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

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

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

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

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

and the patient in a community mental health team and, once more, the issue of 'balance of power' will change within the team.

Psychologists are often core members of the multidisciplinary team, although in the USA and Australia this is a variable phenomenon; in some teams psychologists do not carry a caseload, rather they act as consultants to other team members and may only provide specific psychological interventions. Over the past 20 years or so, psychological interventions such as CBT are being used increasingly by professions other than psychologists, and there is now substantial evidence (Turkington et al., 2006) that nurses may be very effective in providing CBT to patients with schizophrenia after a relatively brief course of training. Similarly, family interventions are now provided by a very wide range of professionals and, indeed, some non-professionals. While the dissemination of skills is obviously very welcome, particularly because of the potential to reach more patients in need, such developments serve to 'blur' roles even further.

One of the most notable aspects of working of community mental health teams over the three decades since they were established in the USA and then, fairly soon after, in Australia, has been the increasing development of consumers in mental health services. While this involvement has been largely in areas such as advisory roles and advocacy, consumer involvement has developed across a number of other areas, for example in education and training. Perhaps the most radical development has been the employment of user case managers, i.e. people with a history of mental illness who have become case managers themselves and have adopted paid roles within community teams. While this development still causes some raised eyebrows in professional circles, one needs to be reminded that the development of user case managers can be traced back more than 20 years to the community services in Denver, Colorado. Sherman and Porter (1991) evaluated this initiative and showed quite clearly that, not only do user case managers provide direct benefits to service-user outcomes, but their mental health status is also improved. It is also worth noting that many of the user case managers trained in the innovative Denver scheme suffered serious mental illnesses, such as manic depression, rather than the common mental disorders – which of course may afflict very large proportions of the population and, indeed, therefore affect health professionals. As Sherman and Porter (1991) have demonstrated the presence of such a worker in a community team may be challenging and affect team ethos and functioning.

While consumer empowerment is a feature of Australian and New Zealand mental health policy, the implementation of initiatives such as user case management, where such users are paid workers who are fully functioning team members, is probably variable to say the least and it may be many years before one sees this development spread across all states and territories.

Boundaries

Renouf and Meadows (2007, p. 231) argue that in effective multidisciplinary services

> 'there needs to be a certain amount of overlapping (blurring) of roles, and at the same time the specific areas of experience of individual team members will need to be maintained and developed'.

These blurred boundaries can often be viewed by team members as problematic and have the potential to lead to conflict. However, recognition within the team that some degree of role overlap is both necessary and desirable has the potential to further strengthen teams. The role of the team leader is to facilitate this recognition by clarifying common core tasks (e.g. some case management activities) and also specialist areas of expertise. This clarifies the various professional boundaries (e.g. medication review, psychometric testing, etc.).

Another area for potential boundary confusion lies in the distinction between 'upper management', 'middle management' and team leadership. Upper level managers are not usually considered as team members. However, managers 'have considerable influence over team functioning, especially as more sophisticated policies and service frameworks have led to a more interventionist and pervasive managerial role in mental health service delivery' (Renouf & Meadows, 2007, p. 230). The boundary between upper management and team leaders who also have management roles is not often clear. At the same time team leaders are usually team members who also continue to provide direct patient care. The ability to negotiate these various roles can be difficult for managers who are team leaders and also continue to provide clinical services to consumers. It requires flexibility both in the manager and among other team members. In some circumstances, context clarifies the main 'hat' the manager is wearing at a particular time. For example, in a treatment team meeting, where there is discussion of client needs, the manager may contribute as a fellow clinician and team member. However, even within this meeting, there may be a need for allocating cases to already stretched team members, which may require a shift to a more managerial or team leader role. In some circumstances there is a need to be very explicit about which 'hat' a manager is wearing, such as when there is a need to reprimand a team member about some repeated error that has been made.

