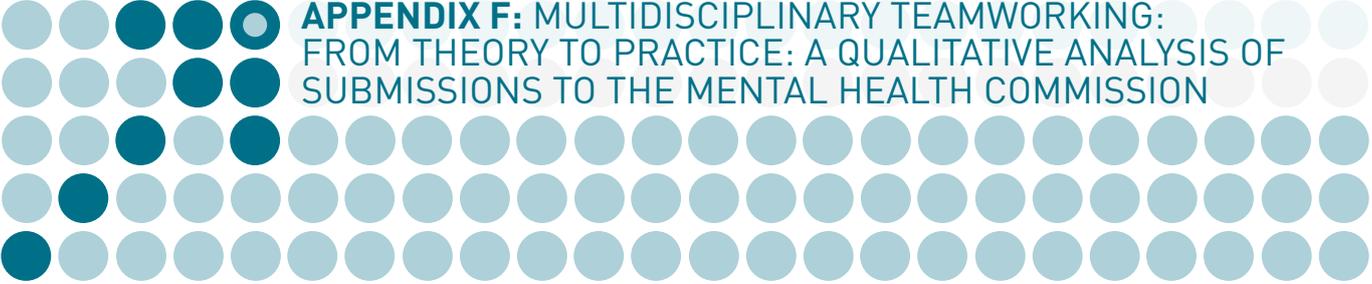
RESULTS

The following sections outline the findings of the thematic analysis. For some of the questions to be addressed, a table of frequencies highlighting the key themes will be first provided, then, a description of themes will be provided (for each question). Throughout the reporting of the results reference will be made to any particularly insightful or detailed submissions. In addition, emphasis will be placed on particular strength of feeling among any given groups that may have emerged in the analysis of the submission responses.
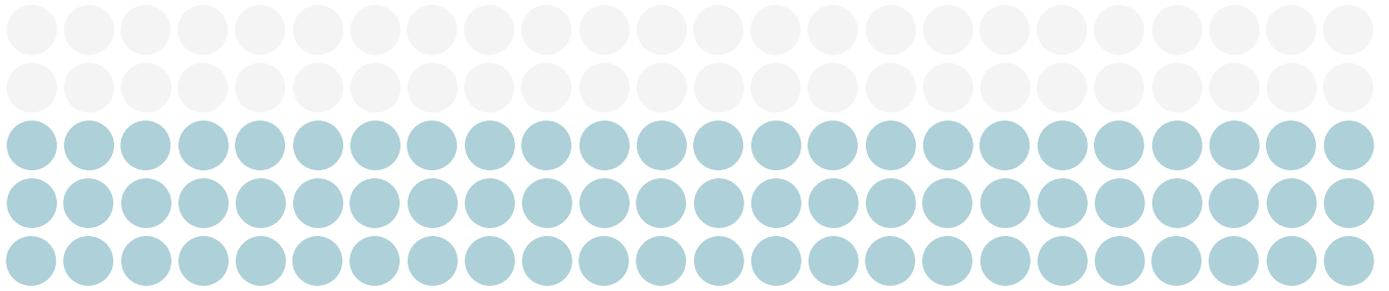
Question 1.
Given the definitions in Chapter Two, which term best describes team working in mental health services?

Respondents were asked to identify what they perceived as being the definition that most accurately described team working in mental health services. Although aspects of each definition were highlighted as being useful, the one that received the most support was the definition of a team as:

> *'a group of people with complementary skills who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable'. (p. 11)*

Noteworthy however is the observation that while the majority of respondents acknowledged that the definitions in Chapter Two were appropriate in an aspirational sense, **all respondents** agreed that MDT working, in this sense, does not currently exist in Irish mental services (*'The given definitions do not resemble anything like current practice'*). The Commission are referred to a particular submission that demonstrates a considerable strength of feeling in response to Question one.

Question 2.
In the Irish experience, what are the barriers and facilitators to MDT working?

In Question two, respondents were asked to report the barriers and facilitators, as they viewed them, to MDT working. The most dominant themes that emerged in response to this are displayed in Table 2 below.

Table 2. Frequencies of key themes in responses to Question 2 (% in parentheses). [1]

Barriers to MDT working Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Staffing issues	12 (100)	14 (67)	3 (75)	-	-	-	1 (33)	30 (61)
Training / preparation for teamworking	8 (67)	6 (29)	4 (100)	-	-	-	1 (33)	19 (39)
Understanding / knowledge of other professional roles	5 (42)	8 (38)	4 (100)	1 (25)	-	1 (100)	-	19 (39)
Dominance of medical model	7 (58)	6 (29)	2 (50)	-	1 (25)	-	2 (67)	18 (37)
'Professional balance'	5 (42)	6 (29)	4 (100)	-	-	-	-	15 (31)
Communication	5 (42)	4 (19)	1 (25)	1 (25)	-	-	1 (33)	12 (24)
Lack of resources	2 (17)	6 (29)	-	-	1 (25)	-	1 (33)	10 (20)
Leadership issues	1 (8)	5 (24)	3 (75)	-	-	-	1 (25)	9 (18)
'Professional elitism'	6 (50)	3 (14)	-	-	-	1 (100)	-	10 (20)
Mutual respect	3 (25)	4 (19)	-	1 (25)	-	1 (100)	-	9 (18)

1 These figures reflect the percentage of respondents from each professional grouping (i.e. by dividing by the total number of responses per professional grouping as profiled in Table 1) that highlighted particular themes. These have been rounded up or down to the nearest whole figure.
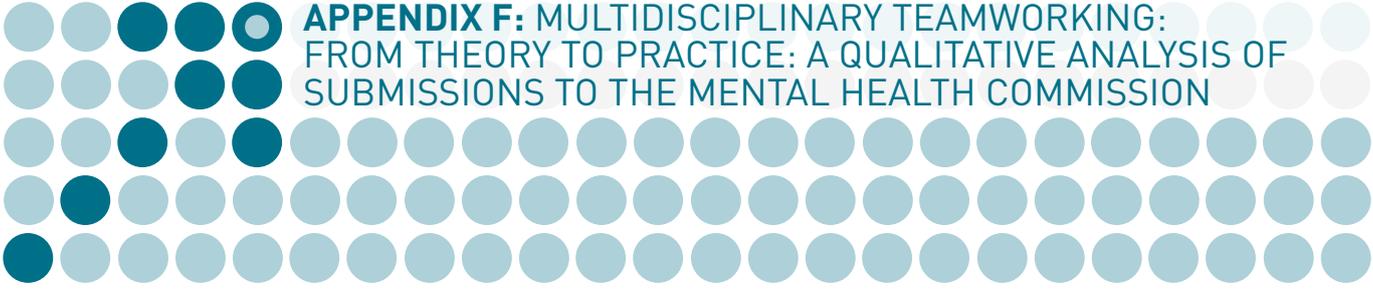
As evident from Table 3, a number of barriers to MDT working were identified by each professional grouping. The most dominant theme emerged in relation to **staffing** issues. Predominantly, **misrepresentation of certain disciplines** (primarily psychologists, social workers and occupational therapists) represented the main grievance in relation to staffing. Respondents maintained that without the funding for additional MDT posts and extra training places in these professions, the misrepresentation of these disciplines on teams will significantly hinder the development of MDTs. Also in relation to staffing, respondents identified the need for providing **career structures** for certain disciplines within MDTs. The consensus was that in the absence of senior and principal grade positions on teams, there would continue to be recruitment and staff retention difficulties.

Lack of adequate **training** of professionals for MDT working was also identified as a significant barrier. The need for teambuilding, team formation days and the provision of training in team-work specific skills in order to prepare professionals for MDT working was emphasised by the majority of respondents *('Teambuilding and preparation of professionals for working in teams is crucial..').* Respondents also highlighted the long-term difficulties associated with disciplines being trained in isolation at both undergraduate and postgraduate level with no experience of working in teams or with professionals from other disciplines. This is closely linked to the next most dominant theme, which refers to the **lack of understanding and knowledg**e between team members in relation to the nature of work carried out by other members *('A main barrier is lack of understanding and recognition of individual roles and responsibilities and the complementarity of these').*

The perceived **dominance of the medical model** in adult mental health services was frequently cited by respondents as a significant barrier to MDT working. Most respondents felt that the adoption of a **biopsychosocial model** or the **recovery model** was necessary to facilitate MDT development and functioning. Tied in with this issue of models were the themes of **'professional elitism'** and **'mutual respect'**. A significant portion of respondents felt that unequal power balances in teams, (usually in favour of the medical profession), and a lack of mutual respect for each individual member's role, contribution and opinion represented a major barrier to effective MDT working.

