Multidisciplinary Team Working:
From Theory to Practice

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Coimisiún Meabhair-Shláinte | Mental Health Commission

Discussion Paper

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Mental Health Commission

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Chapter 1: Introduction

1.1   Working Group - Terms of Reference

One of the statutory functions of the Mental Health Commission is to foster and promote high standards of care and best practice in the delivery of mental health services. In pursuit of this aim, the Commission has formed a number of working groups to examine complex issues in mental health, with a view to preparing a series of discussion documents. These discussion documents will then be circulated to individuals and organisations with a stake in mental health services in order to generate an informed debate and discussion around the specific topic. The Commission will then produce a definitive document on the topic in question, presenting guidelines for mental health treatment and care.

This paper on multidisciplinary team working is the second discussion paper to be produced as part of this process. This is the first step for the Mental Health Commission in producing a definitive statement on multidisciplinary team working to guide mental health service development in Ireland.

Terms of reference

The terms of reference for the group were:

"On behalf of the Mental Health Commission, the working group is to review the available literature and models of multidisciplinary team working and, based on best practice and available evidence, to present different models for multidisciplinary team working and pose questions as to which model might be most suitable for Irish mental health services. Questions should also be posed on other issues around multidisciplinary team working".

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1.2   Setting the scene

Some 20 years ago *Planning for the Future* (Department of Health, 1984) recommended the establishment of multidisciplinary teams as *"different approaches to treatment, and the participation of people from a number of professional disciplines are required to cater adequately for the needs of the mentally ill"*. It recommended that, as well as psychiatrists and psychiatric nurses, psychologists, social workers and occupational therapists should form "psychiatric teams" to provide comprehensive treatment and care for the mentally ill.

One of the four guiding principles of the Health Strategy *Quality and Fairness: A Health System for You* (2001) – person-centeredness, describes very well the central aim of providing mental health care through a multidisciplinary team. A person-centred health system is described in the *Health Strategy* as one which "identifies and responds to the needs of the individual, is planned and delivered in a co-ordinated way, and helps individuals to participate in decision making to improve their health". Mental health services have been to the fore in providing this type of person-centred care for some time.

Our starting point is the individual using a mental health service. Individuals with mental health problems often have a wide range of needs that may be social and psychological. In various recent consultation exercises, service users and their carers have made known their views on mental health services, and what they consider to be high quality mental health services (Mental Health Commission, 2005; Expert Group on Mental Health Policy, 2004a&b). They wish to have access not just to doctors and nurses, but to psychologists, social workers, occupational therapists and other therapists. They want access to the range of interventions offered by this variety of mental health professionals. A key strength of multidisciplinary teams is that the combined expertise of a range of mental health professionals is used to deliver seamless, comprehensive care to the individual. The research evidence supports multidisciplinary team working as the most effective means of delivering a comprehensive mental health service to people with mental health problems, especially those with long-term mental health problems (Tyrer, 1998). The benefits of multidisciplinary team working for both service users and providers are well established and are outlined in Chapter Two.

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In spite of the support for multidisciplinary team working from health policy and service users, there are surprisingly few multidisciplinary teams in adult mental health services. In contrast, multidisciplinary team working has been the model for working in child and adolescent mental health services for many years now. While there are a small number of adult mental health services with well functioning multidisciplinary teams, this has not happened to any great extent nationally (Mental Health Commission, 2005b). There are many barriers to effective multidisciplinary team development and functioning. The explanation that is offered most frequently is that there are too few mental health professionals in the areas of psychology, social work and occupational therapy to create effective multidisciplinary teams. The other explanation is the omnipresent 'lack of resources'. While there is undoubtedly an element of truth in these two explanations they have been overcome in some services. A number of effective teams have been established around the country, some of which are in services that are very poorly resourced. There are other barriers to multidisciplinary working which are not as easily articulated, such as professional rivalry and mistrust, lack of support for team working from key professionals and mental health managers/administrators, confidentiality issues, increased risk, lack of knowledge of what other mental health professionals do and what unique skills they have to offer. Lack of training in team working is also a significant barrier to effective teams. All mental health professions are educated and trained separately, at both undergraduate and postgraduate level. These barriers have been well documented in the literature and are discussed in Chapter Three. These are the real barriers to multidisciplinary team development, and none are insurmountable. It is unrealistic to wait until all members of the ideal multidisciplinary team are in place before things can change. Change can start now if there is sufficient commitment and vision in individual mental health services to make it happen.

1.3   The purpose of this discussion paper

The aim of this discussion paper is to provide information on multidisciplinary teams and how they work, to present the core competencies for multidisciplinary team working (Chapter Four) and different models of multidisciplinary team working (Chapter Six), to present some of the main issues around multidisciplinary team working (Chapter Seven), and in the context of this information, pose questions to provoke discussion among all stakeholders.

This paper sets out a vision of how multidisciplinary teams should work in mental health services, and presents a new way of working that is challenging. The Mental Health Commission is very aware that this is an evolving process and that service delivery may change in the coming years so that this discussion paper will need to be reviewed in the medium term. It is not envisaged that this is how things will be for multidisciplinary teams for the next 20 years. We are also aware of the need to adapt the structure and functions of a multidisciplinary team according to local needs and circumstances, and so this discussion paper is not overly prescriptive.

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1.4 The scope of this discussion paper

This discussion paper discusses mental health multidisciplinary teams delivering secondary level mental health treatment and care, primarily from the perspective of adult mental health teams. The research undertaken in preparing this paper revealed that multidisciplinary teams are in different stages of development in the different mental health specialties in Ireland. For example, multidisciplinary team working is more developed in child and adolescent mental health services. This discussion paper does not presume that 'one size fits all' in terms of multidisciplinary working in mental health services. Instead, this paper presents different models of multidisciplinary working, and presents a range of issues that are of relevance and interest to all mental health services. The Mental Health Commission believes that the multidisciplinary team should be the central component in the delivery of all mental health services, in all specialties. This discussion paper is the first step in preparing national guidance in this area to achieve this vision.

1.5 The audience

This report is addressed to all mental health professionals and all those involved in providing mental health services, including the Department of Health and Children, the Health Service Executive, voluntary groups in the mental health area, the independent sector, service users and carers; in short, all individuals and organisations with a stake in mental health services.

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Chapter 2

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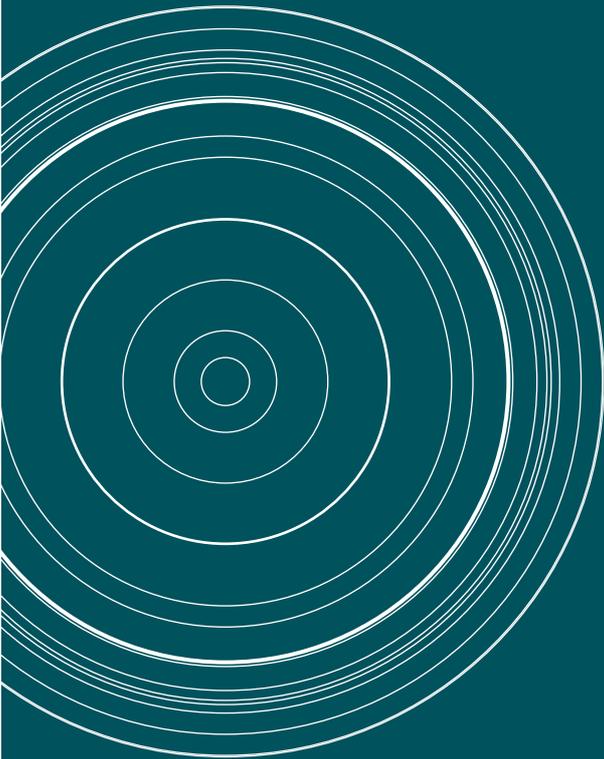
Chapter 2:

Rationale, definitions and benefits of multidisciplinary team working

2.1 Rationale for multidisciplinary team working

Since the 1950's mental health care has moved from the mental hospital to community based care. This movement was the result of improvements in pharmacological treatments along with key social, political and economic trends. These included increasing emphasis on human rights, understanding of the detrimental effects of institutionalisation, the involvement of family and service user organisations, value for money, and the influence of the therapeutic community movement. The latter emphasised the social determinants of mental illness stressing the role of relationships in treatment (Burns, 2001).

The general aims of deinstitutionalisation were to prevent inappropriate mental hospital admissions through the provision of community based alternatives for treatment; to discharge to the community all those in institutions who had been given adequate preparation for such a change; and to establish and maintain community supports for people receiving mental health services in the community (Bachrach, 1977).

As these community services developed there was a fundamental change in the perception of the service user. They began to be seen in the context of their family, their work and leisure pursuits, as members of their neighbourhood and the wider community. It became essential to form a working alliance with the user and their families and to prioritise their concerns. Increasing knowledge of the course of mental illness and recovery made it clear that the psychological concerns and social environment of the service user needed to be addressed. To do this, a wide range of skills was essential, and called for occupational therapists, psychologists, social workers and others to join with psychiatrists and psychiatric nurses within mental health teams. Thus the need to establish community based alternatives to hospital treatment and to ensure coordinated health and social care for the severely mentally ill established the multidisciplinary team as a central feature of virtually all forms of modern mental health care.

2.2 What is multidisciplinary teamwork?

What does the term 'multidisciplinary team working' (MDT) mean? At first glance, it may seem obvious that the definition is *"members of different professions working together"*.

Yet it becomes apparent from the literature that the concept is far from clear. The terms 'multidisciplinary' and 'interdisciplinary' are often used interchangeably. Leathard (1994) identifies the various prefixes ('multi' and 'inter') and adjectives ('disciplinary' and 'professional') which researchers and practitioners use. Multidisciplinary team working is described by Jefferies & Chan (2004) as:

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> *"the main mechanism to ensure truly holistic care for patients and a seamless service for patients throughout their disease trajectory and across the boundaries of primary, secondary and tertiary care".*

Carrier & Kendall (1995) describe inter-disciplinary work as:

> *"implying a willingness to share and indeed give up exclusive claims to specialist knowledge and authority, if the needs of clients can be met more effectively by other professional groups".*

A team is described 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."*

According to Junor, Hole & Gillis (1994) multidisciplinary team working is known to "maximise clinical effectiveness". These different definitions and descriptions capture important features of multidisciplinary work. It is not just a matter of getting different mental health professionals together and magically multidisciplinary team working happens. Teams need to have shared goals and values, need to understand and respect the competencies of other team members, need to learn from other disciplines and respect their different views and perspectives. Individual team members may need to reassess exclusive claims to specialist knowledge and authority in order to form effective multidisciplinary teams which can provide the best possible care to the individual service user.

2.3   Why are multidisciplinary teams important?

Multidisciplinary teams convey many benefits to both service users and the mental health professionals working on the team, such as continuity of care, the ability to take a comprehensive, holistic view of the service user's needs, the availability of a range of skills, and mutual support and education.

According to Moss (1994), multidisciplinary teams working in the community enables the following three key functions to be available to service users:

- continuing proactive care of those with long-term serious mental health problems
- 24-hour access to information and support, intervention and treatment before and during crises, and
- an organised response to requests for help from primary care.

