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Community Mental Health Teams:
Determinants of Effectiveness

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SETTING THE SCENE

Community mental health teams have their Irish origins both in the deinstitutionalisation policy of the 1984 "Planning for the Future" framework[1] and the challenge of intervention and recovery strategies for acute episodic and enduring mental illness. In 1994, Corrigan et al.[2] observed that rehabilitation produces a set of barriers that are best overcome by multi-disciplinary teams (MDTs). The multidisciplinary approach was again emphasised in the Government's 2006 policy document, 'A Vision for Change'[3] and the Mental Health Commission's 2005 study on quality in mental health care[4]. The reality of the performance of such an approach, however, has not met stakeholder expectations, according to the Commission's discussion document on MDTs[5]. It states, that despite user access to such teams during the past 20 years, only a small number of well functioning MDTs are operating in the Adult Mental Health Services.

Mental health problems, as reported by the WHO in 2005[6], account for nearly 20% of the burden of ill health in Europe, coming second only to cardiovascular disease, and that does not take into account the negative effects of mental ill health on physical health. The delivery of specialist care is increasingly dependent upon complex technologies, diverse skill-sets and therapeutic interventions. This occurs within a context of national policy on health systems and specific services that are underpinned

[1] Department of Health (1984), *Planning for the Future,* Dublin: Stationary Office
[2] Corrigan, P.W., MacKain, S.J. & Liberman, R.P. (1994), Skills training modules: A strategy for dissemination and utilisation of a rehabilitation innovation, In Rothman, J. & Thomas, E. (Eds.) Intervention Research, pp. 76-81, Chicago: Haworth Press.
[3] Mental Health Commission (2006), *A Vision for Change,* Report of the expert group on mental health policy, Dublin: Stationary Office
[4] Mental Health Commission (2005), *Quality in Mental Health-Your views,* Report on stakeholder consultation on quality on mental health services, Dublin: Stationary Office
[5] Mental Health Commission (2006), *Multidisciplinary team working: From theory to practice,* Dublin: Stationary Office
[6] McDaid, D., Knapp, M. & Curran, C. (2005), *WHO policy brief: Funding mental health in Europe*, European Observatory on health systems and policies.

by the principles of equity, quality, accountability and patient-centeredness. Multidisciplinary, team-based organisations place the patient at the centre of their mission and care processes and are constantly endorsed as the most effective organising arrangement, particularly in specialist care.[7]

While the contribution that team working makes to overall organisational effectiveness has been widely established in the literature, little research has been conducted on MDTs in the Irish mental health-care sector. Neither has there been a significant amount of international research on this topic that combines both qualitative and quantitative methodologies. Our proposed study will combine both approaches, which will facilitate depth, generalisability and flexibility in the research enterprise. Our study adopts a pluralist strategy, the first stage of which includes a multi-site case study of designated teams. This will allow us to access participants' perceptions and interpretations of their experiences of their MDT, as it is important to understand their beliefs and attitudes of and to gain an understanding of their 'world'. This information will feed into the second stage, involving the design of a national survey, which is augmented by secondary data and document analysis.

In the research proposed here, we explore the determinants of and barriers to team effectiveness and how to improve team working in community mental health, by understanding how high-performing teams' function. To date, very little, if any, academic enquiry has addressed a topic of such urgent interest to the mental health services in Ireland. Neither has any data been generated to profile the reported status of all community mental health teams (CMHTs). This is also a key question to be addressed by this study

[7] Carter, S., Garside, P. & Black, A. (2003), Multidisciplinary team working, clinical networks and chambers in the NHS, *Quality and Safety in Healthcare*, 12: 25-28.

in order to identify barriers to effectiveness and to contribute relevant developmental responses. We will consider key stakeholder outcomes/outputs that are of concern to the patient, the team and the delivery system e.g. innovative interdisciplinary practices in the care process and patient and team member well being.