Effectiveness of multidisciplinary teams

While the multidisciplinary team is ubiquitous in mental health services there is very little research that has evaluated or challenged the view that such an approach provides more effective care. Burns and Lloyd (2004) reviewed the limited research that assessed whether such teamwork is beneficial. They suggested that historically, the most evidence comes probably from studies in which assertive community treatment that uses a team approach was found to be superior to individual case management approaches. However, this provides only peripheral evidence. The authors could only locate three empirical articles that suggested that aspects of multidisciplinary team functioning produced positive outcomes, but none appeared to have control group comparisons. Given

the high cost of running a multidisciplinary team, and that less than 50% of working time may be spent in direct patient contact, Burns and Lloyd (2004) argued that much more research regarding the cost-effectiveness of multidisciplinary teams was warranted.

Although there is little empirical research establishing whether multidisciplinary teamwork leads to better care, a number of authors have outlined their views on what constitutes effective teamwork. The following two examples not only have areas of overlap, but also differences in emphasis around team functioning versus the types of services effective teams should offer.

Renouf and Meadows (2007) highlighted:

- high-quality personal relationships between workers, clients and carers
- clearly defined tasks and care for a well defined client group
- services that target needs beyond just psychiatric symptoms (e.g. housing, employment, family, recreation)
- team ability to flexibly respond to client need (as opposed to sticking with historical staffing patterns)
- clarity about team member roles and responsibilities
- sanctioned team leadership with agreed systems of co-ordination
- collaborative and participative leadership style
- team links with external community services
- team receives regular feedback about its achievement of objectives
- individual members' performance is assessed, with feedback, supervision and professional development.

The attributes of an effective psychiatric rehabilitation team were summarised by Liberman et al. (2001). They suggested:

- high accessibility (preferably 24 hours a day)
- consultation and co-ordination of services with external agencies
- prioritising those with serious and disabling mental disorders
- focus on improving a wide range of areas of need (not just symptoms)
- emphasis on community reintegration
- meeting cultural and linguistic needs of consumers
- maximising clients' natural supports and self-help
- flexible levels of intervention (e.g. crisis to long-term maintenance)
- individualisation of services
- ongoing monitoring of a client's progress
- persistent effort with each client
- accountability and competencies in the team to deliver evidence-based services.

Liberman et al. (2001) particularly emphasise the need to provide services that are individualised and prioritised to meet the personal goals of the client. Such lists of attributes provide ideas about what should be considered as potential goals for a team leader. However, the 'style' by which teams are led is at least as important.

Management and leadership styles

There is a range of management styles and most people would be familiar with some of these either through their own experiences with a manager or because such terms are now common in the management lexicon. Space does not permit an extensive discussion of all of the various styles, but it is important to realise that these styles occur in combinations and that most of these styles have both advantages and disadvantages.

Authoritarian managers typically make the decisions and then pass these onto the team members and expect that they will then be followed as directed. Such approaches are quite hierarchical with directions being communicated from senior management to middle management and then to team members with little discussion or flexibility in how the directions should be implemented. Such approaches can create problems in teams ranging from resentment due to a lack of autonomy to a loss of motivation due to dependence on all decisions being made for them.

Democratic management styles emphasise a greater degree of equity in decision making and seek extensive discussion and communication between management and the team. Generally, there is an attempt to get some consensus about the way forward on a particular issue. This is often determined by a 'vote' with varying degrees of formality with the majority guiding the decision. The advantage of such an approach is that team members feel more empowered and involved in decisions, but a potential disadvantage is that this process can be very time consuming. Further to this, if there are multiple teams or groups in an organisation they may come to different decisions based on such an approach, which can lead to inconsistency in the way services are delivered. However, more participative management styles have been associated with greater employee satisfaction (Kim, 2002) and most mental health staff want greater involvement in decision making.

Perhaps most problematic for a team are situations where there is a lack of an active and clear leadership or management style. In multidisciplinary teams there are situations where the role of the team leader or clinical manager is somewhat foisted on the more senior member of the team. This may be highlighted in situations where there are very few incentives for taking on the team leader position (e.g. flexible hours, remuneration). These reluctant team leaders may avoid the duties of management, and often what results is confusion about both procedures and directions. The need for active management was highlighted in a study of 96 business school students participating in a group project. It was concluded that active conflict management promoted better performance and that an agreeable conflict management approach promoted group satisfaction (DeChurch & Marks, 2001). Not surprisingly, avoidant conflict management styles do not lead to as effective decision making as with other styles (Kuhn & Poole, 2000). Fortunately, avoidant, passive or laissez-faire styles of management are probably more the exception than the rule and in a study of 77 nurse managers it was found that an avoiding style was least frequently used in managing conflict (Kantek & Kavla, 2007). Experienced directors of psychiatry tend to have a management

style that is both high in task orientation where they specify how, when and where to do various tasks and also high in relationship components such that they provide psychological support and opportunities for shared decision making (Marcos & Silver, 1988).