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Specific advantages for service users have been shown in the literature. Multidisciplinary teams working with people with severe and long term mental health problems in an outreach model (i.e. providing care in the individual's home) have shown particular benefits. Such teams reduce bed use (Marks *et al.*, 1994; Burns *et al.*, 1993; Merson *et al.*, 1992; Dean *et al.*, 1993) and ensure that people with severe mental health problems maintain service contact after discharge from hospital (Ford *et al.*, 1995). Service users and carers prefer the care provided by such teams when compared to standard services (Marks *et a*l., 1994; Simmonds *et al.*, 2001; Tyrer *et al.*, 2003). They are cost-effective (Knapp *et al.*, 1994; Burns *et al.*, 1993) and positively evaluated by referrers (Onyett *et al.*, 1990).

In addition, multidisciplinary team working provides the skill range to meet the increasingly complex needs of service users who require the different skills of different professionals (Ovretveit 1993), enables the provision of a wide range of services and resources for service users (Campbell *et al.*, 1998) and provides a seamless service to users which enhances continuity of care (Towell and Beardshaw 1991).

These benefits of multidisciplinary teams for service users are increasingly recognised. In the consultation exercise undertaken by the Mental Health Commission (2005a) on what constitutes a quality mental health service, one of the key themes to emerge from all stakeholders was the importance of multidisciplinary teams. This theme summarised the various contributions in the following way:

> *The provision of a holistic, seamless service, and the full continuum of care, provided by a multidisciplinary team, are essential features of a quality mental health service.*

The consultation exercise also noted that:

> *There was a strong consensus among the different stakeholders that a comprehensive, seamless continuum of appropriate support, matched to the individual needs of each person, and which can be drawn upon at any stage of a person's journey to recovery, is an essential feature of a quality service. (Mental Health Commission (2005a)).*

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Multidisciplinary team working also conveys benefits on staff working in teams and on services themselves, which possibly explains the increasing acceptance and adoption of this way of working. Multidisciplinary team work and support from colleagues is often cited as an important source of reward to team members (Onyett & Ford, 1996). While many multidisciplinary team members experience the work as demanding, job satisfaction and personal accomplishment tend to be high (Carson *et al.*, 1991; Onyett *et al.*, 1995). The advantages to mental health professionals of multidisciplinary working include:

- close-knit peer support for all health professionals and consideration for the complex and sometimes distressing clinical work to be done i.e. involuntary admissions, violence, suicide, etc.;

- division of labour to ensure multidisciplinary service delivery, i.e. ensuring that all "bio-psycho-socio-cultural" components of intervention and care are delivered;

- ensuring that all members of the multidisciplinary team are used in a way that is maximally effective, i.e. service users who need a specific input/skill set can have access to that immediately, rather than having multiple assessments;

- cross-fertilisation of skills between professionals (Hoult, 1986). The team begins to demonstrate the benefits of true multi-skilling without compromising or sacrificing the distinct contribution or professional standards of each discipline;

- multidisciplinary peer review of all casework at team meetings e.g. formal multidisciplinary debriefing of all service users, peer review at predetermined intervals and each case-manager doing assessments and other work jointly with the psychiatrist or other team professionals as required. This ensures that other team members see and know others' work, can give advice and provide informed cover when people are away;

- staff acquire new skills, participate in decision making and take on more responsibility leading to increased job satisfaction (Onyett & Smith, 1998);

- delivering services that are planned and co-ordinated (Ovretveit, 1993);

- delivering services that are cost effective (Knapp *et al.*, 1994);

- enhancing information sharing and streamlining work practices (Hornby, 1993).

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However, multidisciplinary teams as a model of working in mental health services are not universally accepted. Galvin and McCarthy (1994), in their critique of Community Mental Health Teams (CMHT)s, believe that deficiencies in CMHTs can be directly attributed to fundamental flaws in the concept of inter-professional working. Onyett and Ford (1996) argue that these flaws are due to poor implementation and not to the concept of multidisciplinary team working itself.

Working in teams also presents challenges to the mental health professionals involved and the mental health services, particularly around management, leadership, confidentiality, and conflict management and resolution. These issues are discussed in Chapter Seven.

Chapter 3
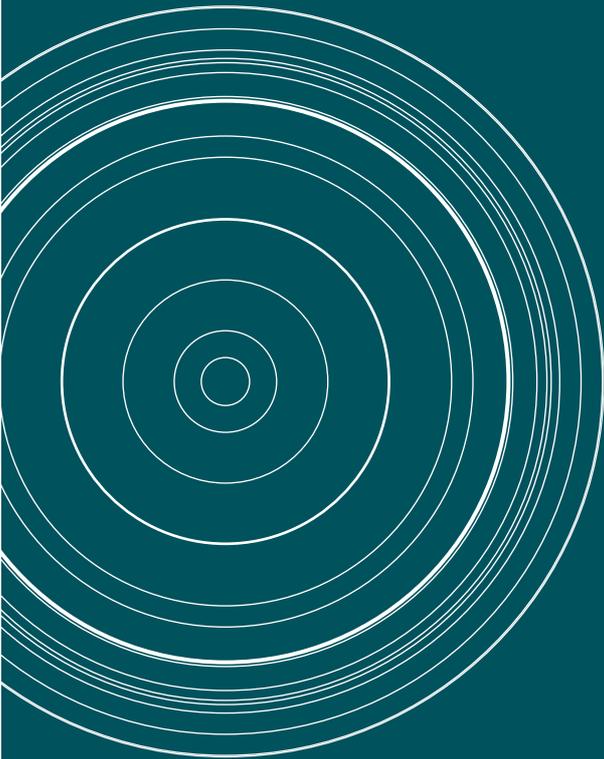
Chapter 3:

Factors which influence effective multidisciplinary team working

3.1   Introduction

Working in multidisciplinary teams can be experienced as difficult for a number of reasons. Professionals can find themselves torn between allegiance to their profession and to working to realise team goals. The latter often requires an 'unlearning of traditional patterns of professional interaction' (Lang, 1982). However, this is not easily done, and team members often report low team identification but high professional identification (Onyett *et al.*, 1997b). Indeed, CMHT working may inadvertently encourage boundaries between professionals (Brown *et al.*, 2000).

Some research studies suggest that there is a poor state of inter-professional working in adult community mental health services (e.g. Norman & Peck, 1999), and that one way to address poor collaboration would be to formulate a best-practice multidisciplinary team model or a set of principles for good team-working.

However, very little is known regarding what makes some teams work very well, while others seem to have the experience of individual professional groups basing their work on an allegiance to their own professional disciplines rather than a shared allegiance to the multidisciplinary team. However, a number of important factors have been identified.

3.2   Management structures

Given the increasingly multi-professional nature of CMHTs, it has been recommended that a shared model of team management be considered as a factor in promoting team cohesion (Hannigan, 1999). It may be that a comprehensive operational policy document for multidisciplinary teamwork needs to be drawn up to serve as a basic resource for the team (Ovretveit, 1993). Given the scope for additional tensions arising between multidisciplinary teams and wider management structures, it may be important to have general service managers present at specific team meetings (Onyett *et al.,* 1997).

3.3   Alignment of employment contracts of team members with broader employment policy

The effectiveness of teams is limited unless they have a clear role and position in the organisational structure of the service (Harris & Beyerlein, 2005). Organisational structures should reflect the multidisciplinary team as the unit of care delivery. Hospital management structures have tended to be simply replicated in community settings where they can mitigate against multidisciplinary team functioning. It follows that the optimum arrangement for staff on multidisciplinary teams is to be managed by an arrangement which respects the needs of the team.

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3.4   Balancing generic vs specific professional roles

An important factor is whether individual professionals feel valued for the unique
expertise and commitment they bring to the team, in addition to the generic mental
health expertise they share with other members of the group. To facilitate continuity
of care, team members may perceive a pressure to 'stretch' themselves to provide
aspects of care beyond their job descriptions, so that there are not too many team
members involved with each service user (Burns, 2004). This expectation to be less
precious about disciplinary boundaries can promote 'creeping genericism' (Berger,
1991) and role blurring, thereby running the risk of losing the specific contribution
of each profession (Peck & Norman, 1999). On the other hand, this more flexible
approach may facilitate the 'seepage' of values and concepts from one professional
group to another which may in turn promote teamwork and clinical expertise to
respond to service user needs (Sheppard, 1990). If the issue of specialism vs.
genericism is not clarified within teams, certain professionals may feel their
professional identity being eroded over time (Onyett & Ford, 1996), and begin to
exhibit a high degree of ambivalence towards working with teams (Peck & Norman,
1999). However, if the team can successfully identify shared core roles and
responsibilities, and distinguish these from the specific unique skills that individuals
and disciplines contribute, this can facilitate the success of multidisciplinary team
operation.

3.5   The client group of the team

Good multidisciplinary team functioning requires consensus regarding the client
group of the team (Onyett *et al.,* 1997b). The ability of a team to focus on the care
and treatment of a specific client group using agreed and unambiguous eligibility
criteria has been noted as a key success factor in multidisciplinary team working
(Onyett & Ford (1994).

3.6   Conflict resolution

Creative tension between disciplines can easily give rise to conflicts between them
(Peck & Norman, 1999). Team members typically place varying degrees of emphasis
on the distinct elements of the biopsychosocial model of mental health and ill-health
(Hannigan, 1999), so much so that there may be divisive debate about treatment
approaches (Norman & Peck, 1999). Hence, clear mechanisms for conflict resolution
are required (Onyett *et al.,* 1997, Byrne 2005), preferably through multi-professional
consensus. Recognition of some authority structures to resolve disagreements may
be required (Burns, 2004). Having such clear mechanisms may in and of itself
predispose to less conflict (Onyett *et al.* 1997).

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3.7   Training and preparation for working in multidisciplinary teams

A significant determinant of multidisciplinary team functioning may be the presence of team members who have a personal commitment to this approach. Such team members typically do not have 'a particular disciplinary axe to grind' (Wilson & Pirrie, 2000). The ideology of community based multidisciplinary service provision is rarely addressed as a component of professional training. In order to encourage this 'competency' across the various groups who will comprise a multidisciplinary team, some consideration needs to be given to ensuring this facet of training is included across all professional courses, at undergraduate and postgraduate level.

## 3.8   Information sharing and communication

While verbal communication is central to all aspects of CMHT functioning, a single integrated system of record keeping may also facilitate team functioning (Onyett *et al.*, 1994). Regular and structured review meetings using up-to-date integrated records can prevent clinical care drifting (Burns, 2004). Where a number of professionals are involved in the provision of an integrated care approach, it may also be important to identify a "lead clinician" who can coordinate and harmonise all elements of the recovery plan.

3.9   Insufficient nurturing of teams

Some teams are simply told by management that they 'are' a multidisciplinary team (Onyett *et al.*, 1994). This may reflect the ill-fated hope that teamwork will grow organically (Brown *et al.*, 2000). The passage of time may facilitate some 'maturation' of teams (Oberlander, 1990). However community mental health teams may 'fail to thrive' if not adequately nurtured (Heginbotham, 1999). While organisational and/or managerial solutions alone may not provide adequate nurture (Hudson, 2001), a combination of measures including team development training (e.g. developing sufficient levels of trust in order to share tasks), formulation of operational policies, and integrated management systems that span disciplines may do so (Onyett *et al.* 1994; Byrne, 2005).

