A Response to the Mental Health Commission’s Discussion Paper ‘Multidisciplinary Team Working: From Theory to Practice’ (January 2006)

Michael Byrne

Dr. Michael Byrne is a Clinical Psychologist with HSE Dublin Mid-Leinster. Correspondence regarding this article may be addressed to him by email to michael.byrne2@mailq.hse.ie.

Introduction

In February 2006 the Mental Health Commission published a welcome discussion paper on multidisciplinary teamwork entitled ‘Multidisciplinary Team Working: From Theory to Practice’ (http://www.mhcrf.ie/publications.htm). This was a substantial achievement given that the complex nature of teamworking in mental health services has both defied exact description and made discussion difficult, as evidenced by the dearth of associated research.

To summarise, the discussion paper firstly profiled the rationale and influencing factors of multidisciplinary teamworking, and the required core competencies and the potential team membership for multidisciplinary teams. Two models of multidisciplinary team working were presented. The ‘Keyworker’ model with triage at point of referral proposed a single point of access and allocation of referrals by a team coordinator, along with a clinical leader and a business manager who together formed a shared (tri-partite) management structure. The more variant ‘Care/case management’ model was also proposed, with each service user assigned a ‘case manager’.

I hope that the Commission will both use some of the following feedback to broaden the ongoing debate and continue to commit to facilitating the necessary dialogue between the relevant stakeholders so that effective teamworking can be more readily realised. Ideally, a multidisciplinary research programme will also inform this ongoing dialogue. Such research, in highlighting the current inadequacies in multidisciplinary teamworking, needs to create the sense of urgency required for change. It is no less than service users and staff of our mental health services deserve.

Structure of this document

The Commission requested feedback on their discussion paper in the form of answers to 22 questions (listed below) detailed in Chapter 8 of the Commission’s discussion paper (p. 50-51). Hence, the structure of this document is divided into 22 sections followed by a concluding section.

Focus on Community Mental Health Teams

Although the (generic) Community Mental Health Team (CMHT) may be set to become extinct in some jurisdictions in favour of a plethora of specialist teams (Peck, 1999), it appears that the Community Mental Health Team (CMHT) will for now remain the standard service configuration in adult mental health services in Ireland. Therefore, the feedback contained herein centers primarily on CMHTs. However, the issues discussed are also relevant to teamworking in most multidisciplinary mental health teams.

Questions arising from the Mental Health Commission discussion paper on multidisciplinary teamworking:

1. Given the definitions in Chapter 2, which term best describes teamworking in mental health services?
2. In the Irish experience, what are the barriers and facilitators to multidisciplinary teamworking?
3. Is the concept of competencies and/or capabilities useful for describing what is required of multidisciplinary team members in a mental health service?
4. What are the skills, knowledge and attitudes required to work in multidisciplinary teams? Does the list in Chapter 4 capture everything that is required?
5. Who should be on a multidisciplinary team in an adult mental health service?
6. Taking into account the answer to question 5, what is an appropriate caseload for a multidisciplinary team in an adult mental health service?
7. Is the model outlined in Chapter 5 a useful model to describe the links that are needed between the multidisciplinary team and other services?
8. What is the best way to ensure that service users are involved in their care planning process?
9. What is the role of trained/expert service users in mental health services?
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.
11. Which model of multidisciplinary teamworking is most appropriate to the provision of adult mental health services in an Irish context?
12. What is the most appropriate referral pathway for effective multidisciplinary teamworking?
13. From your experience, what is required for effective multidisciplinary teamworking?
14. What are the key challenges in team formation and how should this process be facilitated?
15. How can we ensure that there is effective leadership in teams? What is an appropriate leadership model for multidisciplinary teams?
16. What is the most appropriate and effective model for multidisciplinary team management?
17. How should ongoing training be facilitated and provided?
18. How should conflict be managed on multidisciplinary teams?
19. What is the most effective model to provide both discipline-specific supervision and supervision by team members?
20. What is a useful definition of clinical accountability? What is the most effective way of ensuring clinical accountability in multidisciplinary teams?
21. How should confidentiality be dealt with in a team situation? How should this be explained to service users?
22. What are the essential policies for a multidisciplinary team and how might these be drawn up?

1.1 What is a team? What is a team working? Given the definitions in Chapter Two, which term best describes team working in mental health services?

1.2 What is a multidisciplinary team? The medical (and uni-disciplinary) emphasis by Jeffries and Chan (2004) on the ‘disease trajectory’ of patients (in their definition of multidisciplinary teamworking is somewhat unfortunate. Additionally, their definition does not elaborate on the ‘mechanism’ that distinguishes multidisciplinary teamworking from other forms of collaboration. A more apt definition may be ‘workers, operating out of their disciplinary bases, work parallel to each other, their primary objective being that of co-ordination’ (Opie, 1997, p. 263). While such teams highlight professional roles with little emphasis on group processes (Kane, 1980), ‘co-ordination of effort appears to be the distinguishing characteristic of multidisciplinary teamworking (Davis, 1988).

1.3 Interdisciplinary working Further along the teamwork continuum yet not reaching the status of transdisciplinary working is interdisciplinary working. This describes ‘an arrangement whereby members operate from within their particular disciplinary orientations but undertake some joint collaborative work’ (Opie, 1997, p. 263). Given the inherent belief in interdependence (Kane, 1980), the essence of interdisciplinary working is the ‘integration’ of expertise and perspectives of professionals from different disciplines (Farhall, 2001). Hence, it goes beyond interdependence and deliberately encourages role blurring in pursuit of realising collective goals (Nolan, 1995).

1.4 Teamworking in CMHTs Probably adding to the confusion as to what constitutes ‘true’ CMHT working has been the indiscriminate use of the terms...
Such dysfunction may predispose CMHTs to be a manifestation of the sometimes 'dysfunctional' relations between disciplines (Farrell, 2001), spawned by the collision of numerous environmental, personal, occupational and professional factors that CMHTs have to contend with.

The Mental Health Commission’s discussion document highlights the majority of these factors. However, as with previous publications concerning multidisciplinary teamworking (e.g. Byrne, 2009) the informality may need to further address the informal, submerged or process factors that are a prerequisite for positive multidisciplinary teamworking. The following feedback will endeavour to highlight these and the more obvious formal factors that influence teamworking.

2.2 Research to date

While appreciating that benefits may be difficult to ‘capture in the data’, research to date indicates that the concept of multidisciplinary teamwork in mental health teams is yet to be fully realised (Norman & Peck, 1999). Teams may be delivering parallel services, largely organised along (traditional) disciplinary lines with little interdisciplinary integration (Martin et al., 1999). While these teams may not be ‘teams from hell’, they appear to fall far short of the ideals of high-performing ‘dream teams’ (Richards & Moger, 1999). Some commentators have argued against clinical priorities (Byrne, 2006b). Hence, this appears to be the ‘feel’ of CMHTs (Burns, 2004) that may be that teamworking can only be studied situationally (Stark, Stronach, & Warne, 2002). However, despite the lack of research to date, there are particular factors, the presence or absence of which can serve as barriers or facilitators to multidisciplinary teamworking.

2.3 Multitude of influencing factors

Such is the variety of factors that determine the ‘feel’ of CMHTs (Burns, 2004) that it may be that multidisciplinary functioning can only be understood situationally (Stark, Stronach, & Warne, 2002). However, the lack of research to date is far short of the ideals of high-performing ‘dream teams’ that have to contend with. Alternatively, they may be ‘teams from hell’, they appear to fall far short of the ideals of high-performing ‘dream teams’ (Richards & Moger, 1999).

2.4 Environmental factors

2.4.1 Legislative changes

From a legal perspective, it appears that the provisions of the Mental Health Act (Government of Ireland, 2001) concentrate primarily on involuntary admissions, independent reviews of detention, and consent to treatment (Millis, 2002). Hence, it appears that this Act will not impact significantly upon CMHT functioning. However, there is a need for interdisciplinary debate regarding the consequences of this legislative change.

2.4.2 Strengthening of non-medical professions

Psychiatry has traditionally dominated the mental health services in Ireland. Its biological reductionist tendencies are being challenged by the expansion in the number of approved posts, the increasing pay scales and the upgrading of courses to doctoral status of some non-medical CMHT disciplines. Such developments will aid the evolution of more holistic mental health services (Houghton, 2002).

2.4.3 Increased consumerism

The emergence of consumerism may heighten pressures on occupational groups within CMHTs to defend their individual territories (ownership in service provision) with a consequent heightening of traditional power struggles (Nolan, 1995, p. 306).

2.4.4 Increasingly diverse population

As is already apparent in most HSE areas, the increasing ethnicity of the Irish population will continue to influence clinical need, the composition of CMHTs, and how these teams function in response to such evolving needs (Byrne, Lee & McAluliffe, 2006).

2.5 Team structure

2.5.1 Insufficient resources

CMHT functioning may be facilitated and/ or impeded by historical service provision practices or by political influences on resource allocation (Royal College of Psychiatrists, 2001). While it is generally accepted that there will never be ‘enough resources’ (i.e. demand for services will always increase to outstrip service provision; Burns, 2004), CMHTs have struggled to acquire adequate ‘ring-fenced’ funding (Oyett, Heppleston, & Bushnell, 1994) or sufficient control over how it is allocated or deployed (Heginbotham, 1999).

A lack of resources is often cited by CMHT members as a primary source of stress (Parry et al., 1998) which in turn can impact negatively upon team functioning (Carter & West, 1999) and staff retention (Payne, 1999). Sharing of personal space (e.g. ‘hot desking’) and lack of necessary materials or professional training opportunities required to execute one’s duties can likewise compromise teamworking (Byrne et al., 2006; Callaly & Minas, 2005; Castka et al., 2001).

2.5.2 Departmental structures

The balance of disciplinary specific departments that may have traditionally secured resources ‘through the creation of local power structures’ may be reluctant to dilute their power by integrating into functional teams as doing so may weaken their power base for resource acquisition (Carter, Garside & Black, 2003, p. 126).

If CMHT members continue to be contracted in from such undisciplinary departments, there remains a potential for conflict as the goals or work practices of these departments might clash with the culture of specific CMHTs (Byrne et al., 2006).

2.5.3 Communal base

Not all CMHT members will inhabit the same location because of the very different working environments that they have come to work in (e.g. Byrne et al., 2006). However, having a communal base can facilitate sociability and informal, frequent intra-team communication that may enhance information transfer (Molyneux, 2001).

2.6 Formal team processes

2.6.1 Weekly team meeting

Given the basic requirement of a team that members at least engage in face-to-face discussions of clinical cases, CMHTs that do not meet regularly may not warrant the title of ‘team’ (Hunt, 1983). Ideally CMHT meetings would have to take place weekly and be minutes (Byrne et al., 2006). Despite the democratic appeal of a rolling chair for these meetings, some team members may feel ill-equipped to assume such a role. Therefore, rather than empowering team members, a rolling chair arrangement may reinforce a sense of inadequacy (Brown et al., 2000).

2.6.2 Lack of appropriate performance indicators

Within CMHTs, statistics such as the number of acute admissions, the numbers of service users seen, and the length of waiting lists have been perceived as ‘good currency’ (Cushion, 1997). However, it is important to guard against only using such administratively convenient performance indicators. If quality of performance is allowed to lose out to such ‘quantification’, teamworking may be impeded by distorted clinical priorities (Byrne, 2006b).

Some commentators have argued against the self-defeating ‘specification’ of indicators as they can undermine the trust that is ‘necessary for an expert system to function effectively’ (Tanoukas, 1997, p. 85). However, in this era of increased accountability, it behoves all CMHT members to embrace output indicators such as accessibility, targeting of the relevant population, and...
the degree of co-ordination or integration of care (Richards & Rees, 1998).