Finally, the issue of **'professional balance'** was a phrase coined by one respondent to describe the difficulty associated with maintaining a loyalty to one's own discipline and to their ongoing professional development within that discipline, while at the same time remaining loyal to the MDT *(' ..important to ensure that the role-blurring and generic activities of team members does not result in deskilling of the individual member's specific skills and unique perspectives arising from their discipline').* Other frequently cited barriers to effective MDT functioning included lack of **communication** between team members, lack of sufficient **resources** (time and budgetary) for team building, training and recruitment of core professionals, and inadequate leadership in teams.

Although not all emerging as dominant themes in each section, many of the barriers to MDT working identified in the first part of this question were also cited inversely as facilitators to MDT working, and vice versa. The most commonly cited facilitators to MDT working are outlined in Table 3.
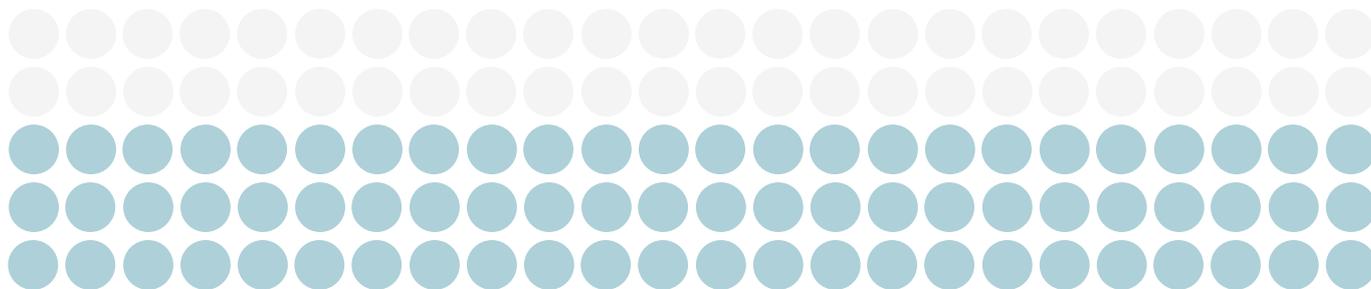
Table 3. Frequencies of key themes in responses to Question 2(b) (% in parentheses).

Facilitators to MDT working Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Training / preparation	6 (50)	9 (43)	4 (100)	-	-	-	-	19 (39)
Commitment / willingness	6 (50)	7 (33)	1 (25)	3)75)	1 (25)	-	1 (33)	19 (39)
Clarity re. roles	3 (25)	5 (24)	4 (100)	1 (25)	1 (25)	1 (100)	2 (67)	17 (35)
Communication	4 (33)	4 (19)	1 (25)	-	1 (25)	-	1 (33)	11 (23)
Physical work environment	3 (25)	4 (19)	1 (25)	-	-	-	-	8 (16)
Models (Recovery / Biopsychosocial)	3 (25)	1 (5)	1 (25)	-	-	1 (100)	-	6 (12)
Support	2 (17)	1 (5)	1 (25)	-	-	1 (100)	-	5 (10)

The themes relating to **training / preparation, communication** and **models** emerged in a similar context to the first section of Question 2 but inversely, for example, lack of training / preparation was initially identified as a barrier to MDT working whereas sufficient MDT training, teambuilding etc. was inversely described as facilitator to MDT working and similarly the same case regarding models and communication (therefore these issues will not be repeated). However, additional themes emerged as facilitators which were not referred to in the section on barriers, therefore these will be discussed briefly.

After training, the most prevalent theme reported as an important facilitator was that of **commitment / willingness**. Respondents strongly emphasised the importance of team members being willing to work together as a team and of being committed to the concept of MDT working as a model of best practice in the area of mental health care. The theme of commitment to MDT working emerged frequently in response to other questions in the survey also. Linking in with this, respondents also highlighted the potential value of including professionals in teams who have experience of working as part of successful MDT teams elsewhere as this would help to foster a sense of commitment to the philosophy of MDT working while also bringing some experience and knowledge of the concept to the team.

Physical **work environment** was also repeatedly cited as an important factor affecting MDT working. Respondents who cited this theme emphasised the importance of a shared work environment for facilitating cohesion, cooperation and communication within teams.
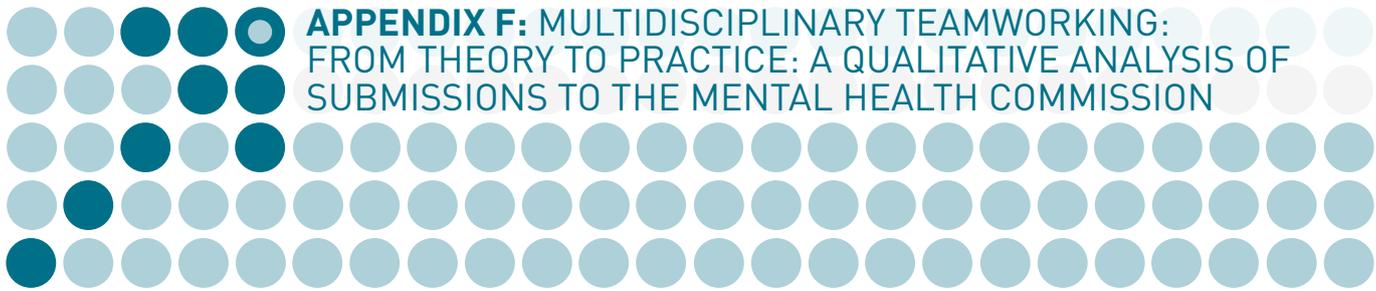
Clarity (especially in relation to roles, responsibilities, policies / standards and accountability) is a word that consistently re-emerged throughout the submissions as crucial for team functioning. In respect of this particular question, clarity regarding individual team member roles was cited as important for effective MDT working.

Finally, the issue of **support** also represents an important theme in relation to the overall responses to this discussion paper. In light of this particular question, the types of support reported as important for team functioning consisted of organisational support, **IT support, administrative support** and **peer support** from other team members. Particular attention was drawn to the importance of IT support and the availability of an integrated computerised record/file system that could be accessed by all team members. Respondents argued that such a system would greatly facilitate the efficiency and effectiveness of team working.

Question 3.
Is the concept of competencies and/or capabilities useful for describing what is required of MDT members in a mental health service?

Table 4. Frequencies of key themes for response to Question 3 (% in parentheses).	
Yes	**No**
34 (69)	-

The majority of respondents agreed that the concept of core competencies/capabilities as outlined in Chapter Four of the document was useful for describing what is required of MDT workers. It was suggested that one of the possible applications of the concept could be in relation to facilitating the **identification of training needs** of the team (*'Such frameworks relative to competency need to facilitate the identification of competency and training need, and have a supportive evidence base'*). A further application of the concept of competencies/capabilities was identified in relation to **recruitment**. Respondents proposed that the concept could facilitate the design of specific **job descriptions** for MDT positions and in line with this could also aid the process of identifying and recruiting **suitable candidates** for MDT working.

In light of the above, it is notable also however that a significant portion of respondents emphasised the importance of **ongoing training** and **continuing professional development** to maintain a high competency level within the team. Furthermore, respondents highlighted the need for emphasising competencies/capabilities specific to **teamworking**, for example, effective interpersonal and communication skills, and in line with this suggested the importance of the provision of specific MDT training for team members. A smaller number of respondents also highlighted the need for team workers to have adequate **assessment** skills as they viewed this as a key function of the MDT.

Question 4.
What are the skills, knowledge and attitudes required to work in MDTs? Does the list in Chapter Four capture everything that is required?