CONCEPTUAL FRAMEWORK

There is a wealth of evidence from healthcare and beyond that suggests that working in teams increases organisational effectiveness and efficiency[8]/[9]. However, despite this there is also a recognition that much team working consistently fails to deliver the anticipated benefits. As service quality provides an overarching concept to embrace team effectiveness, a research strategy that incorporates both qualitative and quantitative philosophies and methods is arguably the most appropriate approach to this enquiry. Specifically, we suggest working within a framework of the Donabedian (1966[10], 1988[11]) components (structure, process and outcome) with the addition of context, and, reflecting Jackson et al's (1996[12]) task and relationship orientations.

The literature suggests that the relationship between MDTs and organisational outcomes is influenced in two main ways through (a) the context and structure of the team (nature of the organisation, team origins, leadership, composition and the nature

[8]Downey-Ennis K, Harrington D, Williams B (2004), Head and heart in quality implementation – applying the quality philosophy within Irish healthcare institutions, *Total Quality Management*, 15(8): 1143-1153.
[9]Firth-Cozens J. (1998), Celebrating teamwork, *Quality in Health Care*, 7, S3-S7. PMID: 10339032
[10] Donabedian, A. (1966), Evaluating the quality of medical care, *Millbank Memorial Quarterly*, 44, Supplement, pp. 166-206
[11] Donabedian, A. (1988), The quality of care: How can it be assessed? *Journal of American Medical Association*, 260: 1743-1748.
[12] Jackson SE. (1996), The consequences of diversity in multidisciplinary work teams, In M.A. West (Ed.), *Handbook of Work Group Psychology*, Chichester: Wiley.

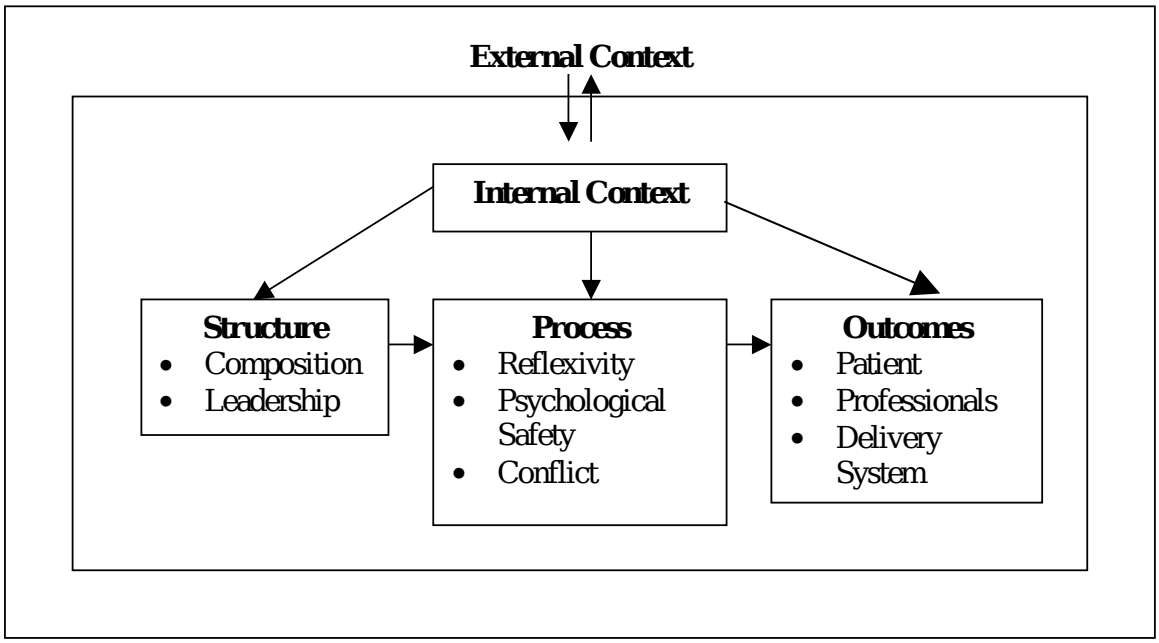
of its work) and (b) the processes i.e. clinical, service and relational, in which the team engages. Since inter-professional team working is dependent upon co-specialisation of knowledge, shared language, communications and sense-making[13] e.g. sharing of psychological skill in task performance[14] and complex human processes, successful MDTs will require good inter-personal relationships and effective group processes if collaboration rather than competition is to flourish. Therefore, we initially explore team working in an inductive fashion, but guided by themes in the broad extant literature on team working, within a framework of context, structure, processes and outcomes. Some of these themes include team characteristics such as demographics, leadership, team processes, in particular relationship- and task-related conflict, psychological safety and a relatively new but important addition to the literature, team reflexivity.

