Irish Journal of Psychological Medicine (2014), **31**, 51–59.
doi:10.1017/ipm.2013.62

REVIEW PAPER

Steps towards effective teamworking in Community Mental Health Teams

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Objectives. This paper aims to show how effective teamworking can be achieved in Community Mental Health Teams (CMHTs), in the context of recovery-focused care.

Methods. A narrative review of various governmental policy documents and selected papers relevant to teamworking and recovery-focused care within mental health services, in an Irish context.

Findings. Effective teamworking within CMHTs is a prerequisite to the provision of quality, recovery-focused care. It requires the management of various environmental (e.g. adopting a 'recovery' model of mental health), structural (e.g. sharing of responsibilities and capabilities) and process (e.g. utilising a clear referral pathway) factors that influence teamworking, as CMHTs develop over time.

Conclusions. Completion by CMHT members of teamworking and other evaluative measures can assist teams in highlighting potential interventions that may improve recovery-focused team functioning and effectiveness.

Received 14 June 2012; Revised 7 August 2012; Accepted 25 June 2013; First published online 5 December 2013

Key words: Community mental health teams, recovery, teamworking.

Introduction

Recent publications by the Mental Health Commission (2005, 2008) highlight the need for our mental health services to provide recovery-focused care that empowers service users to 'take control' of their own recovery. In this person-centred approach, working with their assigned care co-ordinator (or key worker), service users are proactively empowered to define what recovery means to them as individuals, and to accordingly formulate and drive the implementation of their needs-based care plan (Mental Health Commission 2008). Moreover, the role of mental health services is to support service users in fulfilling their potential in all life domains – from their well-being to their participation in social and community activities, education and employment (Mental Health Commission 2008; Byrne & Onyett 2010).

A Vision for Change (Department of Health and Children 2006) recommends the provision of integrated, recovery-focused care that is delivered in the community, primarily by multi-disciplinary Community Mental Health Teams (CMHTs). As detailed in the guidance papers from the Health Service Executive (HSE) National Vision for Change Working Group (HSE National Vision for Change Working Group 2012), this can be achieved by providing a continuum of integrated services (see Fig. 1). Moreover, the Mental Health Commission has developed the evidence-based *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission 2007). This non-prescriptive framework has eight themes, 24 standards and 163 criteria that can be applied to all mental health services, and it aims to place service users at the centre of care through quality, recovery-focused service delivery (Mental Health Commission 2007).

A prerequisite for such integrated, recovery-focused care is effective teamworking within CMHTs. However, achieving this is dependent on environmental, structural and process factors that interact with each other as teams develop over time (Byrne & Onyett 2010). Building on guidelines from the Mental Health Commission's *Teamwork in Mental Health Services in Ireland* (Byrne & Onyett 2010), this paper aims to highlight how to best manage these factors in order to facilitate effective teamworking and recovery-based care in CMHTs. First the stages of team development are outlined. It then considers the factors that influence teamworking and some potential interventions that may realise effective teamworking. Finally, it explores ways to evaluate if teams are working effectively.

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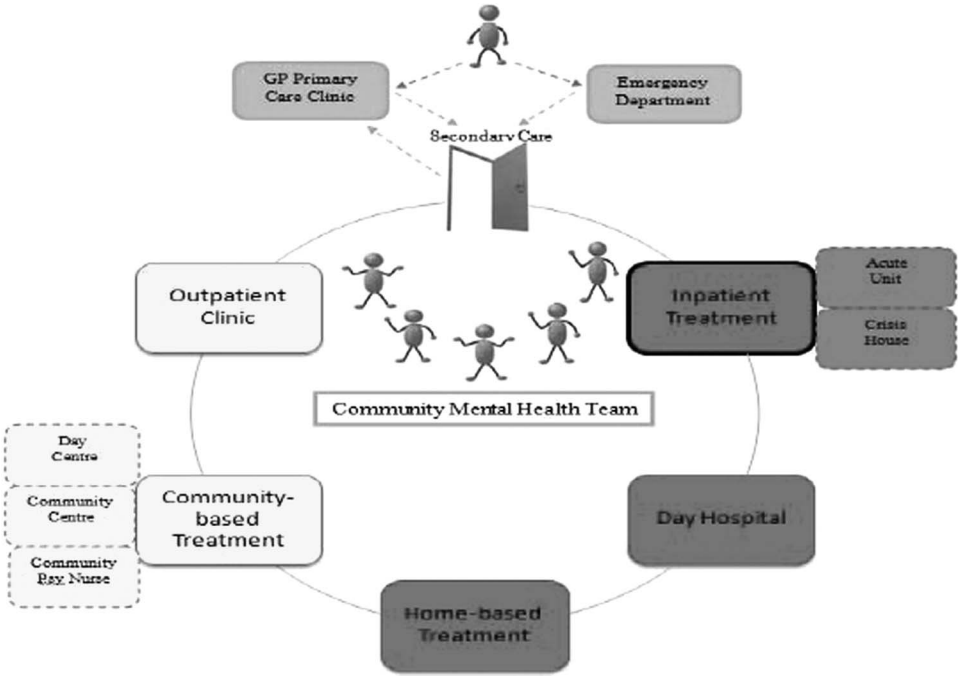

