Clinical Management in Mental Health Services

Edited by

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Contents

Contributors v
Foreword ix

Introducing this book 1
Chris Lloyd and Kevin Gournay

1 Leading a multidisciplinary team 7
Frank P. Deane and Kevin Gournay

2 Managing workload in mental health services 23
Robert King

3 Clinical information management 33
Jennifer Harland and Janette Curtis

4 Budget management 51
Susan Brandis

5 Managing critical incidents in clinical management in mental health services 67
Kevin Gournay

6 Public relations and communication 80
Victoria Maxwell, Debra Lampshire and Samson Tse

7 Organisational changes towards recovery-oriented services 94
Samson Tse and Steve Barnett

8 Clinical supervision 115
Robert King and Gerry Mullan

9 Performance appraisal and personal development 128
Hazel Bassett
Contents

10 Dealing with stress and burnout  
   Chris Lloyd and Robert King  142

11 Quality improvement  
   Frank P. Deane and Vicki Biro  155

12 Evidence-based practice in mental health services: understanding the issues and supporting and sustaining implementation  
   Robert King and Frank P. Deane  173

Index  187
Contributors

Steve Barnett’s career began as a plastic researcher and development chemist, progressing through corporate business owner/developer, to teacher of organisational change management and developed trans-discipline partnerships at the University of Auckland. Steve’s interest in health service organisation sprang from one such partnership. Currently as an organisational communication consultant and business development coach, he applies his expertise in change, production, project, and innovation management to achieving organisational change through changed communication.

Hazel Bassett graduated as an occupational therapist from the University of Queensland in 1980. Since graduation, she has worked solely in the field of mental health both in the UK and Australia. Over that time, she has developed interests in the areas of transcultural mental health and parenting with a mental illness. For her masters degree, she developed an observation that can be used in a group setting and observes the parent–child dyad. In 2003 she moved into a management role and has since managed a mental health rehabilitation team and is currently managing a homeless health outreach team. She has also been a strong advocate of clinical supervision and professional development for staff working in the teams she has managed. The Homeless Health Outreach Team that she manages is a multidisciplinary team that includes medical, nursing, allied health, welfare, and administration staffing. She has written a number of articles on a variety of topics and has presented at state, national and international conferences.

Vicki Biro has extensive experience in mental health nursing having worked in the area for 29 years. She has worked clinically as a Registered Nurse, a Clinical Nurse Specialist, and as a Clinical Nurse consultant. Vicki has also worked on a variety of research projects including schizophrenia, and genetics research, mental health integration, GP partnerships, and bed management. She is currently employed as a Quality Manager with the South Eastern Sydney Illawarra Mental Health Program (Southern Network), and in this role she has been actively involved in the accreditation process, incident monitoring, and participation in clinical reporting. Vicki is an active member of the Australian College of Mental Health Nurses local branch and is an Honorary Fellow of the Illawarra Institute for Mental Health.
Contributors

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Frank P. Deane is a Professor in the School of Psychology and Director of the Illawarra Institute for Mental Health at the University of Wollongong. He has worked in a range of clinical and academic positions in New Zealand, USA, and Australia. He teaches in the Clinical Psychology programmes and has research interests related to the effectiveness of mental health and substance abuse services, the role of therapeutic homework on treatment outcomes and help seeking for mental health and substance abuse problems. He has 110 publications or ‘in press’ peer reviewed journal articles and has co-authored 12 book chapters.

Kevin Gournay is a Chartered Psychologist and a Registered Nurse. Originally he trained in psychiatry, learning disabilities, and general nursing and then in the 1970s as one of the first nurse therapists in cognitive behaviour therapy. After experience as a Charge Nurse, he worked part time to obtain a qualification as a psychologist, obtaining his PhD on the topic of agoraphobia. For the past 30 years, he has combined roles such as: a clinician treating people with post-traumatic stress and anxiety disorders, depression, and psychosis; a researcher; a teacher and a policy advisor to various governments. He has published over 300 papers, chapters and books, and made numerous contributions to TV and radio. He is the President and founding Patron of No Panic, the UK’s largest
anxiety disorders charity. Among various honours, he is a Fellow of the Royal College of Psychiatrists, a Fellow of the Academy of Medical Science, a Fellow of the Royal College of Nursing, and was elected Nurse of the Year of the American Psychiatric Nursing Association in 2004. He was appointed CBE in the Queen’s New Year’s Honours in 1999. He has just retired from the Institute of Psychiatry, King’s College, London, and in semi-retirement works as a clinician and an expert witness.