Transformational Leadership Model

Several studies in mental health contexts have explored the Transformational Leadership Model (TLM) elaborated by Bass (1985). In order to understand the findings from this research, there is a need to briefly describe the components of the TLM. The two factors of transactional leadership and transformational leadership are proposed in this model.

Transactional leadership is more focused on 'the day-to-day tasks which need to be completed to keep a team or a department running smoothly' (Garman et al., 2003, p. 803). Part of this process involves using contingent reward behaviours where team members are rewarded by the leader for achieving established goals or tasks. Transactional leadership is also theorised to involve management-by-exception behaviours. In general, management-by-exception involves identifying 'exceptions' to good practice and thus focuses on correcting problems. Both passive and active management-by-exception strategies can be used. In an active approach a leader would proactively monitor the team's efforts, looking for problems or mistakes, whereas in passive management-by-exception the leader tends to not get involved in the team's work unless more conspicuous problems or mistakes come to his or her attention. Passive management-by-exception has also been closely associated with a 'laissez-faire' leadership style. While the laissez-faire approach has been described as a 'non-leadership' factor (e.g. Garman et al., 2003) together with the passive approach such leaders are characterised as avoidant, resistant to expressing views, delayed in responding to problems (particularly when early or minor), inactive and reactive only to failure or problems (Kanste et al., 2007).

The second major component of TLM is transformational leadership. Transformation leadership goes beyond the day-to-day processes of team activities. It provides a more idealised inspirational form of leadership that includes charisma (the leader's ability to instil respect, loyalty, clear values, mission or vision in the team), intellectual stimulation (ability to support team members' critical thinking, and solve problems in novel ways), individual consideration (ability to treat individual team members with care) and inspirational motivation (the ability to motivate and orient the team toward the future and a common cause). It is thought that this transformational leadership style should lift a team to perform beyond just satisfactory levels and to inspire them to put in extra effort in order to excel. Transformational leadership appears to contribute over and above the effects of transactional leadership in engendering greater perceived effectiveness and satisfaction of leaders among human service workers such as social workers (Gellis, 2001).

Leadership styles and mental health team functioning

TLM not only provides a good description of different leadership styles but also has a substantial research base supporting both its description and measurement. The various components of the TLM are measured using the Multifactor Leadership Questionnaire (MLQ, Bass & Avolio, 1997). An increasing number of studies are now linking different leadership styles to improved team satisfaction and functioning. Garman et al. (2003) assessed 236 leaders from 54 mental health teams that provided services to people with severe and persistent mental illnesses. They found that the two distinct management-by-exception factors were both supported. Active management-by-exception was associated with both transformational leadership and contingent reward and the passive management-by-exception was associated with laissez-faire leadership (Garman et al., 2003). The authors highlighted previous research showing that passive management-by-exception has been related to lower levels of job satisfaction. They speculated that active management-by-exception may have emerged in this context due to the increasingly strict guidelines being placed by external mental health regulatory bodies in the USA.

This same research group developed the Clinical Team Leader Questionnaire (Corrigan et al., 1998); an analysis of the 346 mental health staff surveys revealed six factors: autocratic leadership, clear roles/goals, reluctant leadership, communicating the vision, diversity issues and supervision. All of these factors were positively correlated with transformational and transactional leadership factors and negatively correlated with the non-leadership scale on the MLQ (Bass & Avolio, 1997). Perceptions of an autocratic leadership style, inability to clarify roles and goals, a reluctant leadership style, inability to communicate a vision and a lack of supervision were all significantly related to the emotional exhaustion factor of burnout (Corrigan et al., 1998). A second study with 305 psychiatric rehabilitation staff members further supported the validity of the Clinical Team Leader Questionnaire measure (Corrigan et al., 1999). In this study again the autocratic leadership, clear roles and goals, reluctant leadership and vision factors clearly emerged. For those team leaders who are interested in getting feedback about the perceptions of team members of their leadership the Clinical Team Leader Questionnaire items are in the public domain and provided in the source article by Corrigan et al. (1998, Table 2, p. 117).