Fig. 1. Continuum of care from Community Mental Health Teams (CMHTs) (HSE National Vision for Change Working Group 2012).

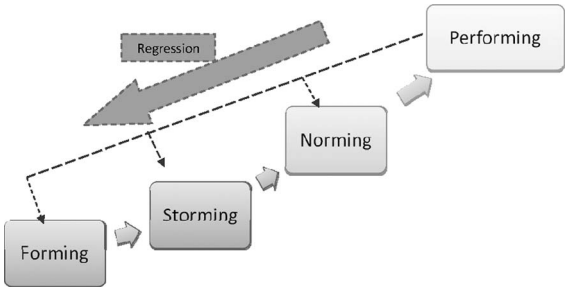

Fig. 2. Stages of team development (Tuckman 1965).

Stages of team development

Tuckman's (1965) group development model describes four stages of team development: forming, storming, norming and performing. During the forming stage, new teams establish provisional ground rules regarding their nature and purpose. During the storming stage, team members reveal their personal goals for the team and there may be some 'jockeying for position'. During the norming stage, formal and informal intra-team conflict resolution strategies are established, potentially leading to increased cohesiveness. Finally, during the performing stage, the emergent solidarity and shared understanding among team members allows them to focus on 'getting the job done' (Farrell *et al*. 2001). Teams ideally progress through these stages but regression can also occur, for example when there is a change in team composition (see Fig. 2). Teams may encounter difficulties associated with each stage of development, and ways to manage these are detailed in Table 1 (Byrne & Onyett 2010).

Team environment factors

The choice of care model is often hotly contested among team members from differing disciplines who may compete to assert the primacy of their preferred model and the superiority of their associated interventions (Singh 2000). However, this competition and subsequent choosing of a particular 'professional' model (e.g., the biopsychosocial model) (Clare 1976) is time poorly spent, as it does not satisfy the diverse needs of service users (Byrne & Onyett 2010). What is required is an integrative and flexible 'recovery' model that:

- Recognises the need to 'develop a tight bundle of relevant responses congruent' with those of service users (Heginbotham 1999).
- Empowers service users to reclaim ownership of their own life story (Owens & Ashcroft 1982) and 'take action' in resolving problems (Mental Health Commission 2008).
- Defines recovery not as total remission of symptoms or cure, but as supporting service users in fulfilling their aspirations as socially included citizens (Byrne & Onyett 2010).

https://doi.org/10.1017/ipm.2013.62 Published online by Cambridge University Press

Table 1. *Problems and management strategies at each stage of team development (Byrne & Onyett 2010)*