These barriers and facilitators are discussed in more detail throughout the discussion paper.
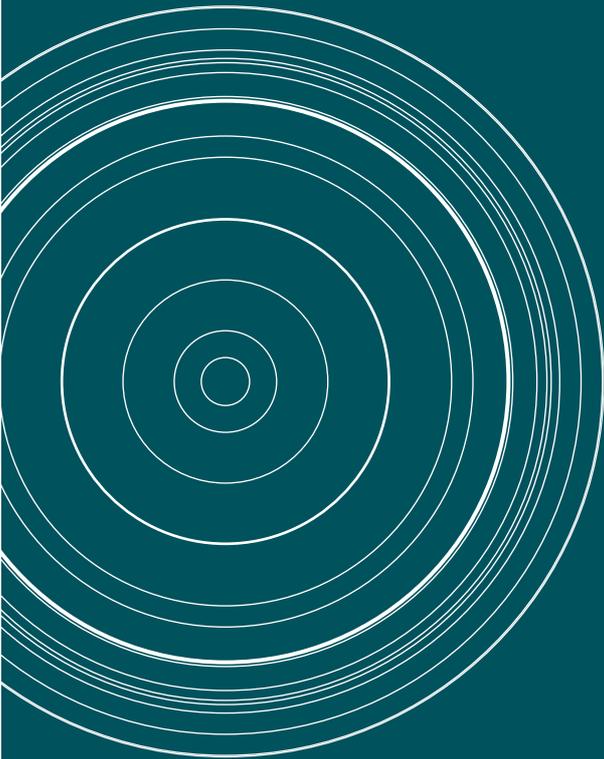
Chapter 4

Chapter 4:

Core competencies for multidisciplinary team working

4.1 Introduction

The delivery of mental health treatment and care by multidisciplinary teams has developed in parallel with the demise of large psychiatric institutions (Leff *et al.*, 2000). Their growth has been largely pragmatic, reflecting a clinical view that 'the needs of the severely mentally ill can rarely be met by a single individual' (Burns & Lloyd 2004; Onyett, 1992). The advantages of team work in the mental health setting have already been outlined (Chapter Two). This part of the discussion paper looks at the multidisciplinary team from the point of view of competencies.

4.2 A capability model

The skills required by the core members of the multidisciplinary team are variously described as "capabilities" and "competencies" (Clarke, 2004). Each individual on a multidisciplinary team brings to their work the skills associated with their particular profession or discipline. These are the skills that are in evidence in their work on the team and with individual service users. Their competence in these skills will vary according to their experience, their qualifications and the work involved in obtaining their qualifications (i.e. the amount of practical, hands-on training they had). Each individual on a multidisciplinary team also brings with them their own attitudes and values which can have a significant bearing on their knowledge, behaviour and skills.

Finally, each team member is a unique individual with their own interpersonal skills, strengths and weaknesses. It is these elements of the individual which may in fact have the greatest influence on how they function as team members. It is relatively easy to list the type of skills needed to work as a multidisciplinary team member. It is more difficult to determine the interpersonal skills and characteristics that make a good team member.

A capability model which pulls together the various competency profiles has been outlined (Sainsbury Centre for Mental Health, 2001). Practitioners require more than a prescribed set of competencies to perform their role. Capability extends the concept of competency to include the ability to *apply* the necessary knowledge, skills and attitudes to a range of complex and changing settings. Thus the emphasis in this model is on effective and *reflective* practice. This requires an underpinning set of values, attitudes and knowledge in addition to their competencies, to be truly effective team workers.

Capability includes:

- o a *performance* component which identifies 'what people need to possess' and 'what they need to achieve' in the workplace

- o an *ethical* component that is concerned with integrating a knowledge of culture, values and social awareness into professional practice

- o a component that emphasises *reflective* practice in action

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- the capability to *effectively implement* evidence-based interventions in the service configurations of a modern mental health service, and

- a commitment to working with new models of professional education and responsibility for *lifelong learning.*

4.3   Core skills, knowledge and attitudes for multidisciplinary working

This concept of capability is combined here with a detailed description of competencies. This list of core competencies has been adapted from that proposed for specialist staff working with adults with severe mental illness by the Sainsbury Centre for Mental Health (1997). Competencies are listed in the areas of:

- assessment

- treatment and care management

- collaborative working

- management and administration

- interpersonal skills.

4.3.1   Assessment

This is the first step in providing comprehensive mental health care for an individual. There is a range of skills required to carry out an assessment in the context of a modern mental health service, whose fundamental unit of operation is a multidisciplinary team. Skills in this area include:

- familiarity with the key skills required to initiate and maintain contact with service users, and ability to use these skills to engage with service users and carers, particularly those who are reluctant to interact with mental health services;

- ability to conduct a collaborative needs-based assessment;

- ability to develop a treatment and care plan based on a thorough and comprehensive assessment of the service user, family and social system;

- assessment of users' needs and requirements of housing, occupation and income;

- ability to apply knowledge and skill in risk assessment and the management of violence and aggression.

- ability to apply knowledge of factors related to the development of 'chronic crises' and skill in assessment and management strategies.

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4.3.2   Treatment and Care Management

As well as particular skills and knowledge relating to their specific professional training, members of a multidisciplinary team should have the following:

- knowledge of the priority target group for that service; their needs, characteristics and clinical symptomatology;

- knowledge of crisis intervention, theory and practice;

- effective understanding of current pharmacological interventions and possible side effects;

- knowledge of basic current cognitive-behavioural and other psychotherapeutic strategies to assist users, carers and family networks to contain and manage a severe and enduring mental illness;

- understanding of the issues in the evaluation and treatment of service users at risk of self harm or suicidal behaviour;

- knowledge and skill in effective inter-personal communication;

- knowledge and skill in creating therapeutic co-operation and developing an alliance with the service user;

- awareness of user perspectives on the provision of treatment and continuing care;

- understanding of the philosophy and background behind recovery principles.

4.3.3   Collaborative Working

The key to multidisciplinary team working is the ability to work in a collaborative way. Specific skills in this area include:

- ability to work effectively as a member of a multi-disciplinary mental health team through clarity about the role and purpose of the team and its individual members;

- willingness and ability to cross-cover between disciplines and role-blur within the limits of their skills;

- ability to work in partnership with service users, carers and social networks;

- understanding of sources of conflict and development of basic teamwork skills including negotiation and conflict resolution;

- comprehension of the need for and willingness to participate effectively in multi-disciplinary team supervision;

- knowledge of what leadership is and how it differs from management, and how good leadership can improve outcome for individual service users.

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4.3.4   *Other knowledge and skills*

Effective members of a multidisciplinary team also need skills in the area of management and administration including an:

- o understanding of mental health law and related legislation, especially in relation to users' civil rights and powers of compulsion and detention;

- o understanding of the roles of the various disciplines and agencies involved in the provision of mental health care and the range of settings within which care and treatment take place;

- o awareness of the role and contribution of non-specialist and support staff, and the ability to supervise and provide support to those staff;

- o ability to maintain clear and accurate multidisciplinary notes;

- o understanding of service planning, audit and evaluation;

- o understanding and appreciation of clinical governance [1];

- o awareness of the unique competencies/skills of other team members.

4.3.5   *Interpersonal skills*

While the skills of a mental health professional described above are essential for an effective multidisciplinary team member, interpersonal skills, characteristics and attitudes are also key to team working. Individuals on a team should be encouraged, through reflective practice and appropriate support, to examine their own characteristics and how they might adapt to a team environment. Skills/attributes in this area include:

- o respect for service users and carers as individuals and understanding of the rights of users and carers;

- o respect for and understanding of, the different training, skills and perspective of other team members;

- o an understanding of multidisciplinary team working and commitment to this as a means of delivering mental health treatment and care;

- o positive attitude to those with mental illness, including a commitment to a holistic approach to mental health;

- o belief in the philosophy and background behind recovery principles;

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1   Clinical governance is a process which aims to improve the standards of clinical care through continuous audit and evaluation of outcomes.

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- o respect for diversity (professional, cultural, models of working etc.) and understanding of diverse views on mental health, illness and treatment and care;

- o value awareness - an awareness of how individual and team values have an impact on every level of mental health care and treatment.

- o cultural awareness - an awareness relevant to their client groups and specifically addressing local diversity.

It is also important to recognise that while mental health professionals may have well-developed clinical skills within their own area of expertise, it should not be assumed that they have all of the skills needed to collaborate effectively with others as part of a team. Therefore, all team members need the opportunity to learn the appropriate communication, leadership, trust, decision making and conflict management skills that will enable them to function as part of a team and therefore enable the team to function effectively as a unit. The central importance of training is covered in detail in Chapter Seven.

Chapter 5
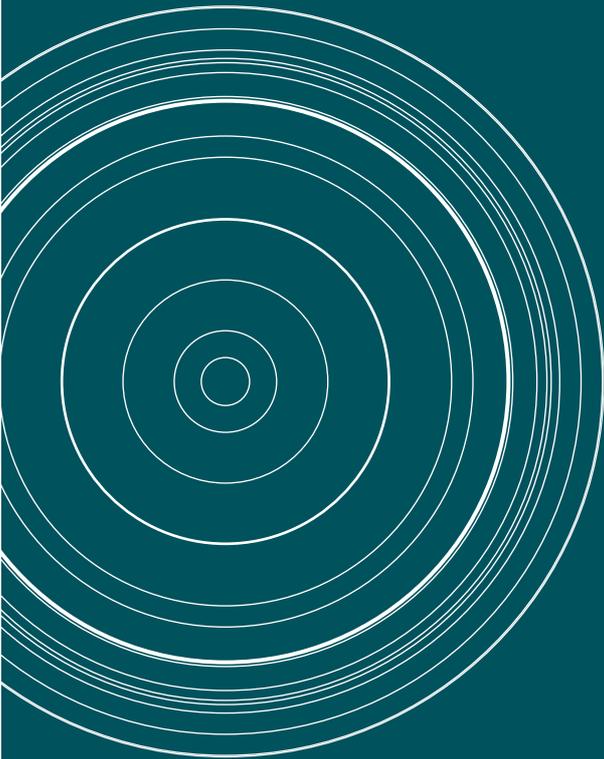
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Chapter 5:

Members of the multidisciplinary team

5.1 Who should be part of the multidisciplinary team?

Most of the literature in this area states that a community mental health multidisciplinary team requires the core skills of nursing, medicine, social work, psychology and occupational therapy. Once the core disciplines are in place, there can be flexibility in the skills of additional members of the team according to local needs. For example, family therapists or speech and language therapists may have skills required by the population the team is serving. The possession of the competencies required to deliver effective care in a multidisciplinary team environment should be the key determinant of team membership. There should also be flexibility in terms of 'sub-teams' that may be a part of the larger team, for example, a home care team. The range of skills on the team should also be responsive to the ethnic profile of the local population.

One of the fundamental advantages of team working is the different perspectives brought in by the different disciplines regardless of the special skills they may have. For this reason it is essential that the core disciplines are represented on multidisciplinary teams. In the concerns about 'generic' mental health workers, it is important to note that the different training of the disciplines means they look at the individual in different ways – each valid but each only part of the picture of a whole person. For example, the unique skill of an occupational therapist is using purposeful activity as a therapeutic tool with an individual with a mental health problem. Their ability to design programmes to achieve this is unique to occupational therapists because they view the individual from this particular perspective. Similarly the unique skill of a social worker is to take, as their primary perspective, a view of the individual in the context of their personal, family, cultural, and socio-economic circumstances, and to propose and carry out interventions in that context. Other disciplines certainly have the ability to acknowledge the social circumstances of an individual with a mental health problem, but it is not their primary perspective and it does not drive their approach to the individual and their carer/family. It is in combining all of the perspectives to be found on a multidisciplinary team that we arrive at truly holistic assessment, treatment and care for the individual. This is the overarching benefit from a multidisciplinary approach – a benefit for both service users and team members. An additional benefit is that in working together, the disciplines begin to understand each other's perspectives and learn and grow in their own practice through this.

