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CLINICAL MANAGEMENT IN MENTAL HEALTH SERVICES

Edited by
Chris Lloyd, Robert King, Frank Deane and Kevin Gournay

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Contributors

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

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

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

Susan Brandis is a registered occupational therapist with additional qualifications in business and health administration. She has many years of management experience having been employed by Queensland Health in roles including as Director of Occupational Therapy, Director of Allied Health, Geriatric and Rehabilitation Services, and Executive Officer Medical Aids Subsidy Scheme. In 2006 she was part of the implementation team responsible for establishing the Quality Monitoring Unit of the Health Quality and Complaints Commission for the Queensland Government. Her career includes leading and publishing a number of state and national quality improvement programmes in areas such as the prevention of falls in older people, improving continence management, consumer engagement and supported discharge initiatives. This has provided her with both theoretical and practical experience and skills in budget and people management. Susan has particular interest in quality improvement, client focused care, cost–benefit analysis, service evaluation and development. She has been an adjunct lecturer at the University of Queensland since 1999.

Janette Curtis is an Associate Professor and Director of Mental Health Nursing in the School of Nursing, Midwifery and Indigenous Health at the University of Wollongong. Janette has been instrumental in developing and implementing the undergraduate and postgraduate mental health nursing programmes. Janette's publications and research interests include: p.r.n. medications, empowering nurses, and drugs and alcohol. As Faculty International Advisor, Janette has established and developed off-shore teaching programmes. Janette has held clinical and senior nursing positions in New Zealand and Australia and is actively involved in professional issues with the Nurses and Midwifes Board of New South Wales.

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

Kevin Gournay is a Chartered Psychologist and a Registered Nurse. Originally he trained in psychiatry, learning disabilities, and general nursing and then in the 1970s as one of the first nurse therapists in cognitive behaviour therapy. After experience as a Charge Nurse, he worked part time to obtain a qualification as a psychologist, obtaining his PhD on the topic of agoraphobia. For the past 30 years, he has combined roles such as: a clinician treating people with post-traumatic stress and anxiety disorders, depression, and psychosis; a researcher; a teacher and a policy advisor to various governments. He has published over 300 papers, chapters and books, and made numerous contributions to TV and radio. He is the President and founding Patron of No Panic, the UK's largest

anxiety disorders charity. Among various honours, he is a Fellow of the Royal College of Psychiatrists, a Fellow of the Academy of Medical Science, a Fellow of the Royal College of Nursing, and was elected Nurse of the Year of the American Psychiatric Nursing Association in 2004. He was appointed CBE in the Queen's New Year's Honours in 1999. He has just retired from the Institute of Psychiatry, King's College, London, and in semi-retirement works as a clinician and an expert witness.

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

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

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

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

the OT Australia National Research Award in the Open Category. Her research interests include aspects of vocational rehabilitation for people with a mental illness.

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

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

Samson Tse qualified as an occupational therapist with additional qualifications in psychology. He is Associate Professor and Director of the post-graduate mental health programme at the School of Population Health, the University of Auckland. Samson's focus in both teaching and research has been in the areas of mental health, vocational rehabilitation, functional recovery and bipolar disorders, and culturally responsive mental healthcare.

Foreword

Over the past 50 years, changes in mental healthcare have seen considerable effort and attention paid to the way in which we structure and deliver services. In most countries models of community service provision have evolved as the focus of care shifted from hospital to community. The aim of service reform has generally been to deliver high-quality care, in the least restrictive way, with good outcomes for the consumer at the lowest cost. Often these aims have been in conflict, but we keep tinkering with the service and funding models to try to get the balance right.

Once we have what we think is a good service model, we usually set about developing standards so we can measure whether there is adherence to the preferred model. We often then require services to be accredited against the standards or risk some kind of sanction. Service models and service standards are important. They provide the framework in which care is delivered. However, much less attention is paid to the knowledge and skills, outside the clinical realm, needed by the workforce who will operate within the proposed service model. The management of mental health services requires a knowledge base and a set of skills not readily addressed in discipline-specific undergraduate curricula or post-graduate clinical training programmes.

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

Clinical Management in Mental Health Services responds to one of the most common criticisms of mental health service reform: that the increased investment

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

Harvey Whiteford
Kratzmann Professor of Psychiatry and Population Health
The University of Queensland
March 2008

Introducing this book

Chris Lloyd and Kevin Gournay

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

Clinical management in mental health services

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

Clinical management is a core part of how mental health services are organised. It is often a difficult task since mental health service delivery is complex and many of the people who are in management positions have no specific training in management skills. Many managers and team leaders have been appointed as a promotion from direct clinical work. People in management positions must fulfil a wide variety of roles to make the multidisciplinary team function effectively, for example, they may be involved in such areas as: workload management; clinical information management; budget management; managing critical incidents; communication and public relations; clinical supervision; performance appraisals and staff development; quality improvement; and promotion of evidence-based practice. They may also be involved in changing work practices and

professional culture, and dealing with such issues as stress and burnout. Indeed managers have a duty of care for their staff and have to balance service efficiency with ensuring that their staff are provided with appropriate levels of support and supervision. If staff members themselves experience work-related stress or other mental health problems, managers need to act with both speed and the highest level of consideration.

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

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

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

of everyday work, but now they have another set of demands from higher up the system to which they must also respond. In community mental health teams there may be some tension between consultant psychiatrists and other professionals who carry clinical responsibility and managers, who are accountable for the management of a service/team and the allocation of finite resources (Gilbert, 2003).

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

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

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

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

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

How the book is organised

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

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

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

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

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

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

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

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

Chapter 9 focuses on performance appraisal and personal development and the way it can be used to improve both individual staff performance and the

quality of service delivery. The chapter addresses the nature of performance appraisal, why is it useful, how to manage the performance of staff and difficult staff issues, and the benefits for personal development.

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

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

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

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

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

Conclusions

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

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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.

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Chapter 2
Managing workload in mental health services

Robert King

Chapter overview

Workload management is a complex challenge for service managers. Considerations include issues of equity (equivalent workload across the workforce); clinical effectiveness (when does workload adversely impact on work quality?); workplace health and safety (when does workload adversely impact on employee health and well-being?); and service efficiency (how can the most work be achieved with the least burden?). This chapter begins by introducing a framework for conceptualising workload in mental health services so as to enable a constituent analysis of workload. It then surveys the available evidence concerning the relationship between workload and workforce well-being and productivity. Finally, it considers workload standards and discusses ways by which service managers might actively manage the workloads of clinical staff.

Understanding workload: characteristics and constituents

Determining what constitutes workload is more difficult than might, at first glance, appear to be the case. There are both subjective and objective components to workload and while, necessarily, this chapter will focus on objective components, it is important to acknowledge the subjective dimension. At a personal level, workload is a little like pain. It is apparent to the person experiencing it but not always easy to communicate to another person. Two people may be doing what appears to be a broadly equivalent job, but one person may experience high workload pressure while the other person finds the job quite manageable. The challenge for the manager is to be able to clearly identify the constituents of a workload so as to make decisions regarding allocation of work, or provide guidance as to how a workload might be effectively managed.

At a conceptual level, workload constituents may be broadly equivalent across a range of human services. Morris et al. (2007) developed a model to identify the constituents of a nursing workload after reviewing the substantial published literature dealing with workload and workload-related issues within the nursing profession. Most of this literature concerned nursing activities other than mental health nursing. However, the general model is applicable to a broad range of mental health roles (Figure 2.1).

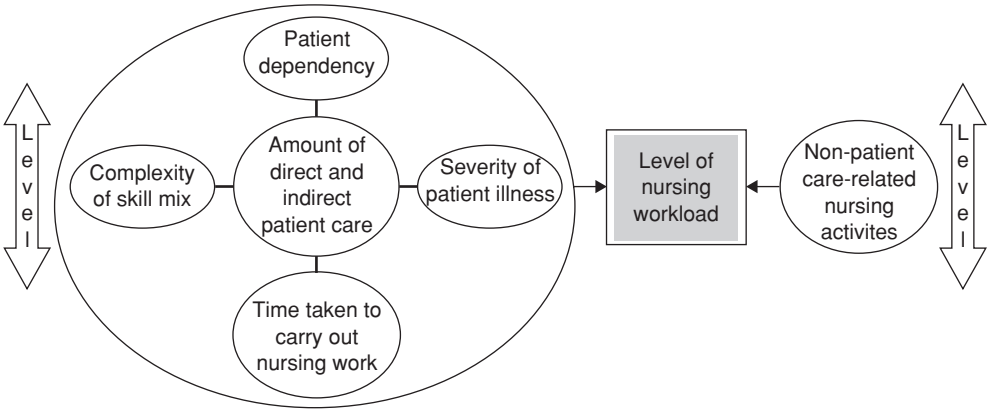

Figure 2.1 A model of nursing workload. Reproduced from Morris, R., McNeela, P., Scott, A., Treacy, P., & Hyde, A. Reconsidering the conceptualization of nursing workload: literature review. *Journal of Advanced Nursing*, 57, 463–471, copyright 2007 with permission of Blackwell Publishing Ltd.

In this model, workload is conceptualised as having two broad components. One relates to work with clients (clinical) and the other relates to non-client-related demands (non-clinical). Within the clinical work component, both client characteristics and the requirements of clinical care tasks impact on the workload. Non-clinical demands are not specified in the model. Stuart et al. (2000) in a study of the activities of mental health nurses classified non-clinical activities into three broad groups: clinical communication (e.g. documentation, team meetings, interagency liaison); management activities (e.g. clinical supervision, quality assurance, development of policies and procedures, co-ordination of services, unit level governance, strategic planning); and clerical activities (e.g. housekeeping, purchases, transport arrangements, scheduling appointments). To these we might add various kinds of project work such as community education, staff training, research and evaluation as well as increasingly common clerical activities such as data entry relating to client contact and client outcome measurement.

Objective measurement of workload requires formal evaluation of the time and effort taken to perform the various work activities. The time and motion study is the standard method for measuring the activities that constitute a workload (Finkler et al., 1993). In this method, trained observers use systematic and structured observation procedures to record both the category of activity and the time spent on the activity over a working day. Unfortunately, no recent time and motion studies with mental health practitioners are available. However, time and motion studies of the work of accident and emergency doctors (Brown, 2000) and general hospital nurses (Burke et al., 2000) suggest that even in high clinical demand environments approximately a third of the activity of clinicians is non-clinical.

Early observational studies (Siegel et al., 1983; Foster & Williams, 1989) and more recent self-report studies (Stuart et al., 2000) of the activities of mental

health professionals suggest that the proportion of non-clinical work activity in the mental health workforce is likely to be even higher. Stuart et al. (2000) found that nearly two-thirds of the work of 330 inpatient and community mental health nurses employed in a US public mental health service were in non-clinical activities (evenly distributed across clinical communication, management and clerical tasks). They also found that respondents expressed a preference for a higher proportion of clinical and lower proportion of non-clinical activities.

As the model presented in Figure 2.1 suggests, knowledge of work activities alone is insufficient to appreciate workload. For example, performing a mental state examination is a common clinical activity for a mental health practitioner. However, a mental state examination with a co-operative client is a completely different experience from a mental state examination with a hostile or paranoid client. The client profile is therefore an important element of workload. Similarly, the type of intervention will have a major impact on workload. Monitoring medication is relatively less time consuming than intensive psychosocial rehabilitation. Client characteristics and intervention effects may be formally recognised as workload variables in specific models of practice. For example, teams that employ the Assertive Community Treatment model (Allness & Knoedler, 2003; Salyers et al., 2003) specify a low client to staff ratio to ensure that provision of intensive services to a highly disabled client group is feasible. However, in a routine practice environment, evaluation of workload requires consideration of both client profile and interventions provided.

At the level of the individual practitioner, management of workload means addressing the subjective experience of workload in the context of the clearest possible understanding of the objective components. Responding effectively to a grievance about workload requires that the manager is able to recognise that a practitioner feels overburdened while at the same time being able to look objectively at the work activities that are the source of burden. Grievances may be about perceived inequity of workload as distinct from the absolute burden of workload. This means that managers need to be in a position to benchmark the workload of the individual practitioners against the workload of others working within the service and also to benchmark typical workload within a service against workloads in broadly comparable services.

Workload, work-related stress and work quality

Effective management of practitioner workload is a key role for the team leader or service manager. Workload affects both the well-being of the practitioner (Cushway et al., 1996) and can also impact on the characteristics and quality of services provided to clients (King et al., 2000).

Cushway et al. (1996) identified workload as one of seven key sources of stress for mental health professionals and specified the following components:

- too much work to do
- too many different things to do

- not enough time to complete tasks
- too many clients
- long hours
- not enough time for recreation.

These are clearly inter-related and are also linked with some of the sources that Cushway et al. (1996) linked to home/work conflict:

- taking work home
- not enough family time
- no time for social relationships.

A study of 187 community mental health case managers in Victoria, Australia (King, 2007), found that responses to these items were closely correlated. Respondents were most likely to report that the global item 'too much work' applied to them, followed by 'too many different things to do', 'not enough time to complete tasks' and 'too many clients'. Respondents were least likely to report that 'taking work home' applied to them. This probably reflects the nature of the work in that much of it revolves around client contact and even the paperwork component requires access to secure confidential files that will normally not be taken home. In this study (King, 2007), workload was the single greatest source of stress for participants – although this has not always been the finding when this measure has been applied with samples of mental health professionals (Cushway et al., 1996; Lloyd et al., 2005). Stress associated with lack of resources and conflict has also been prominent in other studies.

It is well established that the mental health workforce experiences moderately high levels of work-related stress as indicated by scores on the workload subscale of the Mental Health Professionals Stress Scale (MHPSS, see above) and scores on the emotional exhaustion subscale of the Maslach Burnout Inventory (Lloyd et al., 2002). However, teasing out the sources of high stress and identifying the role of clinical workload has proved to be more difficult (Carson et al., 1996). Walsh and Walsh (2002) found that neither the number of clients nor most of the characteristics of clients reliably predicted stress among professionals (although there was evidence that having a higher proportion of male clients and a higher proportion of psychotic clients increased risk). It is possible that the non-clinical components of workload are a greater source of stress than the clinical components (see Chapter 10 for more detailed discussion of stress in the mental health workforce). Furthermore, when a person is feeling stressed, even though work may not be the primary cause of the stress, work is likely to feel more burdensome.

While high workload does not always result in increased stress, there is evidence it does impact on the quality of work done by mental health professionals. King et al. (2000) surveyed mental health case managers in Australia, using a measure of self-efficacy for a range of standard case management activities. Self-efficacy measures ask people to rate the extent to which they are confident in being able to do a given task. There was evidence of a significant linear rela-

tionship between caseload and overall self-efficacy, such that as caseload rose, self-efficacy tended to fall. This relationship was especially clear when caseloads exceeded 28. At higher caseloads, case managers reported they were less able to engage in activities such as visiting clients in hospital and home visiting. Faced with higher caseloads, case managers may attempt to work harder and may work unpaid hours in an attempt to maintain a standard of care but it more likely they will modify the work role and reduce it to the most essential components. This may mean becoming less proactive and less therapeutic, with activities reduced to a minimal monitoring regimen and responding to demands.

It should, however, be noted that, while lower caseloads may enable case managers to undertake a higher range of activities or to provide services more intensively, it cannot be assumed that more services result in better client outcomes. A survey of randomised controlled trials comparing intensive case management, characterised by small caseloads, with higher caseload standard case management (King, 2006), found no evidence of clinical or psychosocial benefits for those receiving higher intensity services.

What this means is that consideration as to what is a reasonable caseload for a community mental health practitioner must take into account a range of considerations. Among these are the well-being of the practitioner, the kinds of services that the practitioner is expected to provide and the likely impact on client outcomes. High caseloads are likely to result in limited reactive services while very low caseloads may mean inefficient utilisation of resources.

Measuring and managing workload: standards, processes and tools

Because of the salience of workload to the well-being of staff and to the quality of services provided to clients, it is important that service managers are able to monitor and adjust workload both to achieve optimal equity and also to make reasonable decisions about resource allocation. As indicated at the beginning of this chapter, workload is complex, being influenced by the volume and characteristics of clients, non-client demands and other considerations such as travel requirements, stage of treatment and the experience of the practitioner.

Inpatient services typically operate with fixed ratios between staff (especially nursing staff) and beds. Ratios vary according to the form of treatment and type of patient with acute intensive care units having higher staff to patient ratios than standard acute units, which have higher ratios than rehabilitation units. However, the presence of standard staffing ratios does not necessarily result in equivalent workload for nursing staff, even when units have nominally equivalent staffing ratios. There are several reasons for this:

- acuity and other patient-related workload factors are quite variable
- workload of more senior or experienced staff is adversely affected by higher proportions of inexperienced or lesser qualified staff
- services often have difficulty recruiting a permanent workforce and rely heavily on casual or agency staff

- workload of the nursing staff may be significantly influenced by the presence or otherwise of allied health staff.

Ryan et al. (2004) in a survey of 93 acute mental health units in England found that although there was a nominal nursing/bed ratio of 1:1 across all units, the actual ratio was 0.51:1 and there was substantial variability from unit to unit. The shortfall reflected an average of 12% vacancy rate among positions for fully trained nurses plus chronic funding shortfalls in many services. Shortfalls were often met through employment of untrained staff, which the authors pointed out increases the work burden on trained staff because of the tasks untrained staff are unable to perform. Because funding is tied to beds and bed occupancy is usually high, there is limited scope for a unit manager to control or adjust the clinical workload of inpatient nursing staff. As a result, units can enter into a 'vicious cycle', in which vacancies and employment of unqualified staff or agency staff increase workload on qualified staff leading to resignations and increased reliance on unqualified or agency staff.