As presented in Figure 1, our research model represents an integrated approach by including the four elements of context, structure, processes and outcomes linked through task and relations.

[13] Merali Y. (1999), *Self-Organising Communities*, London: Caspian Publishing Ltd.

[14] Management Advisory Service (1989) Review of Clinical Psychology Services; Activities and Possible Models (Mowbray) MAS, Cheltenham. Psychology.

Figure 1: Research Model



Team Context

A confluence of external and internal influences affects team formation and performance. External change drivers combine with competing internal systemic interests and priorities. Teams, like organisations, have a complex recursive relationship with their environment and require a coordinated, intelligent behaviour in response to environmental threats and opportunities13.

Team Structures

The composition of the team is an important influence on team functioning. This is especially true in the healthcare context as the skill set and diversity of the team can have an effect on the quality of care given. The members` disciplines, experience levels, functions, tenure and age groups within the team have been found to influence both team processes and team outcomes12. For example, team tenure has been associated with mixed outcomes. Studies have found that long-tenured teams have experience of the organisational system but can be more resistant to strategic change. New entrants to the team can bring fresh perspectives and

innovative approaches but may also engender conflict. Therefore, while team composition has been widely recognised as potentially important in predicting team and organisational outcomes, research evidence about its effects is both contradictory and limited[15].

The use of shared and collective leadership models, rather than traditional top-down/dyadic models, in team-based organizations are currently receiving significant research as well as practitioner interest. Katzenbach and Smith (1993)[16] concluded that high performing teams actively engaged in shared leadership more than others. More recently, the subject literature has addressed new leadership arrangements in semi-autonomous teams as non-hierarchical forms of organising emerge[17]. A meta-analysis undertaken by Burke et al., (2006)[18] examined the relationship between leadership behaviour in teams and behaviourally–based team performance outcomes. Results suggest that both task- and person-focused leadership are almost equally important in team effectiveness and stress the importance of understanding the relationship between leadership behaviours and team performance outcomes irrespective of how the leadership function is delivered. The recent work of Hiller et al. (2006)[19] on the collective enactment of leadership roles and team effectiveness has particular relevance to CMHTs and will be drawn upon.

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[15] Guzzo RA, Dickson MW. (1996), Teams in organisations: Recent research on performance and effectiveness, *Annual Review of Psychology,* 46: 307-338. PMID: 15012484

[16] Katzenbach, J.R. & Smith, D.K. (1993), *The Wisdom of Teams: Creating the High Performance Organisation*, Boston: Harvard Business Press

[17] Day, D.V., Gronn, P. & Salas, E. (2004), Leadership capacity in teams, *The Leadership Quarterly*, 15: 857-880.

[18] Burke, C.S., Stagl, K.C., Goodwin, G.F, Salas, E. & Halpin, S.M. (2006), The Leadership Quarterly, 17(3): 288-307.

[19] Hiller, N.J, Day, D.V. & Vancce, R.J. (2006), Collective enactment of leadership roles and team effectiveness: A field study, *The Leadership Quarterly,* 17(4): 387-397.

Team Processes

The nature of clinical activity dominates the enactment of concurrent and complementary social and organisational processes in clinical teams. These affect the therapeutic climate that permeates the care regime. When exploring the processes in which high-performing teams engage, we will be particularly cognisant of the themes of task reflexivity, psychological safety and conflict. The group process literature suggests that each of these processes have a pivotal role to play in team effectiveness.