Stage	Problem(s)	Solutions/ways to progress
Forming	• Teams in this stage may be perceived as wasteful of resources (e.g., time)	• Spend time getting to know each other as whole people • Create space where members can safely and openly discuss team goals and processes, and their roles and aspirations • Allow ways of working to emerge in a way that promotes ownership of how the team does business
Storming	• 'Turf' conflict over role responsibility and power dynamics • Passive resistance and 'backstage' complaining (Tuckman 1965)	• Spend time in forming stage ensuring that personal values and team goals complement each other • Manage conflict appropriately. Doing so can create a more trusting and psychologically safer team environment • Encourage team members to abstain from 'backstage complaining' and to communicate in an open manner • Engage in constructive controversy. Doing so produces a more realistic consensus regarding core issues such as your team's mission and the division of labour. This also creates greater clarity of roles
Norming	• Overly cohesive and excessively inwardly focused teams can deflect attention from both core issues and appropriate connections with external agencies	• Create space for cohesion to develop • Focus on removing barriers to communication and help everyone find their voice • Organise a social event, and perhaps involve other people from parts of the local service that you need to work with to meet the needs of your target population • Capture the ways of working in written form and share widely, including with referrers, but to be prepared to continue to evolve
Performing	• Stagnancy	• Remain aware that unless you continue to develop you will degrade • Scan the horizon for what might be coming next • Expect things to change and remain aware that roles and practices will continue to evolve, as might your team's target population • Nurture effective relationships with all your key stakeholders and make effective use of feedback • Continue to devote space and time to doing what worked to move your team forward • Build in supports for the better new ways of working and remove anything that supports unhelpful ways of working • Expect setbacks and make good use of your experience to get back on track

- Highlights the necessity of ongoing therapeutic input and the need for significant teamworking and collaboration between different agencies so that all service users' needs are addressed (World Health Organization 2005).
- Rejects the 'sick role' of service users, instead valuing their voice and expertise (Slade 2009).

To best influence the adoption of a 'recovery' model by team members, mutual respect and understanding of each others' preferred assessment and treatment models must be fostered (McHugh & Byrne 2012). While this can be facilitated by ongoing training, it is optimally developed early in professional training when professional identities are still 'forming' (Mental Health Commission 2008).

In terms of current environmental changes, the HSE Service Plan 2012 includes the appointment of over 400 mental health professionals to professionally complete existing CMHTs (HSE National Vision for Change Working Group 2012). This is much needed as the latest report by the Vision for Change Monitoring Group

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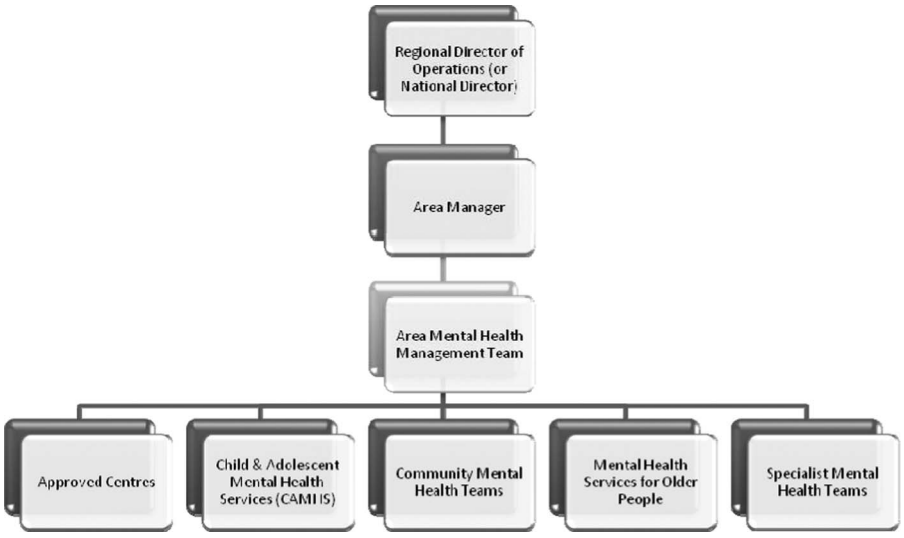

Fig. 3. New reporting structures (HSE National Vision for Change Working Group 2012).

(Vision for Change Monitoring Group 2012) has estimated that 1500 posts in CMHTs across Ireland have yet to be filled, due in part to the HSE recruitment embargo and the Public Service Moratorium. This has led to a lack of development of recovery competencies in service delivery (Vision for Change Monitoring Group 2012). Nevertheless, although the HSE Service Plan 2012 represents a considerable environmental change that may temporarily disrupt the everyday functioning of teams, it also provides an opportunity to boost the capacity of CMHTs and re-orientate services towards a recovery-orientated community care model (HSE National Vision for Change Working Group 2012).