Table 5. Frequencies of key themes for response to Question 4 (% in parentheses).	
Yes	**No**
28 (57)	7 (14)
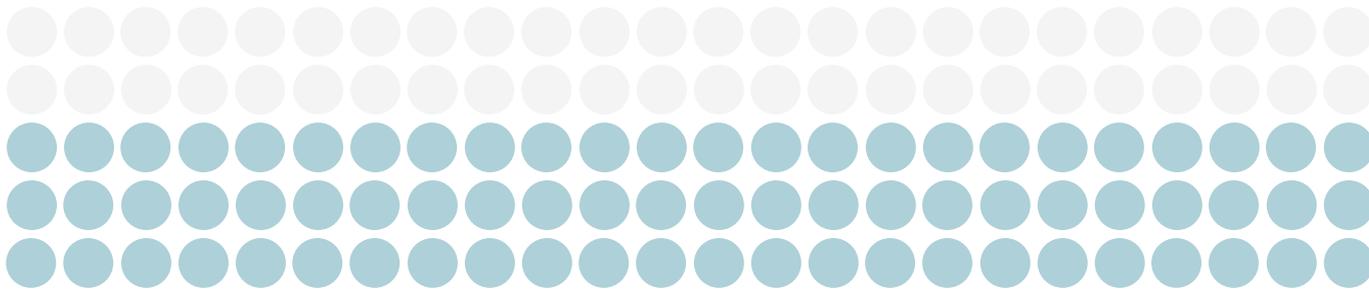
While the majority of respondents agreed that the list in Chapter Four provided a comprehensive collection of the skills and values required for MDT working, a significant portion of these respondents stressed the need for **ongoing training, teambuilding exercises, specific training in MDT working** and **supervision** as crucial to ensuring and maintaining an adequately skilled team.

As in Question 3 above, a significant portion of respondents highlighted the need to particularly emphasise the importance of **team-working skills, interpersonal skills, assessment skills** and **individual professional expertise** in for each team member.

In relation to the minority of respondents who disagreed that the list in Chapter Four captured everything that is required, one specific observation is noted. This respondent acknowledged that it was unnecessary and unlikely that all members of a team would share exactly the same skills, and that the key factor was not that each individual team member possessed all of the listed skills, but that the appropriate '**skill mix**' was present in each MDT. That is, there would be some generic skills relating to each team member (e.g. teamworking skills) but that each team member would have their own specific skills and their role in each individual case would be based on the individual needs of the client.

Question 5.
Who should be on a MDT team in an adult mental health service?

The general consensus from the respondents was that, as outlined in Section 5.1 of the discussion document, that the core skills of **nursing, medicine, social work, psychology** and **occupational therapy** should be represented in a MTD. All of the respondents agreed however that the team and the service user should have access to a broader range of more **specialist services** as needs dictate. A significant number of respondents also identified the inclusion of **full-time administration** and **support staff** as crucial to the MDT.

Some specific issues that relate to Question 5 are emphasised here as they are issues that were referred to frequently throughout the responses to other questions from the discussion document. The need for providing a career structure for each discipline within each MDT is referred to frequently throughout the individual submissions. As the references to this issues occurred across several questions, it did not emerge as one dominant theme for any specific question, however, its repetition and the strength of emphasis placed on the issue each time it was raised is noteworthy. Lack of a **career structure** for individual disciplines was frequently cited as a primary cause of **recruitment difficulties, high staff turnover** and **instability within teams**. Respondents highlighted the need to include senior grades, basic grades and even students / trainees in MDT's and stressed the need to provide full-time permanent contracts rather than relying on temporary/part-time posts which lead to frequent staff turnover (*'Ideally there should be different grades of all professions within each discipline'*).

A particular individual response to the above question also highlighted the role of services outside mental health services in facilitating adult mental health, for example, vocational training agencies, employment support agencies etc.

Question 6.
Taking into account the answer to Question 5, what is an appropriate caseload for a MDT in an adult mental health service?

Responses to this question were too diverse to identify a set of dominant themes. Some respondents did offer estimates of what should represent an appropriate caseload but these estimates varied hugely among these respondents. Many respondents also reported that this question was too difficult to answer as there were many variables to be considered when deciding appropriate caseloads, for example, nature of team, support available to team, availability of specialist services, demographics, catchment area size, client need etc.

Frequently suggested however was the concept of a case weighting system and a case prioritising system. Bearing in mind individual variation in the nature of cases and variation in the level of input from each team member/discipline into each individual case, a **case prioritising / case weighting system** was suggested as a method of assessing an appropriate caseload for each individual team member and for the MDT itself. The Commission's attention is drawn to a specific submission for an example of how such a system might work.[2] Adequate **supervision** was also highlighted as important to ensure appropriate caseloads. One respondent stressed the importance of defining a **maximum caseload** for each individual to prevent one team member being overburdened.

Question 7.
Is the model outlined in Chapter Five a useful model to describe the links that are needed between MDTs and other services?

Table 6. Frequencies of key themes for response to Question 7 (% in parentheses).	
Yes	**No**
25 (51)	3 (6)

It is notable that the interaction/ liaison of the MDT with other parts of the service and other teams in the service network was frequently highlighted across submissions as an important aspect of the MDT functioning. As evident from Table 7, over half of the respondents agreed that the model presented in Chapter 5 was adequate for describing the links that are needed between Multidisciplinary teams and other services. The most commonly cited advantage of the model was the position of the **service users and carers/ family at the centre.**

Although only a very small portion of respondents felt that the model was not useful (See Table 7), there was a significant group of respondents who felt the model *could* be useful but that it needed to be expanded further. Emerging from this trail of thought, the dominant theme was that the model needed to be more **dynamic** in that it should place further emphasis on the **interactive nature** of the various levels surrounding the service user and also, on the **active role** that the service user plays in the mental health system and in their own care (*'..it is important that services involvement can be described in such a way that demonstrates the fluid, flexible and dynamic relationship between service users and services over time'*).

Question 8: What is the best way to ensure that service users are involved in their care planning process?

Firstly, it is noted that there was an overwhelming level of support across all respondents for the involvement of service users in their care planning service (*'The increasing involvement of service users at all levels of service provisions is strongly supported and welcomed'*). In relation to the specific question, three main themes emerged across all groups:
• Education/ Information
• Drawing up of a care plan
• Ongoing collaboration/ partnership

The majority of respondents felt that service users (and their carers/ families is appropriate) should be **educated and informed** regarding the services available to them and regarding the role they were invited to play in the planning of their care. Respondents also suggested that service users be directly involved with the MDT (or their appointed keyworker/ caseworker) in the development of their care plan and in the regular review of this care plan. Overall, the

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2   Programme Co-ordinator from a specific service.
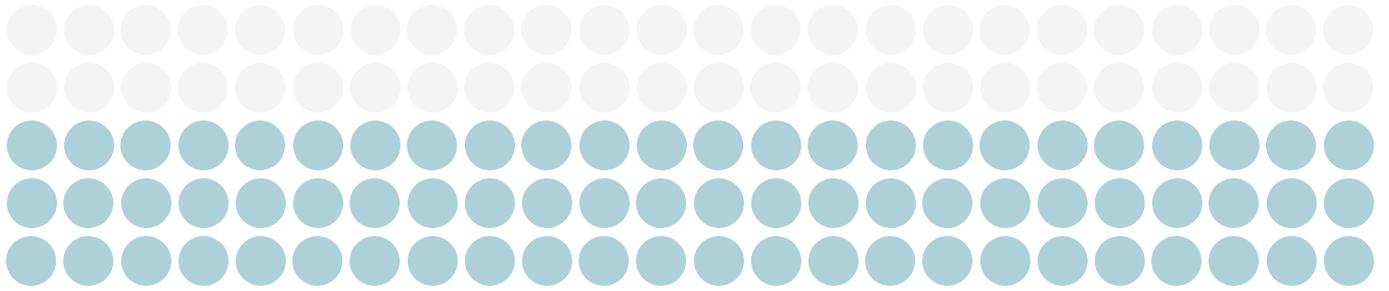
existence of ongoing collaboration between the MDT and the service user/ family was advocated by the majority of respondents (*'Service user involvement is essential as it is they who possess the key to their own recovery'*).