Not all mental health professionals on the team have the same level of skill and experience. The interpersonal characteristics that each individual brings to the team are key. The level of skill in areas such as assessment and different interventions can be developed over time, but if an individual at some core level, does not believe in team working, no amount of training in therapies will make them an effective multidisciplinary team member.

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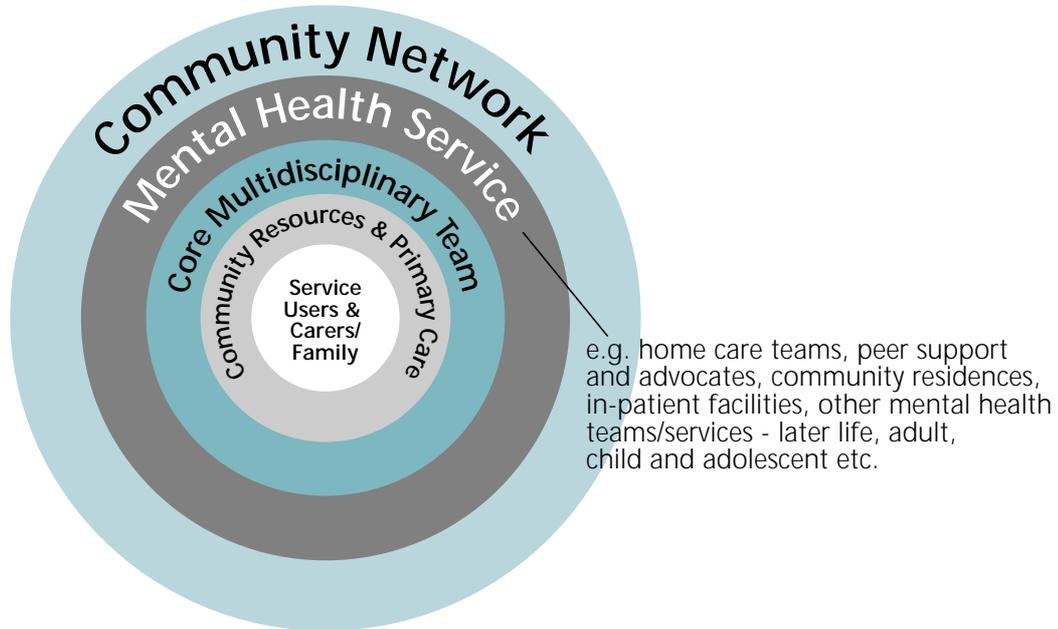## 5.2   Model for multidisciplinary team links

A model for the links required by multidisciplinary teams is outlined here. It can be described as a 'nested' model, with the individual service user and carer/family at the centre, embedded in a number of different formal and informal service structures, including community support groups and primary care services, secondary mental health services in the form of the multidisciplinary team, and other mental health and health services.

A central proposal of this paper is that the service user and their carers/family should be at the centre of mental health service delivery. A core multidisciplinary mental health care team will provide and co-ordinate the direct treatment and care for this individual. The multidisciplinary team is located within a community-based mental health service which should have access to a home care team, peer support and advocates, community residences, a day hospital/day centre, and an inpatient centre. Figure 1 overleaf shows a graphical representation of these relationships. The staff providing these other parts of the mental health service should work in close liaison with the multidisciplinary team and may meet with the multidisciplinary team as necessary. Trained advocates and other peers supporters are a very important part of the mental health service network, but are only now being developed and put in place. A more complete description of the roles of trained service users is outlined in section 5.3.

The mental health service is located within a broader-based community network. The team should have a flexible/permeable structure in the sense that members of the wider network may be part of the team according to the needs of a specific service user. For example, a GP or probation officer may attend multidisciplinary team meetings to discuss a particular client depending on the needs of that individual. Alternatively, a consultation model for these contacts may be appropriate.

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Figure 1: Model of Mental Health Team links

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.

5.3   The role of the service user

A service user is an individual who is currently using mental health services. The role of trained service users as advocates and consultants to mental health services, has changed quite dramatically in the past few years. For this reason, the role of service users is covered here in some detail.

Increasingly in the past decade we have seen a burgeoning development in the role of service users within the mental health system, both nationally and internationally. Service-users are no longer seen as passive recipients of care within an institutional framework. With the closure of the large hospitals, their role and involvement as experts and activists in their own right is becoming much more evident and progressive. With the founding of the Irish Advocacy Network, the last five years have seen users forming strong advocacy links with the mental health care system, providing expertise, empathy and insight for the betterment of their fellow users. Service users are also articulating their experiences and bringing this knowledge to bear constructively onto the system (Expert group on related Health policy 2004b). It is in this context that it becomes a matter of critical inclusive debate that users play an important role in service delivery and in the operation of multi-disciplinary mental health teams. While these developments are very welcome, service user involvement in multidisciplinary teams is practically non-existent in the Irish system.

In this discussion paper a distinction is made between service users in receipt of services (involvement at the individual level) and trained service user involvement at

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the team/service level. The different roles are outlined in Table 1. As the individual in receipt of care, one of the 'roles' of the service user is to work out a care plan in partnership with the multidisciplinary team. In this way, users are centrally involved in their care and have a say in the type and timing of interventions.

Table 1: Different levels of involvement of service users

Individual level (every service user)
- choice of keyworker
- choice of venue to be seen e.g. at home, in day hospital etc.
- drawing up own care plan with the team and information recorded in it
- defining needs and how these are to be addressed

Team/service level (trained service user)
- service monitoring and evaluation
- interviewing and appraisal of staff
- staff training and induction
- linking the multidisciplinary team to service user groups and organisations
- acting as advocates for individual service users
- contributing to the development of the team's operational policies
- advising on the operation of the team.

Trained service users take on many roles in the mental health system. For example, trained advocates and peer supporters are now available in the mental health services in some areas. These advocates offer support to service users and help them negotiate the mental health system. If individual service users request their involvement, the participation of peer advocates/supporters in multidisciplinary team meetings should be facilitated.

User consultants (former service users who have received training in advocacy and further training in management) have a valuable role to play in staff training and induction, and also in the team formation phase. Service users and trained advocates should participate in user forums to inform the management and planning of mental health services. Finally, service users provide services such as support programmes and the Clubhouse model, although these are available in just a few locations.

Many examples of service user involvement in staff selection, in the workforce and in service planning and delivery are in evidence, with several positive evaluations (Tait & Lester, 2005). National policy in the UK has been an important driver in achieving greater service user and carer involvement in mental health services (Livingston & Cooper, 2004).

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5.4   The role of the family/carer

With the increased provision of mental health services through multidisciplinary teams in the community, the families and carers of those with mental health problems have an even greater involvement in the care of their family members. Studies have shown that this increased involvement of family/carers need not result in increased burden on families, if the proper supports are in place (Dean and Gadd, 1990; Keogh, 1997). Findings from consultation exercises have shown that families want to be involved in the care of family members and require more information. If the individual service user is happy for their family/carer to be involved, the multidisciplinary team should include the family/carer in discussions about care plans, the inpatient admission and discharge process and all aspects of the treatment and care of their family member. Support should also be given to the family in the form of family education, home visits and so on. If the service user prefers that their family/carer is not involved in their care plan, information that is not specific to the service user but informs the family about the mental health problem and supports that are available to them should be given, and the family/carer should be involved by the multidisciplinary team as much as possible.

5.5   The current picture of multidisciplinary team provision

There are approximately 8,000 staff involved in delivering mental health services in Ireland. A significant proportion of these staff are still involved in providing mental health treatment and care in an inpatient setting, in spite of the recommendation in *Planning for the Future* that mental health services be predominantly community based. This isn't simply a matter of the *location* of staff. More importantly, working in an inpatient environment means working in a specific way, usually not in a multidisciplinary team, and at some remove from the community where inpatients reside. Therefore most of the staff in our mental health services have little experience of, or specific training or skills in team working. This has serious implications for training and education which is addressed in Chapter Seven.

There is a mixed age and skill profile among the staff in mental health services. Many received their training entirely in an institution while others have never worked in an institution. A number have provided themselves with a range of skills that are additional to their traditional 'title' or profession. An assessment of the staffing and skills situation is difficult as there are large gaps in information. The number of staff by professional title and grade is known (approximately) but there is no information on the skills they possess. For example, many psychiatric nurses have received further training in management and specific therapies, but there is no central record where this information is held. Steps also need to be taken to address the inappropriate deployment of nurses (with many still attached to mental hospitals) and to address the inequities in the availability of nurses in certain areas (such as Dublin). Other barriers to the redeployment of staff to multidisciplinary teams also need to be examined, such as pay structures which mitigate against individuals moving from an institutional to a community setting.

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An obvious gap in services is the relative lack of certain mental health professionals, such as psychologists, occupational therapists and social workers. Creative responses to this lack are needed. For example, clinical psychologists and social work practitioners can enhance the service they provide by using assistants. In the past, in both psychology and social work, trainees worked as 'apprentices' prior to completing their clinical training. It is important to note, however, that such posts are not a substitute for a qualified clinical psychologist or social work practitioner and assistants can only work under close supervision to perform a circumscribed set of tasks.

Another way of maximising the skills of scarce mental health professionals is through the use of a mental health care assistant or mental health support worker. This is an individual with appropriate training, who works as a support for service users on home care programmes, assisting in occupational therapy, psychology or social work programmes and generally providing a monitoring and support function to enhance the capacity of all disciplines.

Current initiatives to increase the undergraduate training places for social workers, occupational therapists and psychologists should help improve the availability of these mental health professionals. However, these students need a positive experience of workplace placement in the mental health services if a career in mental health is to be considered. The issue of recruiting and retaining staff in mental health services needs to be tackled more creatively. It is the responsibility of all staff to support colleagues in all disciplines and to create an environment that is welcoming, respectful and supportive.

5.5.1   Career structure for mental health professionals

The 2003 report of the Inspector of Mental Hospitals (Department of Health and Children, 2004) noted that there has been difficulty in recruiting some mental health professionals to psychiatry and that "as minority professionals, numerically, some felt professionally isolated and their functions and roles little understood and appreciated and so did not favour a career in psychiatry". The numbers and career structure of the medical and nursing staff in mental health have been well established over a long number of years. The numbers and career structure of disciplines such as clinical psychologists, social work practitioners and occupational therapists have previously not been well established or defined. It is recognised that there should be appropriate numbers of basic grades, senior and principals in all disciplines and that these should be available within the mental health service structure.

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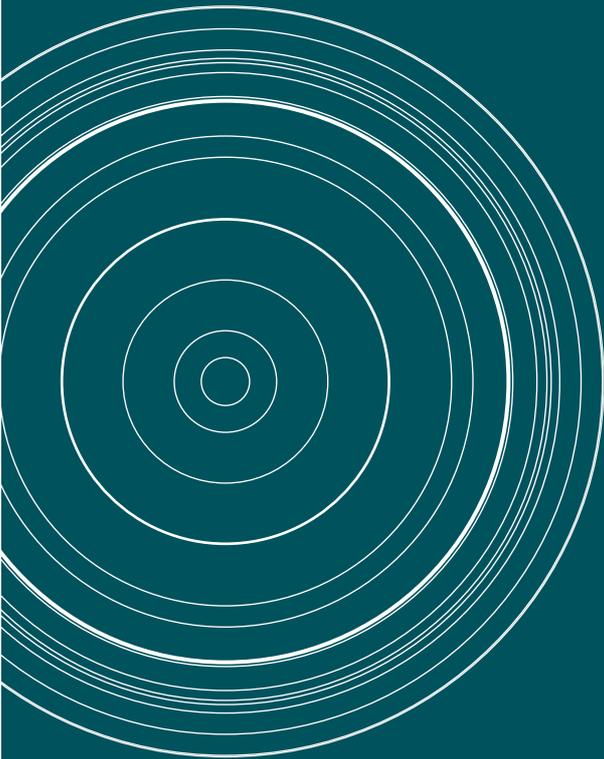
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Chapter 6:

Models of multidisciplinary team working

6.1   Models of Service Delivery

Community Mental Health Teams (CMHTs) function best as discrete specialised teams comprising health and social care staff under single management, which have:

- staff members whose sole (or main) responsibility is working within that team;

- an adequate skill mix within the team to provide a range of interventions;

- strong links with other mental health services and good general knowledge of local resources;

- clear and explicit responsibility for a local population and links to specified primary care teams;

- integrated health and social care staff using one set of notes and clear overall clinical and managerial leadership.