Ryan et al. (2004) suggest that there are few ready solutions to the challenge of inpatient nursing workload because of shortages of trained mental health nurses. These shortages are international and expected to worsen (Roche & Duffield, 2007). As a result, Ryan et al. (2004) suggest that effective management of the clinical workload may ultimately require services to rethink the composition of the inpatient workforce, giving consideration to the use of non-professional staff including consumers and carers. However, in the light of the evidence presented earlier in this chapter, that up to two-thirds of the work activity of an inpatient mental health nurse is non-clinical, one of the most effective means by which a unit manager can reduce workload might be to streamline non-clinical activities.

Community mental health services present different challenges, with workload management being more difficult in some respects but with greater scope for active management in other respects. The major difficulty is that, whereas the number of available beds is a natural work limiting factor in inpatient services there is no equivalent limiter for community services. The closest equivalent to the nurse:bed ratio in inpatient services is the average caseload of community mental health practitioners. The international evidence suggests this is highly variable and dependent on type and location of service. In a review of studies published since 1999 that compared intensive case management with standard case management, King (2006) reported that caseloads for intensive case management ranged from eight to 15 and caseloads for standard case management ranged from 20 to 68.

Within standard case management the high level of variability is probably a function of local norms, staffing (funding) levels and practice models. At the lower end, Hromco et al. (2003) reported that case managers in Oregon had median caseloads of 23 in 1992 and 30 in 2000. This is consistent with an Australian study (King et al., 2000), which found case managers had caseloads of 22 per equivalent full-time case manager. In the mid-range, Hannigan et al. (2000) reported mean caseloads of 37 for community mental health nurses working in Wales. A later

study by Nolan et al. (2004) found similar caseloads in two English mental health NHS trusts. At the higher end, McCardle et al. (2007) reported mean caseloads of 61 for community mental health nurses working in Ireland. This is consistent with anecdotal reports provided to the author by services in western Canada.

This suggests that it is difficult for a service manager to use international benchmarking as a means to setting caseload levels. However, we think there is reasonable consensus that the lower end of caseload range is desirable and some empirical evidence to suggest that lower caseloads are likely to result in superior services. More than 25 years ago, Intagliata (1982) suggested that if case management was to be anything other than reactive caseloads in the range 20–30 were desirable so as to enable service planning, support for families and carers and liaison with other services. Subsequent research by Baker and Intagliata (1992), Onyett (1992) and King et al. (2000) have lent support to Intagliata's (1982) proposition.

Although managers of inpatient services have limited capacity to adjust the clinical workload because it is directly linked to the bed ratio, managers of community services can more actively manage the clinical workload by monitoring and adjusting the caseload of team members. Community services usually have a discretionary range for both intake and discharge of clients and can actively manage changes to total caseload. There is then scope to manage the distribution of caseload among team members.

There are two broad approaches to monitoring and adjusting individual caseloads. One might be termed informal and involves the manager or team leader making judgements based on observation of and interaction with team members. This could be supported by very basic quantitative information such as the total number of clients for which each practitioner is responsible or the total number of clinical contacts or contact-hours. The other involves the use of tools or algorithms and attempts to manage complexity by measuring the variables thought to be important and calculating the workload of each team member after taking into account each of the variables.

A variety of workload tools have been used in both general health (Baldwin, 2006) and mental health settings (King et al., 2004). While workload management tools offer the potential benefit of reducing errors associated with human judgement by integrating a complex range of factors to yield a single numerical score, they have been criticised on the grounds that they fail to capture or distort key elements of the practitioner–client relationship (Forchuk, 1996) or that information yielded is unreliable because it is inaccurately or incompletely compiled (Baldwin, 2006). It has also been pointed out that when workload tools substantially rely on practitioner reports of client contact rates, there is risk that practitioners will over-service 'easier' clients to maintain a caseload that appears high but is not well targeted (King et al., 2004). Examples of caseload management tools used effectively in mental health services can be found in Meldrum and Yellowlees (2000) and King et al. (2004).

In an evaluation of the implementation of a caseload management project across Victoria's community mental health services, King (2007) found that most service

managers used informal means of monitoring and adjusting the caseloads of team members. They frequently relied on information provided in team meetings or supervision meetings and caseload was often managed more by the practitioner indicating availability to take on new cases than by active intervention on the part of the team leader or manager. King (2008) found that, for the most part, practitioners were satisfied with this approach to caseload management. Even when required under an industrial agreement to introduce a more formal caseload management system that made use of tools or algorithms, services tended to continue to rely substantially on informal approaches. Among those who trialled more formal methods, some abandoned them because of the workload implications of the data collection or because of poor compliance with data collection by key service personnel, while others found them very useful, especially in providing a framework for supervision meetings with team members. One benefit of the use of algorithms or other standardised approaches to caseload management is that it enhances transparency. This means there is reduced risk of actual or perceived unfairness in allocation of cases.

Team leaders and service managers may need to think about workload management at a team level as well as at an individual level. It is not unusual for a team as a whole to feel overburdened and overworked. This may reflect broader morale problems or may be an indicator that the team needs to collectively rethink its approach to the work at hand. The role of the team leader or service manager in such circumstances is to assist the team to identify the source of the problem and to find workable solutions. This may be moderately time consuming but, unless the problem is very simple, is likely to be more effective than a solution based solely on the team leader's assessment and imposed from above.

Conclusion

Mental health workload is a key issue both in management of the individual practitioner and management of the total service. Mental health workload is made up of both clinical and non-clinical components, with the available evidence suggesting that more than half of the work activity of the average mental health practitioner is devoted to non-clinical activity. Non-clinical activities are often linked to clinical activities so the total workload will be related to clinical demand. However workforce supply factors can also impact on workload when there are high vacancy rates. In inpatient services, clinical demand is associated with the staff to bed ratio, whereas in community services, caseload provides the best general indicator of clinical demand. Clinical demand is not a function of numbers alone and will also be influenced by both client characteristics and clinical interventions utilised. In managing workload, team leaders and unit managers need to identify where there is scope to control clinical demand factors and where there are opportunities to streamline non-clinical activities. The use of standards and tools can assist in decision making.

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Chapter 3
Clinical information management

Jennifer Harland and Janette Curtis

Chapter overview

Clinical information management is increasingly important in healthcare delivery. The probable reason that you have turned to this chapter is because someone has mentioned 'datasets' or 'standardised measures' and although you nodded knowingly at the time, in actual fact you are struggling to understand how and why this information is important to you and your unit. You are not alone. Managers in mental health come from a range of backgrounds, so have a variety of experience with clinical information management. This chapter will give you the theoretical fundamentals you need and, through the use of case studies, highlight how you can integrate this information in practice. It is important to note that this chapter is concerned primarily with the management of data systems, although references are provided for exploring information management systems that will assist clinicians in working individually with consumers of the health service.

Introduction

Mental health managers and clinicians face similar issues to managers in other areas of care. It is seldom that the words 'clinical information management' sparks joy and excitement. Deliberating over tables and sets of numbers often seems to merely distract from direct patient care. However, health informatics is central to good patient care and provides important links between what could appear abstract and time-wasting managerial activities (Katona, 2002). In fact the rising costs of healthcare is causing great concern, and information technology is viewed as an enabler for introducing efficiencies into the health system (Dogac & Kashyap, 2005).

From both a quality and security perspective, the integrity of clinical information is critical to patient care. Due to changes in politics, government legislation and reforms, managers need to be equipped with the necessary tools and skills to be able to lead and manage effectively (Phillips, 2005). Managers also need to be confident that electronic patient records are secure and information is kept confidential (Osborne, 2006). Understanding the databases that you use is crucial to increase this confidence.

Information technology is capable of transforming healthcare organisations and delivering measurable value (Mahoney, 2002). Practitioners, case managers, consumers and policy makers are increasingly basing their healthcare decisions on timely and relevant clinical data (Connolly, 2002). Increasingly, there is a need to offer 24-hour access to services and towards this end, in the UK, the government granted the National Health Service (NHS) six billion pounds to 'revolutionise its computer systems' (Toofany, 2006). NHS Direct is one such initiative which consist of a sophisticated telephone service staffed by nurses who can give information and advice as well as dealing with emergency calls 24 hours a day (Bloomfield & McLean, 2003).

Historical perspective

Simpson (2003) outlined a history of clinical information systems that many of us will remember with varying degrees of enthusiasm. Diagnostic Related Groupings (DRG) was a reimbursement-centred strategy in which providers had to justify what they did by proving it produced an outcome worth paying for. However, it soon became apparent that the information system could not collect enough patient data or the type needed to truly analyse and justify care.

As a result of an increasing emphasis on patient-centred care, patient-centred clinical information systems were developed but many professional groups were slow to embrace technology. In addition, such systems were designed with little input from groups such as nurses. As a result nursing interventions went unrecorded and unrecognised (Simpson, 2003). This is gradually being rectified with the emergence of numerous systems aimed at capturing what it is that nurses and other healthcare workers actually do. There is now an awareness of the importance of involving clinicians before and during the installation of data systems and offering ongoing training and support (Venkatesh & Davis, 2000).

Why is it important to manage clinical information?

Information management is one of five key areas of Quality Improvement or Performance Improvement. The other four areas are: people, infrastructure, work processes and culture (Nash & Goldfarb, 2006). Systematically collected patient information can be analysed and used at local, organisational and national levels and allows information to be available to inform mental health service management (Katona, 2002).

Measuring and quantifying the outcomes of care are essential activities for the ongoing operation of mental health facilities. Centres need a data collection system to collect meaningful data that assist with the development of programmes and services, measure clinical outcomes and promote health policy. Accomplishing these objectives is especially difficult in mental health settings. When tracking the care process over time, it is possible to drown in the data, especially qualitative

data. Leonardo et al. (2004) suggested that to be successful, nurse-managed health centres and all providers must systematically evaluate their data and information needs, as well as available systems, and then implement an action plan. Systems are available for accessing medical advice immediately, managing caseloads (Stuttle, 2006), booking appointments, accessing records (Parish, 2006), bringing different datasets together (Lee, 2006), reducing waiting times (Dogac & Kashyap, 2005), prescribing and tracking prescriptions (Kaufman, 2007), conducting clinical trials (Enman, 2006), reducing staffing costs (Tachakra et al., 2006) and telepsychiatry (May et al., 2001) as well as many other functions.

The key challenges of clinical information management

For the majority of clinicians the term 'information technology' is vague and often met with a look of disdain. Their primary concern is to deliver effective, high-quality care to patients. However, consideration of two aspects of modern mental health services draw attention to the information challenge for clinicians (McClelland, 2002). One challenge is the variability in healthcare practice evident in diagnosis, treatment plans and management strategies. One of the major sources of such variability is a lack of readily accessible information on best practice (McClelland, 2002). A second information challenge is that care within mental health services involves multiple contacts with different professionals across a variety of settings. Effectiveness of clinical care depends on the collection, exchange and transfer of information between clinicians and other services in a flexible form at each and every point of patient contact (McClelland, 2002).

The use of computers in behavioural healthcare has evolved in a steady fashion over the past decade with a veritable explosion in technology in the past few years. Consequently, the behavioural healthcare industry is witnessing an unprecedented capacity to quickly access and process enormous amounts of information (Meredith et al., 2000). Collecting, storing, analysing, interpreting and reporting clinical data promise to dramatically affect the design, delivery and scope of behavioural healthcare services. Computer technology not only facilitates the practice of behavioural healthcare, it also forces change in the delivery systems themselves. Consider the following case study.

Members of a mental health assessment team were informed that a new computer triage system was to be installed. It had been developed by a computer programmer and was based on the Mental Health Outcome and Assessment Tools (MH-OAT; standardised forms used to collect patient information across New South Wales in Australia). This raised a number of questions within the team:

- What training would be provided?
- Had it been tested?
- When and how would it be installed?
- What would happen to the current database?
- How would the information be merged?

One of the clinical staff members who had previously worked as a business analyst raised concerns about the level of testing the new system had been through before the 'go-live' day. After numerous meetings the following plan was implemented:

- The clinical staff member (the tester) with experience both in mental health assessment and system analysis was removed from her current role within the mental health inpatient unit to work in the assessment unit.
- Her role would be to test the new program as part of the assessment team.
- The predicted timeframe was three months.

At the beginning of the testing phase it was found that the system crashed frequently over the first three weeks. Each time this occurred an error report would be generated and the computer programmer would be notified via email and the problem would be fixed. During the testing phase, the triage/assessment information had to be entered twice; once on the old system and once on the new system. This affected workloads as the tester was included in the assessment team numbers, not as supernumerary support. Over time, modifications were made and error reports declined. All staff were trained on the system prior to the official 'go-live' day, six months after the initial testing. The training consisted of one full day training for all intake staff and ongoing support as required. This included the development and distribution of training and user manuals. The staff's level of computer experience varied considerably and extra computer training was offered. Night staff were trained during their shift with the tester providing support.

Measuring the efficacy of the system was important. As part of the audit process the assessment team's clinical nurse consultant (CNC) met with the community team once a month to discuss the quality of the information collected in the assessment form. This included a random audit as well as the opportunity for community staff to bring along examples of completed assessment forms that required further clarification. This information was fed back to the assessment team by the CNC; necessary changes were implemented, thus closing the quality loop. The tester returned to the inpatient unit 12 months later when all staff were confident with the system and her support was no longer required. On reflection, the tester offered the following advice when considering introducing a new clinical information system:

- There is need for user input throughout the development of any clinical information system.
- There is need for 'buy-in' from all levels.
- Be mindful of effects of change on staff. They need to be informed about:
  - why the change is being made
  - how it will affect clinical management
  - what the perceived benefits to client care are
  - what is expected of the staff
  - what is the ultimate goal.

Making it work for the mental health unit

A crucial set of ingredients for effective information management is the necessary professional skills and understanding in information management, a valuing of information and recognition of the importance of information and information sharing. Learning about clinical information management needs to be embedded in clinical practice and integrated into education and training for all staff. Be aware of your staff's expertise and use all available resources. The best resource when implementing a clinical information system is a data information manager.

The clinical information/data manager

Most mental health facilities have a clinical information or data manager attached to them in some capacity. The data manager has an intimate knowledge of the unit's data information systems and will be able to advise on how to manage it for the best outcome. The data information manager can explain the meaning and relevance of standard data reports and will be able to advise about generation of unique or specific reports.

The data information manager should be involved in all decisions with regard to the development, purchasing and implementation of any information system. They will be able to advise on which systems 'talk' to each other and whether your investment of time and money is a sound one. Consider the following example.

Staff in a methadone unit were keen to install an automated dispensing device. Following considerable research they purchased one worth Aus$100 000. The machine not only offered automated dispensing but also would store and supply information about the clients and alert staff for key information regarding follow-up, etc. The company offered in-service and ongoing support. The unit did not include the data information manager in the process. Once the automated device was installed the data information manager was contacted to resolve an issue. When the data information manager assessed the issue they realised that the new machine could not 'talk' to their current information system. Although the staff could still use the machine it was not working at its full potential because data had to be entered into both systems separately. If the data manager had been involved in the purchasing process they could have alerted the buyer early and looked at different options.

If you do not have the luxury of a data information manager in your unit, the following ten tips from data information managers are worth considering:

(1) Spend time getting to know your information system. This may mean investing in a course to understand the capabilities of the system.
(2) Remember that the data you extract is only as good as the information you put in. Taking the time to set the data collection fields to the specifics of your needs is essential.
(3) Ensure that all staff are trained in the information system. This may include understanding basic computer technology or finding experienced staff who can support and educate others.

(4) Remember that any field you enter has the capacity to produce a report and this information can be as large or specific as needed.
(5) Look for interesting ways to use the data to guide practice. For example when looking at demographics and drug use there may be a trend of adolescents using cannabis in one particular suburb. This information could be used to look at what current youth and drug and alcohol services you have in that area.
(6) Know and understand the reports generated. They are not just random numbers but can highlight trends, gaps in service and areas for further development.
(7) All new staff members need full orientation to the clinical information system. This may be by either spending one-on-one time with the data manager, using a web-based package or teaching package.
(8) Consider building the use of information systems into staff performance appraisal criteria.
(9) Embrace technology, understand it and customise it for your own purposes.
(10) Identify and support clinical information management 'champions'.

Confidentiality in clinical information systems

An issue often raised with clinical information systems is confidentiality. While many methods have evolved for ensuring the *actual* security of electronic data, it is often the *perceived* security of information that managers need to address (Caspar, 2004). Staff members may be reluctant to collect and store information for fear that it may end up in the wrong hands or the information may be used for malicious purposes. It should be emphasised to staff that in the case of an electronic medical record, access is password protected and may in fact be more secure than a hard copy file that can potentially be left in a public area. By understanding the security features in the clinical information system, the clinical manager is able to better explain these features and reassure their team members.

Ethical requirements

Research into the use of technology in mental health settings must adhere to strict ethical requirements. Researchers and healthcare professionals need to adhere to the basic Hippocratic Oath. However, there are guidelines available such as Roberts and Dwyer's (2004) concise guide to ethics in mental health that has provided solutions to specific dilemmas. Coyle et al. (2007) have built on this work and suggest that technologies are:

- based on accepted theoretical models of mental healthcare
- designed in full collaboration with mental health professionals
- designed to integrate with existing working methods
- used by clients under the guidance of a professional therapist.

Engaging staff

When looking at engaging staff in the use of clinical information management it is important to involve them in the process. This would include ascertaining your team's understanding of the process, the team's existing knowledge and experience with computers, involving the team members in the selection and development of the tools to be used, providing training in the management of the system, investing in staff with a special interest in the area, reporting back on the changes made from data collection and reporting changes in clinical practice.

The condition of data in a database

Clean data are error free or have very few errors. Dirty data have errors including: incorrect spelling and punctuation of names and addresses, redundant data in several records or simply erroneous data (not the correct amounts, names, etc.). It is vital that all data collected are clean in order to ensure reports are accurate and meaningful. A great amount of time can be wasted if inaccurate data are entered, because this results in the clinicians needing to pull clinical files again to re-enter the data. In such situations staff will become disgruntled with the process and possibly add to staff reluctance to enter data. Staff need to be trained and encouraged to collect and enter accurate data at all times. The consequences of not collecting accurate data should be highlighted.