Additional suggestions were made in relation to the need to put the onus on the service to involve service users in their care planning, and the development of **policy** in line with this. Furthermore, a small number of respondents suggested that ensuring service user involvement required a change in the **culture** or **philosophy** of services to one where service user involvement was central to the care planning process.

Question 9.
What is the role of trained / expert service users in mental health services?

Similar to Question 8, it is noted that there was overriding support for the role of trained / expert service users in mental health services. There was however, considerable variation among respondents as to what the specific role of trained/expert service users should be. It was observed that some of the roles outlined in Section 5.3 of the discussion document were re-echoed by respondents, for example;
- Service monitoring and evaluation.
- Staff training and induction.
- Acting as advocates for individual service users.
- Contributing to development of the team's operational policy.

Overall, respondents acknowledged that there is a role for trained service users at multiple levels of the service, although a small number of respondents cautioned against involving trained/expert users in individual cases (outside of advocacy and support). A small number of respondents who reported having experience of working in health services where trained/expert service users played a major role reported it to have been effective.

Question 10.
What is an appropriate management structure for mental health professionals, especially where there is a scarcity of such professionals? Account should be taken of the need for management and supervision within teams.

Analysis of the responses to Question 10 revealed considerable diversity in relation to what would be an appropriate management structure for mental health professionals. A thematic analysis did however identify three recurring themes from this set of responses (see Table 7).

Table 7. Frequencies of key themes in responses to Question 10 (% in parentheses).								
Key themes	**HSE / Ind Ind**	**HSE / Ind Gr**	**Prof Body**	**Res / Acad**	**Volun / Advo**	**Specialist**	**Other**	**Total**
Shared management structure	2 (17)	3 (14)	-	-	-	-	1 (33)	6 (12)
Professional representation	2 (17)	3 (14)	-	-	-	-	1 (33)	6 (12)
Distinction between clinical and operational management	2 (17)	2 (10)	-	-	1 (25)	-	1 (33)	6 (12)

The **shared management structure** as outlined in the discussion document did emerge as the most dominant model put forward by the respondents. However, it is noted that this figure represents only a small percentage of the respondents and a variety of other models were proposed (e.g. a tripartite structure, the current social work structure, the model outlined in the Vision for Change document etc). Issues identified as important for an appropriate management structure however were identified. A number of respondents felt that each profession / discipline should have **some representation** at management level, or at least one psychosocial representative.

In addition, similar number of respondents highlighted a preference for distinguishing between **professional / clinical management** and **operational management** in a mental health management structure. Also mentioned were the importance of management **training** and the presence of **senior grades** of all disciplines on the MDT.

Question 11.
Which model of MDT working is most appropriate to the provision of adult mental health services in an Irish context?

As evident from Table 8, the majority of respondents favoured the keyworker model over the case management model. It is noted however that many of the respondents did not select either of the above (or any) models as appropriate for Irish adult mental health services. Several respondents highlighted the importance of choosing a model that is most appropriate for the specific team while an individual respondent emphasised the **need to train / educate staff** in the particular model in use by the team.

Table 8. Frequencies of key themes in responses to Question 11 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Keyworker	6 (50)	4 (19)	1 (25)	1 (25)	-	-	1 (33)	13 (27)
Care / Case management	2 (17)	1 (5)	-	1 (25)	1 (25)	1 (100)	-	6 (12)
Other	2 (17)	-	-	-	-	-	-	2 (4)

Question 12.
What is the most appropriate referral pathway for effective MDT working?

The specific nature of this question and the consequent diverse nature of the responses meant it was difficult to identify any dominant themes in the analysis therefore a narrative discussion of themes will be given instead.

Several pathways for referral were suggested throughout the responses. The main incongruities observed were mostly in relation to the **initial point of referral** and to who should be involved, and also in relation to the **initial assessment** and who should carry it out. From an analysis of the responses, two *general* pathways can be identified; one where the initial referral is dealt with by an appointed person, (e.g. team co-ordinator, duty
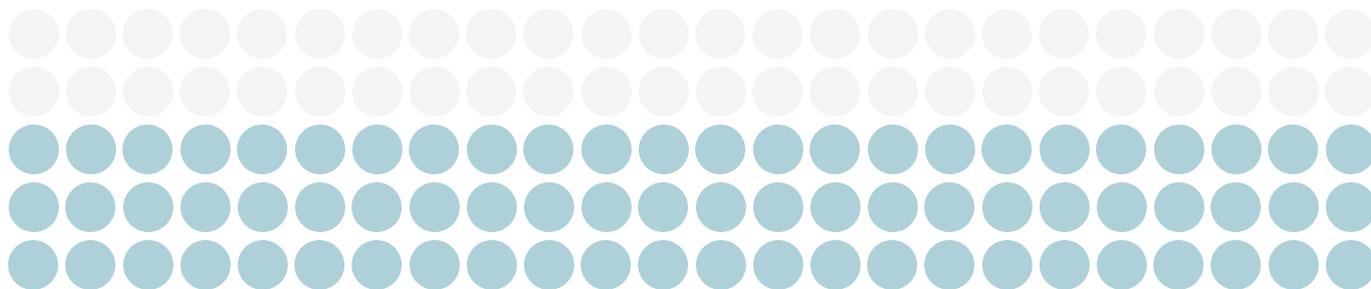
person, keyworker, case manager, etc.) and then appropriate keyworker allocated or two, where the initial referral is fully screened by the MDT (or at least a sub-committee of the MDT) at a team meeting, and then allocated for assessment and keyworker by the team. In relation to assessment there is a general theme pervading the responses that the person carrying out the assessment should be the most appropriate team member to do so and that all referrals should not be assessed by the same person (i.e. the consultant) as they may not be the most appropriate person to do so in each case (*'All members of the multidisciplinary team should be equipped and trained in the area of initial intake and assessment. This document should not over-rely on the need for a full medical assessment except where acute illness is evident'*). Following initial referral and assessment most pathways suggested involve allocation of most appropriate caseworker/keyworker, team input into the care plan and regular team reviews of progress and care plan. The Commission's attention is drawn to one particular submission, which highlights the importance of assessment and diagnosis and suggests that once initial assessment / diagnosis is made (by the most appropriate person) the service user should immediately be referred onto the most appropriate specialist services.

Question 13.
From your experience, what is required for effective MDT working?

There was considerable overlap with responses to this question, and responses to Question 2. Also many of the components identified as requirements for effective MDT working in response to this question emerged inversely as challenges MDT team formation in the next question (Question 14). Bearing this in mind the key themes emerging in response to this question (Question 13) are displayed in Table 9 below.

Table 9. Frequencies of key themes in responses to Question 13 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Common vision	5 (42)	6 (29)	4 (100)	1 (25)	2 (50)	1 (100)	1 (33)	20 (41)
Effective leadership and management	4 (33)	6 (29)	3 (75)	2 (50)	1 (25)	1 (100)	2 (67)	19 (39)
Clarity re. roles	4 (33)	5 (24)	3 (75)	1 (25)	-	1 (100)	-	14 (29)
Training	6 (50)	5 (25)	1 (25)	1 (25)	-	-	-	13 (27)
Client-focused service	4 (33)	6 (29)	1 (25)	-	1 (25)	-	-	12 (24)
Resources	2 (17)	7 (33)	2 (50)	-	-	-	-	11 (22)

The most prevalent theme emerging following analysis of the responses to this question was that of a **common vision** among team members. Respondents stated that having a common vision, which each team member was committed to would help overcome some of the barriers reported earlier in Question 2, for example, lack of mutual respect between disciplines. This also overlaps with the theme of **commitment / willingness** discussed in Question 2. The theme 'client focused' (see Table 9) is also closely linked to that of a common vision as for many respondents the common vision or focus of the service should be in relation to the service user's best interests. Although this is the only section where the client-focused theme has emerged as one of the most dominant, it is a theme that is frequently referred to across many questions and respondents. A significant number of respondents who highlighted the importance of a **client-focused, needs-based** service, also reported that where this exists it would help remove many of the barriers outlined in Question 2. That is, if the focus of all team members is on the client's best interests, the barriers relating to professional self-interest will be eradicated (e.g. professional elitism, choice of models, interventions, etc.).