2.7 Informal team processes

2.7.1 Communication

Intra-team communication is a strong predictor of positive team functioning (Molyneux, 2001), in part because it serves to promote a ‘shared’, ‘convergent’ or ‘common’ mental model of team functioning (Molyneux & Dumville, 2001). Resultant ‘solidarity’ or focus on agreed processes to realise shared goals related to service user needs can help transcend traditional barriers, improve team effectiveness and reduce the negative impacts of stress on team members (Almo-Metcalfe & Almo-Metcalfe, 2003; Headrick, Wilcock, & Batalden, 1998).

However, team communication is often lacking or is stifled. For example, there may be differing interpretations of team buzzwords and professional jargon (Leipzig et al., 2002), and team members may remain blind to the language of different disciplines (Pietroni, 1992). Minimal liaison between professional bodies may prolong this status quo (Wilson & Pirrie, 2000). Poor communication may also manifest as team members striving consumers to be uncooperative and negative, and ultimately to be avoided (Nievaard, 1987).

There may also be little debate (and consequent resolution) of ‘unspeakable’ but central issues such as inter-professional boundaries (Bailey, 1977). Effective communication also protects against the tendency in teams to rehash shared information at the expense of pooling unshared information (e.g. Stasser, Stewart, & Wittenbaum, 1995).

While communication may be facilitated by a trust-based atmosphere of psychological safety, a socialised communication hierarchy may conspire against it.

2.7.2 A foundation of trust (Refer to Section 14.5.3)

The ‘sphere of’ quality of trust is critical for successful collaboration (Maslow, 1965). It is necessary underpinning for the intra-team ‘synergy’ that characterises improved team performance (Erdem, Ozen, & Atsan, 2003). However, it is dynamic and fragile rather than a stable and robust characteristic of teams that has to be nurtured (De Dreu & Van Vianen, 2001). Within teams, ‘collective’ trust is ‘a function of other team members’ perceived ability, integrity and benevolence’ and of the ‘members’ own propensity to trust within teams’ (Jarvenpaa, Knoll, & Leidner, 1998, p. 29).

2.7.3 Socialised communication hierarchy

Hierarchy, or power distance, can thwart attempts to develop an atmosphere of ‘psychological safety’ so that ‘subordinates’ may either refrain from voluntary communication or resort to the ‘hint and hope’ model of speaking indirectly (Leonard, Graham, & Bonacum, 2004). Indeed, many ‘allied health professionals’ may be reluctant to voice their opinions in multidisciplinary healthcare teams (Atwal, 2015). The relative youth and inexperience of some of these professionals may also predispose to a tendency to ‘bite their lip’ (Peck & Norman, 1999).

Given that their training and professional culture remain nested within a hierarchical model that reinforces large authority gradients, some ‘lead’ professionals may not be equipped for facilitating ‘psychologically safe’ horizontal communication within multidisciplinary settings (Sainsbury Centre for Mental Health, 1999b). Hence, both reticent CMHT members and team leaders may inadvertently inhibit open team discussion and (reciprocally) perpetuate poor intra-team communication, thus prolonging the infusion of psychiatric thinking in CMHTs.

2.7.4 Potential for ‘groupthink’

There is also a real danger of a CMHT being influenced by the most dominant team member to team matters to the extent that ‘group-think’ occurs. This describes how teams close up against outside messages and strive prematurely for unanimous agreement on a course of action (Ahlgner & Esser, 2001). In contrast to such conformity, there may be chronic consensus seeking or ‘analysis paralysis’ whereby teams, possibly giving excessive attention to the trappings of democracy, cannot reach agreement on issues and remain in constant conflict. Ideally, an equilibrium will be maintained between cognitive consensus and diversity (Mohammed & Peck, 2001) which may facilitate team members engaging in ‘constructive controversy’ in relation to decisions.

2.7.5 Information systems/sharing

A single integrated system of record keeping may enable team members to keep track of the work with each service user and aid team members’ understanding of each other’s roles (Baker, 1996; Molyneux, 2001). However, the limits of confidentiality of some professions may limit the sharing of information within CMHTs and, ultimately, team collaboration (British Psychological Society, 2001). For example, Psychologists might keep separate session notes but make entries into the permanent integrated file.

Although ‘communal’ files help avoid duplication, they can become quite voluminous, making it difficult to readily locate clinically-relevant information. Hence, regular and structured review meetings to formulate a summary of the current clinical approach may be needed to prevent clinical care drifting (Burns, 2004).

2.7.6 Distinct occupational cultures

CMHT members typically have a set of profession-specific values that are further nurtured by the complex process of professional (or secondary) socialisation (Atkins, 1998; Peck, 1999). While professional bodies may safeguard professional standards, the training programmes they accredit can transmit a distinct occupational culture that can ultimately manifest as ‘tribal loyalty’. Such ‘tribalism’ is ‘originated and perpetuated anew in every cohort and generation of student professionals’ (Beattie, 1995, p. 16). Tribal (inter-professional) boundaries can subsequently be maintained through ‘professional reductionism’ or claims to unique competencies in specific areas that can counteract openness to ‘role blurring’ (Hugman, 1991).

These distinct occupational cultures and associated models of care can be disruptive of assumptions about expertise and professional groupings (Wall, 1998). CMHTs can also violate the ‘ingrained’ medical dominance in health care (Samson, 1995). Team members typically place varying degrees of emphasis on the ‘biological’, ‘psychological’ and ‘social’ aetiologies of mental illness (Hannigan, 1999), so much so that there may be particularly divisive debate about treatment approaches (Norman & Peck, 1999). The client advocacy of some professions (Bronstein, 2003) may also conspire against the benefits of others (Peck & Norman, 1999). Indeed multidisciplinary working involving health and social services professionals appears to heighten, rather than resolve, their distinct professional ideologies and cultures (Adams, 1998).

2.7.7 Stereotyping of other professions

While membership of social groups (e.g. a profession) may protect practitioner self-esteem, as per social group theory, it can also predispose to the perception that in-group attributes are superior to those of out-groups (Shute, 1997). Hence, medication management might be elevated above daily living skills training. However, such stereotyping can perpetuate the tendency to under value what other professions have to offer. Subsequent under use of the skills of out-groups can generate hostility in out-group members (Farhall, 2001).

2.7.8 Autonomy, accountability and responsibility (Refer to Section 20)

CMHT members are socialised for clinical autonomy, or the exercise of ‘considered’ and ‘independent’ judgement (Keenan, 1999). With autonomy comes accountability or answerability to authority for one’s responsibilities (Maa & Jacox, 1977) or the set of tasks or functions demanded by the authority (British Psychological Society, 2001). As practised in co-ordinated teams, the perception of many CMHT members is that they are operationally accountable to the CMHT manager but professionally accountable to their respective line managers (Peck & Norman, 1999). Thus, there may be friction between team and line management objectives (Onyett, 1998).

While team members appear to be willing to try to be flexible in aligning their priorities with CMHT goals and activities (Peck & Norman, 1999), their clinical autonomy may sometimes be asserted as a defence against authority. This assertion may be unrealistic, while management procedures may tend to ignore professional accountability (British Psychological Society, 2001), thus potentially creating increased intra-team conflict.

2.8.1 Team interactions: the lack of clarity regarding responsibility and accountability in CMHTs. Despite substantial reports (e.g. Department of Health and Social Security, 1980) and the absence of a body of case law, many Consultant Psychiatrists equate their ‘medical responsibility’ with ‘ultimate clinical responsibility’ so that they feel accountable for their team’s actions (Onyett, 1995). This potential misinterpretation of terms has suggested to Consultant Psychiatrists ‘a framework for authority within CMHTs, that is often not shared by other professionals and, thereby, creates conflict and inhibits team relationships’ (Norman & Peck, 1999, p. 226). Hence, there is a need to clarify this issue (Onyett, 2004; Royal College of Psychiatrists, 2001).
2.7.9 Balancing professional role vs. generic working
If there is a significant discrepancy between the expected and actual roles of a team member, conflict may occur (Cox, 2003). Alternatively, there may be role ambiguity or a lack of clarity regarding the behavioural requirements of a role (Acker, 2004; Martin et al., 1999). To facilitate continuity of care, CMHT members increasingly perceive a pressure to ‘stretch’ themselves to provide aspects of care marginally beyond their job descriptions so that there are not too many team members involved with each consumer (Burns, 2004). This expectation to be less precious about socially-valued disciplinary boundaries promotes ‘creeping genericism’ (Berger, 1991), role blurring (Acker; Onyett, Standen, & Peck, 1997b) and the loss of the specific contribution of each profession (Peck & Norman, 1999; Simpson, Bowers, Alexander, Ridley, & Warren, 2005).

While more generic working may require an ‘unlearning of traditional patterns of professional interaction’ (Lang, 1982, p. 160), this more flexible approach may facilitate the ‘seepage’ of values and concepts flow from one professional group to another which may mean teamworking (Sheppard, 1990). However, evidence to date would indicate that CMHT working may actively encourage boundaries between professionals (Brown et al., 2000). Indeed, clearly defined boundaries may facilitate establishing an ‘exploratory space’ in which team members can tap into and use team skills, thus harnessing the diversity of multidisciplinary teams (Rushmer & Pallis, 2002).

Given that defined roles are integral to their professional persona and self-identity, some professions may feel like an ‘endangered species due to increased specialisation and colonisation of (their) territory by other professions’ (Norman & Peck, 1999, p. 223). They may not have reached ‘professional adulthood or autonomy’ or the requisite high level of confidence in their own roles and therefore lack confidence in their own professional identity. When team members do not feel sufficiently safe to share and defer their professional autonomy to work with other professionals (Norman & Peck, 1999), they may not have reached ‘professional adulthood or autonomy’ or the requisite high level of confidence in their own roles and therefore lack confidence in their own professional identity. When team members do not feel sufficiently safe to share and defer their professional autonomy to work with other professionals (Norman & Peck, 1999), they may not have reached ‘professional adulthood or autonomy’ or the requisite high level of confidence in their own roles and therefore lack confidence in their own professional identity. When team members do not feel sufficiently safe to share and defer their professional autonomy to work with other professionals (Norman & Peck, 1999), they may not have reached ‘professional adulthood or autonomy’ or the requisite high level of confidence in their own roles and therefore lack confidence in their own professional identity.

There is also the possibility with generic working that the most powerful professional group might absorb overlapping areas of work (Corrigan & Garman, 1999). Hence, fearing dilution of their professional identity, some team members may feel obliged to defend their own position (i.e. ‘protectionism’; Øvretveit, 1991; Molyneux, 2001). Failure to achieve professional autonomy is a threat to professional identity to work with other professionals (Norman & Peck, 1999). However, evidence to date would indicate that CMHT working may actively encourage boundaries between professionals (Brown et al., 2000). Indeed, clearly defined boundaries may facilitate establishing an ‘exploratory space’ in which team members can tap into and use team skills, thus harnessing the diversity of multidisciplinary teams (Rushmer & Pallis, 2002).

2.7.10 Other sources of intra-personal conflict
There are a variety of other sources of intra-personal conflict. Job dissatisfaction (and associated negative team functioning) might also occur when there is misassignment and/or over-specialisation whereby frustration is experienced due to not having the appropriate expertise to perform an expected role. Additionally, there may be inappropriate demand on capacity that can come in two forms (Cox, 2003). Capacity overload may occur when the demands of a task exceed a professional’s maximum capacity output. In contrast, the demands of a role may not be adequately challenging. Such intra-personal conflict can be an underlying cause of interpersonal conflict (Price, 2000). The constraints of strict practice guidelines, introduced in this era of ever-increasing accountability, may also predispose to intra-personal conflict (Acker, 2004).