Swift and West[20] define reflexivity as the "uniquely human ability to reflect upon processes, events, sensations, past experience and the physical being". Reflexivity in a healthcare setting involves individuals or teams reflecting upon their preferred clinical practices and interventions and modifying them where necessary according to the needs of the patient, task or environment. Task reflexivity has been found to influence team and organisational effectiveness and also to be associated with team innovation[21] and team effectiveness[22].

Edmondson[23] (1999: 354) defines psychological safety as "a sense of confidence that the team will not embarrass, reject, or punish someone for speaking up. This confidence stems from mutual respect and trust among team members". Her 1996 study found that teams reporting high levels of psychological safety were more open about reporting errors, leading to innovative ways of rectifying them, hence increasing both patient and team member

[20] Swift TA, West MA. (1998), Reflexivity and Group Processes: Research and Practice.
ESRC Centre for Organisation and Innovation, Institute of Work Psychology, University of Sheffield.
[21] West MA, Anderson N. (1996), Innovation in top management teams, *Journal of Applied Psychology,* 81(6): 680-693.
[22] Tjosvold D. (1990), Making technological innovation work: Collaboration to solve problems, *Human Relations*, 43: 1117-31.
[23] Edmondson, A.C. (1999), Psychological safety and learning behaviour in work teams, *Administrative Science Quarterly,* 4(4): 350-384.

safety. Other studies have found links between psychological safety and perceived task performance, team satisfaction, stress levels[24], team commitment24 and extra role behaviour[25] in the expected directions.

The third group process theme is conflict. Simons and Peterson[26] found that the type of conflict experienced within the team played an important role in determining the overall effectiveness of those teams and Zukoski and Shortell[27], in their study of 25 community health partnerships, found that effective conflict management was related to overall partnership effectiveness.

Outcomes for key stakeholders: Patients, Professionals and Delivery System

Approaches to the assessment of outcomes in mental health are usually over-simplistic. Our evaluation of team effectiveness is multi-dimensional and encompasses key stakeholders i.e. the patient, the professional providers (team members) and the system (management)[28].

Patients

The involvement of the mental health service user in evaluation is essential, although challenging. It may therefore be supplemented by proxies such as carer and advocacy groups. National health and

[24] De Gilder D. (2003), Commitment, trust and work behaviour: The case of contingent workers.
Personnel Review, 32(5): 588-604.
[25] Tyler TR. (2003), Trust within organisations, *Personnel Review*, 32(5): 556-569.
[26] Simons TL, Peterson RS. (2000), Task conflict and relationship conflict in top management teams: The pivotal role of intra-group trust, *Journal of Applied Psychology*, 85: 102-111.
[27] Zucoski A, Shortell S. (2001), Keys to building effective community partnerships,
Health Forum Journal. 2001; Sept/Oct: 22-26. PMID: 11565175

[28] Birch Q., Field S., & Scrivens E. (2000), *Quality in general practice*, pp.27-28. Abingdon: Radcliffe Medical Press.

mental policy emphasises patient-centredness and user involvement in feedback. A tested adaptation of the dimensions in the Picker questionnaire (Coulter and Cleary (2001)[29] combined with Birch et al's (2000)28 patient indicators, such as access, responsiveness, appropriateness and effect of treatment, offers a preferred alternative to standard patient satisfaction surveys which are often conceptually flawed and methodologically weak[30]. Relevant, patient reported indicators that reflect the service and treatment process will be used to effectively disclose the patients' experiences.