The additional themes displayed in Table 9, overlap considerably with this already discussed in Question 2, for example **training, effective leadership / management**, availability of and access to necessary **resources** and **clarity** regarding individual team roles. The re-emergence of these themes in light of this question draws attention to the **strength of feeling** among the respondents in relation to the relevance of these issues for effective team working.
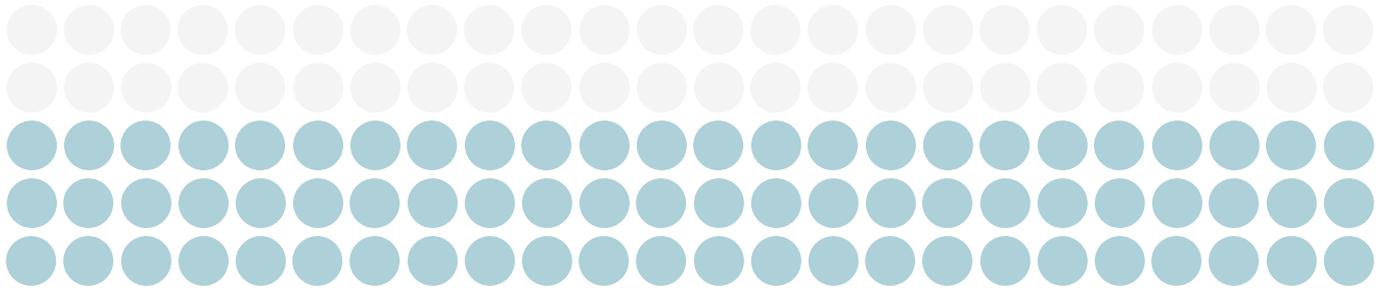
Question 14.
What are the key challenges in team formation and how should this process be facilitated?

Again there was considerable overlap in relation to the responses to this question and those to questions 2 and 13. Re-emerging as key challenges to team formation were the availability of and access to necessary **resources** (time, money, professionals, specialist services, IT system etc). The staffing issues referred to in Question 2 were also re-emphasised with misrepresentation of certain disciplines (usually psycho-social) on MDTs being reinforced as well as the need for establishing career structures for individual disciplines on MDTs. Training and preparation for teamwork were also highlighted again, with particular emphasis being placed on the need to partake in teambuilding, team planning and the fostering of a '**team ethos**' to facilitate team formation.

Table 10. Frequencies of key themes in responses to Question 14 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Resources	1 (8)	8 (38)	2 (50)	-	-	1 (100)	-	12 (24)
Staffing issues	3 (25)	7 (33)	-	-	-	-	-	10 (20)
Training	3 (25)	4 (19)	1 (25)	-	-	-	-	8 (16)

Question 15.
(a) How can we ensure that there is effective leadership in teams?
(b) What is an appropriate leadership model for MDTs?

Question 16.
There was no Question 16 in the discussion document.

Question 17.
What is the most appropriate and effective model for MDT management?

There was an extreme overlap in relation to the responses between Questions 15 and 17. The majority of respondents did not seem to distinguish the issues relating to management versus leadership of teams with many providing similar responses to both or simple using 'refer to Question 15' when answering Question 17. Due to this overlap in themes, the responses to both questions will be discussed together.

In response to both questions, a significant number of respondents stated that the role of leader / manager should be based on **suitability** for the role and possession of specific management / leadership **skills** and **competencies** ('..need to avoid an inequitable situation where other roles on the team are competency based while the team leader role is based on privilege of profession without due regard to the competencies required'). This theme of suitability for a specific role recurs frequently across questions and respondents. In addition to suitability, a large portion of respondents stated that people in management or leadership roles should be **adequately trained** in the skills required for these roles.

Table 11. Frequencies of key themes in responses to Question 17 (% in parentheses).								
Key themes	**HSE / Ind Ind**	**HSE / Ind Gr**	**Prof Body**	**Res / Acad**	**Volun / Advo**	**Specialist**	**Other**	**Total**
Competency / suitability based	8 (67)	8 (38)	2 (50)	1 (25)	-	1 (100)	1 (33)	21 (43)
Training	4 (33)	6 (29)	2 (50)	-	-	-	1 (33)	13 (27)
Consultation with team	5 (42)	3 (14)	1 (25)	-	-	-	-	9 (18)
Separation of operational vs. clinical / professional / leadership / management	2 (17)	2 (10)	1 (25)	1 (25)	-	-	1 (33)	7 (14)
One clearly identified team leader	1 (8)	2 (10)	1 (25)	1 (25)	-	-	-	5 (10)
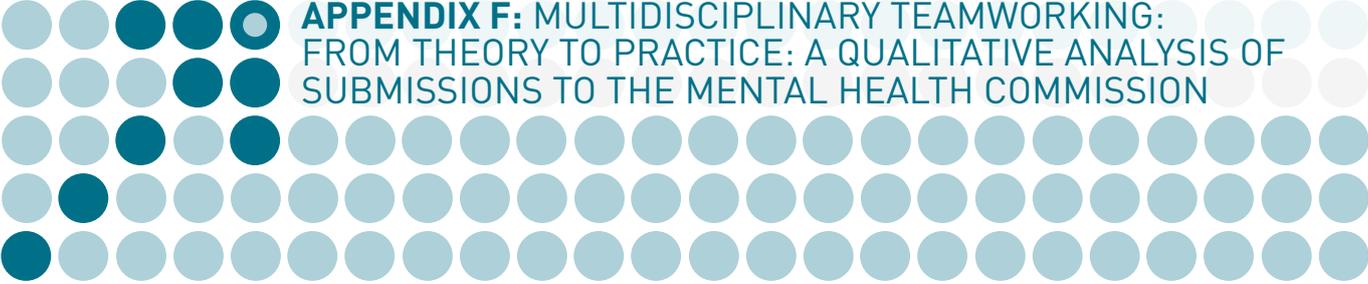
In relation to leadership/management structures/models, a considerable number of respondents reported that there should be a **distinction between operational management** and **clinical leadership**. This is a theme that also emerged in Question 10.

Although there was disparity in relation to the issue, a significant portion of respondents advocated having a **clearly identified leader** within teams. Where this was mentioned however, the majority challenged the role of the consultant psychiatrist as leader and stated that there should be no *'professional veto'* in relation to the role, and that is should be open to all disciplines and based on suitability and competency for the role *('Any of the professions could be a team leader if they have the confidence, knowledge and strength to take decisions and allocate cases').*

In relation to a model of leadership / management, it was highlighted by a smaller number of respondents that there should be **transparency** in relation to leadership and management structures. Reference was also made by two respondents to the Vision for Change document, Chapter 9 in response to this question.
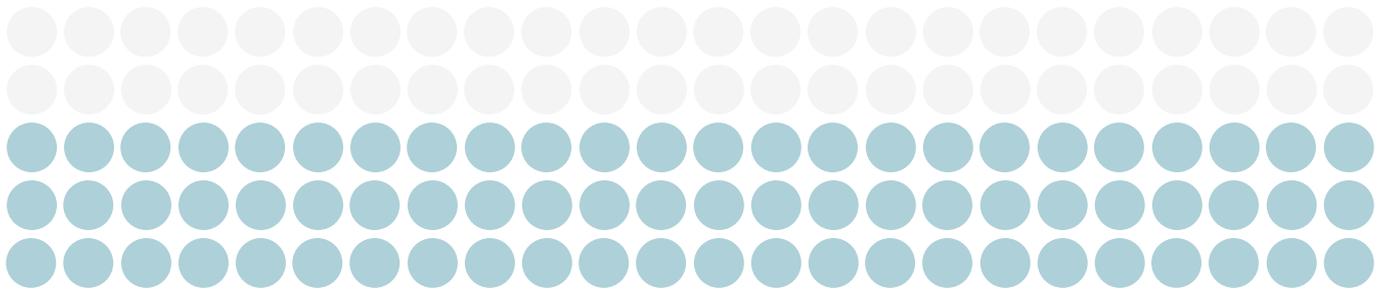
Question 18.
How should ongoing training be facilitated and provided?