Perhaps the most intriguing work related to mental health team leadership is a study of 143 leaders, 473 team members from 31 clinical teams and 184 consumers served by these teams (Corrigan et al., 2000). This study made a substantial step forward by linking perceptions of team leadership to consumers' ratings of satisfaction with treatment and quality of life. Leaders' and other team members' ratings of leadership were correlated with consumer programme satisfaction ratings. For leaders' ratings there was a significant relationship between inspirational motivation and higher consumer satisfaction ($r = -0.40$). Higher levels of passive management-by-exception and laissez-faire leadership were associated with lower levels of satisfaction ($r = 0.50$ and $r = 0.38$, respectively).

When leaders assume a distant, aloof or hands-off approach to leadership, consumers accessing services from their teams report lower levels of satisfaction. In contrast more inspirational leadership is associated with greater consumer satisfaction. Further to this, leaders' ratings of a more laissez-faire leadership style was associated with lower quality of life ratings by consumers ($r = 0.30$). Team member ratings revealed that almost all components of a transformational leadership style (charisma, inspiration, consideration of individual staff members) were related to higher quality of life ratings by consumers (range $r = -0.30$ to $r = -0.40$). Both leaders' and their subordinate team members' ratings of leadership independently accounted for variance in consumer ratings of quality of life. These data are striking in that they raise the possibility that the style of team leadership can affect patient satisfaction and quality of life. However, further research is needed to confirm the direction of the relationships between leadership and patient outcomes.

How to use knowledge about leadership styles to improve your team leadership

So what does this theory and research mean for leading multidisciplinary mental health teams? First, it is important to have some self-awareness of your own leadership style. As noted, even self-review with measures such as the Clinical Team Leader Questionnaire (Corrigan et al., 1999) or the commercially available MLQ (Bass & Avolio, 1997) will give you some insight into your style. In addition, getting team members that you lead to rate such a measure provides an important additional perspective. Clearly, an active versus passive management style is preferable. It has consistently been found that passive and laissez-faire styles are associated with lower satisfaction and greater burnout within mental health teams. Further, such styles potentially have negative 'trickle-down' effects on patients (Corrigan et al., 2000). Although active management-by-exception is preferable to passive approaches, the ability to be charismatic, inspirational, visionary and considerate of individual team members is associated with more positive staff and consumer ratings of satisfaction.

However, not all managers view themselves as innately possessing these characteristics. It has been argued that many of these characteristics can be learned (e.g. Corrigan et al., 1998). Fortunately, you do not have to possess all of these characteristics to be a better team leader. Team members want leaders to clarify team goals and a vision. There are already programmes for leaders to enhance these factors. Preliminary research suggests that self-monitoring to provide performance feedback along with setting goals can lead to improved productivity (higher client contact hours) in mental health teams (Calpin et al., 1988). Most mental health organisations provide global 'visions' for their services and strategic plans provide further opportunities to clarify a vision and goals to achieve in order to realise that vision. These processes are highly consistent with the 'recovery' visions that are now enshrined in mental health policy in many countries. For

example, the Australian National Mental Health Plan (2003–2008) has a key principle: 'A recovery orientation should drive service delivery' (Australian Health Ministers, 2003, p. 11). Embedded within such an aspirational principle are a number of underlying values that may need to be clarified and reinforced at a team level. For example, there is a shift from a purely symptom reduction and behavioural functioning view of improvement to a focus on living a more hopeful and meaningful life. There is greater valuing and support for autonomy and self-determination in consumers. Such approaches allow consumers to take risks to achieve important goals in this direction.

Initially, the role of a team leader may be to provide opportunities for teams to clarify the meaning of these issues for their day-to-day work and functioning as a team. How different professional training, roles, values and expectations might impact on achieving such a vision can be discussed. Establishment of shared team goals and provision of a structure for monitoring progress toward these goals may be needed. It may be that such structuring includes using a framework during treatment team meetings to review a care plan with specific reference to the 'recovery-oriented' vision (e.g. Does the plan focus on strengths? Was the client involved in collaboratively establishing goals? How does this plan enhance the autonomy and responsibility of a client?).