Professionals

Professionals task-related indicators relate to clinical outcomes, professional standards, competencies and knowledge28. According to Simmonds et al.'s (2001)[31] systematic review of the literature, CMHTs are associated with a reduction in hospital admission/re-admission rates, suicides and the maintenance of the care regime. Nurses in England reported that working together in primary health care teams reduced duplication of efforts, streamlined patient care and enabled specialist skills to be used more cost-effectively[32]. Jansson et al.[33] analysed the records of general practitioners and district carers over six years in Sweden. Care teams (GP, district nurse, assistant nurse) were introduced into one region but were absent in another comparative region. The MDTs reported a rise in the overall number of patient contacts and

[29] Coulter A., & Cleary, P. (2001) Patient's experience in five countries, *Health Affairs* 20(3): 244-252

[30] Draper M., Hill, S. (1995), *The role of patient satisfaction surveys in a national approach to hospital quality management*, Canberra: Australian Government Publishing Service.

[31] Simmonds, S., Coid, J., Joseph, P. & Tyrer, P. (2001), Community mental health team management in severe mental illness: A systematic review, *The British Journal of Psychiatry*, 178: 497-502.

[32] Ross F, Rink E, Furne A. (2000), Integration or pragmatic coalition? An evaluation of nursing teams in primary care, *Journal of Interprofessional Care*, 14(3): 259-267.

[33] Jansson A, Isacsson A, Lindhom LH. (1992), Organization of health care teams and the population's contacts with primary care, *Scandinavian Journal of Health Care*, 10: 257-265.

in the proportion of the population that accessed the district nurse. Concurrently, there was a reduction in emergency visits, which they attributed to better accessibility and continuity of care in the MDTs.

The wellbeing of professionals and the contribution of this factor to patient wellbeing should not be underestimated. Lack of employee wellbeing, particularly due to stress and bullying have been identified in research as prevalent and problematic in the healthcare sector [34, 35, 36, 37]. Wall et al.,[38] found that 28% of health staff overall were above threshold for poor mental health on the General Health Questionnaire compared to an average of 18% of workers across all sectors in the British Household Panel Survey of 1993. However, the prevalence of stress among healthcare staff working in teams was 21%, substantially below the average for the NHS[39]. That is, those working in 'real' teams, described as teams with clearly defined goals, whose members worked together to achieve them, with different roles for different members, and recognised externally as a functional team had lower stress levels than those in teams which did not meet these criteria, while these in turn had lower scores than those not working in teams.

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[34] Cryer, B., Mc Craty R and Childre, D. (2003), Pull the Plug on Stress, *Havard Business Review*, 81(7): 102-107

[35] Cooper, C., Drewe, P., and O'Driscoll, M. (2001), *Organisational Stress*, London: Sage Publications

[36] O Connell, P.J. and Russell, H. (2005) Equality at Work: Workplace Equality Policies, *Flexible Working Arrangements and the Quality of Work*, Dublin: Equality Authority

[37] Hatton, C., Emerson, E., Rivers, M., Mason, H., Swarbrick, R., Kiernan, C., Reeves, D., and Alborz A. (1999) Factors Associated With Job Stress and Work Satisfaction in Services For People With Intellectual Disability, *Journal of Intellectual Disability Research*, 43(4): 253

[38] Wall TD, Bolden RI, Borrill CS, Carter AJ, Golya DA, Hardy GE. (1997), Minor psychiatric disorder in NHS trust staff: occupational and gender differences, *British Journal of Psychiatry*, 171: 519-523. PMID: 9519089

[39] Carter AJ, West MA. (1999), Sharing the burden - teamwork in health care settings.
In J. Firth-Cozens & R. Payne (Eds.), *Stress in Health Professionals,* Chichester: Wiley.

Management/Delivery System

Management indicators of effectiveness include resource use, compliance with organisational standards, risk management and service development28. Team working contributes to performance in health care organisations by reducing errors, improving the quality of patient care[5] and effecting cost reduction31. A Vision for Change (2006)3 and The Mental Health Commission's discussion paper on MDTs (2006)5 provide relevant performance indicators for CMHTs that may be augmented by other aspects of best practice such as responsiveness, equality and innovation. It is recognised of course that the development of composite indicators for assessing system performance is problematic due, inter alia, to contextual influences and the consequences of aggregation[40]. Introducing new and improved health care for patients/service users is a fundamental goal of health service organisations. Data from large-scale studies of health care team effectiveness in the UK suggests that team functioning is a positive predictor of innovations in health care in community mental health; primary health care teams[41] and breast cancer care teams[42].