Jennifer Harland’s nursing career spans 25 years and includes mental health, drugs and alcohol, critical care, clinical research, data management, clinical governance, healthcare investigations and teaching. She has held various positions across urban and regional New South Wales including Clinical Nurse Consultant and Nurse Manager roles. She is currently working as a Lecturer at the School of Nursing, Midwifery and Indigenous Health, University of Wollongong. Jennifer’s research interests are in alcohol use in people over 65 and brief interventions.

Robert King is a Clinical Psychologist and Associate Professor in the School of Medicine at the University of Queensland. As well as a substantial research and teaching career he has had considerable practical experience in leadership and administration of mental health services in Australia. He is currently involved in management of a non-government organisation providing psychosocial rehabilitation services in Brisbane. He also has substantial international experience through consultancy, staff training and research collaboration in the UK, Asia and North America.

Debra Lampshire’s career in mental health began as a consumer advisor before entering into the field of education. Debra currently works for a private training organisation as well as being the Project Manager for the Auckland District Health Board Psychological Strategies for Enduring Psychotic Symptoms project. She lectures at the School of Nursing, the University of Auckland, and other tertiary non-government organisation providers, and is a well-known advocate and trainer in the recovery approach throughout mental health services. Debra is a dynamic and thought provoking speaker who has presented at a variety of national and international conferences and events.

Chris Lloyd is a registered occupational therapist. She received her qualifications in Australia and Canada, and obtained a PhD on the topic of stress and burnout. For the past 30 years she has worked in a variety of mental health settings in England, Canada and Australia. She has worked as a clinician, mostly in psychiatric rehabilitation, a researcher and a university lecturer. She has published over 120 peer-reviewed journal articles, book chapters and books. Among her various awards are the Gold Service Award, Australian and New Zealand Mental Health Service Achievements for developing and implementing a creative, innovative range of rehabilitation services, the Partnerships in Wellbeing Award for the design and implementation of a group programme in mental health, and
the OT Australia National Research Award in the Open Category. Her research interests include aspects of vocational rehabilitation for people with a mental illness.

**Victoria Maxwell** since being diagnosed with bipolar disorder and psychosis has become one of North America’s top speakers and educators on the lived experience of mental illness and recovery and successful return to work strategies. In addition to being a mental health worker, Victoria has worked for over 20 years as an actress and writer for both film and stage. Her one-person shows, *Crazy for Life* and *Funny… You Don’t Look Crazy*, tour internationally and have garnered awards in both the USA and Canada. Her company Crazy for Life offers keynote performances and workshops to corporations and conferences worldwide.

**Gerry Mullan** is the Nursing Clinical Supervision co-ordinator for the Northside Health Service District in Brisbane, Queensland, Australia. In this role he has developed a model of clinical supervision, with particular emphasis on issues which strengthen and potentially disrupt the nurse–consumer alliance. He co-ordinates a three-day training programme to prepare nurses to act in the role of Clinical Supervision Supervisor. He has worked in clinical, project and management positions during the course of his career.

**Samson Tse** qualified as an occupational therapist with additional qualifications in psychology. He is Associate Professor and Director of the post-graduate mental health programme at the School of Population Health, the University of Auckland. Samson’s focus in both teaching and research has been in the areas of mental health, vocational rehabilitation, functional recovery and bipolar disorders, and culturally responsive mental healthcare.
Over the past 50 years, changes in mental healthcare have seen considerable effort and attention paid to the way in which we structure and deliver services. In most countries models of community service provision have evolved as the focus of care shifted from hospital to community. The aim of service reform has generally been to deliver high-quality care, in the least restrictive way, with good outcomes for the consumer at the lowest cost. Often these aims have been in conflict, but we keep tinkering with the service and funding models to try to get the balance right.