Addressing the clinician/system gap

Many clinicians are not impressed with clinical information systems. They feel that the entering of information is another burden on their already stretched time. If this is a recurring theme in your unit it may be time to look at the processes that are in place. In one mental health unit a number of disgruntled clinicians reported that assessments were taking double the time. When these concerns were unpacked, it became apparent that they were writing down the initial assessment and then entering it into the system at a later date and time. Of course this is frustrating and also increases the risk of errors. If the clinician missed important information at the assessment, they have to rely on their memory recall or may have to go through their written notes again. If the clinician can enter the information at the time of assessment, it is more likely that the data will be accurate. To ensure clean data the system can be set up with alerts that block the clinician moving on until all fields have been entered. In some areas clinicians hand over their handwritten information to a data entry person for entering. This is far from ideal. The scope for error is large because misinterpretation of collected information may occur.

A manager must also be aware of the staff's familiarity with resources. Marcy et al. (2005) found that doctors' lack of familiarity with systems impacted on their use of resources and it was recommended that a clinical decision support system may improve knowledge of these resources if the design addresses cost, space and time limitations.

Key factors that predict clinical information system success

Much research has been done to identify the key factors that predict clinical information system implementation success. Sittig (2002) claims that over 150 factors have been identified but only two are consistently associated with successful implementation. These are 'top management support' and 'user involvement'. Sittig (2002) identified additional key elements to a successful implementation:

- 'Buy-in' of the organisation is important – all users must see the need for the change if they are to support it (Souther, 2001).
- There must be clear understanding that significant change occurs in multiple stages, and that errors in any of these stages can have devastating consequences (Kotter, 1995).
- Local champions must actively and enthusiastically promote the system, build support, overcome resistance and ensure that the system is actually installed and used (Ash, 1997).
- Senior management must be able to understand and address the challenges ahead and capitalise on opportunities for quality improvement and cost reduction (Pare & Elam, 1998).
- It must be recognised that it can take at least six months of clinical information system usage before any decisions about the success of the technology introduction (particularly in terms of individual worker productivity) can be made (Blignaut et al., 2001).

How clinical information systems can be used

Community Health Information Management Enterprise

The Community Health Information Management Enterprise (CHIME) is an operational clinical information system designed to improve service delivery, outcome measures and productivity through improved capture and management of community-based health service information. It is also intended to improve the mechanisms for reporting at the local, area, state and national levels, thereby improving the quality of community health information available and the efficiency with which it is produced.

The CHIME project is a joint venture between New South Wales (NSW) Health, Queensland Health, the South Australian Health Commission and Australian Capital Territory (ACT) Health and Community Care. The joint venture partnership was initiated in 1996 in response to common needs identified by each health authority. CHIME's mandate is to 'facilitate information management for community based health services by developing a client-focused application that delivers and obtains information from other applications'. CHIME allows community-based healthcare staff to:

- accurately document the assessment of clients
- develop individualised management plans based on best practice principles

- monitor outcomes of clinical care
- generate reports for client and management reporting.

The CHIME application benefits service providers because it has been designed to:

- assist with the development of efficient processes for recording client information across the health system. These processes help to eliminate duplicated recording of demographic data for clients.
- track referrals, appointments and service contacts.
- provide real time information, by storage and retrieval of clients' case management information. This enables information to be transferred to other community-based health professionals who are consulting with a client and enables staff to spend more time on case management.
- enable community-based health staff to develop 'clinical practice norms' and case management guidelines and measures in order to assess the effectiveness of their services.
- enable the collection of workload indicators for community-based health staff. This provides measures to assess service efficiency and costs to assist resource allocation and management.
- facilitate the introduction of a 'case mix type' classification system and benchmarking for community-based health services.

Tangible benefits for health authorities include:

- a reduction in clinician time dedicated to clerical work
- rapid responses to changing healthcare needs
- provision of multidisciplinary service delivery (e.g. specific client information is available to mental health staff from different specialties and thereby reducing unnecessary duplication)
- improved service planning and targeting
- improved understanding of the health and needs of the community
- minimising of duplicated effort and functionality
- best practice clinical pathways to provide better client care and reduce unnecessary costs
- improved management of information between (and within) each health authority
- outcome measurement.

Incident information management

Sadly, the great majority of claims by service users against hospitals and a recurring theme in incident enquiries is that of inadequate or lack of information. The emerging premise is that optimal care and treatment of patients within a modern health environment is highly dependent on the availability, quality and accuracy of information, that is, the ability of professionals to access, use and manage information about individuals and the use of information to enhance

the effectiveness of professional practice including information on whether or not actual practice makes a difference (McClelland, 2002).

The NSW Patient Safety and Clinical Quality Program was launched in 2004. The NSW Health Incident Management Policy (2006) identifies seven key issues in effective incident management:

- Identification
- Prioritisation
- Investigation
- Classification
- Analysis
- Action

The Incident Information Management System (IIMS) is a key component of the programme that incorporates both clinical and corporate incidents. All staff are responsible for reporting incidents. This includes entering the information into a reportable incident brief (RIB). The incident is given a severity assessment code (SAC) and action is implemented depending on the severity of the incident. This can range from full root cause analysis (RCA) involving independent expert clinicians for a SAC 1 incident to a local investigation for SAC 3 or SAC 4 incidents.

The analysis of information generated from IIMS can assist clinical practice by helping clinicians and managers understand how and why incidents occur and identify ways of preventing a reoccurrence. Suitable timeframes for the implementation of recommendations is documented in IIMS. Ongoing monitoring is required to ensure recommendations are addressed in a timely manner and to evaluate the success of any actions taken to achieve improvements (NSW Health, 2006).

Standardised measures

The implementation of standardised measures is part of a broad range of activities that aim to produce greater consistency and a clearer picture of the effectiveness of mental health service provision (NSW Health, 2004). The clinicians and managers need to use the information collected to inform clinical practice and the management of resources.

As outlined by the Centre for Mental Health, NSW Health Department, the use of the information collected by the standard measures and protocols can be categorised into four levels:

(1) Individual client
(2) Service unit
(3) Area health service
(4) State

Each level will have different uses for the information collected. Individual consumer reports are useful for both clinicians and consumers to monitor change and assess the effectiveness of treatments. However, clinicians or case managers

will also want information on their individual caseloads or have the ability to compare caseloads.

Most importantly all collectors and users of the information should have an interest in using the information collected responsibly and be committed to assuring the quality and integrity of the data collected. However, clinicians often voice their concern about the amount of time taken filling out forms. Consequently, they need to receive feedback about outcomes and be clear about the meaning of these reports in order to value the process and to continue to collect high-quality data. Consider the following example.

A clinician's story

I sometimes worry about the relevance of all the data we collect. It seems to be time consuming and takes us away from spending time with the clients. I remember a consumer once speaking up at a conference and saying 'this information does not measure what is relevant to a consumer'. This comment has stayed with me. I often wonder where all the collected information goes and does it actually improve patient care or are we just collecting information to justify what we do? I have also had discussions with my colleagues about the possibility that the use of standardised assessment forms can deskill the workforce. A standardised assessment form may be a useful guide for beginning practitioners but it may limit the development of their own assessment skills.

It is often hard for clinicians to complete all the parts of the forms. We are audited and our completion rates are measured. Our unit used to have trouble reaching the 85% completion rate benchmark. I think this was because a lot of staff could not see the relevance. However, our completion rate increased dramatically once a 'champion' was identified. This person was trained in the field and was able to answer all questions. They were motivated and as a result motivated others to complete the forms. This has had a real flow-on effect and we have consistently exceeded the 85% benchmark in recent audits.

I now realise the information collected is useful for providing a snapshot of the client at admission and this is a helpful reference point when measuring progress and planning for discharge. I have found that the information is useful when planning care with the community team as we can measure the progress of the patient.

Mental Health Outcome and Assessment Tools

MH-OAT is a NSW state-wide initiative to strengthen the mental health assessment skills of clinical staff. The project involves the implementation of uniform assessment protocols and outcome measurement tools across the state. The aim of the MH-OAT initiative is to ensure that:

- clients are accurately assessed and provided with appropriate interventions
- the mental health assessment skills of all direct care clinical mental health staff involved in conducting assessment is strengthened

- all area health services conduct, record and report the mental health assessments and standardised measures in a comprehensive standardised way.

Most health services have implemented a computerised clinical information system to support MH-OAT. Clinicians can enter and view client information directly from the workplace. A clinical information support officer generally co-ordinates the implementation and management of MH-OAT-related protocols throughout the area mental health service. The collection protocols are the rules that guide the standardised collection of outcome measures throughout the state. The protocols serve as guidelines so that clinicians know what measurement tool to use and when to use them.

There are several ways that such information can be used.

Consumers

- Self-assessment information can be used to inform and empower consumers to monitor their own progress.
- Self-assessment information empowers consumers to become more actively engaged in their own treatment.

Clinicians

- It supports individual treatment planning.
- It supports case management activities.
- It supports the monitoring of progress by tracking of consumer scores on standard measures over time.
- It supports the revision of treatment plans.
- It identifies consumers who might benefit from additional/alternative approaches.

Clinical supervisors, team leaders, nursing unit managers

- It supports better understanding of service usage patterns and their relationship to outcomes.
- It involves clinicians in the identification of service gaps and the effectiveness of services.
- It supports clinical supervision by providing a focus for review.
- It supports human resource decisions including continuing education opportunities.
- It supports evidence-based clinical quality improvement.

Addressing the needs of clinicians

Most clinicians are largely unaware of the information that is collected and held in health information systems (e.g. Greater Metropolitan Transition Taskforce, 2004). Certain specialties have more advanced clinical data systems, but the

information is rarely sufficiently detailed to meet clinicians' needs, nor are reports available as needed. Local clinical data on patients' treatment and outcomes have been kept by clinicians, but few have had the necessary resources available to capture all the information on which to base clinical judgements and decisions. Ideally clinicians would like a system which ensures:

- all of the data considered useful for a particular clinical group is defined and captured in accordance with clinical and business processes
- data entry and management are accurate and efficiently maintained
- patients' pre-admission information is captured
- post-discharge information on patient outcomes, readmissions, etc. are captured
- there is a common data format
- all sites have the IT hardware, software and systems infrastructure required and that these are compatible with area health service and state health systems
- all clinicians receive the necessary training to access, analyse and capture information
- hospital systems are changed so that capturing patient data becomes an integral part of the episode of care from admission to discharge
- there is scope to interrogate data gathered over time, i.e. to turn 'data' into 'information'
- timely reports on clinical incidence, prevalence, distribution, treatments, outcomes, etc. are provided through shared information processes.

Most clinical groups have expressed the view that more funded data manager and data entry positions are needed to achieve these objectives. In the case of the information systems in the Greater Metropolitan Transition Taskforce (GMTT), as the programs evolved, it was clear that each clinical programme had significant information management needs. Many of the programs created a position for a data manager. Depending on the scope of the work to be undertaken, appointments varied in term from short projects to permanent positions. Enhancing the clinical information capability within each program was a significant focus.

Improvement in clinical data gathering and promptly relaying back meaningful outcome information to clinicians was slow to achieve. The GMTT found that over time, providing clinicians with support to address their information management needs not only helped to provide clinicians with vital feedback about the outcomes of their patients and about their practice, but also informed patients about their choices. Information on the efficacy of different treatment modalities, the relative risk of procedures undertaken in different hospitals, health outcomes resulting from conservative versus aggressive approaches to care were also thought to be of great interest to the public. As more clinical data became available there was scope for greater transparency in the provision and outcomes of health services.

The manager has a major role to play in these processes. They may need to advocate for additional training and additional data managers to support ongoing development and training of staff as well as working with staff to identify

what their data feedback needs are. For example, what continual reporting information is needed, what one-off reports are required. Managers need to take responsibility for accessing information and reporting back to staff during team meetings. They also need to support staff in learning how to access this information so that they can generate their own reports.

As stated earlier in this chapter, managers need to be aware that there are many applications that are suitable and designed for individual client information and therapy. While the following list is not exhaustive, it does touch on some of the individual types of therapies and provides additional references that the manager can follow up as needed.

Computers in talk-based mental health interventions

The cost to society of mental illness is substantial. Computer-assisted mental health interventions have the potential to assist in improving treatment and offering cost effective interventions. It is outside the scope of this chapter to go into great detail, but it is important that mental health managers are aware of some of the programs that are currently available.

Electronic contact and online information sources

Email, videoconferencing, text messaging and other information sources are a natural extension of traditional face-to-face therapy. In addition, websites providing psycho-educational information have mushroomed over the past decade (see Heinlen et al. (2003) for examples).

Computerised questionnaires for assessment, diagnosis and outcome monitoring

Computerised versions of psychological questionnaires have been validated for specific conditions against paper-based interventions. Many of these programs can be used from any internet-enabled device (PCs, laptops, personal digital assistants (PDAs), mobile phones) (e.g. see Butcher, 2004; Percevic et al., 2004).

Computer-supported treatment

Many DVDs are available which use multimedia and cover the core self-help elements of cognitive behaviour therapy (CBT) (Wright et al., 2002). More recent studies have explored the potential of PDAs in computer-assisted therapy (Przeworski & Newman, 2004).

Stand-alone treatments

Stand-alone computer therapy systems do not aim to fully remove human intervention, but rather they aim to minimise the required contact time (see Proudfoot et al., 2003a, b).

Virtual reality treatments

Virtual reality exposure and systematic desensitisation are both widely used in the treatment for many anxiety and panic disorders. Virtual reality is often used in conjunction with CBT (e.g. see Weiderhold & Weiderhold, 2004).

Therapeutic computer games

There are many therapeutic computer games aimed specifically at adolescents and young people. *Personal Investigator* is a non-biofeedback three-dimensional computer game which incorporates a solutions-focused therapy (Coyle et al., 2005).

Future directions

Improving technology will continue to change how care is planned, delivered and documented (Peth, 2004). The growing demand for information is juxtaposed with the technological status of today's behavioural healthcare providers (Freeman, 1999). Healthcare facilities will always aspire to improve the quality of care and service while simultaneously reducing costs.

Willmer (2005) recognised that professions such as nursing must deal with increasing use of information technology in day-to-day operations. Patient admissions and discharges have been held on computer databases for decades. Education must therefore reflect this need and encourage student and newly graduated nurses to acquire advanced skills in information and communications technology. Willmer's literature review confirmed that success in this area requires sound change management, an understanding of national health service culture, and effective people leadership skills. One such initiative is the use of a Nightingale Tracker, where nursing students use a computerised clinical communication system to document client care, electronically transfer clinical information to their instructors, and maintain a systematic method for storing clinical data for further use in programme planning, prediction of healthcare trends, and other research endeavours.

French (2005) studied factors influencing research use in nursing and found that wider skills than information management are required. French's research looked at the additional skills required for clinical nurse specialists to put evidence-based research into practice, including being aware of the informal cultural work of organising, facilitating, and maintaining links across professional, team and organisational boundaries.

Slawson and Shaughnessy (2005) discussed the need to teach the applied science of information management along with, or perhaps even instead of, teaching the basic science of evidence-based medicine. All students, residents, and practising physicians need three separate skill sets to practise the best medicine: foraging 'keeping up' tools that filter information for relevance and validity; a hunting 'just in time' information tool that presents pre-filtered, quickly accessible information at the point of care; and the ability to combine the best patient-oriented evidence with patient-centred care, making decisions by placing the

evidence in perspective with the needs and desires of the patient. Practising medicine requires life-long learning, so students and residents must be prepared with these information management skills.

Conclusion

Incorporating best evidence into the real world of busy clinical practice requires the applied science of information management. Clinicians must master the techniques and skills of finding, evaluating and applying information at the point of care. This information must be valid and relevant to both themselves and their patients. Technology marches on. As mental health professionals we need to become familiar with new systems that become available at an amazing rate – systems that will make it easier to collect data and allow the services offered to patients to be better planned and more effective.

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Chapter 4
Budget management

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Chapter overview

Resources are an essential requirement of any service or initiative. This encompasses both financial assets and human assets. A budget is a tool to assist managers in managing resources and achieve the mission and goals of the service. It comprises an estimate of intended expenditure and should balance with the actual amount of resources available.

A budget is defined as

> 'a systematic means of allocating financial, physical and human resources to monitor progress towards organisational objectives, help control spending and predict cash flow'
>
> The Australian National Audit Office (2000, p. 31)

Budgets do not stand alone and should be closely linked with organisational strategic planning and governance structures. This chapter aims to provide an introduction to the skill of budget management, in the context of managing a mental health service or team.

Budget management context

Legislation and financial management standards

Numerous pieces of legislation, standards and accounting practices apply to the management of finances. In Australia, as in many countries, these exist at both a state or local level and at a national or Commonwealth level. The detail of legislation may vary across jurisdictions, but generally include acts to define behaviour in relation to financial administration and audit (Queensland: Financial Administration and Audit Act 1977; Australian Financial Management and Accountability Act 1997), tender and procurement standards (Australian Government Procurement Policy Framework, 2005), and taxation acts. Professional accounting standards and practices ensure that specific financial data collection, analysis and reporting are consistent and comply with public expectations of accountability and transparency. While a detailed understanding of these is not required at the service level, awareness off the existence of these things is appropriate. For example, changes in fringe benefit taxes, superannuation plans and approaches

to depreciation need to be considered when the annual budget is being developed. A properly trained and qualified financial accountant can advise on the interpretation and application of these things.

Funding models

From an international perspective the prevalence rates for the majority of psychiatric disorders are fairly consistent, however, different health systems identify different levels of need for mental health services, allocate different levels of funding and choose different ways to deliver them (McDaid et al., 2005).

Funds for health services come from a variety of sources. In Australia, the main sources of funding for mental health are from the Commonwealth and from the state governments. Insurance providers are a significant player in the private sector. Mental health services are provided through inpatient, hospital-based and community-based services, across all age groups, and a range of funding sources may exist in a manager's area of responsibility. The separation of mental health funding from physical health funding in some countries also poses challenges as to the optimal service delivery model (Druss & Newcomer, 2007).