Another influential and evolving environmental factor within CMHTs is the reporting structures in place. In an effort to implement the recommendations of A Vision for Change (Department of Health and Children 2006), reporting structures are being reformed. Singular Area Mental Health Management Teams (MHMTs), one per Service Area, are replacing all existing mental health management structures. Consisting of a business manager, clinical psychologist, director of nursing, occupational therapist, service user, social worker, and chaired at least initially by an executive clinical director, these teams report to the HSE Area Manager who then reports to the Regional Director of Operations or, if appointed, a National Director of Mental Health Services (see Fig. 3) (Mental Health Commission 2008). The effectiveness of each Area MHMT will largely depend on their functioning well as a team and the extent to which they work effectively with other mental health structures (e.g., Approved Centres). However, the proposed National Mental Health Service Directorate (Department of Health and Children 2006) has yet to be put in place and the uncertainty surrounding plans to do so may adversely affect teamworking (Vision for Change Monitoring Group 2012).

Team structure factors

Team structure factors which provide a framework for team processes include the level of service user involvement, governance structures, model of clinical responsibility and skills mix (Byrne & Onyett 2010) as well as team leadership style (Byrne *et al*. 2006) Table 2 below highlights how some of these factors relate to teamwork, and how they might be managed to realise improved teamworking.

Team process factors

Team process factors determine how tasks and interpersonal dynamics are handled and how teams transform inputs into outputs (Byrne & Onyett 2010). These factors include the referral pathway, the process of work, workload distribution, communication, supervision and training (Byrne & Onyett 2010).

Referral pathway

The referral pathway (see Fig. 4) determines the service user's journey into a CMHT. Ideally, it should be clear, integrated, and easily navigated (Byrne & Onyett 2010). This can be achieved through the rigorous application of inclusion criteria and team member agreement on the extent of the referral net (i.e. who the team can accept referrals from) and the number of access points (i.e. who on the team can accept referrals and bring them to the team meeting) (Byrne & Onyett 2010).

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Table 2. *Team structure factors, their impact on teamwork and recommended actions*

Factors	Impact	Recommended actions
Level of service user involvement	• Service users provide relevant information concerning health education, consultation, audits, and participate in improvement (Poulton 1999)	• Recognise the service user as the expert (World Health Organization 2005) • Cultivate service user choice and enable informed decision making. This will increase engagement and 'give them what they want' (Byrne & Onyett 2010) • Recognise service users as true partners in mental health teams (Colombo *et al*. 2003), in collaboration with their care co-ordinator (or keyworker) (Byrne & Onyett 2010)
Governance structures	• The governance structure of business manager, clinical leader and team co-ordinator is responsible for motivating team members to 'buy in' to the vision and goals of the team (rather than the individual) (Department of Health and Children 2006)	• Ensure explicit awareness of leadership roles to avoid power conflicts (Ovretveit 1997) • Work in a cohesive, collaborative and co-ordinated manner to balance independence and positive internal relations (Onyett 1998)
Model of clinical responsibility	• A 'star' model of clinical centralises responsibility but a more distributed model determines responsibility by team members' relative contribution to each episode of care (McHugh & Byrne 2012)	• Avoid 'centralised' model as it leads to the crossing of professional boundaries as well as the disempowerment, devaluing, and demotivation of team members (Rosen 2001) • Utilise 'distributed' model as this promotes collaborative leadership (Rosen 2001) However, ensure this model is accepted by all team members (McHugh & Byrne 2012)
Skills mix	• An over-reliance on specific skills of different team members leads to fragmented care and (unjustified) protection of professional identities (McHugh & Byrne 2012)	• Regularly negotiate and review role boundaries (e.g., through skills audit). Doing so will prevent role conflict and increase the potential for meaningfully co-ordinated care (Rosen & Callaly 2005) • Promote the 10 shared capabilities (National Institute for Mental Health in England 2004) in each team member
Leadership style	• Leadership needs to encourage 'respectful followership'(Byrne *et al*. 2006) and transform loose groups of individuals into a cohesive unit (Bartol & Martin 1994) • The main challenge is the balancing of operational management and professional autonomy (Byrne *et al*. 2006)	• Invest time in building one-to-one and trust-based relationships with team members (e.g., by remaining accessible and open, listening actively, giving feedback, adhering to procedural fairness) (Sheard & Kakabadse 2002) • Work with team members to resolve recurrent care problems, using a 'recovery' model that takes into account the stage of your team's development (Byrne & Onyett 2010)

Process of work

This is an iterative cycle that determines how referrals are processed internally (see Fig. 5) (Byrne & Onyett 2010). It involves the ongoing review of clinical progress after initial assessment and involves decisions concerning the assignment of a care co-ordinator (or keyworker), referral back to source, outgoing referrals and care plan suitability (Onyett 1998).