Once we have what we think is a good service model, we usually set about developing standards so we can measure whether there is adherence to the preferred model. We often then require services to be accredited against the standards or risk some kind of sanction. Service models and service standards are important. They provide the framework in which care is delivered. However, much less attention is paid to the knowledge and skills, outside the clinical realm, needed by the workforce who will operate within the proposed service model.

The management of mental health services requires a knowledge base and a set of skills not readily addressed in discipline-specific undergraduate curricula or post-graduate clinical training programmes.

Reforming service delivery is about much more than service restructuring. Changing how clinicians and managers carry out their tasks is often necessary, much harder, but arguably far more important if we are to achieve desired mental health reform. This text brings together state-of-the-art information in areas about which the modern mental health workforce needs to be cognisant. Some of the areas covered, including information systems, budget management, performance appraisal and quality improvement, are core to running a good service. Others such as managing workload and critical incidents, supervision, and dealing with stress and burnout in staff are less often addressed but critical to being able to sustain high-quality care. And sustaining high-quality service delivery is not easily achieved. Other areas covered, such as leadership, have been given even less attention in the mental health reform literature but are crucial to motivating staff and transforming services. The chapters devoted to these areas provide practical, distilled information.

Clinical Management in Mental Health Services responds to one of the most common criticisms of mental health service reform: that the increased investment
and expansion of services into the community has not been matched by a commensurate rise in the delivery of quality care. The underinvestment by governments and health providers in the knowledge and skills needed to manage the delivery of modern mental healthcare will potentially undermine decades of structural service reform. We should stop tinkering with service and funding models and start investing more in the people who work in the services. What they do is what matters to consumers. The authors of this text have brought together the evidence base for how to do this.

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March 2008
Introducing this book

Chris Lloyd and Kevin Gournay

Although there is an increasing recognition that mental health problems are highly prevalent in the population, and that there is a need to develop higher-quality services and improved treatments, there is very little guidance on how to manage the services themselves. Indeed to provide effective management requires a wide knowledge base and skills employed at the individual, team, unit and service-wide level. This book sets out to assist and inform all those responsible for mental health service management to make the most of what, in reality, is a case of finite resources targeted at problems of enormous proportion. At the outset we need to say that managing mental health services is not simply for the Chief Executive or Chief Nursing Officer of each local mental health service, all those who work in mental health services have a responsibility for management. This book sets out a range of topics, some or all of which will touch the working lives of clinicians and managers alike.

Clinical management in mental health services

How do people in management positions prepare for the work that they must carry out? People usually learn the skills they require on the job (Metcalf, 2001). This may include the documentation from the previous manager, attending in-service sessions on aspects of service delivery, reading journals and books relating to what it is they need to know, and undertaking a post-graduate course. How a person learns new skills is very much up to the individual. What may suit one person does not necessarily suit another. This book is designed to provide a manager with the basic knowledge required to manage a mental health team.

Clinical management is a core part of how mental health services are organised. It is often a difficult task since mental health service delivery is complex and many of the people who are in management positions have no specific training in management skills. Many managers and team leaders have been appointed as a promotion from direct clinical work. People in management positions must fulfill a wide variety of roles to make the multidisciplinary team function effectively, for example, they may be involved in such areas as: workload management; clinical information management; budget management; managing critical incidents; communication and public relations; clinical supervision; performance appraisals and staff development; quality improvement; and promotion of evidence-based practice. They may also be involved in changing work practices and
professional culture, and dealing with such issues as stress and burnout. Indeed managers have a duty of care for their staff and have to balance service efficiency with ensuring that their staff are provided with appropriate levels of support and supervision. If staff members themselves experience work-related stress or other mental health problems, managers need to act with both speed and the highest level of consideration.

System factors such as buildings, equipment, financing arrangements, referral systems, the work of clinical and non-clinical staff and procedures for recruitment have an impact on whether it is possible to carry out high-quality clinical work. All of these subsystems, such as finance and human resource management, and the supra-systems, such as policy frameworks and regional health system organisation, need to be designed, sustained, and continually improved (Callaly & Minas, 2005). This requires effective management. Much of the pressure experienced by people working in mental health can be attributed to the rapid and frequent changes that have been initiated in recent years (Australian Health Ministers, 2003; Department of Health, 1999, 2001). The proliferation of initiatives put forward as necessary for the improvement of quality, reduction in disparities and improvement of efficiency, all contribute to the sense of overload experienced by practitioners (Callaly & Minas, 2005).