2.7.11 Informal hierarchy
Multidisciplinary mental health services are still dominated by the medical profession, a dominance that often exacerbates organisational and professional problems when trying to work in a multidisciplinary manner (Mohr, 1995; Barker et al., 1998; Samson, 1995; Stark et al., 2002). Many Consultant Psychiatrists reject the notion that CMHT membership means equality of status (Peck & Norman, 1999). They appear to be positioned at the peak of the CMHT power pyramid, particularly in relation to mental health nurses (Martin et al., 1999; Morrall, 1998). Psychologists may also regard themselves as a ‘senior’ discipline within CMHTs supported by the other ‘junior’ occupational groups (Morrall, 1997). In contrast, it may be that both Consultant Psychiatrists and Community Mental Health Nurses are perceived to top the CMHT power pyramid (Byrne et al., 2006).

Although dissatisfied with this informally negotiated ‘order’, many CMHT members may collectively perpetuate this status quo. A shared history may lead to the production of ‘habitus’ or a set of unexamined assumptions and interpretations of how multidisciplinary teams work (Skidmore, Warne, & Stark, 2004). They come to expect that these are the ‘rules of the game’ (Bourdieu, 1990). Augmenting this ‘habitus’ are the often misinformed and different beliefs about what other team members do. Operating on an individual level, the ‘conservative impulse’ of team members (Morrell, 1974) may also mutually support this distinct structural attitude (i.e. ‘habitus’). Together, these processes predispose to conforming to the usual rules of engagement i.e. ‘traditional’ hierarchical practice (Skidmore et al.).

Such is their combined power that staff often find it difficult to change (Minghella & Ford, 1997). Dissatisfaction with the habitus may be expressed in a number of ways. Team dynamics might be replicated in professional–managerial interactions. For example, mental health nurses, subordinate to other team members, may engage in social control (Morrall, 1998) and not interact therapeutically with consumers (Porter, 1993). Indeed, service usage can be sometimes characterised by oppressive experiences (Warne & Stark, 2004), with consumers perceiving the mental health service culture to be steeped in a discourse of treatment and care, control and compliance and professional expertise (Warne & Stark, 2004). Alternatively, teams that have become over-cohesive (possibly in response to external hostility) may neglect information that conflicts with team assumptions (including structural), and may bring strong social pressure to bear on and/or marginalise the contributions of ‘difficult’ team members who oppose the ‘habitus’ (Carpenter, Schneider, Brandon, & Wooff, 2003; Gibson, 1989; Watts & Bennett, 1983).

2.7.12 Defensive practice
There may be a widespread expectation that mental difficulties are ultimately solvable and manageable (Peck & Norman, 1999). This may predispose to ‘risk adverse’ clinical activity such as over-management of consumers. As it is likely that CMHT members will react differently to such an approach, this may create intra-team tension.

2.7.13 Lack of a research culture
Relative to other care groups, there appears to be an apathy regarding conducting research in mental health services. Where CMHT members have aspired to conduct such research, whether it be clinical or service-based, some management teams have vetoed research proposals without adequate explanation. Such experiences only serve to reinforce the tendency to conduct research with other care groups where managers may be more enlightened. Hence, HSE Area Ethics Committees may need to wrest control of approving research proposals from local mental health managers.

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

3.1 Adoption of a capability model
The proposal to adopt a capability model is a welcome development. Professional training does not necessarily guarantee capability, something that can sometimes go undetected with subjective interviewing techniques. However, in order to promote commitment to this model, a number of factors need to be considered.

3.2 Teaching versus training
Many CMHT members may erroneously claim competence to practice in particular clinical areas based upon experience, attendance at ‘ad hoc’ training events and/or short courses. While competence does not necessarily flow from experience, the latter ‘teaching’ events do not impart competence to practice. Rather, professionally-evaluated systematic training programmes, incorporating ongoing supervision, are required to raise an individual’s skill base to a predefined (and safe) level of competence (Galvin & McCarthy, 1994). Hence, caution needs to be exercised in using training as a way of promoting higher competence. A ‘skills audit’ may facilitate this process (British Psychological Society, 2001).

3.3 No monopolies on expertise
At the same time, it is important to recognise that no one discipline has a monopoly on discipline-specific expertise. Many CMHT members have undertaken additional training enabling them to deliver high-quality interventions (McCourt, 2002).

3.4 Collaborative working
As previously outlined (refer to Section 2.7.9), the degree to which CMHTs are expected to ‘cross-over between disciplines’ needs to be clarified. Excessive role-blurring can negate the unique contributions of specific disciplines and decrease...
satisfaction (Simpson et al., 2005). It may also be important to clarify the meaning of collaborative assessments. This can equate to joint assessments. While there are advantages to such assessments (Mitchell & Patience, 2002), they are based on the unproven assumption that two heads are better than one (Middleton & Caldock, 1997). They may also be a poor use of resources and be clinician-, as opposed to client-, centred.

In relation to ‘multidisciplinary team supervision’, in the absence of formal agreement between national professional organisations, a more realistic option may be the provision of ‘educational support’ so that ‘team turnover’ and vicarious liability is minimised. It is important for each discipline to consider if what it offers is ‘consultative’ and/or ‘facilitative’ (McCourt, 2002). The latter involves facilitating reflective practice and acquisition of skills (but not necessarily competence) and promotes integrative working.

3.5 Need for a broader spectrum of competencies

It might profit to extend the competency framework beyond its core remit to include specialist competencies such as service evaluation, service planning and development, audit, research, community development, training, teaching, education, and research. Such skills are at risk of being lost or deprioritised because of their ‘invisibility’ (Cushion, 1997). Likewise, specific competency frameworks may be required for certain team positions. For example, development of leadership competency frameworks may guard against using ‘personality’ to (subjectively) identify potential leaders (Alimo-Metcalfe & Lawler, 2001).

3.6 Performance management

(Refer to Section 2.6.2)

As recently implemented in some HSE areas, team-based performance management initiatives may promote both team accountability and solidarity (Byrne, 2006b). However, such systems may be prone to social loafing and may need to be complemented by individual performance management, possibly conducted by a CMHT manager.

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

4.1 Overview on personality

It is not unusual to hear of personality clashes marring the performance of multidisciplinary teams (Farhall, 2001). However, it is both irresponsible and unproductive to reach for this explanation when conflict erupts. More commonly, personalities ‘only intensify structural conflicts that would, over time, produce an intolerable and impossible situation for anyone’ (Ovretveit, 1995, p.43). Hence, it behoves CMHT members to look beyond overly-simplistic explanations of conflict.

4.2 Commitment to teamwork

A significant determinant of multidisciplinary team functioning is the presence of team members who have a personal commitment to multidisciplinary teamworking. Such team members typically do not have ‘a particular disciplinary axe to grind’, perceive themselves to be a ‘bit of a hybrid’, receive ‘eclecticism’ and are ‘adaptable’ (Molyneux, 2001; Wilson & Pirrie, 2000).

4.3 Loss of faith in the system

There may be CMHT members (including team leaders) who are reluctant to comply with operational directives. This may be due to many factors including their having lost faith in the system within which they work (Norman & Peck, 1999). If work loses its ‘personal meaning’, commitment, motivation and morale may decrease among team members (Ovrett, 2003). Based upon previous negative experiences, they may have a cynical attitude to new developments (Bronstein, 2002; Rees, Huby, McDade, & McKechnie, 2004). In this sense, they may be institutionalised. This could possibly account for why there is minimal commitment towards interdisciplinary working in some community mental health services (Farhall, 2001).

4.4 Realistic expectations

Disappointed expectations and poor teamworking will be minimised if CMHT members have appropriate expectations of service delivery and teamworking. For example, team members may need a tolerance for ambiguity and a degree of conflict, and an openness to being influenced by the ideas of others (Byrne et al., 2006).

4.5 Communication

Of utmost importance is an ability to listen to service users, their carers and CMHT members. Without the ability to listen respectfully, mutually enhancing relationships cannot develop. Providing such information, both verbally and in writing, is also a necessity for good multidisciplinary teamworking.

4.6 Commitment to self-care

Transference can predispose to splitting in teams (Burns, 2004). Insufficient processing of emotions related to working with individuals with significant mental health difficulties may predispose to team members using psychological defence mechanisms such as ‘blaming the victim’ (Onyett, 1998). To avoid such emotional reactions, team members need to commit to self-care and ‘self-audit’, so that they (and consumers) remain contained (Byrne et al., 2006).

5. Who should be a multidisciplinary team in an adult mental health service?

5.1 Team composition

The rationale for CMHT composition is rarely thought out. Based along the lines of a disciplinary ‘shopping list’, there is typically input from Psychiatry, Nursing, Social work, Psychology, Occupational therapy and Administration. There may also be Family Therapists and a team manager or co-ordinator (McGuinness, 2000). Regrettably, composition may merely reflect a bias among CMHT management to prioritise the recruitment of medical personnel and/or a process of relocating existing staff (Byrne et al., 2006). This may increase the numerical strength and over-representation of some disciplines (e.g. Nursing), resulting in an unhealthy imbalance in team composition and CMHT ethos (McCourt, 2002).

Research, preferably involving some element of epidemiological needs assessments (Hanrahan, 1998) and/or the establishment of the optimal skill-mix within CMHTs to meet local clinical need (Galvin & McCarthy, 1994). The existence of other local services can also influence team composition. The cost-effective use of non-professionals such as coaches or care assistants may be a viable alternative for team expansion (Liberman, Hilty, Drake, & Tsang, 2001). Lack of appropriate rooms can also limit team expansion, as can a lack of management and practitioner support for training and assistant posts.

5.2 Grade of team members

The presence of staff on similar grades may promote a shared perception of egalitarianism and, consequently, decreased inter-professional defensiveness and jealousy (Molyneux, 2001). For example, employment of Senior Occupational Therapists can provide the assertive input required to adequately represent this discipline (Simpson et al., 2005). However, provision of appropriate promotional opportunities in an effort to facilitate staff retention may lead to inevitable inequities (Burns, 2004). There may also be variability in the quality of ‘Trainees’ on placement, who may add or detract from the quality of service provision.

5.3 Team size limit

In large teams there may be a tendency for reduced compliance, to work ‘solo’, or to coast on the team’s efforts as one’s contribution may not be heard or be as identifiable (LePine & VanDyne, 1998; Rutte, 2005). In addition, knowledge of what is going on (Mussnug & Hughey, 1997). Such information transfer or transaction problems (among team members) can be exacerbated by a high percentage of part-time staff (Burns, 2004).

5.4 Retention difficulties & team instability

Given that CMHT members create what the HSE sells (Downey-Ennis & Harrington, 2002), it is imperative that every effort is made to retain them. However, there is typically a constant turnover of relatively non-medical) staff (Acker, 2004). While there may be many reasons for such poor retention, these professionals may simply not want to work in medically dominated CMHTs (Houghton, 2002) where they feel undervalued, disrespected and overworked (Peck & Norman, 1999). Managers may also make the mistake of assuming staff motivation purely on the basis of the social value of the work, whereas motivation may have to be engineered (Byrne, 2006a).

Reduced tenure may predispose to team instability and discontinuity of relationships with consumers, the latter typically being problematic in times of crisis (Thorncroft et al., 2003). Interestingly, dissatisfaction may increase with longer work experience for team members.
6. Taking into account the answer to question 5, what is an appropriate caseload for a multidisciplinary team in an adult mental health service?

6.1 Determination of caseloads by local need

As evidenced in CMHT caseload studies (e.g. Greenwood, Burns, & Harvey, 2001), assigning an ‘appropriate’ CMHT caseload may be an academic exercise given the multitude of factors that can determine local clinical need. The catchment population and the degree of deprivation therein will influence the prevalence and severity of clinical need (Muijen, 1993). More severe (e.g. ‘category A’) consumers with previous involuntary admissions due to psychosis may spend relatively more time in the acute or stabilisation phases of their disorder and demand more intensive team input (Liberman et al., 2001), thus decreasing a team’s caseload capacity. However, the latter may increase as the team matures.