The principles underlying team functioning should be the same across all speciality community mental health teams. Some teams may be larger than others. Some teams may have sub-teams contained within them, such as home-based treatment and assertive outreach.

6.2   Models of multidisciplinary team working

There are two well-established models of multidisciplinary team working, i.e. the keyworker model and the case management model. These are presented here as examples of how to structure and carry-out multidisciplinary team working. Examples of multidisciplinary teams working in mental health services were sought by the working group. A description of a multidisciplinary team in Australia is included in Appendix 1 as an illustrative example of a multidisciplinary team in action.

Model 1:   Keyworker model with triage at point of referral

The keyworker model has been in use for some time in the UK. The model that is described here incorporates triage at the point of referral. Keyworkers are the prime therapist for each service user and can come from any of the professional disciplines. In exercising this role, keyworkers coordinate and lead the care plan and serve as the service user's and carers' main access point to the team. Every individual in receipt of care has a keyworker. In most services that operate this model, any of the mental health professionals on a community mental health multidisciplinary team can be keyworkers. Their primary role is to deliver and manage care to service users.

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6.2.1   Key roles in this model

A shared management structure operates in this model, with three key roles, that of clinical leader, team coordinator and business manager.

The **clinical leader** of the team exercises a broad range of functions. These include ensuring probity of team functioning, achieving team cohesion and providing vision and direction for service development. These functions can only be served in a setting of genuine respect between different professionals on the team and in the sharing of decision-making. A close working relationship between the team leader, team co-ordinator and team manager is critical to the successful functioning of the team.

The **team co-ordinator** manages the team's clinical business. The team coordinators serve as a single point of access to the team, a function that brings them into close relationships with general practitioners and other referring agencies. They have responsibility for monitoring the workloads of all team members and taking a lead role in auditing team activity. They have responsibility for keeping team members informed of relevant clinical matters and team activities. They have particular responsibility for liaising closely with the clinical team leader and liaising with other mental health services and with groups and agencies in the wider community.

The **business manager** is responsible for all the administrative tasks associated with ensuring the smooth running of the multidisciplinary community mental health team. This person has responsibility for managing the budget and related administrative functions. They also have a role in enabling audit, review and monitoring functions, and ensuring that support systems to enable this are in place, such as IT systems and administrative support staff.

6.2.2   How this model works

Step 1: The first point of contact with the service is through the team co-ordinator (as described in the referral pathway in Appendix 2). The team co-ordinator triages the referral and assigns the case to the most appropriate member of the team so that an initial assessment can be carried out prior to the presentation of the referral to the full team. A multi-dimensional assessment is done with the service user. This assessment covers the bio/psycho/social/cultural/environmental elements specific to the service user. This assessment results in key needs being identified, and also triggers areas for more detailed assessment.

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Step 2: The case is presented to the full team and, based on the needs identified, a keyworker is allocated. The keyworker works with other team members who have the necessary skills to meet the needs/investigate the needs in more depth. For example:

Need	Action
psychotic symptoms	review of mental state by doctor
family difficulties	review of family situation by social worker

Step 3 – Care plan: The case is presented and actioned at the next team meeting by the keyworker. A full care plan is identified based on the assessment results. The care plan is developed with the service user and a copy of the care plan is given to the service user. This care plan follows the person through a range of service options, i.e. the community team care plan might include a period of hospitalisation. In this case the careplan is then copied into the hospital process. An essential pre-requisite to the effective functioning of this care pathway process is that each service user has one set of notes only. All disciplines are required to use this set of notes. The advantages of this include the unnecessary duplication of administrative details, all information relating to the care of an individual is in one location, accessible to all team members. A sample care plan could look as follows:

Name:	Keyworker 1:
Address:	Keyworker 2:
Identifying details…	

Goal	Action	Person responsible	Date of review
1. Reduce psychotic symptoms	1. Commence a course of (specified) medication	Consultant/NCHD	
	2. visits by CMHN	CMHN	
2. Address family difficulties	1. Commence family therapy	Social worker	
3. …	…	…	

A date is set for a formal review. In the interim, the keyworker (who is also actively involved clinically with the individual) liaises with and reviews the progress with other team members involved.

Table 2: **Summary of the care pathway in this model of multidisiciplinary team working.**

Step	Level of input	Process	Outcome
1	1st point of contact	Multi-dimensional assessment by any member of the team: Bio/psycho/social/cultural/ environmental	• Identify care needs • Trigger areas for further assessment
2	Initial keyworker	Identify members of the team who need to provide action/input	Clear picture of needs
3	Case conference/care planning	• Develop care plan • Set goals and objectives • Identify key people responsible for each objective • Set review date	

Model 2:   Care/Case management

Case management was initially introduced in the USA as a mechanism for coordinating fragmented systems of community care (Intagliata, 1982). There is no fully agreed typology of case management for those with mental health problems (Marshall, 1996) and at least six separate models have been articulated: brokerage; clinical case management; assertive community treatment (ACT); intensive case management (ICM); the 'strengths' model; and the 'rehabilitation' model (Meuser *et al.*, 1998). The common purpose shared by all forms of case management is 'to help patients survive and optimise their adjustment to the community' (Meuser *et al.*, 1998).

In its simplest form (referred to as brokerage) case management is a means of coordinating services. Each service user is assigned a 'case manager' who is expected to:

o assess the person's needs

o develop a care plan

o arrange for suitable care to be provided

o monitor the quality of the care provided

o maintain contact with the person.

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Brokerage case managers, as characterised by this model which was in place in the UK in the 1990s, often lack clinical qualifications and tend to work outside established mental health services. This model has evolved into more sophisticated, but somewhat poorly defined models. In these models the brokerage role is combined with the delivery of interventions and is therefore much more embedded in the mental health system. These models (clinical case management, intensive case management, the strengths model and the rehabilitation model) are now usually delivered by multidisciplinary teams, albeit with a variety of compositions.

One model of intensive case management (ICM) which has been described (Holloway *et al.*, 1996) consists of a small team (four nurses and one occupational therapist) with part-time involvement of two psychiatrists and a clinical psychologist. Case loads were eight clients per core team (approximately 40 clients). This service provided direct care to clients and acted as advocates for their clients in linking with other health and social services.

There is some debate over whether assertive community treatment (ACT) is a form of case management or not (Marshall *et al.*, 1997). The essential difference is that case management emphasises the individual responsibility of case managers for 'clients', where ACT places great emphasis on team working. In ACT the vital link is between the team and the service user rather than individual team members and the service user. In this way ACT is a much 'purer' form of multidisciplinary team working than case management per se. In ACT several team members typically work with the same service user and deliver the interventions themselves rather than act as broker. There is ongoing discussion about the effectiveness of the various models of case management.

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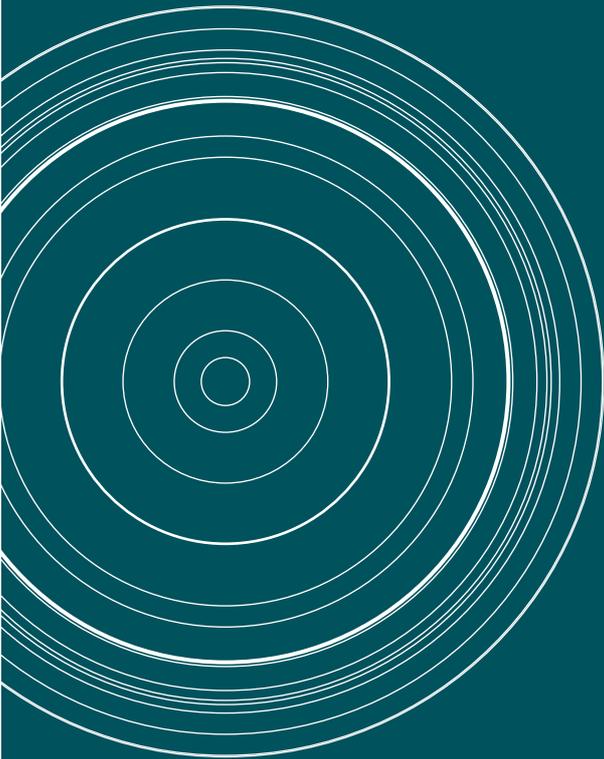
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Chapter 7:

Issues in multidisciplinary team working

7.1   Introduction

Working in a multidisciplinary team can be experienced as challenging and/or rewarding for a number of reasons. Factors identified from the literature which can inhibit or facilitate the effective functioning of teams were discussed in Chapter Three. Other key issues in multidisciplinary team working have emerged throughout this paper. These issues are examined here in detail, and include:

- team formation and implementation

- leadership

- management

- training

- conflict management

- supervision

- accountability

- confidentiality

- team policies.

7.2   Team formation

The experience of team working in other areas of health reveals some useful learning for mental health. The Primary Care Steering Group is charged with implementing the *Primary Care Strategy* nationally. The experience of the ten implementation sites has resulted in a set of guidelines/recommendations for developing team working, many of which are relevant to the development and formation process for multidisciplinary teams in mental health services:

- **teambuilding** – a formal programme of team building should be undertaken at the earliest stage of team formation to enable the team to develop a common vision and principles of operation

- **service focus** – the team needs to be very clear on the needs of the population it is serving and meeting those needs. This focus should inform the roles and responsibilities of team members and should also determine the competencies required by the team

- **organisational/management support** – organisational structures and management must be supportive to team development and team operation. Barriers at this level need to be addressed by those responsible who are outside of the team

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- **budgets and accountability** – budgets should be devolved to multidisciplinary team level and management structures need to be put in place to support this

- **agreed operational procedures need to be developed and documented**. These procedures clarify the business of the team as time passes and also help in the induction of new team members. An important area of operations relates to documentation and the need for a single chart/file for each service user. Appropriate technical support (e.g. a computerised information system) needs to be available to facilitate this.

7.2.1   Shared Values

The first step in team formation is to come together to agree the vision, and shared values and principles of the team. While the specifics of these may vary from team to team, multidisciplinary community mental health teams should have agreed principles under the following headings:

- agreed or group purpose and values - for example, well-defined values, standards, functions and responsibilities, and strategic direction;

- performance - which will involve leadership, competent management, good performance records and effective internal performance monitoring and feedback;

- consistency - including thoroughness and a systematic approach to providing care;

- effectiveness and efficiency - the team assess the care provided, and its clinical results;

- a chain of responsibility - demonstrating that responsibilities are well defined and understood;

- openness - for example, willingness to let others see in, and evidence of performance presented in ways that people outside the team can understand;

- overall acceptability - for example, the performance and results achieved by the team inspire the trust and confidence of service users, employers and professional colleagues and are motivated by a desire to focus on client's needs.