Workload distribution

Workload distribution in mental health teams is often based solely on quantitative data (e.g., how many cases each team member is responsible for). However, this method of measuring workload does not take into account many other factors including caseload complexity, report writing and supervision responsibilities, and meeting and travel commitments (Byrne & Onyett 2010).

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Sole use of administratively convenient but limited data may lead to workload inequities and team member burnout, anger and envy (Lankshear 2003). To avoid such negative repercussions and to maximise fairness and balance, team members need to openly discuss all of the above factors as well as each members competency set (McHugh & Byrne 2012). Moreover, if a team has an excessive number of open cases with no additional capacity for taking on new cases, it either needs to reconfigure how it works to free up some capacity for taking on new referrals and/or make representations to its Area MHMT regarding the recruitment of extra staff (with the appropriate competencies) (McHugh & Byrne 2012).

Communication

Communication, both informal and formal, in a CMHT takes place both internally and externally to the team. This needs to be both open and honest as it determines how well all of the other team processes link together (Salas *et al*. 2004; Byrne & Onyett 2010). To enable such openness, team leaders and members need to promote an atmosphere of psychological safety whereby all can voice their honest opinions without fear of ridicule or rebuke, and there is a focus on learning from mistakes rather than apportioning blame (McHugh & Byrne 2012). Moreover, conflict resolution strategies need to be in place to ensure disputes are resolved in a pro-active manner, thus minimising the possibility of escalation (Byrne & Onyett 2010). When communicating with service users and others, the language used needs to be as jargon-free and understandable as possible (McHugh & Byrne 2012). The need to improve such communication has been highlighted in a recent survey ($n = 79$) that reported service user dissatisfaction with their communications with a Dublin-based community mental health service (Hill *et al*. 2009).

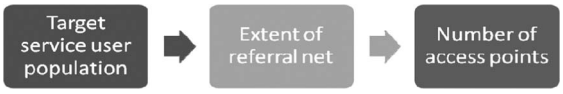

Fig. 4. Referral pathway (Byrne & Onyett 2010).

Supervision

Supervision in CMHTs can take the form of clinical supervision and/or peer consultation (Byrne & Onyett 2010). Its primary purpose is to provide support and a safe place for learning based upon evidence-based practice (Fleming & Steen 2003) but it can also have a monitoring function (Byrne & Onyett 2010). Peer consultation values the team as a resource and can take place in team meetings or on a one-to-one basis, often between disciplines (Byrne & Onyett 2010). In contrast, clinical supervision typically does not span disciplines (British Psychological Society 2001) given that it is an intra-disciplinary process, and because the supervisor needs to be trained in the areas of work being supervised so that she/he can be held accountable for that work (Byrne & Onyett 2010). Hence, some disciplines