Funding models for mental health services may include the following:

- Appropriation funds allocate money from treasury to a specific department for a set range of services on an annual recurrent nature. This includes core services such as inpatient beds, outpatient clinics and services (for example). Appropriation funding follows an annual cycle and is driven by the federal and state or area treasury budget process. Behind this are the negotiations which occur in Australia (for example) at a Commonwealth and state level, specifically around the Australian Health Care Agreement 2003–2008, and the National Mental Health Plan 2003–2008 (Australian Health Ministers, 2003), and regulatory requirements (Australian Health Care (Appropriation) Act 1998; Appropriation Act (No. 1) 2005–2006).
- Special grants and initiatives allocate money for a specific range of initiatives to be delivered within a defined time. Special initiatives for rural and remote services are an example of this and the national policy agenda will have a direct bearing on articulating priorities.
- Capital grants include funds targeted at a specific item such as a building, facilities or equipment. These may be by annual appropriation, such as depreciation, or one-off allocations such as funding for a new information management system.

While it may sound elementary, the budget manager does need to understand the nature of the funding to be managed as specific reporting and allocation strategies may be required. An activity-based model may require dollars to be matched with episodes of care and direct client costs such as medications. A specific programme initiative can request information to be collected on a number of clients from a particular demographic, or moneys spent on specific interventions (e.g. counselling services or rehabilitation programmes). Funds for a particular

programme can be time limited, with a requirement that unspent funds are returned. In other instances these can be rolled over to the next financial year, or reallocated internally depending on service demand. The service delivery framework, particularly one that has a goal of service integration, might receive financial support from a variety of sources. In these situations, the funding bodies frequently require reporting on their component only. Implicit in this is an accurate understanding of who funds what, their outcome intentions and reporting requirements. A budget analysis is an integral part of any programme evaluation.

Responsibilities and accountabilities

As a budget manager the responsibilities are large, yet often dismissed. Unless one is running their own business, the funds managed will belong to someone else. This may be the government, the insurance provider or, ultimately, the tax payer. Most organisations will have a defined list of financial and human resource management delegations which state the amount of expenditure, or type of employment agreement that a position can approve. This is one way that agencies manage their financial risk. The authority to approve tenders or purchase external services such as consultants may be restricted to specific positions. So while a manager of a unit might have the money in the budget, he or she may not have the delegated responsibility to purchase particular items.

It is suggested that managers should be clear about what their responsibilities and accountabilities are, including documented delegations. An informed discussion with the direct supervisor and/or financial controller can help clarify and manage expectations, and limit personal risk.

Ethics

Being a budget manager is not only about managing the budget but also about managing a service and meeting client needs. A particular challenge is the ethical dilemma of managing costs of services in an environment of high demand. In addition to this, people with mental health disorders are disproportionately represented in lower socio-economic groups, are highly vulnerable, and may require care over a longer period time (Amaddeo & Jones, 2007).

The Australian federal government's Charter of Budget Honesty Act 1998 states that 'it is the right of the Australian people to be fully informed about the current state of the Government's finances and the future outlook'. This legislation is one of the drivers and underpinning elements for transparency and accountability in government financial management in Australia and there are similar pieces of legislation in other democratic countries.

Budget definitions

The two models of accounting are cash accounting and accrual accounting. Accrual accounting is more commonly used in health services (Zelman et al., 1998).

Cash accounting

Cash accounting is a system of accounting in which revenues are recorded when actually received and outlays are recorded when payment is made.

Accrual accounting

In accrual accounting revenue and expenses incurred in the same period are matched. The manager places an order for a new photocopier, which takes a month to arrive, and it takes another month for the finance department to process the payment. The cost or liability for the photocopier is recorded on the day the order is placed. Accrual accounting enables the manager to get a day-to-day picture of the current budget status and to plan expenditure accordingly.

Revenue or allocation

The revenue or allocation is the portion of money assigned to a particular service or unit. This is the bottom line and specifies the resources available to operate a service.

Expenditure or costs

Expenditure is simply the cost of providing a service, and changes in relation to activity. To understand costs, these can be classified according to the impact they have on output. Costs can be described as fixed, variable, semi-fixed and semi-variable (Cleverley, 1992).

Fixed costs

The costs that do not change for the budget period are called fixed costs. These are easier to predict and are the fundamental items required to run a service. Salaries and wages for permanent staff are fixed costs. The annual salary of the employee is known. Other examples include leasing costs, rent, accommodation expenses, journal subscriptions and software licensing. Fixed costs are just that – 'fixed' – so irrespective of the number of clients who are seen in a month, the cost of the salary, rent, licence or subscription is set. Fixed costs may also be recurrent costs in that they occur on a regular basis, year to year.

Variable costs

Variable costs include things that fluctuate depending on external factors. In a health service setting, this is most commonly influenced by service demand. Some months have high activity, others have less. For example, a service providing a home visiting service will have variable costs that include transport and petrol costs, medications, disposables and clinical supplies. The amount spent on these

things will vary with the number of clients accessing the service, the complexity of their individual cases and other factors difficult to contain. Where possible, variable costs are predicted on historical data, and a cost modelling approach is used. In the absence of this they can be projected using a scenario-type approach. They are usually constant and change in a proportional way. For example, if the number of injections doubles, the cost of syringes will double as well.

Semi-fixed costs

Some costs will change with activity, but their increase or decrease is not proportional. Salaries are an example. An additional full-time staff member, to increase staff from four people to five full-time equivalents, does not necessarily result in a proportional increase in activity of 20%. It may be that a percentage of a position is required, but due to workforce issues a full-time position is a more favourable option in terms of recruitment and retention of staff.

Semi-variable costs

In the same way that fixed costs may fluctuate, variable costs may also include both fixed and variable components. Electricity and water are good examples of this. The manager knows there will be a core cost for basic utilities, but there is also a direct relationship to the volume of activity in the unit and the utilisation of these.

Other cost concepts

Accounting is a complex process and there are a myriad of terms that are used. Some additional cost terms include avoidable costs, sunk costs, incremental costs and opportunity costs. Avoidable costs are associated with a decision-making process which provides the manager with the opportunity to 'avoid' the budget impact. There may be an element of risk, in that cost avoidance now may result in an increased cost at a later point in time. An example of this is administrative staffing. A receptionist may add to the efficiencies of the service but not directly to client outcomes. One could increase the number of administrative hours provided to a team, and in doing so, release clinical staff for clinical duties, or current staffing levels could be maintained. The cost is avoidable, but there are some sound reasons why the manager might choose to do this. Sunk costs are unaffected by the decision. Irrespective of whether the service has a receptionist or not, a communication system will be required to manage client enquiries. The unit will still require phones and a reception area for client attendances.

Incremental costs are significant in that they are dependent on a management decision. In some cases the management decision may be made in another unit and the incremental costs reflected elsewhere. From a macro perspective decisions to reduce hospital length of stay may have reduced costs in inpatient units,

but there has been an incremental cost increase in other services such as general practice and community health services (Rothbard et al., 1998; Schreter, 2004). A decision in one area to commence a new outpatient treatment programme (e.g. for people with depression) may increase costs for the pharmacy as a different drug regimen is required. The provision of an extended-hours service will not only increase salary and wages but also lead to additional costs such as travel allowance, meal allowance and other industrial entitlements.

The final area of costs to think about are those related to the value missed by using a resource in one particular area, instead of an alternative. This is called opportunity cost. In the situation of multiple service demands this is a frequent dilemma. Imagine the manager has been given an increase of Aus$25 000 in the budget. How will they allocate this? In the reception example, there are two pressing needs:

- The work volume for the clinical staff is high and a waiting list has developed. The staff argue that all clients should be assessed within a 24-hour period of referral and that a particular skill set is missing from the team which would assist in a more comprehensive and efficient assessment process. There is a strong argument for funding some additional clinical sessions with the purpose of recruiting a specific skill set that would assist with the backlog and complement the current team structure. This would also assist in meeting specific service standards.
- An internal review of administrative processes has identified a high number of missed telephone calls, disorganised office systems and frequent loss and misplacement of files and referral letters. The second pressing need is to employ a receptionist/administrative officer. This alternative would provide a person to oversee the office functions so as to support the clinicians to focus on the clinical work. Improving internal processes would assist in the triage process and allow the clinicians to better organise their workloads.

There are benefits and disadvantages of each suggestion, but only enough money to do one of these two things. The opportunity cost is the effect of not investing in the second (the administrative officer) and choosing to employ an additional clinician. Tied in with both of these options are considerations in relation to other cost impacts of the decision. In any situation of choice there will be non-budget impacts as well. Of particular note are legislative requirements and industrial considerations. The receptionist may be argued from a workplace health and safety and efficiency perspective. The clinician may be supported from an industrial workforce perspective.

Depreciation

Depreciation is a fixed cost which warrants particular attention as it is easily overlooked. All goods owned will depreciate or lose value over time. The term ‘depreciation’ refers to an estimated or expected view of the decline in value

of a tangible asset over a period of time (Zelman et al., 1998). This is particularly relevant where a service may require a large investment in equipment. It is acceptable financial practice to include depreciation in a budget. This may be done at the organisational level, or at the service budget level. The reason this is important is to ensure that the cost of the ageing asset is recorded to enable replacement. This wear and tear on equipment is considered a cost of doing business. For example, the community mental health service owns a van for assisting clients to attend group therapy sessions. In a depreciation model a percentage of the life of the vehicle will be recorded, and the vehicle will have an estimated book life. So the depreciation of the vehicle may be recorded as 20% a year over a five-year period. There are some quite complex mathematical formulas for calculating depreciation. While it is not necessary for the manager to grasp the mathematical detail, an appreciation of the assets within one's area of responsibility and the budget impact of these is useful.

Budget lifecycle and business planning

To this point, what is apparent is that budgets are unpredictable and that decisions are rarely straightforward. What is predictable is that the budget process of all organisations runs in a 12-month cycle. In an ideal world the budget process will be aligned with the strategic planning process. A strategic plan is developed with a vision for the service. This plan is underpinned by a series of business plans or operational plans at a unit level, and a budget allocated accordingly. In a constrained budget environment, the service vision needs to be contained by the budget reality.

For public sector managers, budget cycles link closely with broader policy debate. An understanding of the budget timeframes and processes, and a degree of business acumen will assist in engaging in the wider debate about government financial priorities and policy implications (Wanna et al., 2000). In this context a manager can take a more strategic and entrepreneurial approach to the management of a specific service. In order to make a submission for additional funding, it is critical to know what the timeframes are, and what the government sees as priorities for funding. A budget submission can have a role to inform the policy agenda (Di Francesco, 1998) and greater input by services into policy development may yield cost-effective gains and assist with prioritisation at a government level (Vos et al., 2005).

Knowing timeframes and government agendas may reveal a growing political interest in a particular subset of clients. Armed with this knowledge, the manager can then be proactive in informing public policy, and in advocating for additional funding. Of importance is the recognition that while the government routinely delivers a budget at a particular time of year, the planning and negotiations and policy formulation will have been in action for several months, and sometimes years prior to any public budget release.

Steps in the budget process

This section describes the generic stages in budget development, formulated from numerous examples published by a range of public agencies.

1. Review the operational context

This stage includes a scan of the environment, identification of themes, trends and policy directions. For example it may be apparent that the government is increasing emphasis on the health and well-being of homeless people. What is also apparent is the trend to treating people in a community setting, and providing culturally appropriate service options. Such a climate may dictate that an initiative for homeless people be viewed more favourably than an expansion of inpatient beds. Demographic data and local knowledge can also be a source of information to assist planning. Shortages of a particular trained specialty may determine the scope of services that are viable, and lead to the development of innovative models of service delivery. The expansion of the multidisciplinary team and generic health worker roles is evidence of this.

2. Evaluate prior performance

There has been increasing interest in the area of programme or service evaluation in recent years with varying degrees of success in achieving the goal of cost savings (Di Francesco, 1998). In health, this has been largely driven by concerns in relation to the safety and quality of healthcare, and the significant systems failures where quality care has been compromised by tight fiscal constraint, accompanied by increasing public scrutiny. Approaches to health service evaluation are in some cases a part of the national health agenda resulting in additional demands at a local level. The concepts of scorecards, league tables and quality of life indicators can also guide performance evaluation, and there is a growing body of research into the effective use of measurement indicators to support budget considerations (Kelley et al., 2005; Schmidt et al., 2006). Contemporary approaches to budget review have moved beyond mere bean counting, and frequently include an assessment of performance in a number of areas including consumer satisfaction, workplace performance and innovation, as well as financial success at a service level (Waldersee, 1999; Coop, 2006).

3. Set budget parameters

This stage will include a list of givens. There may be very little flexibility regarding number of full-time staff employed, fixed costs and existing commitments such as rents and leases. Many agencies also have caveats on what can be included in a service budget. For example, expenses for information management technology, software licences and internet access may be absorbed at an agency level, or alternatively be allocated to cost centres on a user pays system. A definitive list of what is in the budget and what is not is an important part of the process.

4. Prepare the budget action plan

The budget plan for the coming period is often based on the history of the previous period and the learnings from a thorough evaluation of costs and income. It characteristically provides a monthly allocation of costs or resources required. Some costs are a one-off fee, which is charged on an annual basis. Journal subscriptions are an example of this. While the cost is a monthly fee, the actual account is payable annually. Salaries and wages, while being apportioned to the period they have accrued, still vary from month to month. Fluctuations may be the result of staff taking annual leave around peak holiday periods, and the effect of the different time periods of the calendar month. Most financial spreadsheets will factor these variations into the formula. Seasonal variations can also affect service demand as some diagnostic categories are more prevalent at particular times of the year. Accurate information systems can aid in making as good as is possible estimates of expenditure for the budget year.

5. Finalise annual planning and implementationlaction plans

This stage will require the definition of key performance indicators and identification of risks (Likierman, 1993). Outputs or outcomes expected will also be documented. The literature around outputs and outcomes is large and growing and includes a range of approaches: from case-based payment systems to a more quality-of-life indicator-type approach. In summary, the key components of an action plan are:

- identification or name of the goal
- timeframe for achievement
- the measures or indicators of performance
- resources required
- risks or barriers to goal achievement
- onus of responsibility.

Often this information will be developed at a global or organisational level, with an under-layer of operational or business plans at a service delivery level. Frequently these are presented in table form and may form part of an annual report for a board/community and are open to public scrutiny.

The timing of these five steps may fluctuate according to the nature of the service and the funding model employed.

Monitoring variance

Budgeting is the phase of accounting that involves preparing a plan or forecast of future operations. One of the primary functions of a budget is to provide a reference point for comparison and to inform management of the activities necessary to achieve its strategic mission.

A budget is a plan, and variance is the ongoing measurement of actual expenditure and activities measured against this plan. Budgets formalise agency outcomes, goals and objectives and monitoring variance is significant as it can guide management decisions. A positive variance means that there are areas of underexpenditure (savings); a negative variance indicates overspending (deficit). The goal is to have the variance balance each other out by the end of the cycle. Vacant positions are one way in which a business unit might have a positive variance show in an end-of-month report. The core budget often is fixed, and the only areas that can be actively managed are where there is a variance. Using an approach of quality review can assist in identifying areas for future improvement. Any budget situation must be sustainable. Targeted campaigns to raise awareness about mental health conditions may result in longer-term increase in demands on mental health services and require effective funding partnerships to be sustained (Hickie, 2004).

Developing a budget

Individual agencies will have a range of templates and approaches to documenting a budget. The budget development process is often co-ordinated by a business manger or financial controller. The following list provides a basic breakdown of components that should be included:

(1) *Labour costs* include salary and wages, and 'on costs' such as superannuation contributions, annual leave and entitlements loading. A percentage of the salary is used to calculate on costs. Training and development expenses can also be included here.
(2) *Non-labour costs* are items such as leases rent, equipment, consumables/materials transport and travel cost. Licences may be included here as well as clinical supplies such as pharmaceuticals.
(3) *Operational expenses* can be listed to account for items such as stationery, electricity and information technologies.
(4) *Establishment costs* are those identified in the set-up of a new service. These are one-off costs and can include equipment, capital works, telecommunications, furniture, signage, specific training required to provide a service, books or tests. These are vital considerations in a budget proposal for a new or enhanced service.

A basic sample budget for a new service proposal is presented in Table 4.1. The second year budget would omit set-up costs and include depreciation of capital assets.

An example of a monthly budget statement is also provided for the project (Table 4.2). The table shows how the project is tracking financially and identifies budget variance or overspending and underspending. What can be seen is that the project is under budget for the first month. A larger percentage of the capital costs have been apportioned to the first month to cover set-up costs.

Table 4.1 Basic sample of a new service proposal.

Labour costs	Comment	Cost (Aus$)	Total (Aus$)
Salaries and wages	1 FTE level 2 worker	40 000	
On costs	25%	10 000	
Professional development	Two training courses	1000	
Total labour			**51 000**
Non-labour costs			
Car lease	For home visits	5000	
Operating costs	Rent, security, utilities	4000	
Administrative costs	Stationery, postage	2000	
Clinical supplies		5000	
Total non-labour			**16 000**
Capital set-up			
Computer and licences		2000	
Furniture	Workstation, chairs, files	3000	
Tests and equipment		2000	
Total establishment costs			**7000**
Total budget			**74 000**

Table 4.2 An example of a monthly budget statement.

Budget summary Month 1	Month to date	Year to date	Full year
Budget	**9010**	**9010**	**74 000**
Labour	4170	4170	51 000
Non-labour	1340	1340	16 000
Capital	3500	3500	7000
Expenditure	**4470**	**4470**	**4470**
Labour	2170	2170	2170
Non-labour	300	300	300
Capital	2000	2000	2000
Variance (deficit/surplus)	**+4540**	**+4540**	**+4540**

Controllability and risk management

There is much theory, legislation and standard practice surrounding the management of a budget, which leads to the question, 'What then is "controllable" by the manager?'. Controlling activities include meetings, regular budget reports and analysis and local budget policy. These are internal controls with an intention to manage risks. In a mental health service, types of risks to the budget include unfunded activity, unplanned expenditure, waste and corruption.