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7.2.2   Team development

Teams are not created overnight but develop over time and require investment on an organisational, professional and interpersonal level. The process of development is not always straightforward for team members. It is described by the Interdisciplinary Association of Mental Health Workers 1989 as: *"a balancing act between maintaining professional identity and blurring professional boundaries"*.

A useful exercise in developing teams is that reported by Peck and Norman (1999) in the second of two papers which explored inter-professional role relations in community mental health services. The methodology employed in this exercise is recommended as a simple, accessible but nonetheless effective means of clarifying roles and professional identities, and how these might be supported, in a multidisciplinary team context.

7.3   Decision-making in teams

The issue of leadership in teams can be a contentious one, although some professional groups have come together to produce an agreed statement on their role in multidisciplinary teams, for example, the Position Statement prepared by the Royal Australian and New Zealand College of Psychiatrists (See Appendix 3). Instead of considering the leadership issue directly it can be useful to examine this issue through a consideration of one of the central functions of a team leader - that of decision-making within teams. Literature from the areas of organisational theory and management practice are useful in this regard.

In the course of everyday practice teams must make decisions in a wide variety of areas, from individual clinical care plans to service management issues. Decisions may also need to be made urgently. An examination of the decision-making process using a simple typology from the field of management theory can clarify some of the issues around leadership models. Analysing the decision-making process based on the practical implications of the alternatives of democracy, consensus, anarchy and leadership can be helpful in understanding the process of team function, the importance of the leadership role and what is required of team leaders. The following section draws on the work of Renouf and Meadows (2001).

7.3.1   Democracy

A simple description of this approach is that each voice in a team carries equal weight in decisions and is weighted equally as choices for the team are determined – 'one person one vote'. A democratic approach to team management is often vaunted as the most desirable approach to the running of teams, in particular, to the decision-making process. However, a consideration of what this approach literally means in clinical practice reveals that this approach is neither desirable nor appropriate. With a democratic approach, each team member has a voice of equal weight, from the most experienced, most senior or most highly qualified, to the

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most recent and junior inexperienced recruit. A democratic approach to team management and decision making negates one of the most powerful advantages of team working; the wealth of experience and professional knowledge being brought to bear on an individual case.

7.3.2   Consensus

This type of decision-making implies that everyone must agree before a decision is made, and that all members have the right to veto. Where specific professions have mandated responsibilities, this approach is not appropriate. While a certain amount of consensual decision-making may work in well-functioning teams, this model does not work when one member of the team takes a different view to the others.

7.3.3   Anarchy

It is important to consider this model as accounts from teams often indicate that this is the model in operation. In anarchic teams there is no recognition that the team has any hold or constraint on the actions of the individual member. People may participate in team discussions but by their actions it is clear that they do not recognise the authority of the team. Anarchy may be overt (in team setting members claim the right to do as they see fit) or covert where there is participation in discussion but actions occur without reference to this discussion. Sometimes the team may not be given all the information required to make a decision and are therefore marginalised from the decision-making process. This type of team dynamic is dysfunctional, and where the care of individuals is concerned, can be dangerous.

7.3.4   Leadership

In a leadership model of decision-making, there is a person or small sub-group in the team that is recognised at some level within the team as having a particular role in decision-making that is different from other team members. This usually arises through the possession of power, authority, or both.

A reading of the literature on leadership, particularly in relation to decision-making, reveals that the most effective leadership involves guiding a team towards a decision. As Tobin & Edwards (2002) state: *Leadership is the process of influencing others to engage in the work behaviours necessary to reach organisational goals.* To do this the leader must have an understanding of the task and of the group processes, and must have the skills to bring this about. In everyday practice this involves the use of different styles within the group, depending on the decision to be reached. The whole purpose of multidisciplinary team working is to ensure broadly based clinical assessments and delivery of agreed integrated packages of care, in order to provide the best possible care to an individual with a mental health problem.

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The difference between authority and power in this context of decision-making in a team is that authority is often granted by the team on the basis of accumulated experience that the team has been heard, attended to and respected in routine decision-making. Often, this process in itself provides the basis for the acceptance by the team that on occasions, the leader will override the views of some or even the majority of the team. Successful leaders rarely have to resort to the use of power to achieve the adoption of decisions by the team.

7.4   Management

"Management is the process of achieving organisational goals by the four major functions of planning, organising, leading and controlling" (Tobin & Edwards, 2002). Ovretveit (1997) proposes that the work of a team manager in managing practitioners should involve three key tasks:

- ensuring that standards of practice are met

- establishing and implementing a framework of policies and priorities to determine caseload, referral procedures etc.

- staff support and development.

Onyett *et al.*, (1994) emphasised the need to strengthen strategic management in the planning and operation of teams within the wider context of local provision. Their survey of CMHTs in England showed an apparent 'management vacuum' within teams, as evidenced by the fact that only one in five team co-ordinators held overall responsibility for the allocation of cases to team members. In examining the increasing multi-professional nature of community mental health teams, Hannigan (1999) recommended that a shared model of team management be considered as a factor in promoting team cohesion. One possible 'shared model' is that where the roles of team leader (a clinician), team co-ordinator (a clinician) and team business manager are defined. This ensures that the 'clinical' management as described by Ovretveit above is carried out (by the clinical leader), that the triage and allocation of cases is carried out (by the team co-ordinator) and that the management of budgets and other operational issues is carried out (by the business manager).

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Training

CMHTs must see that their training needs are given appropriate priority within the joint training plan. Induction periods are needed for new staff (even if they have come from another CMHT). Users and carers should be involved in the delivery of staff training, which should include:

- skills in delivering the main interventions used by the team;

- team building, team working and peer support;

- familiarisation with the principles and philosophy of the team and with all operational policies;

- medication management - including local policies on administration, storage, legal issues, and assessment of side effects;

- knowledge of the Mental Health Act, 2001;

- information on the range of interventions;

- engaging and interacting with other services - both within the health services and primary care, and with other agencies such as the police and probation services;

- suicide awareness and prevention techniques and approaches.

There are two separate issues in relation to training and multidisciplinary team working. The first is the training that all mental health professionals receive at undergraduate level. The second is training in multidisciplinary working. One of the key barriers to multidisciplinary team working is the fact that mental health professionals (in common with all health professionals) are trained separately – often referred to as the 'silo effect'. Different disciplines rarely encounter each other until they are expected to come together and function as a 'multidisciplinary team'. Not only are the professions trained and educated separately, they rarely if ever receive training in multidisciplinary working – a skill in itself.

Arising from the experience of the ten implementation sites for the *Primary Care Strategy*, the steering group made a number of suggestions to the *Working Group on Undergraduate Medical Education and Training* (2004). As these suggestions are relevant to all health professionals including mental health they are listed here:

- the development of a range of common education modules for undergraduate medical, nursing and health and social care professionals;

- appropriate organisation and support of clinical placements in both secondary and primary, community and continuing care settings for undergraduates within a multidisciplinary team working context;

- development of new training modules at both undergraduate and postgraduate levels in clinical governance, management skills, communication skills, social and community issues and influences, multidisciplinary team working and IT skills.

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The *Primary Care Steering Group* emphasised "the importance of providing opportunities for medical undergraduates to train with other health and allied health professionals". This model for the education and training of all health professionals is essential if these professionals are to work together effectively in multidisciplinary teams.

At practitioner level, Ovretveit (1995) argues that a multi-disciplinary team without differences is a contradiction in terms. In addition to the normal differences that occur between people at work, it is well known that those in multidisciplinary teams have to cope with differences in worldview, professional identity, pay, educational background, status and attitudes. It is often stated that multidisciplinary working constitutes a threat to professional identity and that conflict in these situations can be attributed to 'tribalism', 'jealousy', or 'protectionism', and consequently may be regarded as adverse to the team process. The implementation of multidisciplinary team working requires training for staff who are likely to be working together if they are to function effectively. Ideally this should be conducted after staff have developed a firm concept of their own base discipline and more opportunities for multidisciplinary in-service education should be identified.

7.6   Conflict management

Team members bring different ideas, goals, values, beliefs and needs to their teams and these differences are a primary strength of teams. These same differences inevitably lead to some conflict. One of the ways in which team members can help each other improve their abilities to function in multidisciplinary teams is to work with each other to develop their understanding of conflict and their capabilities to manage and resolve conflict.

Conflict may be defined as a struggle or contest between people with opposing needs, ideas, beliefs, values, or goals. Conflict on teams is inevitable; however, the results of conflict are not predetermined. Conflict might escalate and lead to non-productive results, or conflict can be beneficially resolved and lead to quality final products. Therefore, learning to manage conflict is integral to a high-performance team. Although very few people go looking for conflict, more often than not, conflict results because of miscommunication between people with regard to their needs, ideas, beliefs, goals, or values. Conflict management is the principle that all conflicts cannot necessarily be resolved, but learning how to manage conflicts can decrease the possibility of non-productive escalation. Conflict management involves acquiring skills related to conflict resolution, self-awareness about conflict modes, conflict communication skills, and establishing a structure for management of conflict in the environment.

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7.7   Supervision

It is particularly important within a multidisciplinary team that each professional maintain their own professional skills. To ensure this, an agreed system of clinical supervision should be in place. This system needs to balance the need for discipline-specific supervision with the need to maintain the pre-eminence of the team as the primary provider of support and daily supervision through case review.

7.8   Accountability

A review on clinical accountability within the mental health sector by the Mental Health Commission of New Zealand (1998) found that while everyone is agreed that clinical accountability is very important, there was no shared definition of this concept and no commonly agreed framework or model to guide thinking in this area. There was also agreement that clinical accountability sits within a broader framework which includes economic accountability, managerial accountability and political accountability. An interesting finding from this review was that the majority of service providers (mental health professionals and managers) and service users expressed some form of personal accountability. A critical issue was the lack of clarity regarding the roles and responsibilities within the multidisciplinary team. Confusion regarding the boundaries of accountability were particularly noticeable in relation to the roles of keyworkers/case managers and psychiatrists.

7.9   Confidentiality

Confidentiality – specifically the need to maintain 'doctor-patient' confidentiality is often cited as a barrier to multidisciplinary team working. Service users expect confidentiality when they meet a mental health professional. However, team working is a very different way of working and needs to be discussed and negotiated with the service user. There are two issues relating to confidentiality in multidisciplinary teams. The first is the need to share information between team members. One of the central principles of the model of multidisciplinary team working proposed in this discussion paper is the central involvement of the service user. Multidisciplinary work is not 'done to' the service user – *it is done with the service user*. The service user is closely involved with the team and their keyworker in negotiating and working out a care plan – *their* care plan. Secondly, the carers/family should also be involved in this process, with the agreement of the service user. This should help address concerns often cited by carers/families that they can be excluded from any discussion concerning the care of their family member, and yet are expected to provide 24 hour informal care as needed.

As in other health areas, the need for confidentiality must be balanced with the principle of providing treatment and care that is in "the best interests of the patient". Hence in other specialities such as oncology, the diagnosis and treatment is routinely discussed with the family – the family sometimes requesting that the individual who is ill not be told their diagnosis. In many specialities, the treatment

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and care of an individual is often discussed with other colleagues, usually not with the explicit consent of that individual. What is proposed here is a model of working in which issues of confidentiality are intrinsically addressed by the model – that of working in partnership with the service user.

Confidentiality is one of the issues that must be addressed in team formation and agreeing team values and principles. Mechanisms of maintaining confidentiality must be in place and a formal policy prepared to assist in training and induction of new team members.

