Interdisciplinary teamwork and leadership: issues for psychiatrists

Alan Rosen and Tom Callaly

Objective: *To review the constructs and applications of interdisciplinary teams in mental health services, with a particular view to ascertaining the most effective types of teams and their leadership.*

Method: *Some of the most challenging questions from a psychiatrist's viewpoint regarding the functions of interdisciplinary teams in the mental health service are addressed.*

Results: *The effectiveness of the interdisciplinary team in mental health service is supported by an extensive literature that is much more qualitative and descriptive than quantitative and empirically rigorous, except as part of packages of variables subjected to randomized control trials.*

Conclusion: *Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks, and requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices. No one profession should hold a monopoly on leadership.*

Key words: *interdisciplinary, leadership, management, multidisciplinary, psychiatrists' role teams, teamwork.*

Life used to be so simple. Doctors used to be able to assume leadership of the clinical unit almost by divine right, other professional disciplines knew their place as 'handmaidens', hospitals were the centre of the known health-care universe and administration was done centrally and unobtrusively with budgetary stability assumed as 'last year's budget plus 5% for inflation'. Generic community health teams, with their flattened hierarchy, developed in the 1970s in Australia to provide mainly preventive services, and were often dismissed by entrenched hospital clinicians as 'small groups of people, sitting in circles, smoking, drinking coffee and plotting revolution'.

This phase was superseded by the concurrent shift away from reliance on stand-alone psychiatric institutions in favour of general-hospital-based inpatient units, and the development of distinct community mental health teams, organized around specific functions, often evidence-based, focused mainly on the needs of individuals with severe mental illnesses and their families living in the community (e.g. 24 h home-visiting crisis and assertive community treatment teams). In the 1990s, encouraged by National Mental Health reforms in both Australia and New Zealand, clinical and management integration was promoted between general-hospital- and community-based mental health services. Following a period of service innovation and growth, responsibility for shrinking budgets was devolved to service managers and team leaders, whose teams magically transformed into 'cost-centres' often forcing them to make unpalatable choices and cut staff.

Many psychiatrists have been ill-prepared in their training for working within the interdisciplinary team. Although psychiatrists have belatedly recognized that 'the other members of the team are not the handmaidens of the doctors

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and have to be treated on an equal professional footing', they can still find that their sense of responsibility to consumers and the discovery of their limited leadership and management authority can cause conflict and frustration both for themselves and for other team members.[1]

In order to promote readability in a necessarily brief overview of a large topic, the most challenging questions commonly asked by perturbed or otherwise sceptical psychiatrists regarding interdisciplinary teamwork and leadership will be addressed.

Q1. Do we really need teams in mental health services? Do they really work, or do we just idealize 'teamwork' to paper over the cracks between the warring approaches of different professional disciplines involved?

A team can be thought of as a small group of people who came together for a common purpose,[2] or as a method for organizing the contributions of people in different roles required to complete a task.[3] An interdisciplinary team in a modern mental health service brings specialist assessments and individualized care together in an integrated manner and is the underlying mechanism for case allocation, clinical decision-making, teaching, training and supervision and the application of the necessary skills mix for the best outcomes for service users.[4] However, while the interdisciplinary team can be an efficient, effective and satisfying the type of work organization, it can also be a disaster, torn with conflict and leading to disrespect with the pretence of cooperation.[2,3] Service users, their families and health workers can all benefit and grow from good teamwork or all suffer and be diminished by poor teamwork. Good teamwork depends on clear structure and accountability, good leadership, delegation of tasks, role delineation and mechanisms to resolve role conflicts.[2,3,5,6] Sound interdisciplinary teamwork has the ability to bring different expert points of view and bodies of knowledge to bear on the person's problems. Alternatively, a veneer of gestural teamwork may be employed in a futile effort to superficially 'paper over the cracks' of interprofessional differences. These include: interprofessional misperceptions, misunderstanding, ignorance and stereotyping of each other's roles, for example, psychiatrists who do not value or comprehend the skills of an occupational therapist [7] or a social worker;[8] interprofessional rivalries – based on a disturbing tendency regarding the unique aspects of one's own profession as superior to the unique aspects of other professions (this is unfortunate because most of these different approaches are complementary and potentially synergistic); and power, status and salary differentials that can lead to simmering resentments about differing rewards for seemingly similar activities.[2] Rather than focusing on within-team rivalries and ideological differences over treatment philosophies, these should be put aside in favour of the principle 'the service-user comes first', and focusing on the combined tasks of the team to meet the needs of that individual and their family.[5,6,9,10] Embroiling the service user in conflict over treatment approaches will often result in more turbulent or destructive behaviours.[6]

Q2. What is meant by the multidisciplinary team? Doesn't every clinical unit claim to be one? Isn't it an inflationary currency?