The team can be thought of as a small group of people who come together for a common purpose. Teams in mental health bring specialist assessments and individualised care together in an integrated manner. However, to achieve this requires a carefully considered and systematic approach to case allocation and deciding on a suitable evidence-based approach to the person’s needs. This process of course requires a suitable infrastructure of teaching, training and supervision. There is a need for effective application of the necessary skills mix for the best outcomes for the service users. While working in multidisciplinary teams can be efficient, effective and satisfying, it can also involve conflict and inefficient work practices (Rosen & Callaly, 2005). Good teamwork depends on clear structure and accountability, good leadership, delegation of tasks, role delineation and mechanisms to resolve role conflict.

A manager is the person who controls the day-to-day business of the mental health service and organises the team to do what is required by, not only the district mental health services, but also the Department of Health. According to Gilbert (2003) mental health services’ greatest assets are the practitioners who provide the care and their managers. Managers come from a variety of disciplinary backgrounds. They may be nurses, occupational therapists, psychologists, psychiatrists or social workers. Often people in management positions have worked through the ranks and applied for the position of manager with no specific training or educational background in management. This may put them at some disadvantage in running a team because they may lack knowledge of all the aspects of mental health service delivery that they are expected to manage. There is also the issue of serving senior managers and simultaneously needing to be the team champion, which may at times result in a conflict of interest. From their own clinical experience, new managers are aware of the practicalities and demands
of everyday work, but now they have another set of demands from higher up the system to which they must also respond. In community mental health teams there may be some tension between consultant psychiatrists and other professionals who carry clinical responsibility and managers, who are accountable for the management of a service/team and the allocation of finite resources (Gilbert, 2003).

Mental health service delivery has changed substantially over the past decade with far more accountability being required today. Consumers of mental health services are demanding better quality and more responsive services, increased accountability, and inclusion of consumer views in the planning, delivery of care and evaluation of services (Callaly & Minas, 2005). Managers are also guided by the Department of Health and the corporate values that they expect of everyone. These values concern work practices, appropriate and effective peer and team relationships, and outputs and outcomes that are expected to be achieved. In turn, there is further influence of the health service district and its vision and organisational goals, which are an essential part of what people do in the workplace. Finally, there is the team in which one is employed, which has to meet both the corporate values and the mission and organisational goals of the local district. At the centre of these expectations is the delivery of patient care and the provision of the best care and treatment that is possible. To assist in optimal patient care there are a number of steps that are commonly used. There are routine work requirements such as documentation, outcome measures, and patient reviews that are carried out routinely by staff members. In addition, there are usually requirements for staff development and supervision in order to enhance patient care. Managers are regularly expected to implement, and be accountable for, a vast number of changes (Arnold, 2005). This can occur without the benefit of a comprehensive understanding of the processes involved in initiating, implementing and sustaining change.

In the past few years, in Australia, New Zealand and the UK mental health care has become much more of a priority for governments and as a consequence we have seen an enormous number of policy initiatives ranging from action on youth suicide to improving services for people who suffer social exclusion (Office of the Deputy Prime Minister, 2004). These initiatives are often accompanied by target setting and the unenviable task (for managers) of spending more on priority areas without any real increase in resources. Managers therefore need to keep fully up to date with government thinking. This necessitates not only hours of reading, but also building networks with civil servants and politicians.

In contrast with the situation which prevailed only a decade or so ago, today’s managers need to keep abreast of evidence. Services now need to have at their core interventions which are proven. Both service commissioners, as well as the public at large, have such evidence readily available through their computer’s search engine. Thus, managerial skills must now include an ability to consider evidence in a discriminating way and to ensure that services adapt accordingly.

Information technology has brought considerable benefits but also major challenges. For example, developments such as electronic patient records and computerised cognitive behaviour therapy require the manager to address the
Clinical Management in Mental Health Services

financial dilemma of how much of one’s budget should be invested in these innovations at the potential cost to current services.