6.2 Active control of caseloads

Given that excessively large caseloads are often a source of dissatisfaction in CMHTs (Acker, 2004; Parahoo & Barr, 1994) and the necessity of protecting capacity for new referrals, active control of caseloads is desirable. To prevent potential in-house hostility, there is also a need to control for intra-team caseload equitability (Lankshear, 2003). Having caseload guidelines for individual team members may reduce the potential for social looting. Implementing performance management utilising mutually agreed performance indicators (Byrne, 2006b) may also reduce the latter.

In case-mix also needs to be controlled both at the individual and team levels. Doing so within the parameters of eligibility criteria for ‘caseness’ (Burns, 2004) and working with service users who are in the recovery phase of their disorders may ensure staff retain a sense of perspective and do not experience ‘burn-out’ (Greenwood et al., 2000). Job enrichment in the form of engagement in different types of work (e.g. research, teaching) may also protect caseload capacity.

7. Is the model outlined in Chapter 5 a useful model to describe the links that are needed between the multidisciplinary team and other services?

7.1 Need for inter-agency working

While the figure outlining the ‘hatched’ model of mental health team links (Mental Health Commission’s discussion document p. 28) may need to be more detailed, the model itself appropriately recognises how intensive inter-agency working is required to provide the range of services needed to meet the complex mental health and social care needs of this population (Onyett, 1999). As appropriate, the repertory grid-like representation places the service user and his/her carers/family centre stage. Where there is loss of family contact, the replacement informal network needs to be maintained (Warne & Stark, 2004). Given that GPs deal with 90% of psychiatric morbidity (Department of Health, 1984) and the primary care treatment preferences of service users (e.g. Lang, 2005), robust links with primary care are needed. These can manifest as liaison services, ‘shifted outpatients’ whereby service users are seen in primary care settings (Burns, 2004) and/or as regularly timetabled meetings with primary care liaison teams. Given that the risk of suicide is highest in the first week post-discharge, continuity of care via close liaison with in-patient teams and discharge planning is a necessity. Links with the community network also need to be further elaborated upon. It may also be advantageous to ‘strategically deploy specific team members’ in liaison roles with specific agencies (Onyett, 2003, p.155).

While making all of these links important, direct clinical time with service users has to be protected by making realistic decisions as to how much time can be devoted to liaison work.

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

8.1 Care planning

Care planning can be defined as ‘a continuous process of developing and reviewing actions, stated as achievable tasks, allocated responsibilities and agreed timescales’ (Morgan & Akbar-Khan, 2000, p.77). As such, while it involves a cyclical process of task engagement and monitoring and review, the foundation for effective care planning is relationship building. This process begins with the service user possibly choosing and linking up with a suitable team member. More commonly, though, the team member may have to persevere in selling the care planning concept to the service user.

8.2. Democratic teamwork

In contrast to their unfortunate but common experience of control and professional expertise (Warne & Stark, 2004), service users need a more self-empowering experience whereby they are treated as an equal in conducting their initial assessment (including risk management and identification of their significant ‘relapse signatures’). In essence, a democratic team process involving whomever the service user wishes, can roll out and maintain the care planning process. Doing so will involve putting in place many of the factors detailed in this document including nurturing relationships via communication and trust building, while all the time respecting the service user’s right to refuse help (Onyett, 2003).

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

9.1 Welcome inclusion of service users

Service users have traditionally been perceived as ‘the enemy’ (Aitken, 1984). Hence, their inclusion in mental health services has to be welcomed.

9.2 What is a service user?

However, it remains unclear as to what constitutes a service user? Is it someone who has an acute illness and is now in the recovery phase? Or is the individual fully recovered, and if so, would it be unethical to continue to label him/her as a service user? Should he/she not fully recovered, will there be subtle pressure to remain in an ‘illness’ role if he/she is employed as a trained/expert service user?

9.3 How is the service user recruited?

The recruitment procedure may determine the flavour of input by trained/expert service users. For example, the chosen individual might favour psychological approaches over medical treatments. Hence, the issue of who chooses these individuals needs to be thoroughly examined. Should it be the CMHT manager? Or should it be a decision by individual service users or a representative body such as the Irish Advocacy Network?

9.4 Ability to engage in an equal manner

Given that the prevailing culture of mental health care may remain ‘steeped in a discourse of control and compliance’ (Warne & Stark, 2004, p. 654), service users may continue to relate with CMHT members in a ‘one-down’ manner. If so, service users, whether or not they are trained, may not adequately fully the various roles expected of them, particularly the client advocacy role. On the other hand, if CMHT members surrender power to what they might perceive as lower status workers, then these service users might be truly empowered.

9.5 Role of trained/expert service users

The detailed roles expected of trained/expert service users appear ambitious and may meet with resistance from some disciplines. For example, their recruitment and appraisal powers might make CMHT members wary of all service users. However, these service users, in fulfilling their roles, might provide CMHT members with a greater understanding of the perspective of recipients of mental health services. Doing so may appropriately remind all team members that service users have trained/expertise in meeting service users’ needs and direct attention away from inter-professional struggles.

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.

Refer to Sections 15, 16 and 20.

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

11.1 A variety of multidisciplinary teamwork models (Refer to Sections 11, 12, 15-21)

While there may be almost as many models of multidisciplinary teamwork as there are teams (O’veretit et al., 1997), there a number of particular team configurations that CMHTs frequently adopt, each of which will significantly impact upon team functioning. In order to determine which of these models, or which elements of these models, are most appropriate for adult mental health services in an Irish context, each could be piloted in a one or more sites.

(Acker, 2004). A high turnover of senior mental health managers likewise can result in significant instability (Peck, 2001). Additionally, the periodic turnover of Trainees (e.g. Junior Doctors, Psychologists, Psychiatric Nurses in Clinical Training) can also predispose to team instability and discontinuity of care (Byrne et al., 2006).
11.2 Profession-managed networks
In profession-managed networks or associations, individual CMHT members remain firmly attached to their respective departments, management and their professional line managers and accept direct referrals. They are only teams in the loosest sense in that there is no team leader, no shared operational policy, and professionals may communicate about communal service users without management input (Onyett, 2004).

In essence, this collaborative structure represents parallel service provision organised along strict disciplinary lines. That it affords a diversity of access points and potentially maximum clinical autonomy among CMHT members may account for its popularity (Onyett & Ford, 1996).

11.3 Fully-managed teams
At the other end of the spectrum, the functioning of fully-managed teams is tightly controlled by an all-powerful leader who manages all CMHT members and through which all referrals flow. While consensual decision-making is encouraged, this leader retains ultimate accountability and authority.

The advantages of this structure include an unambiguous referral route, co-ordinated service, and the potential to set clear priorities (Onyett, 1998). However, this ‘command and control’ style structure can generate conflict with professional line managers, decrease practitioner autonomy (and satisfaction) and can result in creative stagnation (Callaly & Minas, 2003).

11.4 Co-ordinated teams
Co-ordinated CMHTs with shared management are possibly the most commonly used structure in CMHTs (Onyett, 1998). Team members are contracted in from their (disciplinary) departments so that there is dual accountability: operationally to the team co-ordinator and professionally to their line manager. While line managers ‘have the final say on issues of clinical practice’, members are normally ‘informed by the views of the team’ (Onyett, 1998, p. 168). The team co-ordinator retains responsibility for the operation of the CMHT. Referrals may be to the team or pooled after referral to individual team members. While this structure can potentially offer the optimal balance of clinical autonomy against team management, it can predispose to conflict between team and line management objectives (Onyett, 1998).

11.5 Democratic teams (Refer to Sections 18.3.3 and 20.3)
Exemplifies management literature as reflecting a good organisational structure, CMHTs can also be self-directed (or self-managed). Such CMHTs have the potential for great success or failure (Conti & Klein, 1997). There may be a co-ordinator role rotated among team members or leadership may be assigned for specific aspects of team functioning (Onyett, 1998). While minimal external supervision, such teams need to be integrated into the macro management system and adhere to organisational goals.

There may be significant cross fertilisation of ideas among members who have a high degree of clinical autonomy (Firth-Cozens, 2001b) and reduced staff turnover. However, the distributed co-ordinator/leader post may complicate communication with other managers or agencies, impair the continuity of associated relationships, and become marginalised as some (fearful) team members may not fulfill their inherent professional responsibilities (Onyett, 2004). Additionally, the journey towards ‘adequate’ democratic self-management can be difficult and consume substantial resources (Hirshorn, 2005).

11.6 Care / case management
While some have argued that case management is an almost redundant function in resource-rich contexts (Onyett, 1998), typically vulnerable service users may need assistance in ensuring appropriate negotiation of service options. Having one or a minimal number of people co-ordinating care on behalf of the client can decrease confusion about who is doing what and promote effective communication (British Psychological Association, 2001).

However, not all team members may be suitably competent to fulfil such a role, one that might be far removed from that of a teamworking role. There might be an overemphasis on assessment to the detriment of other aspects of care (Onyett, 2003) and the associated administrative duties combined with reduced time for clinical work can predispose to team member dissatisfaction (Parry-Jones et al., 1998). Despite these drawbacks, many CMHTs formally employ care management (Onyett et al., 1994) and many others use it informally.

11.7 Keyworker model
11.7.1 Absence of rationale
The unfortunate absence of referenced texts in the Mental Health Commission document compromises the consideration of what is termed the ‘keyworker’ model. The dichotomy made between the keyworker model and care (formerly case) management systems is also confusing as the latter can also involve keyworking (Onyett, 2003).

Hence, the rationale for both approaches and the differences that exist between them may need to be further elaborated so that relevant stakeholders can appropriately consider their suitability.

11.7.2 Tripartite management structure (see Sections 15, 16)
The proposed shared management structure is a welcome concept. For example, given the immense burden of both, the clinical and managerial roles are typically separated in most countries (Muijen, 1993; McGuinness, 2004). However, many professionals, particularly among the allied health disciplines, may perceive the proposed tripartite structure merely as a reworking of the old triumvirate of medicine, nursing and administration; a case of ‘old wine in a new glass’ (Byrne et al., 2006).

Hence, it is important to further elaborate on this model and allow open competition for the associated new discipline non-specific roles if it is to be considered and accepted by all CMHT members.

11.7.3 Strengths of the keyworker model
Among its many advantages, this model can facilitate better integration of care based upon service user needs and the emphasis on ongoing monitoring can promote maintenance of therapeutic gains. The emphasis on stable one-to-one relationships can also promote continuity of care and reassurance that support can be accessed at critical times (Onyett, 2003). The former is important given that service users are particularly vulnerable to loss of contact from services (Marriott, Malone, Onyett, & Tyrer, 1993).

11.7.4 Weaknesses of the keyworker model
This model also shares the weaknesses of other care models above (see Section 11.6) including the associated increased administrative burden, reduced clinical time and potential for team member dissatisfaction. Such dissatisfaction may also be due to the required ‘role blurring’ of the ‘generic’ keyworking role (Rees et al., 2004). Such genericism also comes at a cost, with highly paid professionals engaging in keyworker activities that could, for the most part, be executed by less costly (and potentially better value for money) non-professionals.

The ‘spider web’ (as opposed to the ‘star’) model of accountability that is necessitated by keyworkers having to make on the spot decisions can be disruptive of assumptions of hierarchy (Muijen, 1993). Additionally, coercion in the form of ‘enormous pressure’ and ‘meddling’ from other managers or agencies, impair the journey towards ‘adequate’ democratic self-management (Norman & Peck, 1999). This model also shares the weaknesses of other care models above (see Section 11.6) including the associated increased administrative burden, reduced clinical time and potential for team member dissatisfaction. Such dissatisfaction may also be due to the required ‘role blurring’ of the ‘generic’ keyworking role (Rees et al., 2004). Such genericism also comes at a cost, with highly paid professionals engaging in keyworker activities that could, for the most part, be executed by less costly (and potentially better value for money) non-professionals.