The diversity of responses to this question of how training should be facilitated / provided meant it was too difficult to identify a set of major common themes. Respondents varied most in response to *how* they felt training could be provided but a number of themes did emerge in relation to the *type* of training that should be provided. For example, almost all respondents who answered this question felt there should be training at a **discipline-specific level** and also at a **team-level**, depending on need. One particular response will be highlighted as it represents the best summary of the various issues identified by all respondents. The respondent in question proposed three categories of training need (not in any particular order of importance) as follows:

1. Professional/discipline specific needs
2. Team needs
3. Service user needs.

These three needs provide a good framework for identifying overall training needs. For example, each team member will need ongoing **discipline-specific** training on both a personal level (to keep abreast of changes in their own profession and for CPD), and at a team level so that they can continue to make their unique contribution to the team. To function as a team, many respondents felt that there were sets of *'shared skills'* that should be common among all team members and for which training at a team level should be provided (interpersonal skills, group facilitation training, communication skills etc). Additionally, also in line with 'team need' some team members may need training in **management and / or leadership skills**, on a personal level to ensure competency in their respective roles, but also in respect of overall team functioning through the provision of competent leadership and management. Finally both 1 and 2 are strongly linked to service user needs as team composition will ultimately be based on the needs of its service users. In addition, some members of the team may need to undertake **specialist training**, also dictated by the particular needs of its service users.

On a general level, the majority of respondents felt that training should be **ongoing** and that a *'culture of learning'* should be fostered within the team. Additionally, there was strong advocacy among respondents for the provision of MDT level training at **undergraduate** and **postgraduate** level. The Commission is referred to a particular submission that provides particularly insightful and detailed response to Question 18.

Question 19.
How should conflict be managed on MDTs?

Following a thematic analysis of the responses to this question, a number of key themes emerged (see Table 12). A significant number of respondents reported that the **team leader** should be trained in the necessary conflict resolution skills to facilitate resolution of difficulties within the team. As suggested by the table, respondents also reported a need to have specific **team policies** or codes of practice in place to deal with conflict *('Clear policies should be made on the pathways needed for conflict resolution by each multidisciplinary team')*. A prevalent theme in relation to this question was that of **communication**. This theme was referred to both as a means of preventing conflict, (through voicing concerns from the outset) and in the resolution of conflict, (by talking out the issue). Another preventative measure identified was that of ensuring **clarity** of team member's individual roles and responsibilities. While most respondents stated that the conflict should be resolved within the team, most also reported that there should be access to an **outside facilitator** should the need arise. One respondent pointed out the importance of attending to the causes of any conflict to make sure that issues didn't continue to resurface.

Table 12. Frequencies of key themes in responses to Question 19 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Team policy / standards / codes of practice	2 (17)	4 (19)	3 (75)	1 (25)	1 (25)	-	-	11 (22)
Leadership intervention	2 (17)	1 (5)	2 (50)	1 (25)	1 (25)	-	1 (33)	8 (16)
Communication (preventative and reconciliatory)	1 (8)	5 (24)	2 (50)	-	-	-	-	8 (16)
Prevention - clarity re. roles / responsibilities	1 (8)	5 (24)	2 (50)	-	-	-	-	8 (16)

Question 20.
What is the most effective model to provide both discipline-specific supervision and supervision by team members?

The responses to this question were too sporadic and, partly due to the nature of the question, too specific to compile a table of key themes. Most respondents did not propose an actual model of supervision but rather gave specific suggestions as to how discipline-specific supervision and supervision by team members could be provided to team members. The most frequent or helpful of these suggestions are listed as follows:

• There should be a distinction between clinical, managerial and MDT / peer supervision.
• Discipline specific supervision should be defined by each individual discipline's own professional code.
• Clear line management structure should exist.

- Peer supervision could take place at regular team meetings.
- There should be some responsibility placed on the individual to seek / receive supervision.
- Clarity should exist regarding accountability.

Several respondents put forward that there should be a **supervision policy** in place, which has been agreed upon by the team.

Question 21.
(a) What is a useful definition of clinical accountability?
(b) What is the most effective way of ensuring clinical accountability in MDTs?

(a) Due to the specific nature of this question, it was not feasible to conduct a frequency analysis of themes, instead a narrative of themes will be provided. The Commission's attention is drawn to a specific submission for a definition of clinical accountability.

The largest portion of respondents to this question stated that each professional should be personally responsible and professionally accountable for their own practice in line with each individual's own professional code of practice.

A strong theme emerged however in relation to the issue of ultimate accountability. On this issue respondents disagreed as to whether there should be **collective** or **individual accountability** for the team. While certain individual respondents stated that one person should not be held ultimately accountable for the entire team, a slightly larger number reported that ultimate accountability should lie with the consultant psychiatrist. The Commission's attention is drawn to a specific submission where a reference is provided in relation to this question.

(b) Due to the more general nature of this part of the question, it was possible to identify a set of key themes and their relative frequencies (see Table 13).

Table 13. Frequencies of key themes in responses to Question 21 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Policy / codes of practice	5 (42)	2 (10)	1 (25)	1 (25)	-	1 (100)	-	10 (20)
Supervision	3 (25)	1 (5)	-	-	1 (25)	-	-	5 (10)
Record keeping	2 (17)	2 (10)	-	-	-	-	-	4 (8)
Audits	3 (25)	1 (5)	-	-	-	-	-	4 (8)
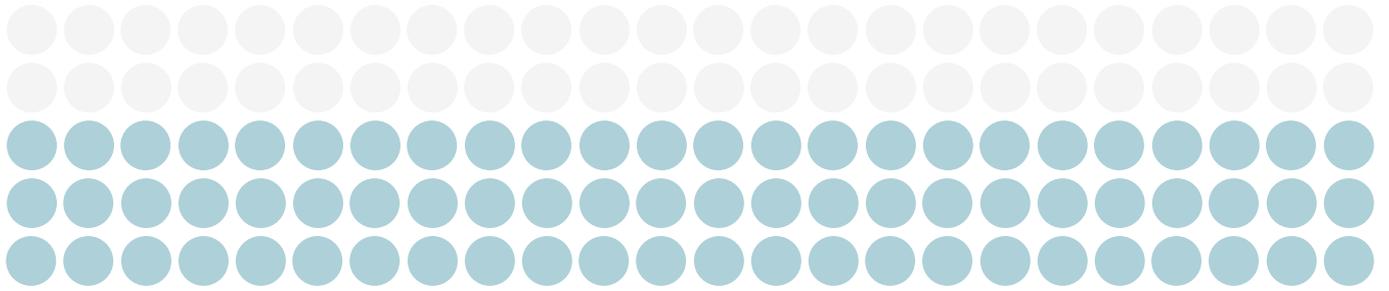
As evident from the table, the majority of respondents to this question stated that the development of **organisational / team policies** in relation to clinical accountability were an effective step towards ensuring clinical accountability in teams. Appropriate **clinical supervision**, insistence on individual **record keeping** and regular **audits** were also suggested as ways to ensure clinical accountability.

Question 22.
(a) How should confidentiality be dealt with in a team situation?
(b) How should this be explained to service users?

(a) Following a thematic analysis of the responses to this part of the question, it was identified that the majority of respondents to the question stated that information relating to an individual service user was **confidential *to the team***. That is that each member of the team has full access to all information/records/documentation relating to the service user, that team members may discuss this information with other members of the team or consult them as necessary but that information is confidential to the team. There was one individual respondent who advocated a 'needs to know' approach where information was shared purely on a need to know basis. However, other respondents stated that, to achieve a 'seamless service', all staff should have access to information relevant to the service user (*'It is essential that confidentiality does not work against effective multidisciplinary intervention to clients'*).

Table 14. Frequencies of key themes in responses to Question 22 (a) (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
Confidential to MDT	4 (33)	5 (25)	3 (75)	1 (25)	-	-	-	13 (27)
Policy / standards / codes of practice	3 (25)	4 (19)	4 (100)	1 (25)	-	-	-	12 (24)
Agree by team	1 (8)	1 (5)	2 (50)	1 (25)	-	-	-	5 (10)

As displayed in Table 14, a large number of respondents stated that confidentiality should be dealt with through **organisational / team policy**, while a smaller number of respondents specified that these policies should be **agreed upon by the team**.