This review of research on the links between team working and outcomes in health care is consistent with the large body of research in organisations across all sectors, which indicates the value of team-based working structures for organisational effectiveness. Many health organisations implementing self-managing MDTs experience problems because

[40] Smith P.C. (2001), *Developing Composite indicators for assessing Health System Efficiency*, OECD Conference, Ottawa, 5-7 Nov. 2001
[41] Ross F, Rink E, Furne A. (2000), Integration or pragmatic coalition? An evaluation of nursing teams in primary care, *Journal of Interprofessional Care*, 14(3): 259-267.
[42] West MA, Tjosvold D, Smith KG (Eds.) (2003), *International Handbook of Organizational Teamwork and Cooperative Working*, Chichester: John Wily & Sons, Ltd.

they fail to realise the importance of group process and the context in which the teams work. By studying CMHTs and considering important contexts, structures, processes and outcomes, this study offers us a means of understanding and actively creating high-performing CMHTs.

RESEARCH PROGRAMME

This research programme will comprise five main stages.

Phase 1: Literature review, document analysis and consultation

The initial stage of the research will involve an extensive literature review, document analysis, an examination of secondary data and a process of consultation with key informants and knowledgeable researchers in the area of multi-disciplinary team effectiveness in the mental health sector. The aim will be to identify the most appropriate measures of team effectiveness to use in our research in order to identify high-performing teams.

Phase 2: Multi-site case study

This phase consists primarily of a multi-site case study[43] using a modified grounded theory method[44] & [45]. The methods for data collection are focus groups, semi-structured interviews and non-participant observation. Initially a pilot study will test, assess and review the conceptual /research framework and qualitative methods in context. Software supported analysis will facilitate the generation of an analytic text describing an emergent model that can provide a link to the quantitative data report.

[43] Yin, R. (1994). *Case study research: Design and methods* (2nd ed.). Beverly Hills, CA: Sage Publishing

[44] Partington, D. (2000), Building grounded theories of management action, *British Journal of Management,* 11: 91-102.

[45] de Burca, S. (2003), *The nature of internal mediator and moderator influences in a health care system in transition,* Unpublished PhD thesis, Brunel University, London

Phase3: Quantitative national study

Once the themes that have emerged from the qualitative aspect of this study have been identified and explored, we will develop a framework to explain high performance among CMHTs. This will involve combining the performance-influencing factors identified in the qualitative phase of this research as well as those variables identified as influencing high performance in the extant literature. This model will theorise as to the linkages between the variables in each of the context, structure and process areas. We will carry out a national survey of CMHTs, which will involve quantitative data collection and analysis. Primary data will be collected by means of a self-completion questionnaire. One of our collaborators, Dr. Saunders is a biostatistician and has extensive experience of analysing health-care data as well as advising on statistical methodology to be used in many different research designs/areas and questionnaire design.

Phase 4: Triangulation of qualitative and quantitative data

This phase involves examining the findings of both the qualitative and quantitative results of the study. This allows us to check for the alignment and variation of the data obtained from both methods and to theorise about explanations for the findings.

Phase 5: Final report

We will prepare two high-quality comprehensive reports, which will be reviewed at length between the research team and the expert panel. One report will be strongly research oriented with an emphasis on the methodology used and the statistical analysis, as well as some contextual information. The second report will focus more on the findings of the research and provide practical suggestions for implementing our findings in a useful way within the Irish mental health services.

DISSEMINATION

A very important objective of our research is not only to contribute quality knowledge through research that is appropriate, rigorous and robust, but also to devise translation and adoption strategies to get the research into practice (GRIP). We will pursue two dissemination strategies; one aimed at practitioners, policy-makers and healthcare providers and the other aimed at adding to the extant academic knowledge on the topic of MDT's in healthcare.