12. What is the most appropriate referral pathway for effective multidisciplinary teamworking?
12.1 Multiple influencing factors
There is divisive debate as to whether ‘closed’ as opposed to ‘open’ referral pathways are most conducive to effective multidisciplinary teamworking. The distinction between these two types of referral pathways is determined by a number of factors. These include the extent of the referral net, the number of access points into the CMHT, the nature of the allocation process, and the number of professionals (or keyworkers) that service users have to negotiate. However, CMHTs must first decide their target service user population.

12.2 Target service user population
There appears to be a divergence of opinion among CMHT members as to the nature of the enterprise in which their teams are engaged (Byrne et al., 2006). This divergence is manifest in whether the aim of teams is therapeutic or containing and in the associated nature of the target service user population (Norman & Peck, 1999).

12.2.1 Severe and enduring mental illness
Good CMHT functioning necessitates deciding the service user group of the team (Onyett et al., 1997b), with some advocating that CMHTs focus their efforts on only one service user group (Miller, Freeman, & Ross, 2001; Øvretveit, 1993). This service user group typically comprises individuals with severe and enduring mental illness, with Consultant Psychiatrists in CMHTs perceiving their core remit to be treating these individuals (Royal College of Psychiatrists, 2001).

12.2.2 Time-limited disorders
It appears that many CMHTs accept a role in working with service users with...
The Irish Psychologist

Vol.32 No.12  p 330

July-Aug 2006

moderate presentations and time-limited disorders who may not reach the threshold for eligibility criteria (Byrne et al., 2006; Greenwood et al., 2000). The latter may be treated briefly by a GP and an accepted team practice and an acknowledgement of the associated and significant nature of service user disabilities (Melzer, Gill, Petticrew, & Hinds, 1995). However, it may also reflect how team practice differs from team intentions (Norman & Peck, 1999).

12.2.3 The myth that General Practitioners (GPs) only treat the 'worried well'

That GPs deal with 90% of mental health presentations and only 10% attend secondary mental health services (Department of Health, 1984) might be taken to indicate that GPs only deal with the ‘worried well’. However, GPs are often the only point of contact for individuals with mental health difficulties, and up to one third of individuals with severe and enduring mental illness are solely under the care of their GP and do not attend secondary mental health services (Tylee, 2005).

12.3 Extent of the referral net

It appears that neither model of multidisciplinary services (Department of Health, 1984) the Mental Health Commission’s discussion document (p. 34-38) addresses the issue of the extent of the referral net. As outlined in the ‘pathways to care’ model, the traditional route of referrals to secondary mental health services is through the GP (Goldberg & Huxley, 1980). In contrast, backed by an ideology concerned with promoting access for all, many (predominantly non-medical) professionals advocate accepting referrals from multiple sources.

12.3.1 GP only referrals

The rationale for GP only referral (or ‘closed’) protocols is that GPs, informed by ongoing contact with their patients, provide a necessary gatekeeping function to scarce and already ‘under siege’ secondary care services. As such, GPs can differentiate clinical need from patient demand and filter referrals to more costly specialist services if indicated (Forrest, 2003).

However, there is a variable propensity among GPs to refer to CMHTs (Byrne et al., 2006; Kennedy & Griffiths, 2000). Some GPs may be reluctant to refer to CMHTs for a variety of reasons. These include patient preference for only attending primary care services, the selective entry criteria for CMHTs, and the comprehensiveness of the latter versus the convenience of the former. As such, GPs can differentiate clinical need from patient demand and filter referrals to more costly specialist services if indicated (Forrest, 2003).

12.3.2 Open referral

Traditionally, there is strong advocacy to reject accepting referrals from multiple sources. The primary argument appears to be that such a protocol would result in CMHTs becoming congested with more articulate and demanding patients/users (in need of) severe problems (and who could be more appropriately seen in primary care) to the detriment of service provision to those with severe and enduring mental illness (Patmore & Weaver, 1992). It is argued that ‘clinical drift’ would occur as team members fail to work with the former due to the potential for increased reinforcement in working with service users with whom clinical improvements may be more readily realised (Onyett & Ford, 1996).

In contrast, research also indicates that allowing open referral sources may increase accessibility of services to individuals with severe and endure mental illness (Marriott et al., 1993). Intuitively, such a ‘spider web’ type referral system may be more sensitive to clinical need, especially among those with the most severe presentations who are prone to loss of contact with secondary services. Hence, it is argued that referrals from carers are fundamentally client-centred and need to be accepted. Additionally, acceptance of self-referrals (in as many as 74% of CMHTs in the United Kingdom) appears to result in caseloads dominated by less severe presentations (Onyett et al., 1994; Sayce, Craig, & Boardman, 1991)

12.3.3 Limited referral sources

A middle ground between GP only and open referral systems is acceptance of referrals from selected non-medical sources. Such a system might provide an optimal balance between the convenience of the former and the comprehensiveness of the latter (Marriott et al., 1993). Such a system could also incorporate intra-team referrals, a practice that may be gaining increased acceptance in some CMHTs in Ireland (Byrne et al., 2006).

12.4 Number of access points

Depending upon how they (and other CMHT colleagues) view their professional and their clinical responsibilities, a Consultant Psychiatrist may insist on accepting GP only referrals addressed to themselves. In contrast, other Consultant Psychiatrists have supported direct referrals to individual team members (Byrne et al., 2006; Kennedy & Griffiths, 2000).

12.4.1 Single point of access

As outlined in the keyworker model of multidisciplinary team service delivery in the Mental Health Commission’s discussion document (p. 35), a single port of entry (i.e. to a team co-ordinator) would entail close working relationships with GPs and other referring agencies. Sometimes labelled as a ‘team referral’ system, this structure might facilitate improved service accessibility given that the point of access may be more readily identifiable (Onyett et al., 1994). It may also allow for accurate monitoring and assessment of the level of strain or imbalance on team capacity (Burns, 2004).

12.4.2 Multiple points of access

Some CMHTs have two or more portals of entry (Byrne et al., 2006; Kennedy & Griffiths, 2000). This may reflect how it may be inefficient and unnecessary for many (especially GP) referrals to go through the team when direct referral to specific team members may be all that is needed (Onyett & Ford, 1996). Such direct access, often the only referral pathway that some GPs (in need of) severe problems (and who could be more appropriately seen in primary care) to the detriment of service provision to those with severe and enduring mental illness (Patmore & Weaver, 1992). It is argued that ‘clinical drift’ would occur as team members fail to work with the former due to the potential for increased reinforcement in working with service users with whom clinical improvements may be more readily realised (Onyett & Ford, 1996).

On the other hand, the concerns over the risk of fragmentation posed by multiple portals of access are legitimate (Byrne et al., 2002). The sense of dis-integration may be manifest in (isolated) CMHT members attending to different service user lists (Brown et al., 2000) and the felt sense of a lack of control over workloads. However, such difficulties may be overcome by ensuring that access points are connected or co-ordinated in some manner, as practised in many co-ordinated teams (Onyett, 1998; Onyett et al., 1994). Highly practical (and acceptable to team members) is the ‘integrative’ process where each team member brings the received referrals to the weekly CMHT meeting for recording into the team referral book, pooling and discussion. This arrangement appears to allow both broad access and co-ordination of referrals (Byrne et al., 2006).

12.5.1 Implementing agreed eligibility criteria

That a CMHT may become congested with referrals associated with time-limited disorders to the neglect of individuals with severe and enduring mental illness is not a function of open access. Rather, it may be due to a failure to rigorously apply agreed eligibility criteria (Onyett et al., 1994; Sayce et al., 1991). While this may challenge team members who are accustomed to accepting referrals (Newton et al., 1996), the needs of service users with the most severe presentations must be prioritised. There is a need to develop and implement such agreed eligibility criteria for receipt of services (Onyett et al., 1994). Ideally, they need to consider many elements including severity and duration of symptoms, co-morbidity, resultant disability, immediate safety, history and maturity of coping mechanisms, and access to natural supports.
Given that team allocation may be time consuming (Burns, 2004) necessitates that the allocation ‘section’ of CMHT meetings is structured and disciplined. The reluctance of some team members to take on new service commitments may lead to inequitable caseloads and subsequent ill will between team members (Lankshear, 2003). This tendency may be increased if reallocation on the basis of assessment rarely happens and team members find themselves ‘stuck with’ assessed service users (Searle, 1991). If there is an inclination for the ‘looking at your feet syndrome’ to occur in some teams, this dynamic needs to be discussed openly among team members.

13. From your experience, what is required to ensure effective multidisciplinary team working?

14.4.1 Adequate resources

14.4.2 Agreed team policies and procedures

14.4.3 Management commitment

14.5 Informal factors

13. From your experience, what is required to ensure effective multidisciplinary team working?

Refer to Sections 2, 12, 14-18, 20, and 22.

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

14.4 Failure to thrive

That some teams are simply told by management that they ‘are’ CMHTs (Onyett et al., 1994) may reflect the ill-fated hope that teamwork will grow organically as they coalesce around common goals (Brown et al., 2000; Mickan, 2005). While time alone may facilitate some ‘maturations’ of services (Oberlander, 1990), CMHTs may ‘fail to thrive’ or ‘self-destruct’ (Heginbotham, 1999). If the team experience is poor among team members, individual competitiveness may supplant the need for collective action (Stark et al., 2002; Tjosvold, 1994).

14.2 Incremental trajectory

The ‘big bang’ approach to the transformation of ‘groups’ of diverse professionals into CMHTs may be too radical a solution to achieve genuine teamwork. As articulated in Tuckman and Jensen’s (1977) ‘form-storm-norm-perform’ model of team development, there is general consensus that team development is a process that follows a typically winding path. Hence, an evolutionary as opposed to a revolutionary approach to team development that builds teamwork in incremental steps may be most appropriate. Given that teams are often perceived as time-consuming and wasteful of resources, especially in the formative stages, it is important that there is an appreciation that multidisciplinary teamwork evolves and is not manufactured instantaneously (Carter et al., 2003).

14.3 Address both formal and informal factors

It is often the case that teamwork necessitates a cultural transformation from that of the individual (expert) professional to a collaborative team ethos (Leonard et al., 2004), cultivating teamwork essentially requires effective change management. As such, both the formal (or ‘visible’) and informal (or ‘submerged’) factors that influence the organisational ‘iceberg’ of CMHTs need to be addressed. Unfortunately team-building initiatives typically are directed at the formal factors, to the neglect of the often more influential informal factors (Pearson & Jones, 1994).

14.4 Formal factors

Theoretically, the formal factors that influence teamworking can be modified in rational and open ways, while the informal factors are less amenable to direct intervention (Coughlan & McAuliffe, 2003). Provision of adequate resources, implementation of effective organisational policies and procedures (see Section 22), and management commitment are basic prerequisites in cultivating teamworking.

14.4.1 Adequate resources

The absence of adequate finances to ensure both adequate staffing levels, the composition of which will ideally reflect local clinical need, and adequate physical rooms can hinder the formation and stability of teams. The incremental nature of HSE budgeting often translates into incremental team building whereby team members are ‘added’ as funding becomes available (Byrne et al., 2006). Unless budgeting practices are altered, team development may therefore regularly revert back to the ‘storming’ phase of development as teams attempt to integrate new team members. The periodic turnover of Trainees may also add to such periodic regression.

CMHT members who are recruited in the earlier stages of team formation may also have more opportunities to build intra- and extra-team alliances. Informally, this can facilitate acquiring a more powerful base within the CMHT relative to those members who are recruited last and who may be seen as more peripheral to the needs of the team (Byrne et al., 2006).