Unfunded activity

There are many reasons for unfunded activity, but two common examples are used here to enhance understanding. First, for services operating in geographical areas of high population growth or where there is a changing demographic profile, a situation of unfunded activity can easily develop. Given that the current budget is based on retrospective information, any change in demographics can result in pressures in human services. While a budget may be indexed to account for growth or inflation, this may be insufficient to match the real increase in costs. The ageing of the population or sudden unemployment in a town are examples of social triggers which can (and do) impact on the demand for health services.

The second category of unfunded activity is the result of service delineation models and the inability to fully effect reimbursement for a service provided by a unit that another agency or unit is funded to deliver. This can be a complex situation, and ethically challenging. A case to demonstrate this is funding for chronic diseases such as diabetes, which is often directed to mainstream physical health services. Depending on the funding model employed, it may be difficult for a mental health service to seek reimbursement for the provision of care to a diabetic client with a mental health disorder. Opportunistic health intervention may require that advice on insulin (for example) is provided in an integrated approach with information about other drug therapies. Services that have caseloads with a high percentage of clients with dual diagnosis are often disadvantaged with programme-funded payment systems.

Unplanned expenditure

In the case of the office used previously, imagine a situation where the premises are robbed, mobile phones and laptop computers stolen and the photocopier vandalised so that it is rendered useless. In such a situation, replacement is an immediate and not negotiable action for the service to maintain its operations. Many events are unplanned. These can include loss of human resources due to sudden illness or resignation, catastrophic events such as cyclones and floods, and from a global perspective changes in the value of the country's currency (which affects drug and medical equipment costs) and stock market values (such as oil). All of these can result in increased costs which were unplanned and leave a hole in a well-managed budget. It is suggested that these events are formalised with

an incident report or documentation trail that aligns the increased expenditure with the specific event.

Waste and corruption

Waste is the inefficient and ineffective use of resources. In a climate of cost control, managing waste is an essential component of managing a budget. This may include considerations of the efficient use of human resources (e.g. nursing hours per patient which can be benchmarked) as well as non-human resources (e.g. utilisation of rooms and equipment). Effectiveness is less concerned with throughput and focuses on the outputs achieved. Both concepts are considered in a cost–benefits approach to service review (Haby et al., 2004). Some areas of waste are quantifiable, as in the nursing hour's example, while others may be more difficult to measure. Further examples include waste of stationery stores, inefficient use of lighting and air-conditioning, and damage or loss of valuable plant and equipment.

Corruption is defined as 'the abuse of public office for private gain' (World Bank, 1997). It may involve fraud, theft, misuse of position or authority or other acts that are unacceptable to an organisation and which may cause loss to the organisation, its clients or the general community. The behaviour need not necessarily be criminal and may also include such elements as breaches of trust and confidentiality.

Fraud is a type of corruption and is a deliberate, intentional and premeditated dishonest act or omission for the purpose of deceiving to gain advantage from a position of trust or authority. It includes acts such as theft, making false statements or representations, evasion, manipulation of information, criminal deception and abuse of property or time (Standards Australia, 2003 – Australian Standard AS 8001 – 2003 'Fraud and Corruption Control').

Internal controls will prevent fraud and corruption. The responsibility of the budget manager is to maintain cost-effective internal control structures within their organisational responsibility. Some examples of managerial strategies at an operational level to protect against waste, corruption and fraud are presented below.

- Understand and regularly monitor the budget so as to identify variance and respond to anomalies. Regular reports of payroll, incident reports and service activity may assist in identifying problem areas and developing a targeted budget management plan.
- Ensure quality review and incident reporting systems are in place to identify areas for improvement and manage risk. This may include formal events such as audits, inspections and accreditation processes, as well as informal local systems such as staff suggestion boxes, client feedback surveys and consumer input.
- Implement local controls and policies for managing smaller expenditures of things such as petty cash, travel bookings, and taxi vouchers.

- Have time sheet procedures in place, and processes to prevent time sheet fraud, sick leave abuse and loss of productivity.
- Maintain asset management registers and security systems to prevent theft and loss.
- Maintain a culture of transparency, honesty and integrity.
- Articulate and document a code of conduct and service values.
- Ensure peer review and articulation of professional standards of practice is in effect.
- Implement performance management and review systems to support and reinforce the above.

While this list is not exhaustive, it aims to provide some guidance in strategies to prevent waste, fraud and corruption.

Value for money

Having covered a myriad of terms in relation to budgets, the final concept to consider is value for money. Value for money is often determined by the quality of the product or service. Implicit in this is maximising efficiencies and minimising waste. Central to this is the concept that if you cannot decrease the cost of a service, then to increase value you must increase quality. Budgets therefore do not stand alone but are inextricably entwined with all other functions of the management role. Being a good budget manager is much more than counting the beans, including ensuring leadership and governance systems are in place to achieve the clinical and human goals of the service (Druss, 2006). The introduction of new evidence-based approaches may require a realignment of the budget for the service to comply with new standards. There are many clinical practices currently in place which are not cost effective, and many that are evidence-based that are not standard practice (Hermann et al., 2006) and the manager needs the courage to direct the budget to facilitate change.

Workforce management is not only about rostering and skill mix, but requires careful consideration of affordability. An effective budget manager will have a grasp of these issues and be in an informed position to alert the organisation of potential challenges to the integrity of the budget, and balance this against the value to the client.

Conclusion

Budgets are one component of the accounting process but they are an important tool for managing a service. Consideration of a budget requires a big picture view of the world and an understanding of internal drivers and costs within a service. The area of finance is highly legislated and regulated and the competent manager will have an appreciation of the risks and opportunities in budget management, with the ultimate goal of providing effective and efficient health services.

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Chapter 5
Managing critical incidents in clinical management in mental health services

Kevin Gournay

Chapter overview

This chapter will examine the main serious critical incidents that occur in mental health services and describe approaches to prevention of and using such incidents to learn lessons. The main focus will be on three topics:

- Suicide and self-harm
- Violence
- Homicide

The chapter will refer to several websites which provide detailed information concerning each of these main topics. In addition, the chapter will cover a range of related issues to assist managers in dealing with the wide array of challenges that face them.

Critical incidents

Managers in mental health services, whether they are based in the community or located in any one of a variety of inpatient care settings, need to be prepared to face the challenge of critical incidents, which, even in the best of services, will occur from time to time. This chapter will not consider critical incidents such as fire or accidents at work, or trips and falls, but rather focus on the main serious critical incidents that occur commonly in the context of direct patient care. That is not to say that other issues, such as worker health and safety and ensuring a safe environment fit for purpose, are not important. However, such issues lie outside of the scope of this book.

What are the common serious critical incidents that occur in patient care?

There are three general areas that should concern mental health services managers, and there is, of course, some overlap between these areas. However, to do justice to the topic, it is best to consider categories which are, in some senses, arbitrary. These categories are:

- Suicide and self-harm
- Violence
- Homicide

It is also important to be clear at this point that this chapter covers clinical critical incidents across the whole range of mental health problems, from people with the very common mental disorders who are managed in primary care to patients with the most serious and enduring problems, who may be cared for in conditions of high security.

Suicide and self-harm

This is obviously a very broad category and there is certainly no implication, in considering these two topics together, that all cases of self-harm should be treated as failed suicide. It is, of course, clear that in terms of intent, to kill oneself or otherwise, self-harm is a very heterogeneous problem. Nevertheless, the two issues are best considered together because there is a commonality of care approaches, risk assessment and management, and prevention in these two topics.

Suicide

Suicide is the ultimate tragedy that can occur in mental health services. The latest Australian Bureau of Statistics publication covers suicides in Australia registered in the years 1993 to 2003. To put the issue in context, there was a total of 2213 deaths from suicide registered in Australia in 2003. The data are interesting from the point of view of considering gender differences, methods of suicide and the substantial differences in suicide rates between various states and territories, with the Northern Territory demonstrating figures of 77% above the national rate. Unfortunately, Australia – in common with most other countries – has made no real attempt to consider separately, or in any detail, the issue of suicide in people who have a previous history of mental health problems.

However, in the UK, the government has collected data on suicides through the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2006). This Inquiry process was established in 1996 and funded initially by the Department of Health in England. Subsequently, additional funding has been provided by the other three health departments of the UK and now the Confidential Inquiry is truly comprehensive. Its main aims are to:

- collect detailed clinical data on people who die by suicide or commit homicide and who have been in contact with mental health services
- make recommendations on clinical practice and policy that will reduce the risk of suicide and homicide by people under mental healthcare.

This Inquiry, although UK based, has provided an enormous amount of information, which will be of use to managers of clinical services in other countries who need to deal with these tragedies (the section on homicides, below, will also consider data from this Inquiry). The main beneficial outcome of the Inquiry has been the implementation of a number of clinical and managerial initiatives that have resulted in a significant reduction in suicides, particularly in inpatient settings.

From the point of view of managing critical incidents, one of the benefits of knowledge derived from the Inquiry is that it provides a description of the main causes of suicide (and homicide) and, when an individual critical incident occurs, those who are responsible for investigating causation of suicides may be able to use the Inquiry findings as a template for pursuing lines of investigation. Furthermore, once an inquiry into an individual case has been completed, service managers may then be able to look at ways in which the service may respond in order to minimise the possibility that such incidents will occur in the future.

Overview of the method of the UK Inquiry

In the UK, as in Australia, all deaths are publicly registered and the cause(s) of death are entered on the death certificate. The inquiry process then identifies, from all registered suicides, those people who have been in contact with mental health services in the year prior to the suicide. The process then collects detailed clinical data on these individuals, as well as considering the activities of clinical services where that individual received care and treatment.

The latest Inquiry report (Avoidable Deaths), which was published in December 2006 and covers the period between April 2000 and December 2004, can be found at www.medicine.manchester.ac.uk/suicideprevention/nci/. This report provides information on 6367 cases of suicide by current or recent mental health patients between April 2000 and December 2004 – this being 27% of all suicides occurring nationally. The figure translates into over 1300 suicides per year across the four countries of the UK. The report sets out the main methods of suicide, with hanging being the most common method; hanging and self-poisoning accounting for two-thirds of all deaths. Of all suicides, 49% of patients were in contact with services in the week preceding the event and 19% in the previous 24 hours. The Inquiry also reported on a subset of suicides by patients who were, at the time of their death, inpatients in mental health services. This subset of the population comprised no less than 13.5% of the sample, i.e. 856 cases.

Importantly, the Inquiry highlighted a number of areas relevant to prevention in people with a current or past mental health problem. These are discussed below.

Absconding from inpatient wards

Approximately a quarter of suicides in inpatients occur after a patient has left the ward without permission. The most common period of time for this to occur is in the first seven days after admission. The Inquiry noted that the trigger factors for absconding often included a disturbed ward environment or a specific incident involving that patient. The Inquiry also noted that mental health services probably need to consider greater use of closed circuit television and more active control of ward entrances and exits. UK psychiatric inpatient wards are in many senses similar to those in Australia. In both countries, wards vary in their 'open door' policy and, given the significant number of suicides that seem to occur in

absconding patients, service managers obviously need to look again at whether or not ward exits need to be locked, or at least kept under constant surveillance.

Dealing with the transition between inpatient care and the community

Of the suicides that occur in the three months following discharge, 15% occur in the first week and nearly a quarter occur before the first appointment in the community. The Inquiry identified several measures that are needed to reduce the problems that occur in the post-discharge period. There is a specific recommendation that risk is regularly assessed during the whole period of discharge planning and trial leave, rather than, as often occurs, carrying out a single pre-discharge review. Furthermore, the risk assessment plan needs to identify any possible stressors that are encountered on leave and discharge and set out methods for dealing with the same. Once the patient has been discharged, they need to have access to services and this should include the patient being provided with telephone numbers to be used 24 hours a day, seven days a week. Staff who work in community mental health services are encouraged to provide early follow-up after discharge and to augment face-to-face contact in the first week with telephone calls, particularly for patients who may be at higher levels of risk.

Identifying patients at risk, particularly those with severe mental illness and previous acts of self-harm

The report indicates that the risk assessment and risk management plans for patients at the highest levels of risk are often lacking in depth and breadth. The report particularly identifies the need to adopt closer monitoring of high-risk groups of patients and to carry out joint reviews of such patients with other agencies.

Dealing with the situation arising when a care plan breaks down

According to the Inquiry, a significant number of patients who died by suicide, did so when they dropped out of services or when they stopped taking their medication. This finding is particularly sad, given the fact that we have, for more than 30 years, accepted the need to employ assertive outreach to patients with serious mental illness, who by definition are often unable to comply with their treatment and/or have insufficient levels of motivation to actively pursue a treatment programme. In Australia, such outreach services were established in Sydney nearly 30 years ago (Hoult & Reynolds, 1984).

There are, perhaps, lessons here for those responsible for the education and training of mental health professionals (from those responsible for undergraduate training programmes to post-qualification education and training). It seems clear that the possible serious consequences of non-compliance with treatment and/or dropping out of services need to be reinforced. Some mental health professionals

may still hold the belief that people with a mental illness have a right to choose whether they engage with services or not. Arguably, people with a serious mental illness and who lack insight are individuals who do not have full capacity to make such choices and, therefore, in a sense, mental health professionals need to intervene on their behalf. While many mental health professionals will be able to accept this principle without any difficulty, the problem arises when people have, what is deemed to be, a reasonable level of insight and, in the judgement of some members of the team, have capacity. In such cases, there is an obvious need to discuss these issues explicitly and comprehensively and to arrive at an agreed decision.

Changing attitudes to prevention and dealing with the widespread view that individual deaths are inevitable

In conducting the Inquiry, the investigators gathered information on clinicians' views of suicides. The report stated:

> 'A feature of these cases we have investigated is the low proportion that clinicians regarded as preventable – only 19% of suicides. To an extent, this reflects the recognition that mental health patients overall are a high risk group – it is therefore unrealistic to expect services to prevent all suicides. However, there is a danger in going on from recognising the risk in patients as a whole to accepting the inevitability of individual deaths.'

The report then goes on to provide a calculation that 41% of inpatients suicides are preventable and concludes this particular section with the comment:

> 'It is time to change the widespread view that individual deaths are inevitable – such a view is bound to discourage staff from taking steps to improve safety. It may be a reaction to the criticism of services and individuals that can happen when serious incidents occur. Therefore, if mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame.'

Observation of patients on wards

The report highlighted deficiencies in the observation of patients at risk and drew attention to the need to ensure that observation protocols should be strictly followed. Furthermore, the investigators also drew attention to the observation of ward exits and the problems of absconding.

The ward environment

Suicide by inpatients is a problem throughout the world. In the USA, where inpatient services are more restrictive than in the UK and Australia – for example security staff, high levels of surveillance and mechanical restraint are used – consequently, suicide by inpatients is less common. In the UK and in

Australia, where inpatient care is, in some senses, more liberal and less restrictive, inpatient suicides occur more frequently. In the UK, the most common cause of death by suicide of inpatients is still self-strangulation, although in recent years these rates have reduced because of specific attention paid to ligature points in the ward environment. In both the UK and Australia there have been a number of initiatives, such as removing non-collapsible curtain rails, modifying door handles, ensuring that toughened glass is in place and removing 'barn door' type structures, replacing them, for example, by sliding wardrobe doors.

Service managers need to pay particular attention to regular audits of the environment and to learn lessons from completed and attempted suicides, where patients may often find ingenious ways of harming themselves. A corollary of dealing with ligature points is dealing with ligatures themselves and, when risk assessments are carried out, it is most important to consider whether patients should have access to shoelaces, dressing gown cords and so on. In turn, service managers need to consider the risks attached to certain types of bedsheet, which may be used more readily as a ligature. Such issues also require that considerable thought is given to the development and modification of policies on matters such as searching. Some inpatient suicides relate to fire and service managers need to consider a range of matters relating to items such as aerosols and disposable lighters, which are often implicated. Obviously, the decision to remove various items from patients raises the issue of human rights. Once more, staff on wards need to balance not only the risks and benefits but also their duty of care against the human rights of the patient.

Dual diagnosis

Many suicides in the community involve patients who have so-called dual diagnosis, i.e. a mixture of mental health problems and substance abuse. Dual diagnosis is now a substantial problem in both inpatient and community services across the world and, because of the higher rates of non-compliance, violence, suicide and self-harm, such patients present a major challenge. Perhaps the biggest issue relating to this problem is that of effective treatment. At present, there is no gold standard approach and the research literature regarding treatment trials is sparse and, largely, confined to patients who have one substance of abuse; this contrasts considerably to the real-life situation, where dual diagnosis patients often use multiple substances, which may vary over time according to availability and cost.

Suicide in older people

Twelve per cent of all suicides in the UK occur in people over the age of 65 and this population contrasts with people under this age in terms of causative or trigger factors. Older people who commit suicide are characterised by ongoing physical illness and bereavement and loss, and it is these areas that require intervention.

Learning the lessons

One approach that has been used increasingly in mental health services is root cause analysis (RCA). RCA is a technique for approaching adverse events in a system-wide way, while at the same time seeking to understand the underlying contributory factors and causes. RCA examines both organisational failure as well as human error, recognising that organisational failure is a commoner cause (Toft & Reynolds, 1994).

Although RCA is now being increasingly used in mental health services across the Western world, the methodologies involved are still in need of improvement. Nevertheless, it does appear that RCA has been very revealing, in terms of identifying causal factors and then providing solutions (Wald & Shojana, 2001). Space does not allow a detailed description of the process of RCA, however, it is worth mentioning some important elements of the process:

- The collection of as much data as possible concerning the individual patient, the care environment and the carers involved.
- The use of independent assessors for different aspects of the event (for example psychiatric nurse, service manager, psychiatrist, social worker).
- The involvement of service users.
- The provision of training for all of those taking part in the RCA exercise.