Many clinical units that claim to operate as 'multidisciplinary teams'[1] are in fact loose-knit 'network' type teams,[3] which provide easy exchange of information and referral between service providers who may otherwise work separately, in relative isolation from each other. They may or may not meet, except in passing, and usually do not review or assist in each other's work. Such 'multidisciplinary' or 'network' teams may occur in primary health-care centres, large community health centres with little formal structure or any medical specialty. Where this structure exists in mental health services, typically in old-style sedentary adult or child and adolescent mental health outpatient-style units, it is difficult to provide more complex evidence-based psychiatric service components such as extended hours mobile crisis intervention or assertive community treatment intensive case management subsystems. These require cohesive interdisciplinary teams.

The essence of interdisciplinary teamwork lies in the recognition, utilization and integration of the expertise and perspectives of different professionals, which derive from their professional discipline and which are focused on working towards a shared goal.[11] Interdisciplinary teams may involve service providers from several professional disciplines (e.g. medical, nursing, allied health) working simultaneously with the same service user and their family with a division of labour or components of intervention coordinated by one designated case manager. These team members meet regularly and participate in the review of the quality, flow and amount of each other's work.

Q3. Which professions are part of the interdisciplinary mental health team anyway, and which are expected to work from outside the team?

Delineating and clarifying membership often marks a transition from an informal loose-knit group to a more formal and organized team. Five professional disciplines are usually involved with interdisciplinary mental health teams: psychiatry, psychiatric nursing, psychology, occupational therapy and social work. Onyett *et al.* reported, using a standardized measure with 57 community mental health teams across the UK, that the staff who have the highest job satisfaction and lowest burnout are those who have identification both with the team and their profession, and who are both clear about the role of their team and their own role within it.[12]

Other professionals who often work in close liaison with mental health service teams include: general practitioners, primary health-care workers, health educators, indigenous and transcultural workers (e.g. bilingual

counsellors) rehabilitation and vocational counsellors etc. These professionals may or may not be able to participate full time in the interdisciplinary mental health team for practical purposes, but may become essential members of the ad hoc interdisciplinary team set up around particular service users and their families. Other partners outside the team whose inputs are more effective with good coordination and reciprocal communication include: public housing officers, employment and welfare benefit officers, domestic assistance and home nursing carers etc. Managers who do not see themselves as team members often have considerable influence over the team functioning.[13] Boundaries between management and teams are often blurred, so both parties should work progressively on clarifying this relationship.

Q4. Why are there interdisciplinary teams in psychiatry and not in medicine, surgery, paediatrics etc.? Is this just another way for the Government to save money by not employing the number of psychiatrists needed, and by using cheaper alternative staffing?

Psychiatry is arguably ahead of many medical disciplines in its recognition that most severe disorders have a multifactorial biopsychosociocultural aetiology, requiring corresponding multimodal intervention responses. It is unrealistic to expect that each individual psychiatrist, even if comprehensively trained to appreciate all these needs, has either the time or the training to provide all of these interventions effectively. It may be gradually dawning on other medical and surgical disciplines that all clinical disorders have such multifactorial predisposing, precipitating and perpetuating factors, and that they would resolve more quickly and completely if they also employed such a multimodal interdisciplinary approach.

Employing interdisciplinary teams may not be the cheap option, but has been demonstrated to be the more cost-effective strategy, rather than mainly relying on traditional outpatient and inpatient psychiatric services. The use of assertive mobile interdisciplinary teams can result in increased attendances and contact with care, decreased use of hospital-based care, more housing stability and better functional outcomes.[14] In any case, the supply of trainee and consultant psychiatrists is too limited to fill many more positions in public mental health services and teams, even if sufficient funding was available.

Q5. Is there an evidence base for the effectiveness of an interdisciplinary team approach?