7.10   Team policies

The process of team formation involves agreeing a team philosophy, a way of working that is embodied in a set of shared values (see 7.2.1). This agreed philosophy and set of values should be documented as part of the operational policies of the team. The everyday working and functioning of the team should also be documented. These policies and procedures form part of the overall operational policy of each multidisciplinary team. Not only is this policy a written record of agreed protocols, it is essential for the training and induction of new team members.

There are specific policies and protocols that are part of the overall operational policy of the team. These need to be developed, agreed and put in place to deal with particular issues/situations.

Chapter 8
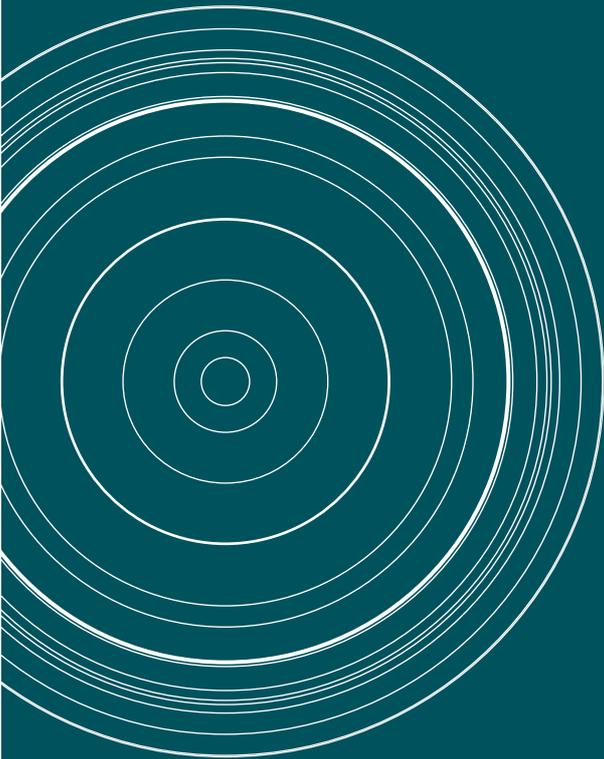
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Chapter 8:

The next step – issues and questions to consider

This discussion paper will be widely circulated to all stakeholders in the mental health services with a view to promoting debate and discussion among all those involved in using and providing mental health services. It is particularly hoped that discussion will take place among teams and mental health professionals involved in delivering mental health services.

A template has been developed to help guide discussion and provide a means of examining the working of your own team (see Appendix Four). This may help to provoke discussion around some of the central issues in this discussion paper.

A series of 23 questions is also outlined below. These questions can be answered by any of the stakeholders in mental health, not just those involved in front-line work.

The Mental Health Commission would appreciate if you as an individual or organisation would answer these questions and return your answers to us. The Commission will then consider all the feedback received and will formulate a definitive statement on multidisciplinary team working in Ireland.

8.1   Questions arising from the discussion paper

Question 1:   Given the definitions in Chapter Two, which term best describes team working in mental health services?

Question 2:   In the Irish experience, what are the barriers and facilitators to multidisciplinary team working?

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

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

Question 5:   Who should be on a multidisciplinary team in an adult mental health service?

Question 6:   Taking into account the answer to question 5, what is an appropriate caseload for a multidisciplinary team in an adult mental health service?

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

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

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

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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 (these topics are covered in more detail in Chapter Seven).

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

Question 12:   What is the most appropriate referral pathway for effective multidisciplinary team working?

Question 13:   From your experience, what is required for effective multidisciplinary team working?

Question 14:   What are the key challenges in team formation and how should this process be facilitated?

Question 15:   How can we ensure that there is effective leadership in teams? What is an appropriate leadership model for multidisciplinary teams?

Question 17:   What is the most appropriate and effective model for multidisciplinary team management?

Question 18:   How should ongoing training be facilitated and provided?

Question 19:   How should conflict be managed on multidisciplinary teams?

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

Question 21:   What is a useful definition of clinical accountability? What is the most effective way of ensuring clinical accountability in multidisciplinary teams?

Question 22:   How should confidentiality be dealt with in a team situation? How should this be explained to service users?

Question 23:   What are the essential policies for a multidisciplinary team and how might these be drawn up?

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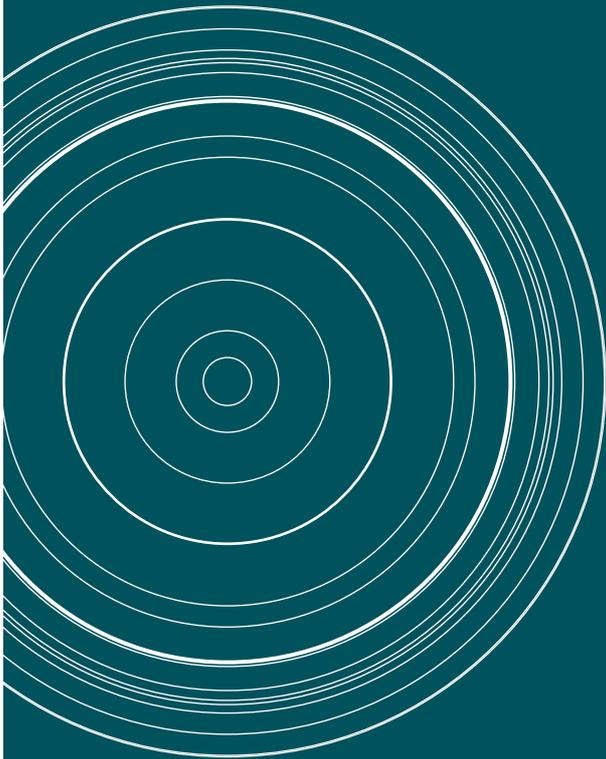
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Appendices
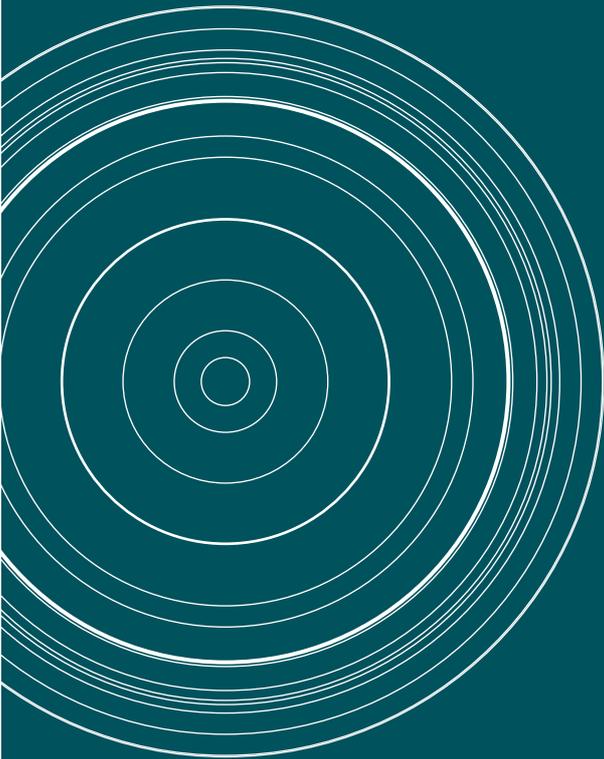
Appendix 1:

Example of multidisciplinary team working from Australia.

This example describes the working of an adult continuing care, multidisciplinary, community-based mental health team.

Team description

This team covers a catchment area of 300,000 population and has an average caseload of about 365 clients at any one time. There are 21 WTE clinical staff on the team, and 3.9 administration staff (a total of 30 people which takes into account some part-time workers). There is a mixture of Psychiatrists, Psychiatric Registrars, Psychologists, Social Workers, Psychiatric Nurses and Occupational Therapists on the team, and a Psychiatric Services Officer (similar to an aide).

Access to other services

The team has access to 25 inpatient beds, a Crisis and Assessment Team, a Mobile Assertive Outreach Team and 20 beds in a Psychosocial Rehab Residential Service. In addition a single point of entry Triage Service operates, which services all teams, and a separate Primary Mental Health/Shared Care Team, whose objective is to work closely with primary providers (e.g. GPs) to improve access and overall management of clients with a mental illness.

Team formation

The team was formed as part of the deinstitutionalisation process of Victorian Mental Health Services. All catchment areas had a Continuing Care team formed.

Training and development

Ongoing team development activities are organised locally and by a staff training and development unit operated by the main health network (NorthWestern mental health) that five different area mental health services can access. All new staff receive a formal two week induction process at the team level, where they enjoy the opportunity to learn about current systems and processes and gradually become familiarised with their caseload. The organisation also provides a one-day orientation to network wide issues e.g. Debriefing.

Team management

The team is operationally responsible to a manager and clinically responsible to psychiatrist. The team also has a team leader whose main role is to support implementation of change by management and ensure overall quality of service delivery. The manager assumes no clinical responsibility (although is a trained

clinician). He is responsible for all operational, strategic and service development decision making. An area manager is responsible for the entire area wide service delivery.

Supervision and accountability

All staff must participate in clinical supervision with either their discipline senior or delegate. Clinical accountability is dealt with in a similar way, via the program psychiatrist who assumes overall clinical accountability.

Confidentiality

Clients are aware that the mental health professionals they see operate as a multidisciplinary team. There are strict confidentiality guidelines for information released external to the agency. There are also policies and procedures, which deal with only relevant people being aware of information within the treating team. Confidentiality principles are enshrined in Victorian legislation.

Team operation

An assessing team which consists of a doctor and case manager is allocated to each new referral. The aim is for the assessment to help determine whether services are required and if so which ones. Each client has an allocated case manager and treating doctor. This makes up the treating team. All clients must have an individual service plan (care plan) that is collaboratively prepared by CM (case manager) with client, carers, doctor and other service providers and this is presented to the multidisciplinary team and signed off by the Consultant Psychiatrist. Files are kept in a secure compactus and all files are tracked through the different teams - there is a single file for each client so transfer of files between teams (particularly inpatient and community) is often required.

Working arrangements

Fortnightly team meetings are chaired by either the program manager or team leader. There is emphasis on portfolios and there is also a quality team who meet fortnightly. The team operates from 9.00am to 5.00pm. There is a senior clinician on duty to assist with day to day decision making. There is an executive team who are regular decisions makers. Conflicts are resolved through communication.

Service user involvement

The service employs two part time consumer consultants who contribute to program planning and development and are part of the service's executive team. They are also involved in developing procedures for receiving feedback from consumers and provide direct support to consumers - particularly at the inpatient unit. They also assist in the ongoing work of the Consumer Advisory Group. A collaborative, client centred approach is required in all aspects of service delivery and reflected in the development of ISPs and treatment plans. The service also employs two part time carer consultants. They are members of the executive and play an active role in service development and in providing direct support to families. They also facilitate the local carers support group.

Information routinely given to clients includes a patient's rights booklet, statement of rights and responsibilities for staff and consumers, orientation package that includes information about the service, the role of the case manager etc.