Some researchers have suggested that management by instructions or by objectives are inadequate in modern, complex and demanding organisations that are constantly changing (Dolan & Garcia, 2002). They highlight the need for a 'new approach, labelled management by values (MBV)' as an emerging strategic leadership tool. Given the push for 'recovery-oriented services' with a strong philosophical and value-based foundation such management and leadership approaches will possibly become increasingly needed.

Team building

It cannot be assumed that all team members understand the expertise and training of fellow team members or have positive attitudes toward a multidisciplinary team approach. For example, surveys indicate confusion among general medical practitioners regarding the qualifications of professionals such as psychologists (Franklin et al., 1998). Further, there is evidence that medical students do not receive sufficient training in interdisciplinary teamwork and may not see the value in such an approach (e.g. Tanaka & Yokode, 2005). It has been recommended that medical training increases students' understanding of the role and responsibility of different healthcare professionals (Tanaka & Yokode, 2005). It has been argued that there is often role conflict, particularly between the psychiatrist and other members of the multidisciplinary team (Diamond, 1996). This is in part because psychiatrists often tend to view themselves as ultimately having overall responsibility for the patient's entire treatment (Diamond, 1996) or inaccurately perceiving that they are legally liable for the work of other team members (Renouf & Meadows, 2007). Together, these considerations have the potential to

Box 1.1 Examples of team building activities.

- Recognise unique skills of team members (e.g. perhaps use 'journal club' type activities to highlight specific skills in different occupational groups)
- Model respect by seeking 'consultations' with team members about cases at individual level
- Support strategies to recognise each team member's special skills or training (e.g. make this explicit during team meetings, 'John can do occupational assessment and job skills training')
- Strengthen team identity – especially around shared philosophies, vision, and values
- Try to connect team values to broader organisational values – develop 'team pride' in performance by highlighting both individual and team success
- Make team projects and goals explicit (e.g. start small and build, e.g. data audit – quality activities – individual client successes)
- Clarify the client groups that the team is delivering services to along with the range of services that are to be provided
- Encourage participation by all team members in information sharing and discussions regarding programme development, service planning, through to decision making in treatment team meetings
- Encourage presentation at conferences or professional meetings of team-orientated presentations (e.g. this may be 'parts' of presenters or team data presented by an individual)
- Pursue internal recognition of team within the organisation (e.g. by writing a letter to the Chief Executive Officer praising team achievements)
- Collaboratively establish team goals or targets (that might be matched to service key performance indicators) and be sure to structure regular feedback about the team's progress
- Support team-based learning or professional development activities

disempower other team members and cause ambiguity about who is responsible for specific components of treatment. These kinds of considerations reinforce the need for team building. Box 1.1 presents a sample of potential team building activities.

There are also numerous opportunities for informal team-building activities which can revolve around events such as lunches, professional society meetings and holiday season festivities.

Managing meetings and team communication

To some extent management of team meetings depends on the purpose and goals of a meeting. Typically the most common meetings are 'treatment team' meetings where client progress is reviewed and there is discussion of care plans, goal attainment and the need for additional support or resources to support the client. Team members typically provide suggestions to the key worker about what might be useful and this draws not only on the collective experience, but also the specific

disciplinary skills that are available. Often these meetings also discuss caseloads and are part of the caseload allocation procedures. In managing such meetings it is important to have a structure so that they progress in a predictable fashion and are completed in a timely fashion.