Although there is an extensive literature, most of it is qualitative and descriptive, and empirically somewhat limited. Interdisciplinary teamwork is often a characteristic of psychosocial interventions that have been subjected to randomized control trials and shown to be cost-effective (e.g. assertive community treatment,[14] crisis behavioural and family intervention[15]), but its effect as a centrally operative variable remains largely unknown, except as part of a package of variables. Nevertheless, 'multidisciplinary team-based care has been demonstrated in Cochrane reviews to provide cost reductions per patient and care that is at least as good when compared with inpatient (based) services'.[10] The evidence regarding interdisciplinary teamwork has been reviewed by Trauer *et al.*;[2] advantages include continuity of care,[11] the capacity to take a broad and comprehensive view of the patients' problems,[16] the availability of a range of skills[17] and synergistic working between providers via mutual support and reciprocal education.[18] This can prevent professional isolation and lead to cross-fertilization of approaches and skills.[19] The team may also be more than the sum of its parts. 'A well-functioning team with a strong sense of shared responsibility can produce significantly more and better work than its individual members working as solo practitioners'.[20] Mohrman *et al.* found that working in teams enabled organizations to rapidly develop and deliver high-quality products and services cost-effectively, allowed the organization to learn and retain learning more effectively, promoted innovation through the cross-fertilization of ideas, achieved better integration of information and saved time by having tasks undertaken concurrently.[21] Opie concluded that advantages of the interdisciplinary team include the development of quality care for users through the achievement of coordinated and collaborative inputs from different disciplines; improved, better informed and holistic care planning; higher productivity; the development of joint initiatives; increased job satisfaction and greater professional stimulation and consequently more effective use of resources.[22]

Q6. Increasingly, multidisciplinary teams are made up of different disciplines playing the same case-management role. Are they not getting an opportunity to practise their particular professional skills, and will they lose them? On the other hand, if they all play separate professional roles, can they be called a 'team'?

Interdisciplinary teamwork, while systematizing core multidisciplinary skills, should also ensure that the distinct contribution of each professional discipline is valued highly within the team, and that strong professional support links are maintained. Australasian guidelines do not support the development of a generic mental health case-manager role, either by merging professions or on a non-professional basis.[23,24] Cooperative effort between professionals of diverse tertiary training and backgrounds brings many more up-to-date skills to bear on shared challenges, enhances peer support and strengthens hybrid vigour, while also maximizing professional ethical standards and the quality of care.[19]

All staff should be encouraged to maintain links with their professional discipline for ethical and professional advice and at least a significant proportion of their postgraduate learning and professional supervision.

Table 1: The 12 practice standards

National Practice Standards for the Mental Health Workforce (2003)[25]

1. Rights, Responsibility, Safety and Privacy
2. Consumer and Carer Participation
3. Awareness of Diversity
4. Mental Health Problems and Mental Disorders
5. Promotion and Prevention
6. Early Detection and Intervention
7. Assessment, Treatment, Relapse Prevention and Support
8. Integration and Partnership
9. Service Planning, Development and Management
10. Documentation and Information Systems
11. Evaluation and Research
12. Ethical Practice and Professional Responsibilities

Although each profession within the interdisciplinary team should have relatively protected time to contribute specialized work derived from their own professional discipline's skill set (e.g. clinical psychologist undertaking cognitive behaviour therapy (CBT)), each professional should also contribute core clinical skills common to all when rostered to do so (e.g. acute intake assessments, continuity of case management). The (Australian) National Practice Standards for Mental Health Workforce defined the core knowledge, skills and attitudes that all mental health professionals should have when working in a mental health service (Table 1).[25] The workforce standards do not attempt to limit the knowledge and skills base or competencies expected to be attained and maintained for each professional discipline.

Q3

The team needs to relative autonomy for each professional, while providing a space within which the various professionals may collaborate with safety and even creatively, together with service users and carers. The level of collaboration required to support the complexity of these interventions demands sophisticated management of boundaries and authority.[4]

Q4

So is role overlap a problem? No – inevitably a great deal of overlap or 'core' case-management function will form the bulk of work with some service users, but there needs to be space for each of the professions to contribute their specific expertise.

Q7. The terms 'team leader', 'team manager' and 'clinical leader' are confusing. Are their real differences or are they just used interchangeably by bureaucrats to confound us clinicians and impose senior management 'plants' on our teams? Shouldn't a real team elect its own leader?