Care of significant others following suicide

It is essential that managers consider the aftermath of suicides in terms of the impact on the family, the health professionals involved and the service in general. Each and every suicide is different and, therefore, the needs of the families, the professionals involved and the service will vary considerably. From the point of view of management, it is essential that every service has a person who is specifically designated, and properly trained, to deal with the emotional aftermath among family members and the healthcare professionals involved. It is essential that this person has the necessary authority to make a referral to the appropriate professional and voluntary agencies. In turn, it is also essential that there are resources available to ensure that, if necessary, people in need of emotional support or treatment can be referred to services outside of the immediate area, if that is more desirable.

Self-harm

Self-harm, rather than suicide or attempted suicide, is a common event. The vast majority of self-harm never comes to the attention of mental health professionals and is variously dealt with by friends and family members, primary care services and emergency departments in general hospitals. By definition, self-harm which occurs within the context of a patient receiving mental healthcare is a critical incident. However, the response to episodes of self-harm obviously varies

considerably. Many mental health professionals will know of patients who may cut themselves many times in a day and that information needs to be recorded. At the other end of the spectrum, self-harm episodes may pose a threat to life and occur within the setting of an exacerbation of a serious mental illness and active suicidal intent.

Service managers need to have clear policies to guide staff in the management of self-harm episodes and also to put in place interventions. In the UK, the National Institute for Health and Clinical Excellence (NICE, 2004) has produced specific clinical guidelines based on evidence and every service in England and Wales (Scotland and Northern Ireland have different processes) is expected to follow these guidelines (see www.nice.org.uk/cg016quickrefguide). The guidance is, perhaps, unique across the world in that not only is it evidence based, but all patients and services users can expect these guidelines to be implemented and, if they do not receive the care outlined, they have proper cause for redress, as these guidelines now carry considerable weight. In summary, the guidance provides advice concerning the physical and psychological management of self-harm and also sets out a number of interventions for prevention in primary and secondary care.

The guidelines provide advice for healthcare professionals working in any setting, whether or not they have a mental health background, and provides detailed advice about the various treatments available for the spectrum of self-harm incidents, including overdose. The guidelines cover advice regarding prescribing to service users/patients at risk of self-poisoning and assessment and management protocols for ambulance personnel. The guidance is particularly focused to treatment in emergency departments and covers that significant population which wish to leave before assessment and treatment. The guidance also includes specific advice for specialist doctors and nurses, including guidance on the collection of samples, interpreting test results and the various information and laboratory services available to clinicians who treat self-harm. There is specific advice about the management of overdose involving paracetamol, benzodiazepines, salicylates and opiates. The guidance covers support and advice for people who repeatedly self-harm, the principles of psychosocial assessment and referral processes. The document also has specific advice on the management of children and young people and older people. Although this guidance is UK based, the vast majority of material published is of considerable relevance to services in Australia and New Zealand, where no such comprehensive guidance exists. The NICE webpage on the guidance document also has links to a comprehensive set of background literature.

Violence

Violence in healthcare is a major issue across the world and is, unfortunately, increasing in incidence. The growing concern about violence in healthcare in Australia was helpfully set out in an article by Benveniste et al. (2005). The authors point out that many episodes of violence occur in emergency departments and

mental health services. Unfortunately, the Australian government has yet to carry out any comprehensive collation of data concerning violence in mental healthcare, or to publish guidelines on the management of violence.

While all service managers will be familiar with acts of violence that cause injury, both physical and psychological, to patients, staff and visitors (in the case of inpatient care) there is very little evidence concerning effective interventions at an individual, service or community level. In the UK, NICE (2005) commissioned a three-year work programme, which led to the publication of comprehensive guidance on the short-term management of violence in mental health and emergency department settings (see www.nice.org.uk/cg025quickrefguide). The document is relevant to Australian services, as the conditions of inpatient care are similar to those of the UK and, unlike many European countries, mechanical restraint is rarely used. For ward managers or service managers, any significant violence, which may, of course, include psychological injury, must be treated as a clinically significant event. After an event occurs, there is of course great opportunity for learning. The UK work on managing violence has demonstrated that all staff working in mental health and emergency settings in general departments need to attend to a very wide range of issues. These include:

- prediction of violence
- prevention of violence
- interventions for managing violence, including:
  - rapid tranquillisation
  - physical interventions
  - seclusion
- review of incidents and protocols for carrying out post-incident reviews
- use of interventions in emergency departments in general hospitals
- dealing with patients' needs:
  - including people with disabilities
  - including dealing with the risk of human immunodeficiency virus (HIV) infection or other infectious diseases
  - dealing with women who are pregnant
  - dealing with mental healthcare environments
- training issues
- implementation issues.

Obviously, the issue of violence in mental healthcare is too large to deal with comprehensively in a chapter such as this and, as with the topic of self-harm identified above, the reader is commended to use the NICE guidance referred to above as a resource that is comprehensive and evidence based. Nevertheless, within the context of this chapter, it is important to address four key issues. Each of these are extremely relevant to running an effective and safe service. These issues are:

- Recording
- Learning lessons
- Policy development
- Training

Recording

Managers have a particular responsibility for ensuring that all episodes of violence are recorded. This, however, is not as easy as it seems. There is still considerable variation in what staff consider to be violence and, in some services, any verbal abuse directed towards another person is seen as a violent incident, while in other services and at the other extreme, only violent incidents that result in physical injury are so recorded. A further difficulty in whether or not violent incidents are recorded, concerns patients who may be verbally or physically abusive on an almost continuous basis. For instance, there are patients who will subject staff and others to constant verbal abuse and this may, of course, be recorded in the patient's notes. However, if this constant verbal abuse is not recorded on incident forms, an objective audit of violence in a particular service may be compromised. Similarly, there are patients – for example those with dementia – who may continuously flail their arms or slap members of the nursing staff, without causing any significant injury. Just how one records the occurrence of such behaviour on incident forms poses some difficulty.

In many services, episodes of violence are very often under-reported because of the inconvenience of filling what can sometimes be lengthy forms, or in the case of the increasingly prevalent electronic systems, needing to log in and set up the relevant computer program. Managers need to be aware of all of these issues, so that, at the very least, they have knowledge of the extent of under-reporting. Accurate reporting is, of course, essential for the purposes of planning appropriate staffing, but the lack of proper recording may also have legal implications in the case of actions being brought against the services.

Learning lessons

Staff working in mental health services are only too well aware of the tragedies that sometimes occur in episodes of violence. Unfortunately, in Australia there is little systematic collection of notification of deaths in mental health services, although the Australian Institute of Criminology, a branch of the Australian government, has published a series of reports from the Deaths in Custody Monitoring Programme based on data from 1992 to 1996 (www.aic.gov.au/publications/dic).

In the UK, the Joint Parliamentary Committee on Human Rights (2004) published a report on deaths in custody (www.publications.parliament.uk) which included a systematic account of deaths in mental healthcare. While such incidents provide a considerable amount of food for thought, such deaths are relatively rare. Conversely, most acute mental health services will experience a significant number of violent incidents in any single week and sometimes in any single day. Such violent incidents may include episodes where the patient needs to be physically restrained by a team of nurses, episodes involving seclusion and, increasingly in mental health services, episodes where it is necessary to call the police to contain a violent incident. It is from such incidents that one can learn lessons, and mental health service managers should use auditing as a method of learning

lessons. It is important that mental health service managers carry out post-incident reviews of episodes where 'something has gone wrong'. Equally, it is important to audit episodes, for example, involving restraint, where episodes have been brought to a successful conclusion. Post-incident reviews should involve holding discussions with both staff and patients and, where relevant, carers. Such reviews often reveal very important information about how procedures may be improved.

In the NICE guidance referred to above, one of the recommendations is that patients should be able to provide an 'Advance Directive'. Therefore, when a patient with a history of violence during their mental illness is interviewed, that patient may well be able to suggest ways that their violent behaviour may be managed in future episodes. Thus, for example, the patient might be able to say what methods might be successfully used to prevent an episode, for example being given time out or provided with an oral dose of tranquilliser. Such advance directives may then be recorded on a card and in the patient's notes, so that the patient's wishes may be taken into account in planning their care.

Policy development

It is essential that all services have robust policies for the management of violence and, in particular, that these policies focus on prediction and prevention rather than physical interventions. It is also important that policies also include an emphasis on environmental management, such as the control of noise and the contribution of safe areas and private rooms. That said, policies also need to provide very detailed guidance on the management of specific episodes and, in the UK, policies now provide extensive reference to the NICE guidelines with, for example, the use of laminated summary cards which can be kept in ward offices. Such cards can provide easy access to guidance or to show the algorithms to be used in procedures – for example, rapid tranquillisation.

Training

Managers need to be aware of a simple principle regarding training. That is that if a violent incident is foreseeable, staff should be appropriately trained to deal with it. A simple template for the training of staff should be as follows:

- For all staff in mental health services, a simple training in conflict resolution, emphasising the need to resolve conflict at an early stage. Such training programmes commonly take one to two days.
- Use of breakaway training. Such training will assist staff in breaking away from assaults and should be made available to all staff working in acute mental health settings and in the community. It should include cleaners, receptionists, and other ancillary staff as well as all nursing staff.
- Comprehensive management of violence training. All staff who come into contact with patients, who are potentially violent, in mental health settings and who may be involved in an intervention, should receive a comprehensive

training, commonly taking a minimum of five days. Such training should cover a very wide range of areas concerning prediction and prevention and also practical training involving the teaching of various physical methods, including control and restraint.

- Training for secure services. Training for secure services will involve a range of management of violence techniques, including control and restraint as outlined above. It should also include much more detailed and practical training on the management of more serious violent incidents and may include interventions involving riot shields and the management of situations that involve hostage taking or sieges. Fortunately, in many forensic services, such training is now essential.

In addition to the above template, the NICE guidelines, referred to above, have also emphasised the need to train nursing staff in the care of patients following rapid tranquillisation and it is essential that all staff involved in such episodes have the relevant training in the use of measures such as pulse oximetry. Finally, it is essential that all training is regularly reviewed and refreshed. Managers should ensure that staff are provided with refresher training at intervals of no more than 18 months.

Homicide

Despite public perception, homicide involving patients in mental health services is a relatively rare event. However, when it does occur, there is often very significant and indeed disproportionate attention paid in the media to the perpetrator's mental health history. The UK Confidential Inquiry collected data on 249 cases of homicide by current or recent patients, occurring between April 1999 and December 2003 (this being 9% of all homicides occurring in England and Wales during this period). This figure translates into 52 patient homicides per year. The number of homicides by persons with schizophrenia is around 30 per year, this being 5% of all homicides. However, it should be noted that only half of the perpetrators with schizophrenia were current or recent patients and a third had no previous contact with services.

Another issue that needs to be taken into account is that the number of 'stranger' homicides (in which the perpetrator and the victim were not known to each other and the perpetrator was mentally ill) is very small. Therefore, the risks posed to the general public by the proverbial 'madman' are also very small. Because of the rarity of such cases, it is difficult to provide managers with specific advice, particularly as such cases will be subject to wider independent inquiries involving criminal justice and other agencies. The main problems that become evident in cases where homicide may be seen as being preventable generally occur when patients slip through the net and where risk assessment and risk management procedures break down. Such cases emphasise the need for robust methods in community services, including the use of rigorous risk assessment procedures and

training for all staff involved. Training is often the Achilles heel in many community services, as risk assessment demands an approach that goes far beyond the ticking of boxes on rating scales and forms.

Conclusion

Managers in the mental health services are faced with a wide range of challenges from the routine, although very important issues concerning worker health and safety, to the extremes involving violence, self-harm, suicide and homicide. This chapter has provided an overview of the central issues concerning the more serious critical incidents. However, it must be emphasised that for this chapter to be properly effective, managers need to follow up their reading by accessing the important website information provided, particularly relating to suicides, homicides, the management of violence, the management of self-harm and the issues relating to deaths in custody. While the emphasis for managers needs obviously to be on the prediction and prevention of untoward events, managers will inevitably be faced with the management of the aftermath of events that may, in their own way, have a lifelong impact on the patient, the family and/or the staff member. Such responsibilities are obviously very significant and it is important that the managers themselves are provided with an appropriate level of resources, not only in terms of managing critical incidents but also in respect of their own training and support and supervision.

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Chapter 6
Public relations and communication

Victoria Maxwell, Debra Lampshire and Samson Tse

Chapter overview

Recovery is a unique process or journey that resides within the person. However, the external environment created by those who live and interact with that person will hugely impact on their recovery process. That is why management of public relations between mental health services and the families and carers, other relevant social services and the general public is an important topic. Therefore, this chapter switches from focusing on individuals with experience of mental illness, psychotherapeutic techniques or mental health systems to managing public relations or an effective communication with a range of stakeholders. Stakeholders refers to families and carers, relevant social services and the wider general public. It is also argued that consumers or users of mental health services can have pivotal roles in this distinctive management function. Three sections follow the definition of key terms. The first section focuses on why it is important to maintain effective communication with families and carers of members recovering from mental illness and what constitutes meaningful communication with them. In the second section, the public relations network grows to include working with relevant social agencies, so that those agencies are able to provide user-friendly services to individuals with mental health problems. The last section describes how mental health services managers can also use public relations as an overarching framework to reduce stigma and discrimination associated with mental illness among members of the general public (Link et al., 1999).

Defining public relations and service users

Defining public relations is not as easy as one would think even though it is so commonplace in the twenty-first century. Long-time researchers on public relations Wilcox and colleagues (2003, p. 7) define public relations as:

> 'a distinctive management function which helps establish and maintain mutual lines of communication, understanding, acceptance and co-operation between an organisation and its publics; involves the management of problems or issues; helps management to keep informed on and responsive to public opinion; defines and emphasises the responsibility of management to serve the public interest; helps management keep abreast of and effectively utilise change, serving as

an early warning system to help anticipate trends; and uses research and ethical communication techniques as its principal tools'.

This definition illustrates that public relations not only has a passive role in terms of controlling damage of public image of the organisation or services associated with the establishment but it also serves the purpose of being strategic in promoting positive co-operation and communication between the organisation and the general public. The term 'publics' denotes the multiple stakeholders that are attended to while managing the public relations. There are many different groups, such as service users, healthcare providers, local residents and politicians, all of whom have distinct information needs and performance expectations (Theaker, 2004).

For the purposes of this chapter 'service users' are defined as individuals with psychiatric illness who have used mental health services and who identify themselves as such. There are variations in how these individuals prefer to be addressed (Mueser et al., 1996; Sharma et al., 2000), with literature from the USA favouring the term 'consumer', while the UK and Europe favours 'service user'. In New Zealand, Maori terms *tangata whai ora* (person seeking wellness) or *tangata motuhake* (people with mental illness) are popular alternatives.

Work with families and carers

The role of families and carers is one of the most significant and challenging relationships for professionals within the mental health sector (Hinshaw, 2005). Families often report being excluded from the rehabilitation process with little or no communication with mental health professionals regarding the treatment being undertaken by their family members.

The definition of families has evolved over the generations and families can now consist of step-parents, same sex parents or birth/adoptive parents; grandparents are also now taking on the role of primary caregiver (Families Commission, 2007). A service user may well identify family as persons who have no blood tie to them but, instead, a profound and well-established connection. This development can prove challenging to processes and procedures which still maintain an adherence to the conventional view of family. It is only correct that clinicians should accept the person nominated by service users as their family regardless of genetics or legal classifications. When a service user is distressed it may well be that they do not wish to have contact with their family members and carers. This does not mean, however, that family members and carers can be excluded altogether. They are still entitled to information regarding the well-being and progress of their family member even if the information is limited.

For clinicians this raises the issue of how to accommodate the needs of the families and carers. Clinicians are highly skilled in engaging service users in conversation and gaining personal and private information. These same skills need to be demonstrated when working with relatives and caregivers. Being honest and open in the communication and being clear about what information may

be shared helps develop a trusting, respectful and professional relationship with family and carers.

Effective elements of working with families and carers

Therapeutic alliance

Families and carers have an ongoing commitment to, knowledge of and concern for their family member. They are not paid to be there. They are there because they chose to be there and they care. They frequently provide ongoing support long after services have removed themselves from a user's life. Families and carers are especially attuned to their loved ones' early warning signs as they are so familiar with minor and major changes in behaviour and mood. Families and carers often have a long history of frustration with professionals. This may mean clinicians have to learn to listen to families express this frustration without defensiveness or judgement in order to cultivate a working relationship that ultimately assists the families and carers and their loved ones.

Mental health professionals need to discuss with families and carers that the recovery process is not linear and they themselves will cycle through phases of hope and then despair. They need to be reassured that the painful and confusing emotional reactions, even intense episodes, are natural and common responses frequently reported from families and carers. Mental health professionals need to be careful not to imply there is something wrong with families and carers and emphasise that reactions are not pathological but, rather, normal responses to stressful and distressing circumstances.

It is important that families and carers know that they cannot make their loved ones recover. This is a journey that the service users must make for themselves. Service users are required to be proactive in their own recovery, developing lifelong skills that will enable them to live the life they would choose for themselves.

Families and carers and mental health professionals can share knowledge and information about recovery and how best to support the family members. Families and carers also need to know there is support available from organisations in the community and through mental health services to cope with the various levels of uncertainty and personal distress they may experience.

Legal issues

In New Zealand family members often talk of being denied information based on use of the Privacy Act (1993 and Amendment Act 1994). There appear to be huge inconsistencies in how the Act is interpreted and is perceived by families as a weapon for clinicians to withhold information.

Needs of families and carers

Families and carers may also need to work through their own recovery process from the shock, denial and disbelief of their and their loved ones' lives being

affected by mental illness. Working through the anger, blame and fear, they may also start examining their own contributions, real or imagined, to their family members' situation. This can be followed by a sense of guilt and shame, feeling the need to keep their loved ones' condition secret or experiencing first-hand embarrassing and humiliating situations that expose their family members in very public displays. Families and carers may have occurrences of depression, and experience loneliness and begin to withdraw and isolate themselves from their own friends, relatives and colleagues. If mental health professionals work actively with the experiences of the families and carers, they can address these common responses and assist them to reach a level of acceptance that they are not in this alone and engender hope for their loved one and themselves.