14.4.2 Agreed team policies and procedures

Along with weekly team meetings (refer to Section 2.6.1), a consensually agreed policies and procedures document is the central working document of CMHTs (Ovretveit, 1993). Without the latter, there will be much confusion regarding many issues including team direction and management, role definitions, confidentiality, intra- and extra-team communication, and caseload sizes (refer to Section 6). Hence, it is critical that CMHTs commit to prioritising (ongoing) development of an integrated policies and procedures document if true teamworking is to be realised (British Psychological Society, 2001).

14.4.3 Management commitment

The ‘tertiary’ socialisation of working within healthcare institutions that have traditionally been characterised by an industrial structure with a focus on individual productivity further restricts the opportunity to learn about true teamworking. Hence, there needs to be visible senior management support for teamworking in CMHTs. One possible manifestation of this could be quarterly management meetings (as opposed to ‘crisis only’ meetings) that also involve professional line managers and the CMHT manager.
that influence the formation of the (often unspoken) 'rules' of CMHTs (Bourdieu, 1990). This may explain why (external) process consultants are often employed to facilitate CMHT development (Galvin & McCarthy, 1994). Preferably, teams can be educated as to what teamwork entails and trained to work through process issues such as trust building and engaging constructively with resistance.

14.5.1 Interdisciplinary training
Interdisciplinary teamwork typically is not prioritised in the training and education of healthcare professionals (Leipziger et al., 2002). Hence, training curricula need to incorporate modules into common foundation programmes that facilitate an increased understanding of interdisciplinary working and potential career switching (Finch, 2000). On-the-job shared inter-professional education could also facilitate this process (Hannigan, 1999).

14.5.2 Education relating to the nature of teamwork
It may be that many CMHT members both do not have an in-depth understanding of the concept of teamwork nor the necessary language to articulate their teamwork experiences (Byrne et al., 2006). Hence, teamwork issues may go unresolved. Therefore, education relating to the issue of multidisciplinary teamwork is required along with a (preferably informal) forum where teamwork issues can be discussed. Resultant dialogue may facilitate the nomenclature, expression and internalisation of the associated concepts (e.g. team cohesion) and increased solidarity among team members.

14.5.3 Engineering trust building (Refer to Section 2.7.2)
The 'small-wins' approach to trust building emphasises engineering successful outcomes to modest collaborative initiatives. Trust can build in itself incrementally with each consecutive positive (interpersonal) outcome in a cyclical manner (Vangen & Huxham, 2003). Initially, 'cognitive' trust may develop so that individuals look for rational reasons to trust each other. This can be transformed through experience into 'affective' trust whereby mutual, emotional investments are made to relationships (McAllister, 1995).

For effective team formation, a process of 'fraternalisation' or 'sociability' has to occur whereby mutually respecting team members come to regard each other as 'intimates' and also offer social support to sometimes over-worked colleagues. Use of a communal space (Finlay, 2000; Lankshear, 2003; Øvretveit et al., 1997) or regular staff support meetings (Onyett, 1998) can facilitate this process. Ultimately, a resultant positive team spirit can facilitate a co-ordinated level of performance that is 'greater than the sum of its parts'.

If trust becomes a primary value of team culture, it can provide an atmosphere of 'psychological safety' whereby team members are empowered to take interpersonal risks (e.g. accept criticisms, discuss mistakes, and honestly express their thoughts; Edmondson, 1999). Lowering the threshold to obtain help also creates a safer interpersonal environment (Leonard et al., 2004). However, excessive amounts of trust are maladaptive as this may result in a lack of critical inquiry and creative criticism (Erdem et al., 2003).

14.5.4 Working with resistance
Resistance might be perceived as ignorance or the 'obstructive protection of untenable privileges'. In wanting to protect the perceived power of their professional role, team members might not actively or compulsively comply with some operational directives that demand a degree of role blurring. Alternatively, (overly insular) CMHTs may reject new team members if they 'dissent' or challenge the existing status quo (Byrne et al., 2006). An appropriate leadership manifestation of the 'struggle to defend or recover a meaningful pattern of relationships and to be able to defend the predictability of life' (Atkins, 1998, p. 304).

It is important to expect and overtly discuss the many potential sources, and forms, of resistance and the nature of power relationships within CMHTs (Heginbotham, 1999). Such dialogue can minimise the negative impact of resistance and can facilitate the realisation of a new equilibrium between autonomy and accountability (Ham, 2003).

For example, a goal of CMHTs could be to develop beyond the 'one-model-fits-all approach to a point where there is no invariant model, but instead the most useful model' for the presenting service user (Slade, 2002, p.11). Developing a 'tight bundle' of relevant responses to choose from might facilitate tailored service provision and decrease resistance among CMHT members to comply with team objectives (Heginbotham, 1999).

14.5.5 Reflective practice
The use of the 'reflective lens' in healthcare teams can realise many benefits including blending 'me' into 'we', developing teamability (i.e. team learning and teamwork) and dealing constructively with both conscious and unconscious resistance (Ghaye, 2005). However, in making intra-team tensions more visible, the process of team reflection can unleash powerful feelings and thoughts linked to team members' 'systems of relevance'. This can predispose teams to becoming overwhelmed. Hence, this process needs planned and skilled facilitation, sufficient time to allow genuine reflection, and is not to be undertaken lightly (Carter et al., 2003).

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

15.1 What is leadership?
While some would argue that there is not a common language about what leadership means (Alimo-Metcalfe & Lawler, 2001), this is generally the case. Furthermore, that it is the 'process of influencing others to engage in the work behaviours necessary to reach organisational goals' (Bartol & Martin, 1994, p. 7). Leadership relies predominantly on influence to get good team players to play together (Liberman et al., 2001). It also tends to be associated more with future change, setting a direction based on a vision of how things could or should be, and with an organisation's place in and influence on the broader external environment (Callaly & Minas, 2005).

15.1.1 Leadership types
While recognising that 'not all of leadership theory sits comfortably' in clinical healthcare settings (Firth-Cozens & Mowbray, 2001, p. ii3), there have been several attempts to classify leadership types. Weber's typology of leadership identifies three types of management (Alimo-Metcalfe & Lawler, 2001)
The 'rational-legal' leader is in a position of leadership as a result of their promotion (on merit) to an organisational role. In contrast, and a rarity in our post-deferential age, the 'traditional' leader is in a position of leadership as a result of the deferential office he/she holds, an office that he/she has acquired via success from predecessors in the position (i.e. preference) or by hereditary. Thirdly, the 'charismatic' leader relies on his/her personality to induce followership.

Bass's (1990) multi-factor model contrasts three leadership styles. There is the essentially ineffective style of 'laissez-faire' leadership, whereby the leader remains aloof, uninvolved, and disinterested in a team's day-to-day activities (Corrigan, Diwan, Campion, & Rashid, 2002). 'Transactional' leadership concerns the use of power (or authority) to get staff to attend to day-to-day operational tasks (or actions) needed for effective service provision. In contrast, 'transformational' leadership involves seeking to inspire and intellectually stimulate staff to change (or transform) service provision to meet the ever-evolving needs of service users (Corrigan et al., 2003). Thus, it appears that transactional leadership equates to the traditional style of 'management' (i.e. use of power and control) and that transformational leadership maps onto both what has been traditionally accepted as 'leadership' and 'charismatic' leadership.

The expectation in the 'leader as servant' (or co-operative partnership) model is that a leader will do his/her best for team members (Alimo-Metcalfe & Alban-Metcalfe, 2000). In contrast to the micro-management of traditional managers, this typically involves power investment or distributing power among team members. Thus, they are provided with as much discretion and control wherever possible. Resultant empowerment has many advantages including reducing the negative impacts of stress on staff (Alimo-Metcalfe & Alban Metcalfe, 2003), creating a sense of justice (Phillips, Douthitt, & Hyland, 2000), building trust and commitment, promoting effective communication and a sense of belonging, and increasing the meaning of work (Searinati & Searinati, 2002).

15.2 The leadership challenge of CMHTs
As in all health services (Firth-Cozens & Mowbray, 2001), effective CMHT working necessitates both transactional and transformational leadership (McGuiness, 2004). However, as indicated by existing CMHT manager job descriptions (e.g. McGuiness, 2004; refer to Section 16), if the proposed business manager (Mental Health Commission's discussion document, p. 35) manages the necessary transactional tasks,
the proposed clinical leader will be more of a transformational leader.

Optimal CMHT working may only be realised if professionals are given clear but minimal specification of what to do and given space to exercise their creativity (Onyett, 2004). Hence, this might suggest that transformational leadership (with its emphasis on empowerment) might be appropriate. Indeed, findings suggest that transformational leadership is more important for positively affecting mental health team functioning than transactional leadership (Corrigan et al., 2002). However, as with the ‘leader as servant model’ that promotes co-active power or power-with (as opposed to power-over), transformational leadership may need a high-trust climate (Coleman & Voronov, 2005).

15.3 Who should be the CMHT clinical leader?
Traditionally, Consultant Psychiatrists have provided both transactional and transformational leadership. However, although highly skilled and experienced, their assumed authority has not been universally accepted by other professions (Muijen, 1993). While some CMHT members are reluctant to take on the clinical leadership role, others advocate making the post discipline-specific and giving it to the individual with the best balance of clinical and leadership skills (Byrne et al., 2006).

15.3.1 Traditional leadership model
The ‘biopsychosocial model’ of psychiatry has an intuitive appeal and commonly reflects the considerable level of skill and knowledge of Consultant Psychiatrists. On the other hand, it presupposes a sometimes-unequalled expertise over both mind and body or a ‘capacity of transcending the philosophy of mind/body dualism’ (Muijen, 1993). This model, in materialising the mind as ‘biological matter’, holds that the malfunctioning of ‘some hypothesised material element’ produces mental illness (Samson, 1995, p. 252). Such an eclectic approach that focuses on principles that can be used to ‘coordinate the internal activities of organisations’ (Bartol & Martin, 1994, p. 43).

16. What is the most appropriate and effective model for multidisciplinary team management?
16.1 What is management?
The term ‘management’ refers to the process of achieving organisational goals by engaging in the four major functions of planning, organising, leading and controlling (Bartol & Martin, 1994, p. 6). Like leadership, management is imposed from outside teams by the organisation to facilitate achieving organisational goals. However, while leadership relies on influence, managers rely more on ‘command and control’. To manage therefore implies the necessity of requisite line management responsibility and/or formal authority that is invested in organisational positions.

Management is predominantly inwardly focused on the present ‘workings’ of an organisation including managing internal relations between people and maximising efficiency (Callaly & Minas, 2005). Managers might also use administration, which is an approach that focuses on principles that can be used to ‘coordinate the internal activities of organisations’ (Bartol & Martin, 1994, p. 43).

16.2 Need for both management and leadership
Both management and leadership are needed for organisations to progress. For example, strong leadership without effective management may produce chaos, while strong management without effective leadership may produce stagnation and conflict with professional line managers (Callaly & Minas, 2005). However, despite these differences, the two terms are often inappropriate and are used interchangeably (Alimo-Metcalfe & Lawler, 2001). Hence, the proposal for both a clinical leader and a business leader in the Commission’s discussion paper (p. 35) may facilitate effective CMHT working and development.

16.3 Scope of proposed business manager role
Many of the problems of CMHTs may result not from the ‘flawed’ concept of multidisciplinary working. Rather, they may be attributable to failure of managers to adequately implement this concept (Onyett & Ford, 1996). Hence, robust management in the form of the proposed business manager role is a welcome development.

Given that the ‘CMHT manager’ role is a relatively new development in mental health services (in other jurisdictions), there is as yet no consensus on the scope, authority or responsibility of this role. However, it is recognised that this dichotomous role combines responsibilities for the organisation (i.e. ‘managing up’) and to the CMHT (i.e. ‘managing down’; Onyett, Pillinger, & Muijen, 1995; McGuinness, 2000, 2004). As such, team goals must be aligned with those of the HSE. While there are many elements to ‘cost consciousness’ (e.g. financial, team dynamics), the greatest challenge may lie in negotiating the tensions between operational management and professional autonomy (Onyett, 1997).