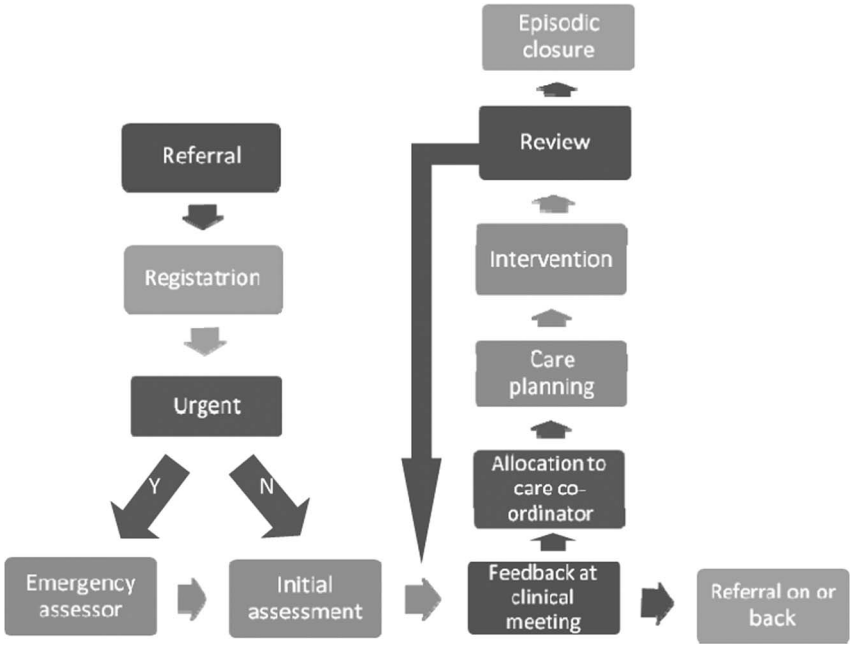

Fig. 5. The process of work (Byrne & Onyett 2010).

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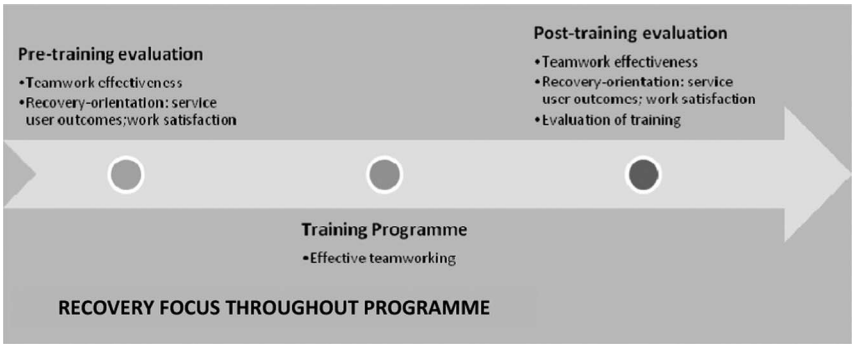

Fig. 6. Enhancing Teamworking Project.

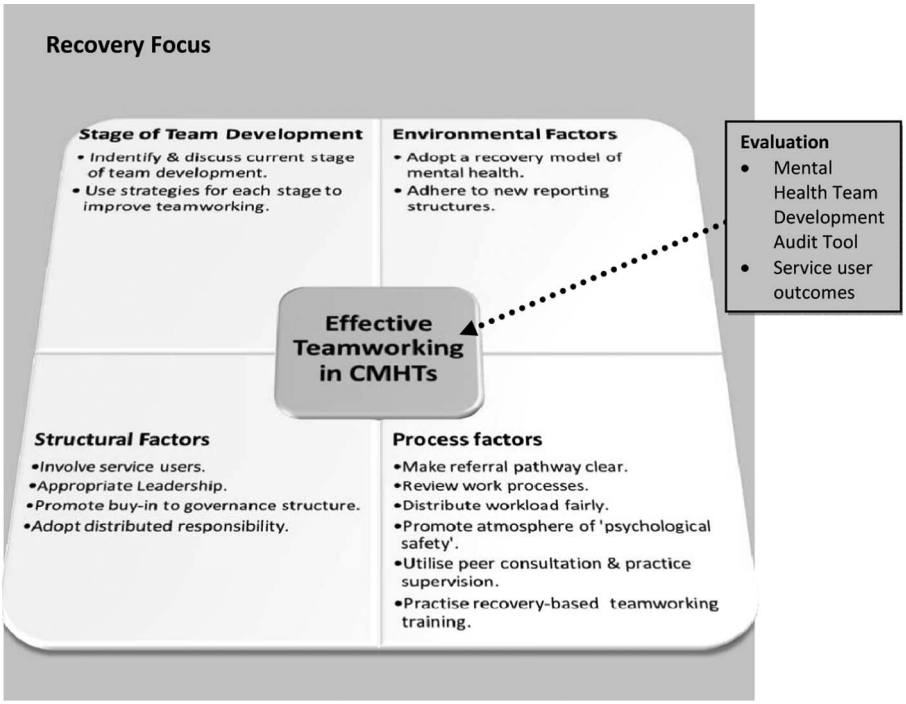

Fig. 7. Steps towards effective teamwork in a recovery context. CMHT, Community Mental Health Team.

may have to arrange supervision external to their team. Whatever form it takes, supervision for CMHTs should perhaps take place on 'neutral ground' or away from the workplace – a study of community mental health nurses ($n = 260$) found that the latter was associated with improved rapport, skills development and ability to reflect (Edwards *et al.* 2005).