Mental health professionals need to demonstrate good interpersonal skills, especially the ability to listen (Dixon et al., 2001). Families and carers want practical advice for common problems. Teaching them stress management and problem-solving skills may be beneficial. Families and carers wish to maintain a collaborative relationship with their loved ones' clinician and negotiate mutual sharing of information. It is important that mental health professionals validate and point out family strengths, let them know they have talents and skills to contribute, and they are also entitled to live their own lives and pursue their own dreams.

Including everyone

Siblings of service users see themselves as the forgotten victims of mental illness, taking on role of the 'good child' or the 'pseudo parent' while parents deal with the service users. Resentment often is directed towards the service users as all energies appear to be put into the one sibling. Routines and events are directed or modified to accommodate the service users regardless of the impact it has on the rest of the siblings in the family. The display of 'parentalism' can continue into adulthood when the loved one's well-being remains the parents' primary concern. This can also work to the detriment of the service user as they remain dependent on the parents well past the time when developmentally it would have been expected a child would have begun living independently.

Empower families and carers by sharing information and knowledge

Families and carers require information about their loved one's specific illness and sometimes they can benefit from a structured psycho-education programme (e.g. Dixon et al., 2001; Pekkala & Merinder, 2001; De Groot et al., 2003). Regardless of whether the information is delivered in group or individual format, written material that can be referred to later on is helpful. Families and carers should be given copies of recovery or wellness plans, if they are included or expected to play a part in those plans. They need to know where they can go to for support and a place that will deal with their issues where their own needs and wants will be validated. They should be informed of their legal rights and the rights

of the service users so they can advocate for their loved ones effectively if required. It is useful for families and carers to have the contact detail of those mental health professionals directly involved with the family member and know they are welcome to contact clinicians should they feel the need to.

Roles of service users in public relations

When the recovery approach was adopted as the preferred way of working within mental health services it necessitated the inclusion of service users to enhance the clinical and scientific knowledge about mental health problems with the wisdom gained from the human experience of distress. Recovery requires clients to be proactive and to take responsibility of the healing process. Clients are no longer passive participants of services and, as such, their role as service users changes. Now, rather than reporting their symptoms *to* clinicians, they work collaboratively *with* clinicians to track factors that contribute to their wellness. This results in service users functioning at a level where they also reclaim the life they envisage for themselves prior to an episode. These skills of self-reflection and articulation prove transferable so clients are now in a stronger position to inform mental health services of the processes and practices that assist them in their recovery and also those practices that impede. There are those who, guided by their experiences both positive and negative within the services, have chosen to share these insights to facilitate better outcomes and advocate for independence and quality-of-life issues for clients through their involvement with mental health service providers (Marsh, 2000; Rigby, 2007). So the development of professional roles played by service users was born. Potential professional roles include case manager, peer-support specialist, patient advocate, or adviser in public policy and public relations.

Work with key social agencies: a case study to achieve common goals

Mental health services need to be proactive in cultivating relationships with social agencies that have associations with mental health service users. It should be seen as core business for a mental health provider to assertively challenge the difficulties faced by clients from social services. One way in which this is being addressed is by providing training to closely related services.

Work and Income New Zealand (WINZ) is a service of the Ministry of Social Development that helps job seekers and pays income support on behalf of the government and includes residential care, support subsidies, superannuation payments to retired people, along with the administration of war pensions. It is also an agency in which a number of service users have consistently experienced prejudice and discrimination. When WINZ was approached, it welcomed the opportunity for its staff to be informed and educated in the area of mental health.

WINZ recognised that mental health service users were a client group that regularly used their services and staff had expressed their anxiety and discomfort in dealing with this group of service users.

WINZ arranged for monthly seminars to be presented by a service user who provided information about the various diagnoses. An environment of safety was created by making all sessions exclusive of senior management and confidentiality (with some limits in regard to safety issues) was guaranteed. At the beginning of the workshop, guidelines were established around how the workshop would be run and then people were given a fun activity to help disarm those who may have felt suspicious of the intent of the workshop. It was important to assure staff the workshop was not meant to imply their professional practices were lacking and it was taken as a given that all staff were endeavouring to provide the most effective service while demonstrating respect and regard to all clients. The workshop was divided into two distinct sections. The first section explained the diagnostic categories from a clinical perspective and the second section explained the diagnoses from the experiential aspects.

The participants needed to be assured that the presenter did have some expertise in the area of mental illness but it was not made explicit that the presenter was a service user. Then they were invited to be as open and honest in their discussions with no fear of repercussions from managers for their comments. They were also asked to give examples of situations in which they had felt uncomfortable, threatened or were beyond their scope of practice. From these examples people discussed ways to alleviate their anxiety and how they could achieve better outcomes. Generally people wished to be better equipped to handle 'challenging situations'. Frank discussions suggested in some cases how staff may have contributed to incidents where clients became irate and possibly became verbally abusive and finally would be required to leave the premises. When explored, staff conceded this occurred due to employees feeling they had no skills to deal with any possible tense situations or simply because they did not want to deal with 'those people'.

Effective elements of working with social agencies

Aim at changing attitudes

Teaching people skills can produce confidence in the area of possible conflict and is a simple solution for management to adopt. What is more complex is dealing with the negative and hostile attitudes people hold for those with mental illness which can often only surface when a person is faced directly with a situation in which they feel unable to cope. These negative attitudes can also be fed if other members of the team also hold such views. Later on the senior staff or those whom the organisation identified as influential in establishing staff culture were also requested to go through the training programme. It was hoped that these individuals would not only act as role models but also champion and advocate conscientiously for service users.

Reframe mental symptoms

During the workshop, participants were able to identify a number of 'symptoms' or traits that either they or family members demonstrated and began to make the connection to human responses to stress and distress. Therefore what was required was a more empathic and common sense approach to service users. By reframing the presentations of service users, participants discovered that the way to work with them was no different than dealing with any other clients. The staff began to feel more comfortable with dealing with service users as they came to the conclusion that the same principles applied when dealing with all clients. If one acknowledged and validated people's responses to stressful situations this approach goes a long way to enabling effective dialogue while also alleviating possible tensions. It was also discussed how staff would respond or feel when they were not listened to, not feeling valued and their concerns were ignored. This gave them an understanding of what service users were exposed to frequently from society, health and social service professionals and even families. Given the opportunity to explore what staff and service users had in common as well as examining differences, staff attitudes changed and they began viewing service users as people first and not as 'dangerous lunatics'.

Service users make significant contribution

The workshop provided an ideal and safe opportunity for a service user to relay to workers their concerns. It proved useful for employees to see that service users are able to participate in the community, the workforce and can cultivate successful relationships and have meaningful lives, filled with family and friends. Staff commented they had no idea that someone with mental health problems got well. They always believed service users would live a life of dependency and illness. Staff members were made aware of the prevalence of mental illness and shown statistics which demonstrate the large number of people who cope with mental health problems on a daily basis but manage to live a flourishing life, supported by family and friends without the intervention of mental health services. The presenter constantly referred to the human desires that drive us all: to have a life worth living, to form significant relationships and to be a valued member of our family and society. This helped employees grasp the concepts of our humanness and the threads that bind us all as human beings regardless of the labels placed on us by others.

Work with general public: a case study of contact, personal narrative and disclosure

Not only can it be effective for service users to provide training to the agencies and individuals who help them, but additionally service users play an essential role in reducing the overriding stigma in the general public. Numerous studies

cite consumer contact produces the highest improvement in attitudes, better than protest, education and control conditions (Corrigan et al., 2001, 2002; Watson & Corrigan, 2006).

Effectively reducing stigma is not unlike advertising or, to coin a phrase, 'mad-vertising'. Like commercials aiming to pocket part of our coveted 'psychic real estate', that is, monopolise our thoughts about one particular product or issue, so too can the best anti-stigma vehicles change our feelings and minds about mental illnesses and the people who live with them. It is logical and, in fact, vital to have persons with mental illness participate in anti-stigma activities. It is not new to have service users actively participate in these initiatives, but the forms to which they contribute have evolved and certain types are emerging as more effective than others.

The more public stigma is reduced the better the chances for improved social inclusion for those with mental health problems. The effectiveness of treatment and the maintenance of positive results cannot happen without considering the wider ecology of the society in which service users are living. Therefore it is imperative public prejudice be reduced as much as possible because recovery from mental illness is enormously difficult without community support and understanding.

Dr. Patrick Corrigan, well-known researcher on stigma and mental illness and principal investigator of the Chicago Consortium for Stigma Research (CCSR), defines 'contact' as 'introducing people with mental illness to the rest of the population'. And face-to-face interaction appears to have the most impact (Pettigrew & Tropp, 2000). Contact can range from discovering a friend or co-worker has a mental illness, collaborating on a community project with a neighbour who happens to have a disorder, to seeing a public service announcement with people disclosing they have a mental illness. Yet another powerful mode is that of personal narrative, the sharing of the 'lived' experience of mental illness.

Personal narrative at its most basic is sharing one's own experience of a particular event or time. When done well, personal narratives allow others to vicariously experience the events that happened to the 'storyteller'. It places the listener in the midst of the action, letting him or her live through that experience. One of the most powerful methods of changing attitudes and dismantling stigma occurs when services users describe their experiences of what it is like to have mental illness, allowing an entry into that particular, very often hidden world of psychiatric disorder (Corrigan & O'Shaughnessy, 2007).

Although accounts revealed by families and mental health professionals of those who face mental illness can prove helpful, their stories are still once removed from the actual insider's experience. Theirs is not the voice of one who actually lived through and coped with psychosis, for example. It is when an individual who has 'been-there-done-that' discloses their story that it has the greatest impact (Corrigan & O'Shaughnessy, 2007).

Memoirs such as *Electro Boy* (Berhman, 2003), *An Unquiet Mind* (Redfield, 1995) and *Brilliant Madness* (Duke & Hochman, 1992) are examples of insightful personal narratives in the tradition of disclosing mental illness, as is when a

person publicly tells of their experience, such as Margot Kidder's disclosure of bipolar disorder, or the recent public admission of Margaret Trudeau's, wife of the former Canadian Prime Minister Pierre Trudeau, having bipolar disorder. Both these varieties of personal narratives can be influential. But there remains another form gaining popularity in recent years that is unique in the approach it takes in comparison to the ones stated above: stand-up comedy centring on the lived experience of mental illness.

Since its inception in 2004, David Granirer has been teaching individuals with mental illness to be comics in his innovative programme *Stand Up For Mental Health* (SUFMH). Over a 12-week period students learn to write, edit and perform stand-up comedy about their mental illnesses and the experiences surrounding them. At the close of the three months, participants perform for the public in a gala show usually followed by a question and answer period. In most cases, the course continues for an additional nine months where students hone their skills and perform up to 20 more shows.

Granirer, a comic and registered professional counsellor who lives with depression himself, founded the programme to teach the art of stand-up to people with mental illness as a way of building self-esteem and fighting public stigma. Classes are held across Canada, with plans to take it to the USA. The SUFMH programme demonstrates key elements of a successful 'stigma-busting' vehicle. Some of these crucial components are: context, face-to-face interaction, credibility, candidness and irreverent humour.

Effective elements of 'stand up for mental health'

Context

The very context within which SUFMH happens, stand-up comedy, works to fight surrounding stigmas on two levels. First, when service users use stand-up to tell their stories, they become the medium that triggers change, not just because of content but because the audience sees people with mental illness doing something they thought they could not – an activity, in fact, most of the general public would find daunting. Granirer explains: 'We reverse the positions of status. Most people would never want to do stand-up comedy. Seeing people with mental illness do it forces audiences to re-evaluate their perceptions and biases against people who are mentally ill' (personal communication, 2007). The individuals on stage become admired for bravery, for talent, directly challenging the myths that people with mental illness are weak, less intelligent and less capable. Attitudes shift because there is dissonance with the status quo of what it means to be mentally ill. In the words of the eminent educator and philosopher Marshall McLuhan: 'the medium is the message'. Here the comedians become both the medium and the message.

Second, identities of those on stage become that of a comic first rather than a 'schizophrenic'. Audience members see a comic who happens to have major depression, further challenging the typical stereotypes of the 'mentally ill'.

Face-to-face contact and interaction

On stage comedy routines provide audiences pivotal 'face-to-face' contact and interaction with service users that engenders reduction in stigmatising attitudes. 'Face-to-face' contact leads to the most significant kinds of changes in attitudes and beliefs (Pettigrew & Tropp, 2000).

Question and answer periods after the shows provide opportunities for the public to challenge their ideas of mental illness through conversation and dialogue. Attitudinal shifts through direct contact are enhanced even more when coupled with discussion and interaction (Gaertner et al., 1996; Corrigan & O'Shaughnessy, 2007).

Credibility and 'relate-ability'

For any impact to be made, comics must identify themselves as service users through disclosure of their experience and illness. That is, they must establish their 'credibility' as individuals who live with mental illness. This authenticates them as the experts they are in the 'lived' experience of mental illness.

Contact with individuals who 'moderately disconfirm stereotypes' (Johnston & Hewstone, 1992; Corrigan & Watson, 2006; Watson & Corrigan, 2006; Corrigan & O'Shaughnessy, 2007) challenge stigma more than contact with celebrities who disclose their experience of mental illness or individuals who highly conform to prevailing public typecasting (for example meeting someone who has a mental illness and is homeless) (Corrigan & White, 2004). This 'middle contact' group is the kind represented by Granirer's students. SUFMH comics can be seen at www.standupformentalhealth.com. And it is this 'relate-ability' that is the linchpin for helping audiences change their beliefs about people who have mental illness. Meeting someone who is similar to oneself can exact a greater anti-stigma influence than any other kind of individual.

> 'My psychiatrist said I'm a paranoid bipolar. So I said: "Where'd you hear that?"'
>
> Joan Stone (SUFMH comic, 2005/2006)

Candidness and honesty

Disclosure is at the core of personal narrative and is the very foundation upon which SUFMH is built. Disclosure has proven to 'massively increase the power of contact on stigma' (Corrigan & O'Shaughnessy, 2007).

All comedy gives expression to the personal and universal, but this 'stigma-busting' stand-up comedy also illuminates the forbidden, the outlawed and the unspoken.

> 'I have to be honest, I have attempted suicide. Obviously I didn't succeed. But I wasn't a complete failure because I learned I *can* tie a knot to save my life.'
>
> Roxanne Teale (SUFMH comic, 2005/2006)

It is this candid and revealing approach that makes the programme so compelling. As comics divulge their personal stories of mental illness diagnosis, medication trials and hospitalisations (to name a few), they also indirectly unearth prejudices, offer information and challenge deeply entrenched perceptions. Audiences are forced back on themselves and their own ideas of what mental illness is all about. This is where the power of personal narrative and comedy lie.

Irreverent humour

> 'Laughter is breaking through the intellectual barrier; at the moment of laughing something is understood.'
>
> Anonymous

Humour, and in particular irreverent humour, is the primary ingredient in the work of Granirer's students. Research shows protest, which uses a 'shame on you for thinking that' approach, is not effective in changing public stigma and in fact can often result in backlash (Macrae et al., 1994; Corrigan et al., 2001).

Humour, however, puts people at ease, giving people permission to laugh at what is usually a serious subject. Humour inspires conversations to begin and allows awkward dialogues to become comfortable. Irreverent humour works in two ways. It guides the audience into sacred and taboo territory to illuminate collective, long-held and erroneous beliefs and then lets us laugh at the ignorance of those beliefs.

> 'I wanted to go to Paranoids Anonymous. But nobody would tell me where the meetings were.'
>
> Paul Decarie (SUFMH comic, 2005/2006)

The comedy works through exaggeration, absurdity and compassion rather than judgement and shame. The audience giggles despite the forbidden nature of the material, and in fact is giggling *because* of the material. That is the gift of irreverent humour. It gives consent to laugh at what is seen as too sombre to joke about. But that very laughter is what allows people to reflect more easily on what they are responding to. It offers a compassionate light in which to see their misconceptions.

Box 6.1 Suggestions for creating 'personal narrative' initiatives to combat stigma.

- Put a call out for service users willing to share their story and participate in panel discussions
- Meet to provide guidance and time to write a five-minute 'my story' talk
- Practise the talks in front of the group first
- Have an invited audience of friends and family followed by a discussion
- Then hold small public event(s); include a question and answer period

Using comedy and disclosure in the way SUFMH does, entices a public, who might otherwise turn away, to look more closely and respectfully at those who live with mental illness. And it is this open-mindedness on the part of the service user, public and mental health providers that will create the transformation that is sought.

Final thoughts

Research strongly suggests that contact with individuals with whom the public can relate to and who disclose their experiences living with mental illness may in fact be the leading method for eliminating stigma and prejudice surrounding mental disorders. It follows that service users must be key players in public relations initiatives if those initiatives are to be successful. In addition, creating opportunities for service user participation in public relations must be a priority.

Through performing stand-up comedy about their illnesses, service users in David Granirer's course SUFMH provide an ideal vehicle for transforming current views of what it means to 'be mentally ill'. Context, contact, credibility, candidness and irreverent comedy prove to be essential ingredients in making his programme flourish and his 'service-users-turned-students-turned-comics' successful.

Stigma is cited as one of the main reasons why people refuse to seek treatment. As more service users become involved in public relations building and the attitudes about mental illness changes, people who suffer from mental illness in secrecy will reach out for help sooner. It is therefore imperative that not only public stigma be reduced, but to have individuals with mental illness be involved in reducing the very stigma they often experience by creating the true and accurate picture of what it means to have a mental illness. Positive results that individuals gain in mental healthcare settings are easier to maintain within a community ecology in which basic knowledge and skills about mental health and mental illness are widely distributed and a community which is less fearful and perhaps even welcoming to individuals affected by mental health problems (Jorm, 2000).