How the book is organised

Chapter 1 examines the important issues around leading and managing a multi-disciplinary team. It addresses the key operational components of managing teams. The areas that are addressed include such aspects as operational and strategic planning, managing meetings, style of management, feedback mechanisms, conflict management, building a culture of excellence and team building.

Chapter 2 explores the central issue of workload management and what is required of people to carry out their job efficiently. The topic of caseload management is reviewed and ways in which this can be managed are discussed. This chapter also explores models of case management, time and resource management, and workloads.

An overview of clinical information management is provided in Chapter 3. This chapter sets out the reasons why clinical information is needed and ways in which it can be implemented. Specifically, it covers how to make clinical information work, ways of interpreting the data and how to utilise the data.

Budget management is a core feature of mental health service delivery and is addressed in Chapter 4. Budget terminology, planning a budget, how to understand and operate a budget are the key elements that are described. Consideration is given to understanding budget terminology, how to write up a budget, use of resources and consideration of the stakeholders.

In Chapter 5, the management of critical incidents is explored. It examines the types of critical incident which may occur and management’s responsibility in handling the situation. Areas that are covered include critical incidents, risk assessment, managing risk and patient safety.

Communication and public relations are addressed in Chapter 6. This chapter explores the idea of communicating with a range of stakeholders and the importance of public relations. Specifically it addresses having a customer focus, procedure, partnerships, stakeholders and how to include stakeholders.

Chapter 7 explores managing work or professional culture. This chapter looks at how workplace culture is established and the difficulties that can be associated with it. It will focus on adopting a recovery approach and the way in which this can be used in working with people with a mental illness. Stages of change, adopting a recovery approach, difficulties and barriers, and the process that is undertaken in changing workplace culture are considered.

Supervision is an important part of practice in mental health services, and Chapter 8 addresses clinical supervision. It explores how supervision can be implemented and discusses the importance of supervision in assisting people to cope more effectively in the workplace.

Chapter 9 focuses on performance appraisal and personal development and the way it can be used to improve both individual staff performance and the
quality of service delivery. The chapter addresses the nature of performance appraisal, why is it useful, how to manage the performance of staff and difficult staff issues, and the benefits for personal development.

The issue of stress and burnout is dealt with in Chapter 10. This chapter explores the causes of stress and burnout in the workplace. It discusses the strategies for handling potentially stressful events and how to minimise or prevent burnout.

In Chapter 11 the topic of quality improvement is addressed. This chapter explores the importance of quality improvement and how to prioritise quality indicators, and strategies for implementing the results into practice.

The final chapter, Chapter 12, addresses evidence-based practice. This chapter looks at what evidence-based practice is and how to integrate results from trials into practice. It also looks at how practitioners can contribute to the evidence themselves by participating in research. Specifically, it covers what is evidence-based practice, the process, creating a culture which is committed to using evidence, and how managers can make it work in the clinical setting.

Each chapter includes some of the following features, which aim to help readers integrate the information into their practice:

- Case studies: these provide practical examples of aspects of clinical management in order to provide managers with guidelines for managing teams.
- Strategies: these are included in diagrammatic form to assist the manager visualise key strategies used to assist in the running of teams.
- Boxes, lists, tables and figures: concise lists and examples of key points discussed in the text are included to assist the manager to quickly and easily identify the context of the chapters.

Conclusions

Managers face important challenges in mental health services today. To meet these challenges, it is necessary that managers have a sound understanding of many aspects of service delivery. They need to implement strategies and policies to establish and maintain an appropriate culture in the organisation. It is only by doing so that they will be able to have a key role in leading an effective service, which should result in less discrimination and marginalisation of mental health service recipients along with improved mental health outcomes.

References


6 Clinical Management in Mental Health Services


Chapter 1
Leading a multidisciplinary team

Frank P. Deane and Kevin Gournay

Chapter overview

This chapter looks at leadership and management of multidisciplinary teams in the mental health context. It provides an overview of what constitutes a multidisciplinary team and how policy can change the roles and relationships in teams. The potential conflict inherent in teamwork is outlined. A brief overview of leadership styles is provided, with a more detailed description of the relationship between different leadership styles and team effectiveness and satisfaction in the mental health context. Finally, suggestions about effective leadership styles and practical tips for team building and managing team meetings are provided.