16.3.1 Managing up
As with all teams, CMHTs need to be aligned to their organisational context to potentially realise their optimal functioning (Harris & Beyerlein, 2005). Ensuring that team goals are aligned with those of the increasingly centralised HSE hierarchy may leave minimal scope for independent decision-making. Business managers also need to formulate submissions (i.e. service plans) to access resources. Dissatisfaction with their non-egalitarian relationship with senior management and inadequate resources may predispose to preoccupation with control and efficiency (Drolen, 1990).

This may result in strained interactions with CMHT members. Hence, it is important that business managers are afforded the requisite authority and resources to fulfil their considerable responsibilities. Additionally, having General Managers work alongside them may be helpful (Onyett et al., 1997b).

16.3.2 Balancing control and autonomy
(Refer to Section 20)
In addition to aligning CMHT goals with those of the HSE, business managers need to maximise the benefit of the resources at their disposal. Achieving such value-for-money may involve re-examining all areas of clinical work ‘to identify the most cost-effective use of professional skills’ (Department of Health, 1989, p.15). Hence, the belief that business managers have traditionally decided on many issues (Onyett et al., 1994).

While such robust management also protects team capacity for new referrals (Department of Health, 2002), it also needs to take account of the professional autonomy and line management of CMHT members. For example, CMHT members may subscribe to the view that it is important to do the work for which they are specifically trained (Wall, 1998). This may contrast with the beliefs of some business managers that generic working optimises service provision quality.

There may be a divergence of opinion on the appropriateness of individual versus group interventions or when service users are to be discharged. There may also be divergence around the most appropriate type of treatment (e.g. medical versus non-medical). The culture in our increasingly ‘cost-conscious’ health services may be to prioritise physical treatments given their advantageous rapidity of effect (Samson, 1995). However, in making resource utilisation decisions, ‘cost conscious’ business managers need to also take account
16.3.3 Matrix management
The perception of many CMHT members is that they are operationally accountable to the CMHT manager but professionally accountable to their respective line managers (Peck & Norman, 1999). Some disciplines have advocated that the former concerns quantitative issues (e.g. time, money, efficiency) while the latter concerns qualitative issues (training, recruitment, effectiveness; British Psychological Society, 2001). However, in seeking to increase managerial power at the expense of clinical power (Peck, 1991), it is likely that the ‘managerialism’ ideology of business managers will generate some intra-team friction (Onyett, 1998).

16.3.4 Managing all disciplines
While not adequately elaborated upon in the Commission’s discussion document (p. 35), CMHT managers in some jurisdictions have managed and provided managerial supervision and appraisals of all staff excluding medical doctors or Consultant Psychiatrists (McGuinness, 2004). Such an arrangement undermines the CMHT manager’s authority and creates structural inequalities that are likely to predispose to the all-to-frequent intra-team power struggles and dysfunction. Hence, if the business manager is to be accepted by CMHT members, s/he must be granted the authority to manage all disciplines (including the proposed clinical leader and team co-ordinator roles).

16.3.5 Clinical governance
Along with risk management and quality assurance, business managers need to commission periodic clinical audits to maintain the quality of, and potentially review the configuration of, CMHT service provision. Thus, the procedures used for assessment and intervention, as well as feedback pertaining to the quality of service provision, need to be reviewed (Onyett et al., 1997b). A culture of increasing clinical audit, it is important to be wary of the ‘law’ of professional practice. This states that the more diverse, plural and unpredictable professional work becomes, the greater will be the managerial pressure towards homogeneity, singularity and coercive specification (Strathern, 2000, p. 316).

16.3.6 Budgetary management
In order to shape service provision, business managers need full control over budgets. However, in direct contradiction with the job descriptions, this often does not happen (McGuinness, 2004). Ideally, they would direct resources towards those service provision elements that are best value-for-money. However, there may be many instances where concerns for optimal efficiencies clash with equity concerns. For example, the running of recovery groups for individuals with chronic psychosis may be costly and affect poor long-term gains. But in the interests of equity, a business manager may decide to run such groups.

16.3.7 Address power dynamics
Address the inevitable conflict within CMHTs, business managers must facilitate an intra-team dialogue to constructively and quickly resolve what most likely will be inter-professional conflict. Failing to do so will inhibit teamwork (Stark et al., 2002).

16.4 Who should be the business manager?
Consultant Psychiatrists have traditionally advocated that they manage CMHTs. However, in the interests of the common good, future business managers need to have a combination of advanced managerial skills and appropriate personal qualities to meet the ‘extremely challenging nature’ of CMHT management (Onyett et al., 1997b).

16.4.1 Traditional management model
Despite the perception that their training does equipping them with the requisite management skills (Tobin & Edwards, 2002) that are instead developed in situ (Muijen, 1993). More recently, research in the United Kingdom has indicated that many Consultant Psychiatrists do not want management responsibility for CMHTs (Kennedy & Griffiths, 2000).

Resorting to the traditional and control concept of management has generated unnecessary conflict with professional line managers, decreased clinical autonomy, and, most likely, increased intra-team resistance (Callaly & Minas, 2005; Henderson, 2001). Hence, such ‘domination’ may prevent the realisation of effective teamwork within CMHTs (Martin et al., 1999). However, it is important to acknowledge that unrealistic assertion of clinical autonomy can elicit such a management style.

16.4.2 Merit-based management model
Given the demands of this challenging role, future CMHT business managers will need a formal management qualification (McGuinness, 2004) in addition to a track record of successful management of multidisciplinary teams. While occupation of this role by certain disciplines may challenge inter-disciplinary boundaries (e.g. Nurses may resent management by Social Workers; Hannigan, 1999), again it is important that this post be designated as discipline non-specific. To this end, there are reasons that a multidisciplinary team without differences is a contradiction in terms’ (Øvretveit, 1995, p. 41). As highlighted by Lankshear (2003), like all health care teams, CMHTs are a site for contest and negotiation due to a variety of factors including differences in world view (Øvretveit, 1995), professional allegiances (Peck & Norman, 1999), and in pay and status (Norman & Peck, 1999). Dual accountability (or matrix management) also offers tremendous latitude for conflict (Galvin & McCarthy, 1994). It may also reflect the interactions between individual team members and their consumers (Øvretveit, 1995; Heginbotham, 1999).

16.4.3 Personal qualities
Given the high turnover of senior mental health managers (Peck, 2001), it may not be surprising to hear that a CMHT manager role is perceived as ‘a crown of thorns’ (Onyett et al., 1995). Candidates need to be tolerant of the ‘time honoured antagonistic attitude reserved for management’ (Callaly & Minas, 2005, p. 30) especially as their ‘managerialism’ is typically perceived to threaten clinical autonomy (Peck) in CMHTs that are typically ambivalent about authority (Burns, 2004). In addition to advanced interpersonal skills, a potential manager will also need a high degree of technical skills that in many instances micro-management may hinder pro-social behaviour, damage team climate and predispose to team failure.

17. How should ongoing training be facilitated and provided?
Refer to Section 14.

18. How should conflict be managed on multidisciplinary teams?

18.1 Inevitability of conflict
The management literature on teamwork may not take sufficient account of the unique context of multidisciplinary teams. There are ‘perhaps few other sectors where relationships are as contested and professional identities so closely guarded as in mental health’ (Henderson, 2001, p. 370). There are many reasons that a multidisciplinary team without differences is a contradiction in terms’ (Øvretveit, 1995, p. 41). As highlighted by Lankshear (2003), like all health care teams, CMHTs are a site for contest and negotiation due to a variety of factors including differences in world view (Øvretveit, 1995), professional allegiances (Peck & Norman, 1999), and in pay and status (Norman & Peck, 1999). Dual accountability (or matrix management) also offers tremendous latitude for conflict (Galvin & McCarthy, 1994). It may also reflect the interactions between individual team members and their consumers (Øvretveit, 1995; Heginbotham, 1999).

18.2 Task versus relationship conflict
Intra-team ‘task’ conflict typically pertains to divergence of opinion and involves an aspect of teamwork (e.g. roles and responsibilities, clinical judgements, caseload sizes). If not adequately resolved, task conflict can transform or escalate into ‘relationship’ conflict (De Dreu & Van Vianen, 2001). The latter concerns insights and information that are unrelated to the task at hand, involves negative emotions and threatens one’s personal identity and feelings of self-worth (Pellet, 1995). Whereas task conflict may motivate team members to look for optimal judgements and decisions, this is a contradiction in terms. Interpersonal conflict may hinder pro-social behaviour, damage team climate and predispose to team failure.

18.3 Managing intra-team conflict
Well-functioning teams are not characterised by an absence of conflict (Senge, 1990). Interdisciplinary ‘creative tension’ can enrich team functioning and predispose to greater innovation and more effective interpersonal relations (Tjøsvedt, 1997). However, if not managed appropriately, lower team effectiveness, reduced well-being and turnover may materialise (Peterson & Rex, 1998). Hence, it is important to consider the variety of ways of responding to conflict. These include responding collaboratively, contending and avoiding, each of which will impact differently on CMHT working.

Vol.32 No.12 p 334
18.3.1 Responding collaboratively
Responding collaboratively involves trying to work out a mutually acceptable solution. A commitment to engagement in ‘constructive conflict’ (i.e. the open-minded discussion of opposing stances) can build mutual respect, facilitate resolution of differences and prevent conflict from escalating unnecessarily (Tjosvold, 1997). Hence, this informal but proactive style appears to be the optimum conflict management strategy (Nichols, 2003).

18.3.2 Contending
Contending is trying to impose one’s will, wishes and perspectives on others. Such a reaction lock individuals into a ‘conflict spiral’. Research indicates that contending behaviours are quickly reciprocated by even stronger contending responses from others. In the process, the benevolent views of opposing parties can be dismantled (Fruitt & Carnevale, 1993) and the conflict can proceed down bureaucratic routes. Such escalation removes conflict from the forum of goodwill and working relationships, predisposes to relationship conflict, and may make conflict resolution more unlikely (Byrne et al., 2006).

18.3.3 Avoidance
Avoidance of conflict can be quite destructive. Possibly out of a fear of jeopardising a favoured intra-team (power) position or possibly in reaction to what they perceive as illegitimate claims to power (e.g. by Consultant Psychiatrists equating medical responsibility with ‘ultimate clinical responsibility’), many CMHT members may minimise or deny the existence of intra-team differences (Oøvretveit, 1995). They may attempt to conceal power relations by advocating ‘democratic’ or ‘non-hierarchical’ teamwork (Norman & Peck, 1999).

However, such concealment predisposes to avoidance of substantive discussion about power relations that only serves to mask intra-team ‘structural inequalities and terminological ideological conflicts’ (Lang, 1982). Hence, these ‘unspeakables’ remain ‘unspoken’ (Byrne et al., 2006) and remain ‘all the more oppressive by being implicit and difficult to challenge’ (Oøyett et al., 1997b, p. 42). Hence, intra-team conflict can remain hidden and sometimes unconscious (Heginbotham, 1999). Augmenting this process in some jurisdictions and serving as a conflict resolution mechanism can be the (perceived) imposition of statutory authority of some disciplines (e.g. Consultant Psychiatrists equating medical responsibility with ‘ultimate clinical responsibility’), many CMHT members may minimise or deny the existence of intra-team differences (Oøvretveit, 1995). They may attempt to conceal power relations by advocating ‘democratic’ or ‘non-hierarchical’ teamwork (Norman & Peck, 1999).