In a qualitative exploratory study of professional communication in interdisciplinary team meetings, three main communication practices were identified (Bokhour, 2006). The first, 'giving report', accounted for 27% of all utterances and involved individual team members reporting on problems, status, goals and interventions written in the treatment plan. The second, 'writing report', accounted for 25% of all utterances and involved actively writing and as part of that process discussing the wording of problems, goals and interventions. The third practice was 'collaborative discussion', which accounted for 32% of time. This was most often initiated by a team member raising questions or commenting on a report given by another team member, and overlap of speech was common (Bokhour, 2006). The implications of these findings revolve around understanding the effects of these various communication practices in order to increase levels of collaboration that involve crossing disciplinary boundaries to jointly determine treatment plans and actions. The author highlighted that high levels of 'giving report' reduce opportunities for team collaboration because one person tends to hold the floor. Although 'writing report' allows greater collaboration, it was still somewhat limited to the appropriate manner to document information in the care plan and was constrained by organisational requirements. Thus, informally tracking the time for various activities so as to maximise opportunities for collaborative discussion may be needed in team meetings.

Considerations in managing such meetings revolve around differential levels of participation. This may not be just at an individual level, but may also be influenced by the way different professions interact. For example, one study found that in multidisciplinary team meetings social workers and nurses were reluctant to voice their opinions compared to others (e.g. Atwal & Caldwell, 2005). Thus, some sensitivity to perceived professional hierarchies and power relationships is likely to be needed in managing team meetings (Mohr, 1995).

Although team leaders need to be alert to the processes in team meetings they also need to be clear on the purpose and tasks of the meeting. As Liberman et al. (2001, p. 1335) indicate:

> 'the team leader should focus the meeting on the needs of clients, on how current services are addressing those needs, and on making changes in treatment plans as needed; ensuring that team members keep clients' progress and plan interventions; setting expectations that the reports presented at meetings by team members will be specific and cogent; involving all staff in prioritising the topics and clients for discussion as well as in problem solving, decision making, and treatment planning; and translating the decisions made at the meetings into the written clinical records.'

Short and relatively informal morning briefings can be instituted to catch team members up on the most current information about clients and these have been

described as 'the mainstay of communication on assertive community treatment teams' (Liberman et al., 2001, p. 1335). Of course a great deal of informal team work occurs outside formal meetings. Informal communication can occur in the context of simple information sharing, relationship building, one-off special projects or training activities.

Conclusion

Leading a multidisciplinary team is becoming increasingly complex as policy and legislative changes lead to further blurring of the professional boundaries of team members. However, there is a growing research base that is providing guidance on leadership and management qualities that lead to better team functioning. Active leadership that is clear about the roles and goals of the team and individual team members is associated with better team functioning. Furthermore, leaders who are charismatic, inspirational, and considerate of individual staff members may improve team functioning to the extent that this is a measurable benefit for service user outcomes.

References

Atwal, A. & Caldwell, K. (2005). Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences*, 19, 268–273.

Auerbach, E. S. (2002). Occupational therapy and the multidisciplinary team (Letter). *Psychiatric Services*, 53, 767–768.

Australian Health Ministers (2003). *National Mental Health Plan 2003–2008.* Canberra: Australian Government.

Bass, B. M. (1985). *Leadership and Performance Beyond Expectation*. New York: Free Press.

Bass, B. M. & Avolio, B. J. (1997). *Full Range Leadership Development: Manual for the Multifactor Leadership Questionnaire*. Palo Alto, CA: Mindgarden.

Bokhour, B. G. (2006). Communication in interdisciplinary team meetings: What are we talking about? *Journal of Interprofessional Care*, 20, 349–363.

Burns, T. & Lloyd, H. (2004). Is a team approach based on staff meetings cost-effective in the delivery of mental health care? *Current Opinion in Psychiatry*, 17, 311–314.

Calpin, J. P., Edelstein, B., & Redmon, W. K. (1988). Performance feedback and goal setting to improve mental health center staff productivity. *Journal of Organizational Behavior Management*, 9, 35–58.

Corrigan, P. W., Garman, A. N., Lam, C. & Leary, M. (1998). What mental health teams want in their leaders. *Administration and Policy in Mental Health*, 26, 111–123.

Corrigan, P. W., Garman, A. N., Canar, J. & Lam, C. (1999). Characteristics of rehabilitation team leaders: a replication. *Rehabilitation Counselling Bulletin*, 42, 186–195.

Corrigan, P. W., Lickey, S. E., Campion, J. & Rashid, F. (2000). Mental health leadership and consumers' satisfaction and quality of life. *Psychiatric Services*, 51, 781–785.