What is a multidisciplinary team?

Multidisciplinary teams consist of individuals from a range of professional disciplines and backgrounds. The size of the teams can vary considerably with one study indicating that among 54 psychiatric rehabilitation teams, the sizes ranged from nine to 41 members (Garman et al., 2003). However, it has been argued that groups of eight to 10 team members tend to function better than larger groups with small teams of three or four people remaining effective (Diamond, 1996). Generally, teams are relatively stable, retaining the same members over time. Occasionally, some team members act more as 'consultants' who work across teams. These consulting members may not attend all meetings, but may be called in when there is a particular issue for a client for which they have special expertise. Team knowledge and skills usually have overlapping competencies as well as the specific disciplinary skills each team member brings. In the context of psychiatric rehabilitation, Liberman et al. (2001) outlined the expected expertise of team members from different disciplines. Table 1.1 illustrates some of the components of expertise for a selected number of disciplines.

Liberman et al. (2001) included several other 'disciplines' in their table including rehabilitation counsellor, case manager, consumer team member, family advocates, employment specialists and job coaches. In addition, there is a wide range of other areas of expertise in clinical activity, but this example provides some sense of the skill sets that different disciplines bring to mental health. Such summaries are always open to debate and this particular example was criticised for not sufficiently recognising the evidence-based practices and research conducted.
Clinical Management in Mental Health Services

Table 1.1 Percentage expected expertise of selected disciplines in a psychiatric rehabilitation team.

<table>
<thead>
<tr>
<th>Area of expertise</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
<th>Social worker</th>
<th>Nurse</th>
<th>Occupational therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>100</td>
<td>75</td>
<td>25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Monitoring psychopathology</td>
<td>100</td>
<td>75</td>
<td>25</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>100</td>
<td>100</td>
<td>50</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Engagement in treatment</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Motivational interviewing</td>
<td>25</td>
<td>75</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Functional assessment</td>
<td>25</td>
<td>100</td>
<td>50</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Psychopharmacology</td>
<td>100</td>
<td>25</td>
<td>0</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Family psychoeducation</td>
<td>50</td>
<td>75</td>
<td>100</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Patient psychoeducation</td>
<td>75</td>
<td>100</td>
<td>25</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Skills training</td>
<td>25</td>
<td>100</td>
<td>25</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Cognitive behaviour therapy</td>
<td>50</td>
<td>100</td>
<td>25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supported employment</td>
<td>0</td>
<td>100</td>
<td>50</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Assertive community treatment</td>
<td>50</td>
<td>25</td>
<td>75</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Team leadership</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Programme development</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

Adapted from Figure 2, Liberman et al. (2001, p. 1336).

by occupational therapists (Auerbach, 2002; Rebeiro, 2002). Furthermore, concerns were raised that occupational therapists were characterised as ‘para-professionals’ and there was insufficient recognition of their role in developing employment-related skills for people with serious mental illnesses (Auerbach, 2002).

Although descriptions such as those in Table 1.1 provide broad guidelines, in practice, there are often considerable individual differences within discipline groups as to the skills that a particular practitioner brings. As will be highlighted further, the role of the clinical manager is to be aware of the knowledge and skills that the individuals in the team possess in order to maximise the benefits for a particular service user.

Multidisciplinary teams provide co-ordination of assessment and treatment activities to best meet the complex mental, physical and social needs of service users. A given service user may have the need for medications to manage mental
Leading a multidisciplinary team

Health symptoms and their diabetes. They may need cognitive behaviour therapy (CBT) to help them better manage anxiety in social situations. They may require support to help them access educational or employment opportunities. Or, they may need direct skills training in order to help them become competitive in employment or assistance with accessing affordable housing or community recreational activities. These multiple and often complex needs require a team with broad knowledge and skill sets. The local service demands and models (e.g. focus on acute management versus recovery-oriented care) along with workforce availability (e.g. rural areas typically have poorer access to all professional groups) will also influence the mix of professionals in a given team. Typically, psychiatrists are the most difficult professional group to recruit whereas nurses are usually available in greater numbers and various allied health professionals usually fall somewhere between these two groups.