18.4 Necessity of a conflict resolution mechanism
Possibly incorporated into a team communication strategy, clear mechanisms for conflict resolution are required (Oøyett et al., 1997b), preferably through multi-professional consensus. However, ‘recognition of some authority structures to resolve disagreements’ may be required, and these need to also address conflict between line managers and operational management (Burns, 2004, p. 63). Hence, if the conflict cannot be resolved firstly by the business manager normally, i.e. ‘collaborative responding’ between line managers and the business manager, the general manager may be called upon to resolve the conflict. Such clear mechanisms may in and of themselves predispose to less conflict (Oøyett et al.). These mechanisms could complement the more preventative measure of building and maintaining intra-team trust that may reduce the likelihood of task conflict developing into relationship conflict (Simons & Peterson, 2000).

18.5 Need for national forum
There may be a need for relevant professional bodies to ‘resolve complex national issues such as the status of individual members, professional training, levels of competence, legal status, entitlement to practice autonomously, and the functional interrelationships between professional groups’ (Galvin & McCarthy, 1994, p. 164). Lack of national discussion (i.e. macro-avoidance) of these ‘fundamental structural problems’ can result in ‘pushing major conflicts down the system’ (p. 165) onto CMHTs that may not be able to deal constructively with these problems. This can predispose to a push for egalitarian CMHT working (or micro-avoidance of discussing these problems) and potential poor teamworking in many sites (refer to Section 18.3.3).

19. What is the most effective model to provide both discipline-specific supervision and supervision by team members?
19.1 What is supervision?
The purpose of supervision is to provide support and a safe place for learning based upon evidence-based practice (Fleming & Steen, 2003). Such support can mediate the stress contributed by factors such as role conflict, role ambiguity and insufficient resources (Acker, 2004). The traditional context of (discipline-specific) supervision is usually one of a formal accountability relationship. Such a relationship is absent in peer ‘consultation’ that is sometimes erroneously labelled as peer ‘supervision’.

19.2 Professional supervision
Some professional bodies advocate that, for both ethical and professional reasons, supervision should not be provided by a line manager who also holds operational powers over a professional (British Psychological Society, 2001). More generally, it is becoming increasingly accepted that professional systems of supervision do not meet the needs of professionals (Mussung & Hughey, 1997). Given the pressures of implementing policy and organisational requirements, supervision may become a site of accountability and be experienced as a form of control (Scanlon & Weir, 1997). For example, it may translate into administrative control (e.g. monitoring clinical load) as opposed to what gets done.

However, if there is matrix management with business managers providing operational management, line managers may want to provide professional supervision. However, given their heavy and diverse workloads, line managers may find it difficult to keep abreast of developments in clinical practice. Hence, they may not be best placed to provide clinical supervision. It is therefore critical in the current context of a lack of career structure for some of the allied health professionals may be external supervision paid in part by the HSE (Byrne et al., 2006).

19.3 Peer consultation
Peer consultation equates to ‘support and advice given within and across disciplines’ (Oøyett, 2003, p. 177). It has been suggested that given the evident overlap of roles within teams, clinical supervision within disciplines should perhaps be replaced by peer consultation within and between disciplines so that a shared team identity is promoted (Oøyett et al., 1997b). Regardless of how safe ’supervision’ has become (i.e. the deference to professionals in the courts (Byrne, 2005b) and the protection afforded by the Clinical Indemnity Scheme), such peer consultation might be considered cross-disciplinary supervision. Specific disciplines may add value to CMHTs by providing highly skilled input. For example, it appears that Consultant Psychiatrists want to have some responsibility to provide input into...
supervision (Kennedy & Griffiths, 2000). However, if the only difference between cross-disciplinary supervision and peer consultation is whether vicarious liability can apply, CMHTs may be best served by continuing with (less contentious) peer consultation.

20. What is a useful definition of clinical accountability? What is the most effective way of ensuring clinical accountability in multidisciplinary teams?

20.1 Autonomy, accountability and responsibility (Refer to Section 2.7.8) CMHT members are socialised for clinical autonomy or the exercise of ‘considered’ and ‘independent’ judgement (Keenan, 1999). With autonomy comes accountability or answerability to authority for one’s responsibilities (Maas & Jacox, 1977). The latter are the set of tasks or functions demanded by the authority (British Psychological Society, 2001). However, accountability is assumed only if the requisite degree of authority to perform the associated functions is granted. Many CMHT members understand that they are operationally accountable to the CMHT manager but professionally accountable to their respective line managers (Byrne et al., 2006).

20.2 Models of clinical accountability (Refer to Section 2.7.8) The lack of clarity regarding responsibility and accountability in CMHTs is partly due to their being no universally accepted model or framework of clinical accountability. While two dominant models appear to have wide appeal among specific disciplines, of greater practical use may be a more fine-grained model based on decision-making methods (Øvretveit, 1995).

20.2.1 Dominant models of clinical accountability There appears to be a lack of clarity regarding responsibility and accountability in CMHTs, as evidenced by the two models that are assumed to operate. Believing that they retain ‘ultimate clinical responsibility’, Consultant Psychiatrists endorse the necessity of a ‘star’ model of clinical accountability whereby, positioned at the centre of the team accountability structure, they are accountable for the clinical work of all CMHT members with service users. This model may predispose to social loafing (refer to Section 5.3) and to service provision bottlenecks if Consultant Psychiatrists insist on personal responsibility. In contrast, many CMHT members believe in a ‘spider web’ type model, whereby they are personally accountable for their own clinical work and have ‘token’ accountability to their professional line managers (Byrne et al., 2006). However, adoption of either of these seemingly ‘polar opposite’ models does not adequately inform the debate about what is the most effective way of ensuring clinical accountability.

20.2.2 Øvretveit’s (1995) model of team decision-making This model outlines five methods of multidisciplinary team decision-making. ‘Practitioner only’ decisions pertain to those that can be made independently by a team member. ‘Practitioner after consultation’ with the team (or possibly business manager) type decisions also grant a considerable degree of practitioner autonomy. ‘Practitioner following team policy decision-making’ may grant CMHT members a small or large degree of decision latitude depending on whether the team policy is ‘prescriptive or generic. ‘Majority vote’ (or democratic decision making) involves having to go along with the majority opinion, while ‘non-consensual’ (or consensual) decision-making grants vetoing powers to all team members. A variant of the former is ‘qualified majority voting’ whereby team members can opt out if they have conflicting responsibilities (Øvretveit, 1995).

Alternatively, decisions can be categorised according to their type (Øvretveit, 1995). They may be profession-specific, care management related, policy and management related or of the planning variety. Each type will involve varying degrees of balance between individual, team and higher management accountability.

A CMHT business manager could, in consultation with all team members and their line managers, use Øvretveit’s (1995) model of team decision-making to develop a decision matrix that could balance achievement of clinically accountable practice with the constraints of scarce resources. However, a number of factors may prohibit doing so including discipline-specific claims to ultimate clinical responsibility, professional registration responsibilities, and the presence of dominant personalities. In relation to ‘mandated’ responsibilities, it is important that these are debated and agreed upon by all team members.

20.3 To be, or not to be, democratic (Refer to Sections 11.5 and 18.3.3) Democratic decision-making (and the associated ‘joint accountability’) has an intuitive appeal as it can promote broad-based ownership of the process and increased support for the implementation of decisions (Øvretveit, 1986, 1995). Some CMHTs may still be regarded as ‘democratic’ in that there may be a degree of participation in decision-making (Oyett & Ford, 1996). However, the process can be time-consuming, can dilute individual responsibility, and can favour the numerically stronger CMHT disciplines. Even more disruptive is the implicit message to teams that they are not sufficiently secure to engage in rational, potentially conflictual, but ultimately healthy debate (Byrne et al., 2006). Hence, democracy is often ‘neither desirable nor appropriate’ (Mental Health Commission’s discussion document, p. 42).

20.4 Cycle of anarchic decision-making Non-consensual decision-making (Kane, 1980) may predispose to disempowerment, intra-team conflict and poor team working (Peck & Norman, 1999; Rafferty, Ball & Aiken, 2005). However, there often is a ‘consultation policy’ after a decision has been made-type decision-making (Byrne et al., 2006). This qualifies as another form of ‘anarchy’ (Mental Health Commission’s discussion document, p. 43). Subsequent feelings of marginalisation can predispose to CMHT members (inappropriately) resorting to enacting in ‘practitioner only’ decision-making (Byrne et al., 2006). Hence, a self-perpetuating vicious cycle of ‘anarchic’ decision-making can materialise whereby lack of consultation from some CMHT members (i.e. what is sometimes labelled as ‘leadership’) elicits a similar (defensive) response in other team members that can be used as justification for the initial decision-making style.

21. How should confidentiality be dealt with in a team situation? How should this be explained to service users?

21.1 Team-based confidentiality Given that many service users might be unaware that service provision is team-based (Warne, Skidmore, Stark, & stronach, 2000), it is important to initially inform them (both verbally and in writing) that confidentiality is assumed only if the service user is satisfied. However, as the goal of service provision is to promote the well-being of service users, it is important to seek their consent in sharing relevant information with CMHT members and/or family members. If consent is not forthcoming, a practitioner needs to break confidentiality and seek their consent instead (British Psychological Society, 2001).

21.2 Sharing information with carers/relatives Given that family dynamics (e.g. enmeshment, family secrets, abusive relationships) may be a primary maintaining factor of clinical presentations, it is important that information not be disclosed to family members without service user consent. As routinely practised, the only exceptions to this policy are disclosure of (potential or existing) self- or other-harm, including abuse of children (Department of Health and Children, 1999). In the absence of confidentiality, it is likely that client disclosure will decrease.

22. What are the essential policies for a multidisciplinary team and how might these be drawn up?

22.1 Need for constructive partnership discussion regarding CMHT functioning needs to be directed away from the ‘round robin of blame’ that sometimes characterises such discussion (Stark et al., 2002). What is required is a focus on constructive debate using a partnership approach between the relevant stakeholders (e.g. clinical leader, business manager, line managers, general manager, trained service users).

22.2 Structure of an operational policy document While leaving a CMHT to work out the details related to the many issues highlighted in this document potentially predisposes to ‘failure to thrive’ (Brown et al., 2000), not every aspect of teamwork can or need be defined or prescribed (McCourt, 2002). At the very least, such a document needs to detail procedures relating to target service planning, professional registration responsibilities (including role definitions, confidentiality, supervision, integrated records, conflict resolution, and liaison with external agencies. As such, a team operational policy document that all team members agree and conform to can serve as the central working tool of a CMHT (Øvretveit, 1995). This must reflect the optimum balance that must be made between shared frameworks (e.g. realising team goals) and giving team members every opportunity to exercise their profession-
specific skills where appropriate’ (Onyett, 1995, p. 283). However, it is important to appreciate that such a document will not prevent conflict and confusion, but it can help reduce both considerably and create a space for responsive and improved inter-disciplinary teamworking (British Psychological Society, 2001).

23. The last word
23.1 Need to get on with it
The last word sits alongside many formal and informal factors that create a ‘messy world’ (Stark et al., 2002). It may be that true teamwork is neither a solution to this messy world nor an achievable holy grail (Gulliver, Peck, & Towell, 2002). Many barriers are valid for formal teamworking in CMHTs just does not exist (Stark et al.). Possibly what is more realistic is to just get on with it and aspire for ‘good enough functioning’ (Onyett, 2004). While it might be more realistic than reality in some teams (Stark et al.), that effective teamworking is evident in other teams is remarkable and perhaps achieved against the odds (Hannigan, 1999).

Similar to how some organisations can become quite internally focused during merger activities (Tetenbaum, 1999), it appears that CMHTs are somewhat self-absorbed with whether they do or do not function well. Moving beyond the polarities of the debate (e.g. good or bad functioning) and reconnecting with the communal supra-goal of meeting service users’ multiple needs may help to push team members beyond professional barriers in the direction of improved team functioning (Firth-Cozens, 2001a).

References
Alimo-Metcalfe, B. & Alban-Metcalfe, J. (2003) Under professional barriers in the direction of teamworking is evident in other teams is remarkable and perhaps achieved against the odds (Hannigan, 1999).