In traditional psychiatric hospitals, line managers often led unidisciplinary professional departments, but this is now less common. Initially, interdisciplinary team leaders were often voted for from within the team, leaving these posts with little real authority. The term 'team manager' connotes more formal management responsibility as well as leadership, and may therefore be more likely to be an officially advertised and appointed post. In its simplest and most common form, the team manager position is held responsible for specified management functions, with delegated authority to ensure that the team applies operational policy, but does not oversee the clinical decision-making of other team members. In this model, the team manager may work in tandem with a clinical leader, who undertakes or ensures all clinical supervision, or the professional line manager may retain responsibility for clinical supervision. In its more complex and richer form, the team manager assumes all administrative functions and overviews of all clinical work allocation, assessment, operational practice review and case termination.[13] In this model, the team manager or supervisor may be assisted by other senior professionals allocated responsibility for clinical supervision of more junior members, or peer supervision dyads or groups may be arranged.

The distinction between management and leadership is critical.[26,27] A number of individuals on a team can simultaneously demonstrate clinical leadership, including the psychiatrist.

Q8. Who is really accountable for care? It is all very well to say that each team member carries clinical responsibility for their own decisions and the case plans they devise, but if something goes wrong isn't it me who ends up in court, while they run for cover?

An unquestioned assumption underlies the traditional response to this issue: 'Obviously, in legal terms the consultant is responsible for (all) patient care'.[1] Guidance from the NHS National Steering Group in conjunction with the Royal College of Psychiatrists states that consultant psychiatrists 'have the ultimate responsibility to diagnose illness and prescribe treatment. This authority may be delegated to other professionals, but the responsibility cannot be abrogated'.[28] This type of authoritative statement becomes a two-edged sword and can result in assumed centrality of psychiatrist responsibility and blame when anything goes wrong during intervention. Boyce and Tobin argued the need for psychiatrist supervision of all other health professionals and insisted on direct psychiatrist overview of and accountability for every case.[29] Such insistence would waste scarce and much-needed medical expertise, delay effective treatment as waiting lists to see 'the doctor' get longer, allow people in need of services drop out, and leave medical staff with no time for home visits or participating in service-system building or service management.[6,30]

Q5

The opposing view emphasizes the difference between responsibility and leadership in stating that because of the circumscribed nature of professional responsibility,

no professional can be held accountable for another professional's actions except in part by negligent delegation or inappropriate referral. This resolves the unhelpful conflation of medical responsibility and ultimate clinical responsibility.[13] Medical responsibility is best regarded as a particular instance of professional responsibility whereby practitioners are accountable for those tasks for which they are recognized as competent as a result of their medical training. Ultimate clinical responsibility is often claimed by the senior medical member of the team when he/she asserts that he/she is accountable for the work of the team as a whole should disaster occur or that although personally blameless she/he may be held accountable after the style of a military commander. But this assertion is almost certainly unjustified. The Nodder Report concluded that there is no basis in law for the commonly expressed idea that a consultant may be held responsible for negligence on the part of others simply because he is the responsible medical officer.[31] In Australasia, unlike the Northern American documented experience, non-medical members of the mental health team, including case managers, are much more likely to be clinical professionals who take professional responsibility for their work. They are held clearly accountable for their own work by their professional bodies (e.g. Royal Australian and New Zealand College of Psychiatrists (RANZCP) position statement 47)[26] and by state government regulation (e.g. New South Wales Department of Health).[32] A recent National Health Service Department of Health Guidance Report advises that doctors in psychiatry are not responsible for the quality of care provided by another team member, and there is no requirement to have a consultant's name on the file of any service user who is not actually seen by that consultant.[28]

Q9. Aren't team managers in an impossible position? The team expects them just to look after the team, and defend their habitual practices, while the bureaucracy considers them to be management, and expects their loyalty in terms of implementing senior management decisions.

Team managers sit on the team boundaries, facing outwards when representing the team to management and other agencies, and facing inwards when supporting the team. Living on the boundary can be difficult and lonely.[13] An effective team manager needs to be both internally in touch with the state of the team and externally aware of the demands on the team as a whole. They often find themselves the receptacle of the group's hostile projections, particularly in a context where structures are constantly evolving and frail, and there is no longer a robust institution to provide containment of these projections.[33] They can neither entirely join the group nor distance themselves from it.