As noted there are also shared tasks that team members take on, such as engagement with consumers, risk assessments, or a range of general case management activities. At times these ‘shared’ activities can also produce conflict within teams. For example, in some community mental health teams there is an expectation that all team members will be rostered for on-call acute emergency assessments for a set number of days per week. This often means that ongoing case work needs to be suspended for these days. However, it can also be argued that rostering all team members to such duties may underutilise their specific skill sets. Similar arguments can be made for some case management activities. In an external international review of the Australian second national mental health plan the authors stated:

‘Psychologists are, by international standards, relatively few within State and Territory mental health services, and too often work as generic case managers. Therefore, their specialist contributions to the delivery of expert psychological therapies are not sufficiently available to people with mental health problems’

Thornicroft & Betts (2002, p. 11)

The challenge for clinical managers is to optimise the utilisation of specific expertise while also servicing the generic clinical activities that are required of a service. This requires decisions about how to best utilise various skill sets in the team while also managing the potential of team members to feel that workloads and conditions may not be equitable. However, it needs to be recognised that there are also wide variations in the education of these different groups, which lead to inequities with regard to remuneration. There are historical relationships between professionals that contribute to hierarchies and power differentials (e.g. doctors and nurses). Further to this there can be relatively new challenges to what were considered unique specialist domains (e.g. prescribing of medications by non-physicians). All of these factors may operate to influence the dynamics between various professional groups in a team. Added to this is the increasing emergence of consumer team members or carer advocates. Often the traditional professional groups (and managers) are unsure of the role of these team members and how they are to function within the team.
Policy and legislative changes affecting team dynamics

There have been several major changes in the skills base of nursing over the past 20 years and these changes will, potentially, affect the boundaries that currently exist between various professions and, arguably, alter the power base. One of the most important changes has been in the legislation, principally in the USA and the UK, which has led to nurses having prescriptive authority. In the USA, the situation is now such that nurses in virtually all states have prescriptive authority and, in many states, can prescribe any psychiatric drug completely independent of a psychiatrist. Having said that, the training provided to such nurses is substantial and their practice is governed by a framework of supervision and continuing professional development. Such changes have benefited many individuals whose healthcare insurance cover (or lack of it) greatly restricted their access to psychiatrists who could prescribe.

In the UK, legislative changes in 2005 have led to very widespread training of nurses to prescribe and, although those nurses will prescribe within pre-set protocols, most of the prescribing that they undertake is, in practice, quite independent of psychiatrists. Arguably, such changes in prescribing have led to the situation where many of the routine prescribing tasks can be undertaken by nurses, thus leaving psychiatrists more time to attend to patients whose needs for medication are much more complex, for example those with co-existing physical health problems or patients who are treatment-resistant. Another argument for nurse prescribing is that nurses have much more time to give to attending to patients’ concerns about medication and to carefully monitor side effects. Indeed, there is substantial evidence (e.g. Gray et al., 2004) to suggest that mental health nurse skills in the detection and management of side effects in patients is of considerable benefit, provided that nurses have the relevant training.

While Australia is somewhat behind the USA and the UK in nurse prescribing, there are now, consistent with the international trend, some legislative changes to relevant nurses’ acts, and drugs and poisons acts, across the Australian jurisdiction. These grant limited prescribing rights to some nurse practitioners (MacMillan & Bellchambers, 2007). Such changes will, undoubtedly, affect the power balance in multidisciplinary teams, although, as in the USA, it may be several years before the changes become apparent.

Another significant change in the role of nurses is to be found in legislative changes, which have empowered nurses to detain patients. At the time of writing, in late 2007, the UK Parliament is drafting changes that will allow nurses to detain patients for periods of assessment. In Australia, nurses across the various states and territories do not have the same legal powers, or indeed use the same terminologies. However, in some states, nurses are able to detain a patient for assessment for 24 hours, while in another a medical doctor is the only health professional who may detain a patient for assessment. In New Zealand, the Mental Health Act 1992 created a new role – that of Duly Authorised Officer – and this has conferred legal powers on nurses (McKenna et al., 2006). The possession of such legal powers may potentially change the relationship between the nurse