DeChurch, L. A. & Marks, M. A. (2001). Maximizing the benefits of task conflict: the role of conflict management. *International Journal of Conflict Management*, 12, 4–22.

Diamond, R. J. (1996). Multidisciplinary teamwork. In: Vaccaro, J. & Clark, G. H. Jr. (eds). *Practicing Psychiatry in the Community: A Manual*. Arlington, Virginia: American Psychiatric Press, pp. 343–360.

Dolan, S. L. & Garcia, S. (2002). Managing by values: Cultural redesign of strategic organizational change at the dawn of the twenty-first century. *Journal of Management Development*, 21, 101–107.

Franklin, J., Foreman, M., Kyriakou, A. & Sarnovski, J. (1998). Awareness of psychologists' qualifications, professional associations, and registration amongst general medical practitioners, psychologists and their clients. *Australian Psychologist*, 33, 217–222.

Garman, A. N., Davis-Lenane, D. & Corrigan, P. W. (2003). Factor structure of the transformation leadership model in human service teams. *Journal of Organizational Behavior*, 24, 803–812.

Gellis, Z. D. (2001). Social work perceptions of transformational and transactional leadership in health care. *Social Work Research*, 25, 17–25.

Gray, R., Wykes, T. & Gournay, K. (2004). Randomised controlled trial and medication management in mental health nurses. *British Journal of Psychiatry*, 185, 157–162.

Kanste, O., Miettunen, J. & Kyngas, H. (2007). Psychometric properties of the Mulifactor Leadership Questionnaire among nurses. *Journal of Advanced Nursing*, 57, 201–212.

Kantek, F. & Kavla, I. (2007). Nurse–nurse manager conflict: how do nurse managers manage it? *The Health Care Manager*, 26, 147–151.

Kim, S. (2002). Participative management and job satisfaction: Lessons from management leadership. *Public Administration Review*, 62, 231–241.

Kuhn, T. & Poole, M. S. (2000). Do conflict management styles affect group decision making? Evidence from a longitudinal field study. *Human Communication Research*, 26, 558–590.

Liberman, R. P., Hilty, D. M., Drake, R. E. & Tsang, H. W. H. (2001). Requirements for multidisciplinary teamwork in psychiatric rehabilitation. *Psychiatric Services*, 52, 1331–1342.

MacMillan, M. & Bellchambers, H. (2007). Nurse prescribing: Adding value to the consumer experience. *Australian Prescriber*, 30, 2–3.

Marcos, L. R. & Silver, M. A. (1988). Psychiatrist-executive management styles: nature or nurture? *American Journal of Psychiatry*, 145, 103–106.

McKenna, B., O'Brien, A., Din, T. & Thom, K. (2006). Registered nurses as responsible clinicians under the New Zealand Mental Health Act 1992. *International Journal of Mental Health Nursing,* 15, 128.

Mohr, W. K. (1995). A critical reappraisal of a social form in psychiatric care settings: the multidisciplinary team meeting as a paradigm case. *Archives of Psychiatric Nursing*, 9, 85–91.

Rebeiro, K. L. (2002). Occupational therapy and the multidisciplinary team (letter). *Psychiatric Services*, 53, 767.

Renouf, N. & Meadows, G. (2007). Working collaboratively. In: Meadows, G., Singh, B. & Grigg, M. (eds). *Mental Health in Australia: Collaborative Community Practice*, 2nd edition. New York: Oxford University Press, pp. 227–242.

Sherman, P. & Porter, R. (1991). Mental health consumers as case managers. *Hospital and Community Psychiatry*, 42, 494–498.

Tanaka, M. & Yokode, M. (2005). Attitudes of medical students and residents toward multidisciplinary team approach. *Medical Education*, 39, 1255–1256.

Thornicroft, G. & Betts, V. (2002). *International Mid-Term Review of the Second National Mental Health Plan for Australia*. Canberra: Mental Health and Special Programs Branch, Department of Health and Ageing.

Turkington, D., Kingdon, D., Rathod, S., Hammond, K., Pelton, J. & Mehta, R. (2006). Outcomes of an effectiveness trial of cognitive-behavioural intervention by mental health nurses in schizophrenia. *British Journal of Psychiatry*, 189, 36–40.