Turquet stated that teams need a manager who can 'bear being used. . .otherwise the negative projections go elsewhere. . .' to an external enemy, or the projections go rocketing around the organization precipitating personalized conflicts among peers, or become reinternalized 'so that workers can no longer find meaning or pleasure in their work'.[34]

So team managers have an important role in containing difficult team emotions,[13] and an equally important role in articulating and standing up consistently for the team and service values and vision based on the experienced needs and safety of its clientele, their families and its staff.

It is up to senior managers to listen to and heed this advice and to ensure that their decisions are well informed by it. Otherwise, bureaucratic pressures (e.g. to save money) can easily eclipse clinical priorities and rapidly denature well-functioning teams.

Q10. With so much bureaucratic interference, how can there be real leadership (or stronger operational management) at team level?

'Transactional leadership' entails influencing others to engage in the work behaviours necessary to reach organizational goals.[35] Transformational leadership goes beyond management and involves challenging the status quo to create new visions and scenarios, initiating new approaches and stimulating the creative and emotional drive in individuals to innovate and deliver excellence.[27]

Corrigan *et al*. demonstrated the superiority of transformational over transactional and laissez-faire leadership styles in 54 mental health service teams. Studies demonstrate that training to improve leadership and team functioning is feasible.[36,37]

Q11. Obviously, I (the psychiatrist) must be the team leader. After all, I have the most comprehensive training. But it seems that some of my team don't really accept this – so what can I do?

This assertion confuses the responsibilities of management with leadership. At the same time, other disciplines all recommend increased leadership roles for their own professionals.[11,39–42] Q6

Boyce and Tobin argue strongly that the psychiatrist's roles as service leader, manager and supervisor of every case and every clinician of other disciplines, are pivotal and base this on the assumption that the psychiatrist has had the longest, widest, deepest and most practical apprenticeship-based training, and therefore is usually in the best position to provide 'comprehensive biopsychological management plans', to offer 'higher-order' diagnostic and treatment skills and to give 'higher-order' consultant opinions on management of complex cases.[29] Other professions would equally claim to provide 'comprehensive' assessments and interventions, with a detailed focus on their particular areas of expertise. If every profession claims it provides a comprehensive or holistic approach, it becomes meaningless to state or imply that any one profession has a monopoly on comprehensive training, assessment or

intervention. The term 'comprehensive' is often employed like the term 'holistic', as an exhortation from within the membership of a particular profession or staff of a type of service to go wider.[6,30]

It follows that it is difficult to construct a comparative hierarchy on the basis of who is more comprehensive in their training or skills. Psychiatrists, among other senior professionals, should be given or encouraged to seek specific training if they wish to undertake the roles of clinical supervision, clinical leadership or service management. The new psychiatry training curriculum now offers such opportunities in both mandatory and elective advanced training modules in leadership and management.[43] A study by Tan concluded that teaching interpersonal and team leadership skills to psychiatry medical staff was likely to improve their multidisciplinary team functioning.[44]

CONCLUSION

Interdisciplinary teams have become the principal vehicle for the delivery of integrated, comprehensive services in modern mental health systems.[45] Although there is considerable evidence of a qualitative and indirect quantitative nature for their effectiveness, much needs to be done to fully evaluate this model. Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks, and requires sound leadership both in terms of team management and clinical supervision. No one profession should hold a monopoly on leadership and management. The RANZCP Position Statement, 'Psychiatrists as Team Members',[26] makes a laudable start in introducing psychiatrists to these complex issues for which we have tended to be ill-prepared. Although the Statement only obliquely concedes that 'Management of a multidisciplinary team is not necessarily the domain of the psychiatrist', it should be amended to say squarely that 'Management should be performed by the person in the team best qualified, experienced, and most committed to performing the management role independent of the type of clinical professional background.' Psychiatrists should be encouraged to learn to understand and participate in management and particularly in leadership roles, and future training for psychiatrists must help equip them for these roles.

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Queries

Q1 Author: Please clarify meaning of "an efficient, effective and satisfying the type of work organization" because this is very unclear. Please provide correct meaning.

Q2 Author: Please check the edit in the sentence 'These include. . .'.

Q3 Author: Please confirm that CBT has been spelled out correctly.

Q4 Author: Please clarify meaning of "the team needs to relative autonomy". Is there a word missing here? Please provide correct meaning.

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