1. GRIP

We will provide a national conference on our research findings as well as a number of regional workshops/interactive sessions. These workshops will aim to engage mental health-care providers and team-members and provide learning around the contextual, professional and organisational issues and opportunities involved in creating high performance CMHTs.

We will develop a 'Best Practice' training pack that will consist of a handbook, CD-ROM, DVD and web site. This will act as a reference for training and development, and as an action research and action learning resource for CMHTs and related service teams and providers.

2. Academic

In order to add to the academic knowledge on CMHTs, we will publish articles in relevant peer reviewed journals, as well as presenting papers at national and international conferences on the various aspects of the research exercise. We also aim to contribute book chapters on MDTs in Health Care.

ANTICIPATED OUTCOMES AND CONCLUSIONS

The objectives of this research project are grounded in the extant literature and the findings and recommendations of the relevant policy and recent service review documents. Moreover the project is a response to the priority status of the CMHT as a subject of research and strategic significance in mental health care. As such, CMHTs merit the attention of policy-makers, professional and managerial stakeholders and agencies alike.

Planning for the Future (1984)[46] envisaged alternative ways of working in the context of de-institutionalisation and the development of the alternative community–based service. Moving from the hierarchical and fragmented structures of the Victorian Institution to looser forms of structuring to facilitate linkages with other service sectors has been problematic for many reasons. These issues and opportunities are well rehearsed in the MDT discussion paper. We set out to establish the evidence of the Commission's discussion paper on MDTs[47] by focusing in-depth on specific fully functioning teams (high performing) and by surveying the general status of CMHTs in the national mental health service.

The research strategy adopted in the study is based on a set of principles that resonate and empathise with the subject area. The research team is multidisciplinary, drawn from the backgrounds of psychology, sociology, statistics and health care management. It engages the worlds of knowledge and practice in a unique way. This combination of disciplines, experiences and methodologies seek to provide a comprehensive, holistic account of a multidisciplinary environment that also contains diversity and the potential for problematic scenarios in delivering a continuous integrated care pathway for the patient.

[46] Department of Health (1984), Planning for the Future, Dublin: Department of Health
[47] Mental Health Commission (2006), Multidisciplinary Team Working: From Theory to Practice-Discussion Paper, Dublin: Mental Health Commission

The expected contributions are targeted at emergent issues as well as those currently reported by policy reviewers. The general categories are related to team formation, implementation and evaluation as a continuing learning process. These are conceptually framed in line with Donabedian's (1966)[48] structure, process and outcome cycle for quality improvement and Jackson et al's (1996)[49] leadership models' duality of task and relationship conflict. Thus, the matters outlined in Chapters 5, 6 and 7 of the MDT discussion paper is encompassed within a linked set of mutually dependent components**.**

The tangible outcomes resulting from this study are directly related to the key stakeholder outcomes. Firstly, patients benefit as recipients and/or active participants. Secondly, professional providers gain in terms of professional and social cohesion in a dynamic learning/reflexive environment. In this environment development is aimed at achieving performance requirements within evidence–based parameters.

The results may also be framed in terms of an implementation strategy to disseminate and translate the results into practice. This commences with co-ownership and a commitment to change to best practice with first-hand knowledge of what works and the context that it is dependent upon or otherwise. The involvement of patients, carers and advocates, will ensure patient focus in redesigning ways of working that recognise the need for participation, flexible working and the necessary blurring of disciplinary boundaries at various levels.

[48] Donabedian A. (1966), Evaluating the Quality of Medical Care. Millbank Memorial Quarterly, 44, Supplement, pp.166-206
[49] Jackson SE. (1996), The consequences of diversity in multidisciplinary work teams, In M.A. West (Ed.), *Handbook of Work Group Psychology*, Chichester: Wiley.

The continuing development of the community-based MHS has to take into account the nature of change emerging in the domain and also the total system context including the socio-economic system within which patient mental health originates. The study will therefore seek contextual sensitivity to identify and ascertain response to inhibitors as well as promoting enablers to facilitate high performance community mental health teams.