Question 23.
(a) What are the essential policies for a MDT?
(b) How might these be drawn up?

(a) While a certain number of respondents refrained from answering this question, a number of respondents provided very detailed responses and despite some variations in use of terminology, there was some

considerable overlap in the recommendations made. A list of the main areas suggested for policy development are listed as follows:

- Mission statement
- Referral procedures
- Assessment protocol
- Intervention
- Review criteria
- Discharge criteria
- Keyworking
- Care planning
- Confidentiality
- Supervision
- Accountability
- Operational issues
- Record keeping
- Inter-agency working
- Health and safety

The general theme emerging from respondents was that all areas of the service should be operationalised in policy. The Commission's attention is directed to an individual submission, which provides a particularly detailed description of the essential policy areas for mental health services.

(b) In relation to how policies might be drawn up, as evident from Table 15, the majority of respondents stated that policies should be **drawn up by** and **agreed upon by the team**. A smaller number of respondents highlighted the importance of referring to **national policy** and **standards of best practice** when drawing up these policies. Another cohort of respondents advocated for the establishment of a sub-committee of the MDT for the purpose of drawing up team policies and standards.

Table 15. Frequencies of key themes in responses to Question 23 (% in parentheses).

Key themes	HSE / Ind Ind	HSE / Ind Gr	Prof Body	Res / Acad	Volun / Advo	Specialist	Other	Total
By team	3 (25)	5 (24)	3 (75)	1 (25)	-	-	-	12 (25)
Reference to national policy	3 (25)	1 (24)	-	-	-	-	-	4 (8)
Reference to best practice	1 (8)	1 (5)	1 (25)	-	-	-	-	3 (6)
Establishment of committee	2 (17)	1 (5)	-	-	-	-	-	3 (6)
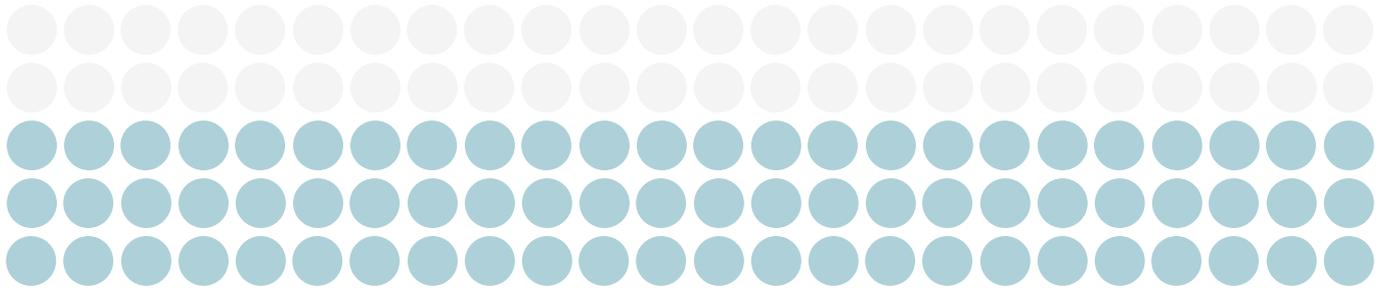
ADDITIONAL ISSUES

Only one additional issue was identified throughout the responses to the discussion document. The issue in question highlighted the need to address **language and cultural issues** in relation to service users in order to ensure accessibility to mental health services. This issue was also raised in relation to people with specific **communication difficulties**, for example, hearing impairments. The Commission is referred to an individual submission for more detailed consideration of linguistic and cultural issues and issues pertaining to refugees / immigrants.
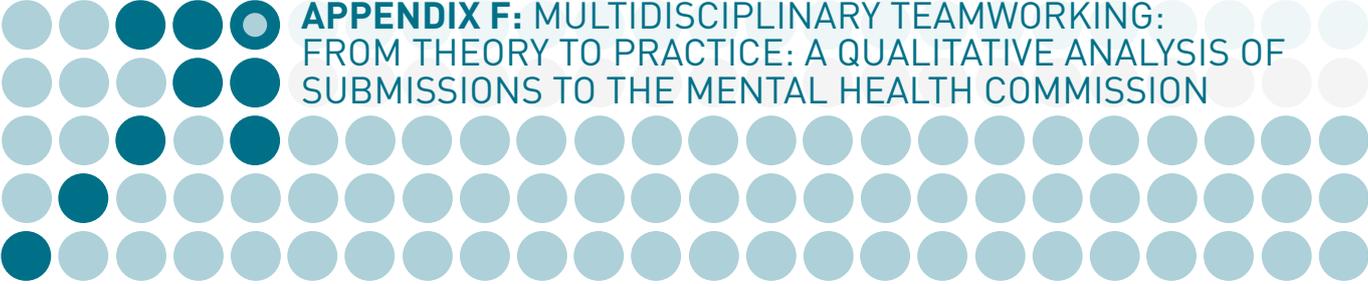
MAJOR CRITICISMS / SUGGESTIONS

Several criticisms and suggestions were identified throughout the responses to the discussion document. These are listed as follows with reference to particularly insightful suggestions / criticisms / comments highlighted where appropriate.
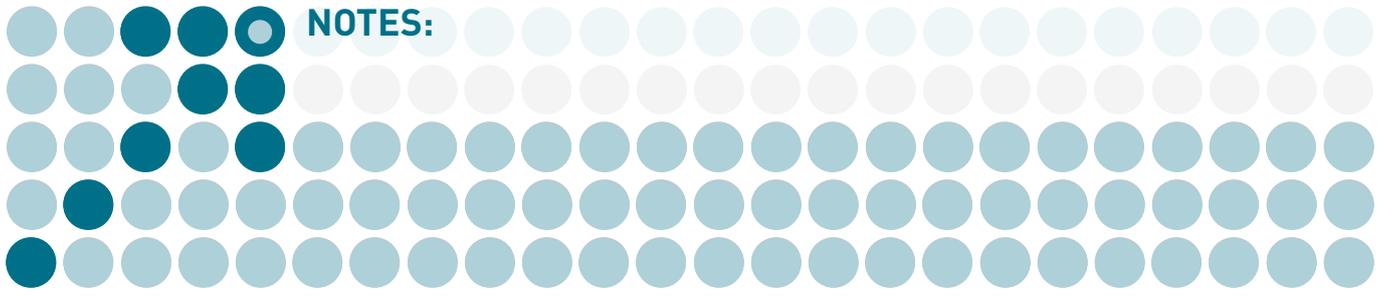
- Authorship of Mental Health Commission discussion paper 'Multidisciplinary Team Working: from Theory to Practice': two respondents asked that the authors of the discussion paper be named and the membership / selection criteria of the Mental Health Commission's five committees be made explicit *'to ensure transparency and broad representation especially considering the potential impact of decisions'.*

- The proposed management structure of MDT as outlined in Model 1 – allows no clear role for psychosocial professionals to be represented.

- Document vague on operational / planning and implementation issues. Implementation of change and *'change management'* needs to be considered if the document is to have any application.

- No reference to 'Vision for Change' document.

- One major criticism levelled at the discussion paper is its failure to suggest improvements for mental health services, especially in the shorter-term. The Commission are referred to an individual submission for further elaboration on this issue as well as a detailed and insightful critique of the discussion document.

- The Commission are referred to a specific submission providing an insightful critique of the concept of MDT working.

- The Commission are referred to a specific submission demonstrating particularly strong feeling in opposition to the concept of MDT working in adult mental health services.

- The Commission's attention is drawn to two particularly insightful commentaries relating to the discussions document. The authors of one of these commentaries also included some publications that may help to inform the final version of the document.

- The Commission are referred to an individual submission to the 2006 discussion paper that was published in the Irish Psychologist (see reference section below).

- The Commission's attention is drawn two specific documents included in the submissions, one entitled 'CMHT Effectiveness' and the other a document describing a 'Workload Weighting System'. The latter was identified by the respondent as key to the effectiveness of particular CMHTs under consideration.