Appendix 2:

Possible referral pathway

Figure A1: Referral Pathway


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                    ┌─────────────────────┐
                    │   Referral Source   │
                    └─────────────────────┘
                               │
              ┌────────────────────────────────┐
              │     CMHT Team Co-ordinator      │
              └────────────────────────────────┘
                               │
                    ┌─────────────────┐         ● Discharge
                    │     Triage      │─────────
                    └─────────────────┘         ● Other Community
                               │                   Services
                               │        ┌──────────────────┐
                               │────────│    Urgent -      │
                               │        │  seen 2 hours    │
                               │        └──────────────────┘
              ┌────────────────────────────────┐
              │        Case presentation        │
              │      Weekley MDT meetings        │
              │           Allocation             │
              │           Care Plan              │
              └────────────────────────────────┘
                               │
                    ┌─────────────────┐
                    │     Review      │──────── ● Discharge
                    └─────────────────┘
                               │
              ┌────────────────────────────────┐
              │   Referral to other team/service │
              └────────────────────────────────┘
                               │
     ┌──────────────┬──────────────┬──────────────┬──────────────┐
 ┌─────────┐   ┌──────────┐   ┌──────────┐   ┌──────────┐
 │Rehabili-│   │  Crisis  │   │   Peer   │   │  Other   │
 │ tation  │   │ Support  │   │Service / │   │  Mental  │
 │  Team   │   │   Team   │   │User      │   │  Health  │
 │         │   │          │   │Support   │   │ Service  │
 └─────────┘   └──────────┘   └──────────┘   └──────────┘
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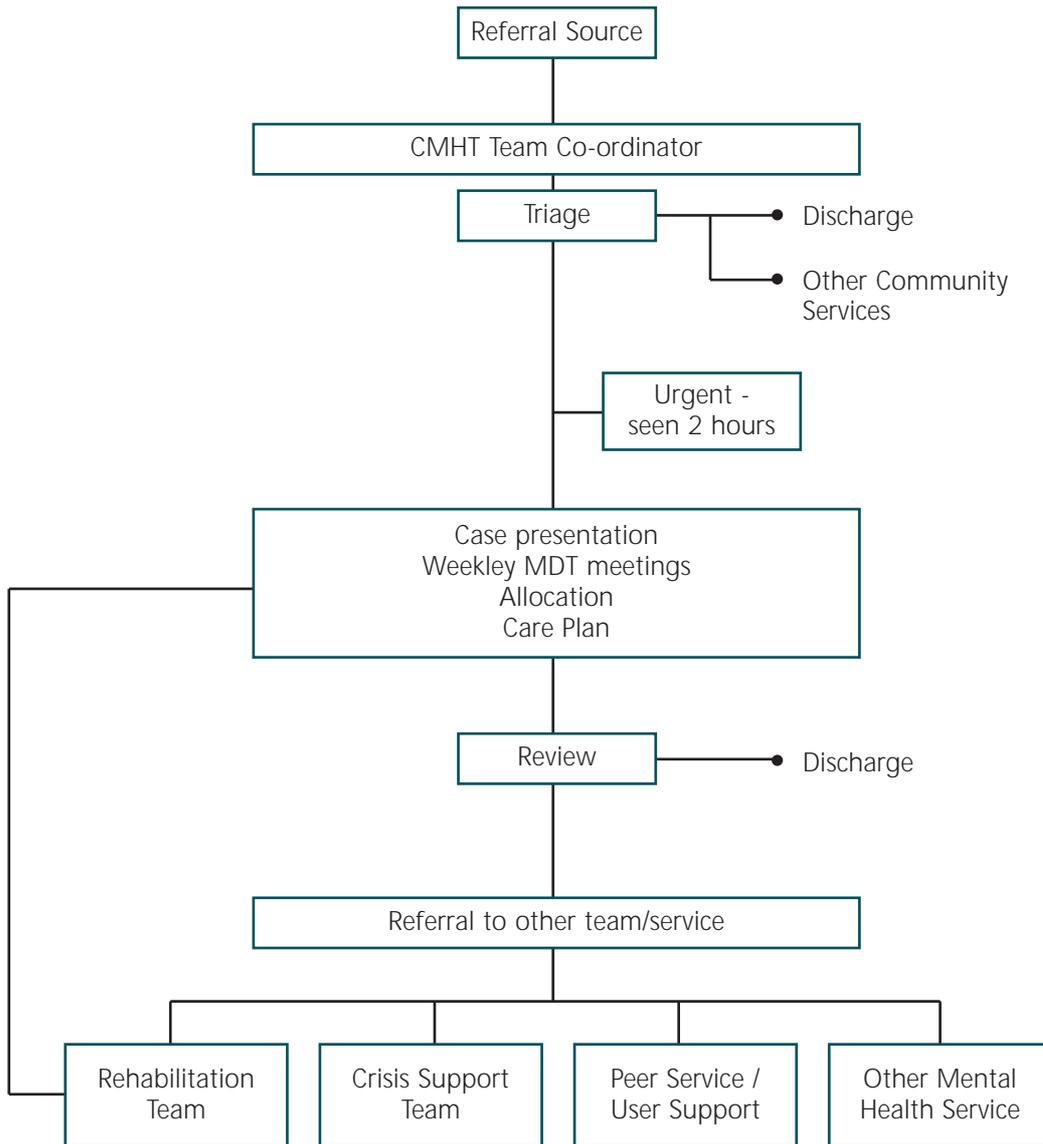
Appendix 3:

The Royal Australian and New Zealand College of Psychiatrists[2] (Position Statement No. 47)

PSYCHIATRISTS AS TEAM-MEMBERS

Health care is increasingly provided by multidisciplinary teams. Psychiatrists are expected to work constructively within teams and to respect the skills and contributions of colleagues. In relation to collaborative practice, the RANZCP acknowledges the following:

1.   Clinical authority is vested in the psychiatrist by virtue of training and experience and can be enhanced by good teamwork.

2.   Psychiatrists working in a team remain accountable for their own professional conduct and the care they provide.

3.   Clinical responsibility, which relates to duty of care and standards of care, rests with every health care professional.

4.   The psychiatrist is an essential contributor to the multidisciplinary team.

5.   Collaborative practice assists in promoting better health outcomes for people experiencing mental illness and their carers.

6.   Effective mental health care requires collaboration between consumers, carers, mental health professionals (including psychiatrists), general practitioners, non-government and government agencies.

7.   Psychiatrists understand and value the expertise of the other mental health professionals.

8.   All mental health professionals need training in the principles and application of teamwork. Training programs need to give trainees a positive experience of collaborative work environments.

9.   Management of a multidisciplinary team is not necessarily the domain of the psychiatrist.

10.   Psychiatry trainees are responsible to their supervising psychiatrist.

---

2   The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal body representing the medical specialty of psychiatry in Australasia and having responsibility for training, examining and awarding the qualification of Fellowship of the College to medical practitioners.

Appendix 4

Template for team discussion

Team composition and access to services

How many people are on the team?

What professions/disciplines are on the team?

What is the population served by the team and the estimated caseload of the team?

What access does the team have to inpatient beds, day hospital places and other residential/day mental health services?

What other teams operate in your area – e.g.

- o assertive outreach teams

- o acute care/crisis management teams

- o rehabilitation teams etc.?

Team formation and development

How was the team formed/developed?

Are there ongoing team development/maintenance activities/programmes?

What is the induction process for new staff?

Team management issues

Describe the management structure of the team?

What are the supervision arrangements?

How is clinical accountability dealt with?

Is there a leader/manager/coordinator of the team?

How does this work?

How is confidentiality handled within the team and what do clients think of their case being discussed and managed by a team rather than being managed by one mental health professional?

Team operation/working arrangements

What is the everyday working system of the team e.g.

- who allocates referrals?
- is a team assessment carried out?
- how are team meetings managed?
- is there a keyworker/case management system?
- what are the hours of operation?
- how is decision making handled?
- how are conflicts resolved?
- is there a multidisciplinary care plan?
- describe record-keeping?

Service user involvement

What is the involvement of the service user in the model of working?

What information is routinely given to service users and carers?

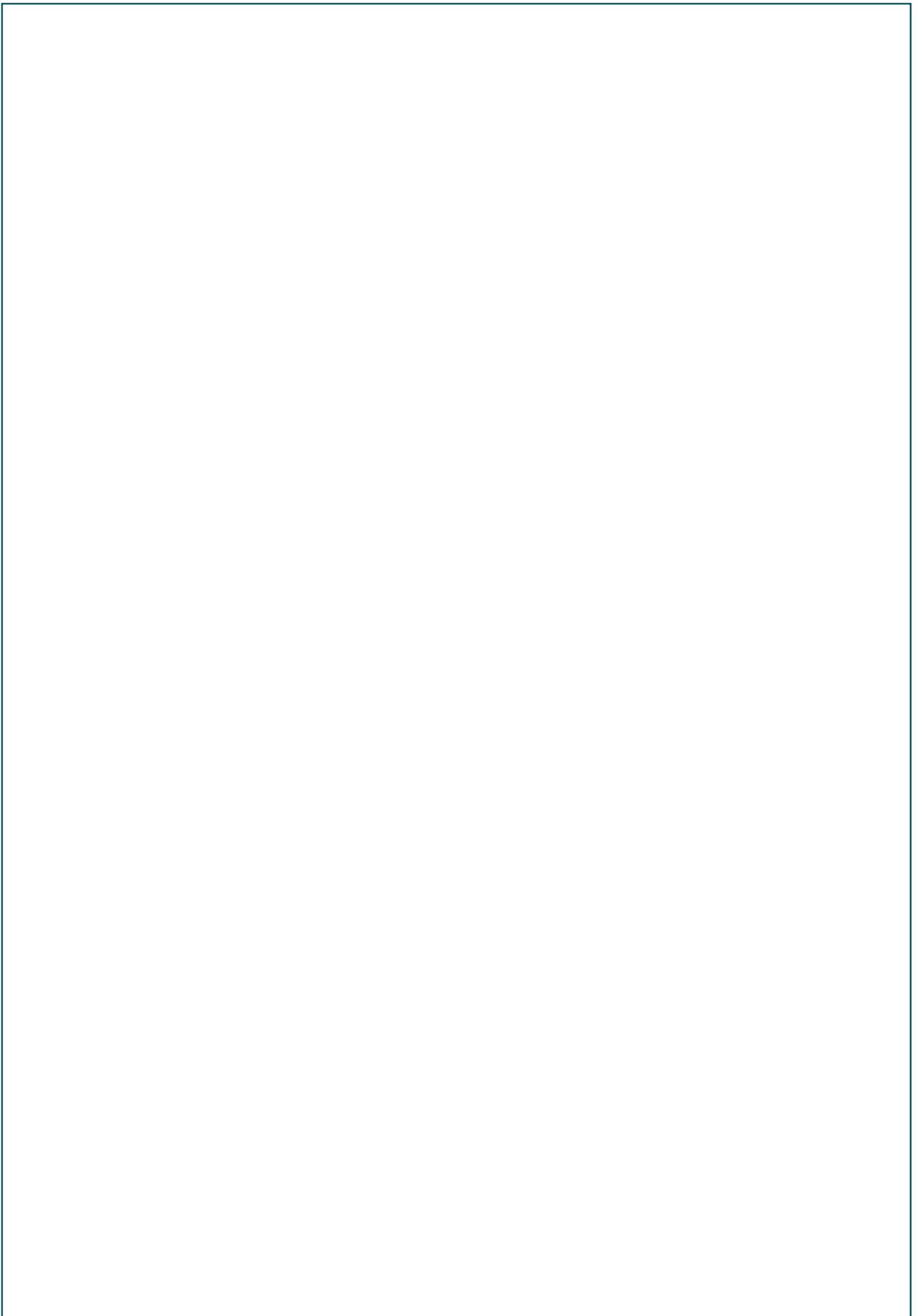Are carers/family routinely involved in care planning? If so, how?

Overall

What do you think your team does well?

Are there any changes you would like to make?

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