Training

Training needs to address teams' knowledge and skill gaps related to recovery-based care planning. This can be achieved by the inclusion of modules relating to understanding and empathising with service users' needs, and modules that advocate the empowerment of service users to enhance their own care (McHugh & Byrne 2012). Ongoing training and continuing professional development need to address both team-specific competencies (e.g., skill sets and responsibilities) as well as multidisciplinary needs such as communication and conflict resolution strategies (McHugh & Byrne 2012). There are various outlets for such training including Dublin City University's (Irish College of General Practitioners 2011) module on *Team-based approaches to supporting mental health in primary care settings* and the online training portal HSELanD (McHugh *et al.* 2012).

Evaluating teamwork

As effective teamworking has been evidenced to be associated with higher quality of clinical care and positive service evaluations by primary care service users

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(Bower *et al*. 2003), its evaluation within CMHTs should be prioritised. Furthermore, given that effective teamwork is a prerequisite to recovery-orientated care (Byrne & Onyett 2010), service evaluations need to explore if effective teamworking is evident and whether service users are in receipt of quality recovery-orientated care.

Effective teamworking

To evaluate baseline teamworking effectiveness, team members can complete the 25-item Mental Health Team Development Audit Tool (MHDAT) (Byrne & Onyett 2010; Roncalli *et al*. 2013). Both convergent and divergent MHDAT data sets can be used as teamwork intervention points. For example, there may be differing perceptions of who does what within a team which would necessitate discussion about an agreement on team member role definitions. Data from the MHDAT could be supplemented by data from other scales including the Team Participation and Team Functioning scales (Alexander *et al*. 2005). Moreover, to evaluate the leadership skills displayed across CMHTs measures such as the Psychological Safety and Team Learning scales (Edmondson 1999) could be completed. Given that work satisfaction is often associated with staff retention and resultant quality of service provision, team members could also be asked to complete work satisfaction questionnaires such as the Minnesota Satisfaction Questionnaire (Weiss *et al*. 1967).

Evaluation of recovery-orientated care

To evaluate the extent to which a CMHT is providing quality recovery-orientated care, service user outcomes can be measured. For example, service users could complete the 60-item Pillars of Recovery Service Audit Tool that was developed in the Irish context (Mental Health Commission 2008) or the Developing Recovery Enhancing Environments Measure (Dinniss *et al*. 2007). However, as these measures are quite lengthy, other non-recovery-specific yet global outcome measures such as the 5-item Work and Social Adjustment Scale (Mundt *et al*. 2002) and the 12-item Health of the Nation Outcome Scales (Stewart 2009) could be used.

The HSE's 'Enhancing Teamworking Project' is being rolled out with a focus on improving teamwork effectiveness and the degree of recovery-oriented care in our mental health services. Evaluation of this project may also incorporate qualitative feedback from team members and other relevant stakeholders (see Fig. 6).

Conclusions

This paper describes ways to manage environmental, structural and process factors that contribute to CMHT work effectiveness and ultimately to the provision of recovery-based care, as CMHTs develop over time (see Fig. 7). Environmentally, a recovery rather than a 'professional' model of mental health needs to be adopted and tight reporting structures are required. Structurally, meaningful service user input and a focus on shared capabilities is needed, as well as trust-invoking leadership, collaborative governance and distributed responsibility. Regarding process factors, teams need an easily navigated referral pathway, a regularly reviewed work process, equitable workload distribution, a 'psychologically safe' atmosphere of communication, a focus on peer-orientated supervision, and recovery-orientated training. In the journey towards effective teamwork, a good starting point for CMHTs is to ask 'How are we now functioning as a team?' Here, as used in the HSE's 'Enhancing Teamworking Project', team members would benefit from completing the MHDAT (Byrne & Onyett 2010; Roncalli *et al*. 2013).

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