- Finally, the Commission are referred to submissions that included a team template describing the function / operation of particular mental health teams.
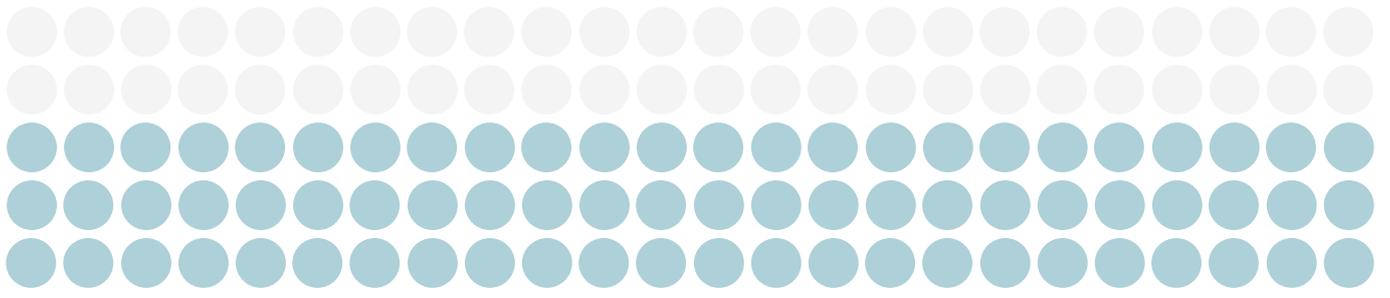
It is noted in light of the above criticisms / suggestions that the overall consensus was that the Mental Health Commission discussion paper 'Multidisciplinary Team working: from Theory to Practice' was a well-researched, impressive document and was welcomed by a significant majority of the respondents.
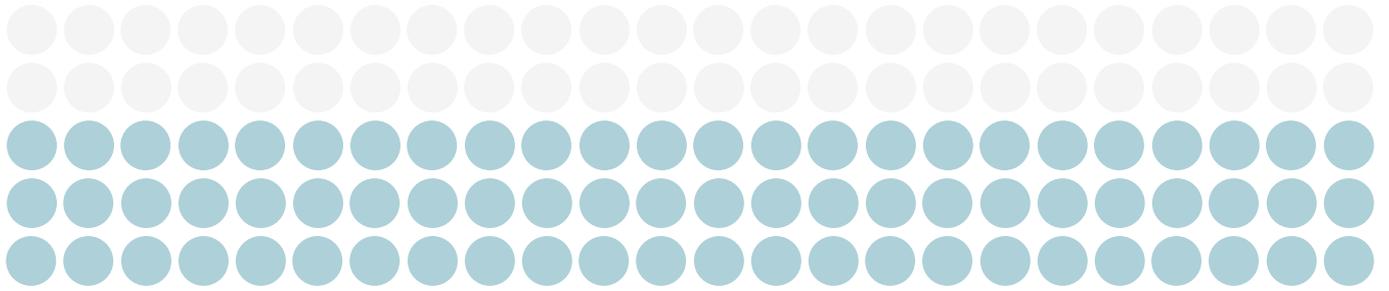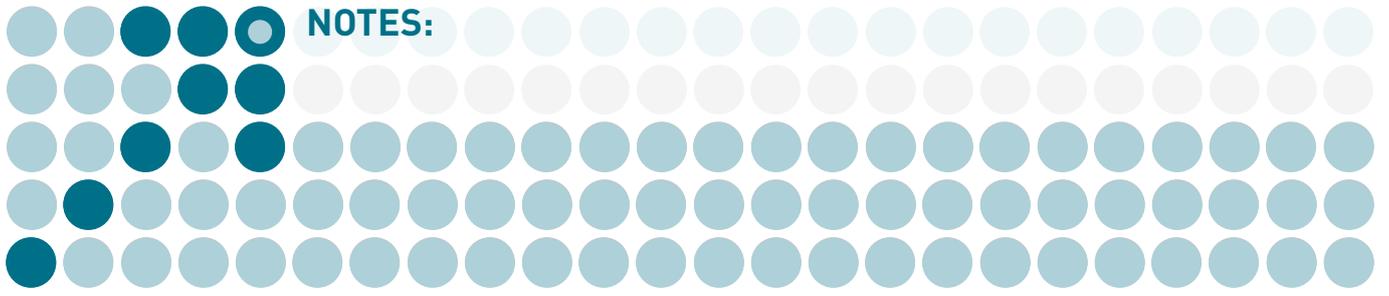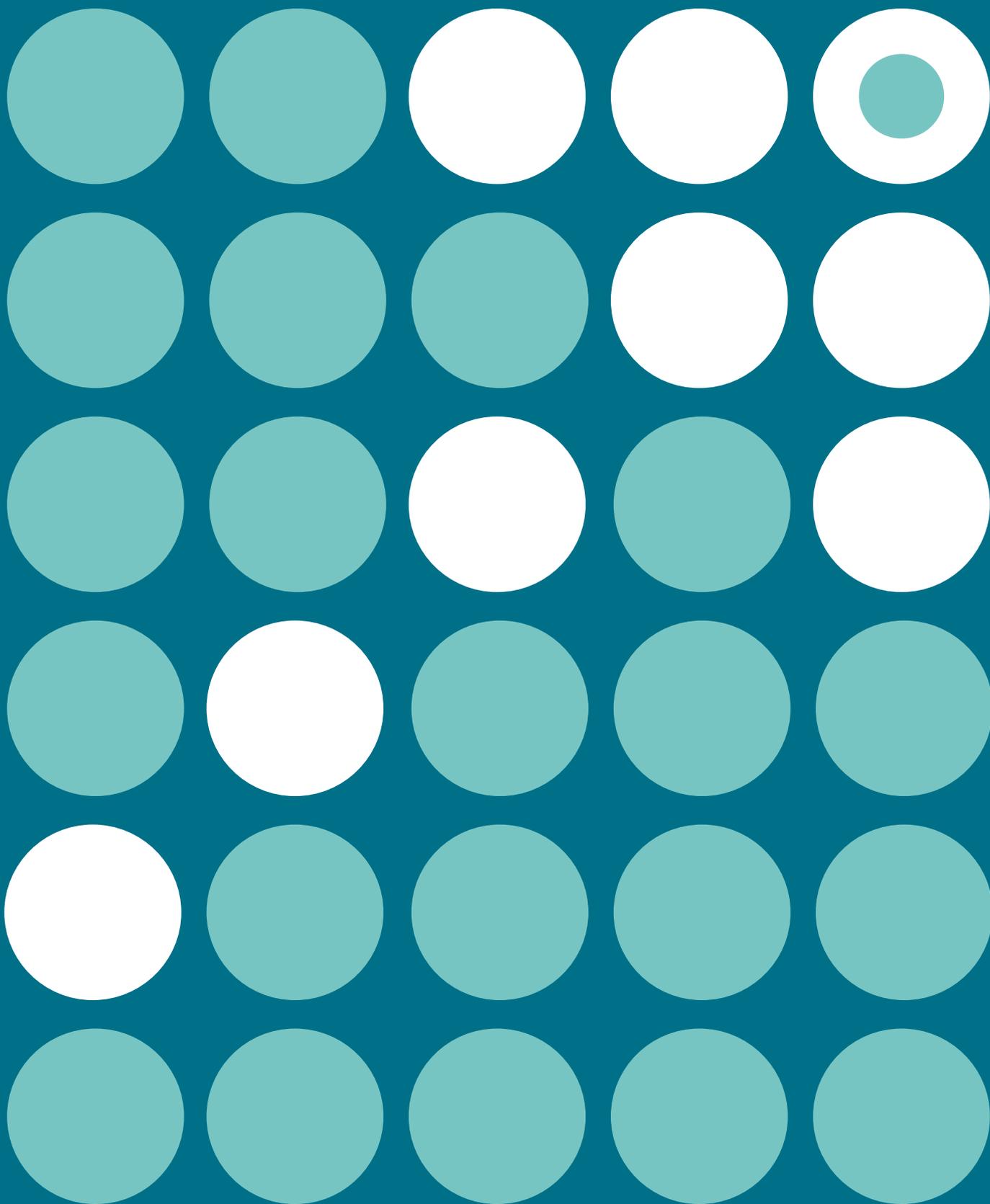
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