Conclusion

The recovery model adopted within mental health services changed the role of service users from passive to proactive. As a result, for service users who wish, there are now opportunities for them to share their 'lived experience' wisdom to advance better outcomes, act as mental health advocates and enhance public relations. The external environment in which a person recovers plays a pivotal function in that individual's road to wellness. Therefore, management of public relations between mental health services and family and carers, related social agencies and the public is a significant issue.

It is critical, yet often challenging, for mental health professionals to create and preserve clear and successful communication with loved ones and carers of

individuals recovering from mental illness. Accommodating the needs of family members and carers, while respecting the wishes of the person with mental illness, is a delicate task requiring diplomacy, clarity and excellent listening and interpersonal skills. A salient element in upholding a helpful relationship with family and carers is offering practical advice and resources about their loved one's illness and what they may face as he or she recovers.

When service users have a central role in anti-stigma initiatives, the greatest impact is seen. Contact with chances for exchange of ideas produces the most significant improvement in attitudes. Community integration and social inclusion for service users can be less difficult when public stigma and prejudice is diminished. When disclosure of one's own mental illness story or personal narrative occurs within the context of this kind of contact, attitudes shift most significantly, more than with anti-stigma protests and education tactics.

It is through the engagement of the wisdom of service users, their insights from living with and recovering from mental illness that will best help public relations prosper. Communities, families, service agencies and other stakeholders learn the most when mental health information is provided by those who know the illnesses from the inside out. The more programmes that are developed with services users as the driving force and at the forefront, the better the outcomes will be.

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Chapter 7
Organisational changes towards recovery-oriented services

Samson Tse and Steve Barnett

Chapter overview

This chapter covers the organisational implications of several decades of changes in the concepts, espoused values and intended design of mental health services. Practical strategies are offered for mental health practitioners who are frustrated that their arguments for change seem to fail. Solutions focus on changed communication and relational behaviour.

The recovery approach is used as a metaphor to interpret presenting organisational problems, reach a diagnosis and outline the indications for intervention to aid recovery. The chapter first describes the organisational setting from the mental health practitioner's perspective with a synopsis of the three main drivers for change in mental health services over the past decade:

- deinstitutionalisation of care
- the rise of the population perspective on mental health
- adoption of the recovery approach as the guiding principle of mental health service.

The organisational perspective is further developed by presenting the issues in organisational change as they likely apply to the mental health settings. In this analysis it is suggested that the issues be regarded as symptoms of organisational illness, then show how the recovery approach, originally devised for intervention of individuals with mental health problems, is applied to organisational illness to regain organisational health. Rejecting conventional management of the transformation process, a change-project management case example is developed along with tools and strategies to manage the transformation.

The changing faces of mental health services

The major shaping forces and locations of the considerable changes in mental health services over the past several decades can be broadly classified into three main themes.

Deinstitutionalisation

Patients are relocated from large-scale psychiatric facilities into the community where care and support are presumably being provided by alternative psychiatric services together within their social network. In the mid-1970s, a series of meetings at the National Institute of Mental Health in the USA resulted in the concept of community support systems (CSS). The CSS was defined as 'a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community' (Anthony, 1993, p. 523). The intention was for community mental health centres to provide the link in helping individuals with mental illness in their transition from institutionalisation to the community. They were to provide for the differing needs of all peoples and support the goal of humane care delivered in the least restrictive way (Morrison, 1997).

Community mental healthcare is considered a different approach from more conventional forms of psychiatric services such as hospital-based acute treatment and rehabilitation services (Sayce et al., 1991). Between 1998 and 2001 a major research project to investigate the concept of good community mental healtcare concluded that good care is associated with (Liegeois & Van Audenhove, 2005):

- a trusting and stimulating relationship between individual clients and their professional helpers
- interventions tailored to meet individual needs
- comprehensive and locally available services which are accessible to those who need them
- support and care provided by the client's family or other informal carers, whose needs for information and backing should also be addressed.

To effectively achieve all these individualised, decentralised, relationship-oriented outcomes for clients, their families and other carers, will require a fairly radical change in professional practice of individual workers and their workplace organisation and culture.

Population perspective on mental health

There is an emergent and rapidly growing concern to address issues of population mental health. In 2003, the World Health Organization (WHO) estimated as many as 450 million people have a mental or behavioural disorder. Nearly one million people commit suicide every year. WHO (2003) also projects that the number of individuals with mental disorders is likely to increase further in view of the ageing of the population, worsening social problems (e.g. family violence, illegal drug use) and civil unrest.

In Australia, depression is the leading cause of non-fatal disease burden in the total population, causing 8% of the total years lived in disability (YLD) in 1996 (Mathers et al., 1999). The latest New Zealand mental health survey, Te Rau Hinengaro, estimates that 46.6% of the population meet criteria for a mental

disorder at some time in their life (Oakley Brown et al., 2006). Such population statistics signal that mental health professionals have to work closely with primary healthcare services, address problems of stigma and discrimination associated with mental health problems, engage in health promotion activities and raise the level of mental health literacy of the general population (Barry, 2001; European Commission, 2005).

Recovery-oriented services

The recovery approach to mental health services has been adopted as a fundamental value and guiding principle in most mental health services. It spans and penetrates funding, policy planning, services development and delivery, legislative support, advocacy and workforce training.

Recovery can be defined as a 'process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society; this process is supported by those who believe in us and give us hope' (Ralph, 2000, p. 27). In the early 1980s, the term recovery seldom appeared in articles. In the late 1980s and early 1990s, the word recovery was introduced in consumer writing by Deegan (1988) in the paper 'Recovery: the lived experience of rehabilitation' and in a non-consumer paper by Anthony (1993) in 'Recovery from mental illness: the guiding vision of the mental health service system in the 1990s'. Since then there has been a surge of research studies and concept papers on recovery. For example: how recovery is defined; the theoretical underpinnings and the psychological construct; the barriers and facilitators during the recovery process; evidence on whether the recovery approach works; how recovery is described by individuals with various backgrounds such as someone with personal experiences of mental illness; and family/other carers and mental health professionals (e.g. Spaniol & Koehler, 1994; Corrigan et al., 1999; Marsh, 2000; Smith, 2000; Carpenter, 2002; Lapsley et al., 2002; Anthony et al., 2003).

Since the beginning of the twentieth century, recovery research has focused very much on how to create a 'recovery enhancing environment' or a 'recovery-transformed system'; and how to measure recovery-based mental health services (e.g. Ridgway, 2003; Zahniser et al., 2005; Andresen, et al., 2006; Crowe et al., 2006).

Essentially the latest focus to advance the understanding and application of recovery approach is on how to reorientate existing services to put recovery into practice and gather evidence about its effectiveness or otherwise. Together, these three main themes highlight change issues:

- individualisation, decentralisation, relationship orientation of practice that is directed not only at patients but also at their families and other carers
- working closely with primary healthcare services and engaging in general health promotion and education
- reorientating existing services to enable the recovery approach to be put into practice and to gather evidence of its effectiveness or otherwise.

They each spell major transformative change: transformation in behaviour, orientation and organisation; a transformation in administrative practice and culture; and transformation of client–practitioner (therapeutic), practitioner–practitioner (professional) and organisational relationships.

Changing workplace culture

Perhaps the most difficult aspect of the transformation is to change the organisational culture within which mental health workers operate. This is because the organisational context is typically not practitioners' primary professional concern, though it may be their primary frustration. It is also because organisational culture is underpinned by a set of assumptions about the form, content and conduct of interpersonal relationships within an organisation. For example, some community mental health centres, which are presumably sources of mental health knowledge and expertise, are criticised by their own colleagues and users for inability to make changes and for lack of recovery vision. This apparent failure might be due to the fact that the service and the set-up is not organised for change but to generate and dispense clinical expertise.

Using the community mental health centre as an example, it is argued that change in practice is precluded by the extant organisational culture and climate rather than lack of expert knowledge. Thus it is proposed that to transform practice, practitioners, administrators and managers must transform their assumptions about their individual and collective identity and the conduct of their organisational relationships.

Mental health practitioners can achieve that provided they learn to apply their knowledge and expertise, normally applied to their clients and client relationships, to themselves and their organisational relationships. In particular they apply the recovery approach to their professional and organisational behaviour.

In developing this organisational recovery scenario it is important to first take a closer look at the likely roots and drivers of the tacit organisational culture. This analysis is extended to indicate how dysfunction between organisation and practice might be characterised as an organisational illness and therefore 'treatable' by using a recovery approach.

Cultural dysfunction and organisational illness

Tacit organisational context lies, iceberg-like, beneath the surface. For instance, the triangular-shaped organisational diagrams consisting of interconnected boxes representing hierarchical positions with subgroups representing departments or divisions are an abstract, partial representation of the actual organisational and interpersonal relationships and processes. These triangular representations are strongly associated with bureaucratic models and the machine metaphor of organisation. This model/metaphor was, and still is, a productive way of

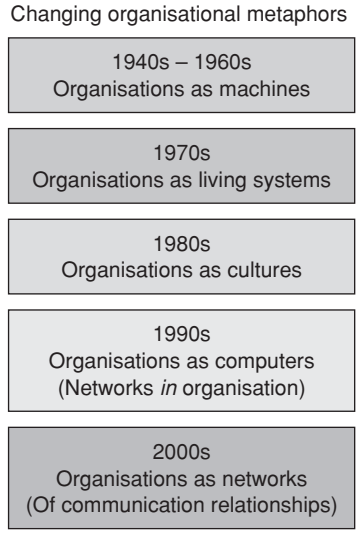

Figure 7.1 Change of organisational metaphors (adapted from Contractor, 2002).

conceptualising and understanding large organisations operating in stable, unchanging environments. However, with increasing rates of change new metaphors have emerged (Figure 7.1) in response to a general need to conceptualise organisations in more productive ways.

The living system metaphor of the 1970s replaced the rigidity of the dispassionate bureaucratic machine metaphor in the 1940–1960s. The culture metaphor of the 1980s highlighted the concept of organisation as consisting of people, the social beings. Organisational change was synonymous with culture change. The computer metaphor of the 1990s seemed to conveniently simplify and objectify the complexity of culture by attending to information, information systems, information management. Knowledge was synonymous with information.

The phenomenon of the worldwide web (www) has given rise to the notion of organisations as networks – blurring organisational boundaries and informational pathways. Furthermore the www phenomena has produced the possibility of organisations as virtual communities that only exist as the intercommunication between members. So the concept of organisation simply as communication relationships has emerged.

These metaphors, viewed together, comprise a colourful and rich description of the various facets of organisation and practice, suggesting possibilities and meaningful models for change and innovation. However, that possibility has been dominated, especially during the past two decades, by managerial ideology (Freidson, 2001; Parker, 2002) focusing on organisational structures, the centrality of managers and their supposedly value-neutral managerial logic. Managerial assumptions, practices and expectations may be productive in some business settings. But when complexity and diversity cannot be avoided, and expectations are not readily manageable, such as in mental health services, then pervasive

Table 7.1 Characteristics of two communication climates (Gibb, 1961, p. 412).

Characteristics of a defensive communication climate	Characteristics of a supportive communication climate
Evaluation	Description
Control	Problem orientation
Strategy	Spontaneity
Neutrality	Empathy
Superiority	Equality
Certainty	Provisionalism

managerial assumptions and practices may produce organisational dysfunction. This dysfunction may be evident in interpersonal conflict between practitioners, between managers, and between practitioners and managers; in passive/aggressive communication behaviours associated with defensive rather than supportive communication climates (Table 7.1; Gibb, 1961).

Under such conditions it is little wonder therefore that: mental health professionals would struggle to maintain and improve service quality within shrinking resources and increasing expectations; in some cases they would appear to become increasingly cynical in their dealings with their employing organisations; mental health programmes would be conceived with little understanding of recovery values and principles; and in the extreme, the dysfunctional organisation would become incapable of delivering recovery-oriented mental health services.

Recovery in practice

Though it describes process and outcome for an individual with mental health problems, the 'guideline to the recovery approach' illustrated in Figure 7.2 can also apply to enable practitioners to better collaborate to develop new individual and organisational identity and support new recovery-centred practice. For instance 'recovery as outcomes' for mental health services might involve: confidence, productivity, (functional) wellness, new knowledge and skills, quality (internal and external) relationships, and mobilisation of external collaboration to develop new opportunities to deliver improved services.

The implications, for professional and organisational culture, of recovery practice have received recent close attention. For example, key ingredients of a Recovery Oriented Mental Health Program (ROMHP) have been characterised by explicit statements about the programme structures such as mission, policies, procedures, record keeping and quality assurance. It has been argued that these factors are consistent with fundamental recovery values regardless of the specific mental health service delivered (Table 7.2; Farkas et al., 2005).

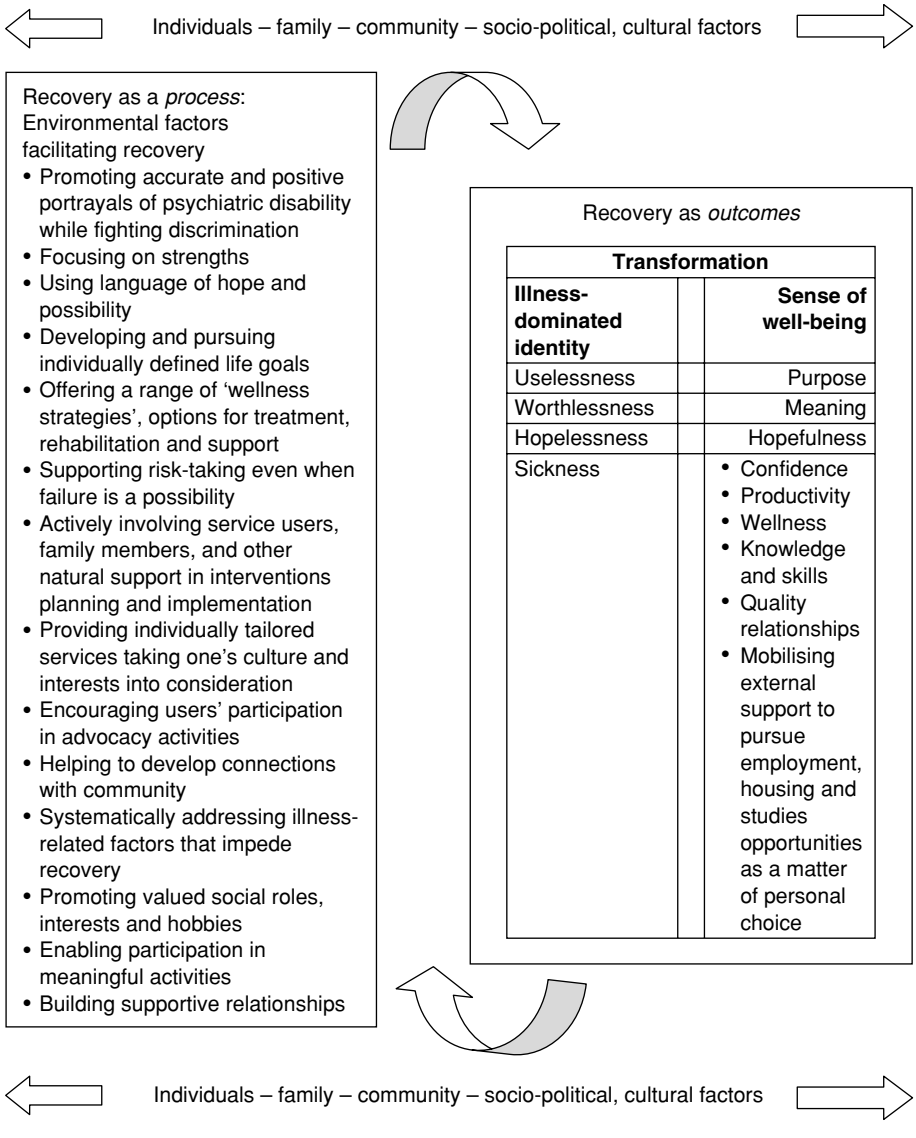

Figure 7.2 Recovery as a process and outcomes (adapted from: Mancini et al., 2005; O'Connell et al., 2005; Roe et al., 2007).

In another example, Crowe and colleagues (2006) provided a two-day training session titled 'Collaborative Recovery Training Program' to increase mental health professionals' knowledge, attitudes and hopefulness regarding the possibility of recovery. The preliminary findings showed that over the course of the session, desired changes were found in trainees' recovery-related knowledge, beliefs and attitudes. This seems to indicate that through intensive collaborative learning processes, mental health professionals can change. However, researchers

Table 7.2 Critical dimensions of recovery-oriented mental health programme.

Key recovery values	
Person orientation	The service focuses on the individual first and foremost as an individual with strengths, talents, interests as well as limitations rather than treating the person as a 'case'
Person involvement	The service focuses on people's right to full partnership in all aspects of their recovery including planning, implementing and evaluating the services that is meant to support their recovery
Self-determination/choice	The service focuses on people's rights to make individual decisions about *all aspects* of their recovery process
Growth potential	The service focuses on the inherent capacity of any individual to recover, regardless of whether, at the moment, he or she is overwhelmed by the disability, living with or living beyond the disability
Examples of values-based recovery standards by programme dimensions	
Organisation and administration	
Programme dimensions	*Examples of recovery standard*
Mission	Help people improve their functioning so that they can be successful and satisfied in the environment of their choice
Policies	People will have the opportunities and assistance to choose and plan for whatever services they want to promote their own recovery
Procedures	Provide orientation steps in different communication modalities to ensure clients receive sufficient information about the programme (e.g. what the programme offers, cannot offer, what it expects and how clients can give feedback)
Record keeping	Records are designed to include process and outcome measures related directly to the programme's mission
Quality assurance	Monitor programme outcomes include measures selected by clients
Physical setting	Programme facilities are for everyone's use
Network	Programme links to services in both community and professional settings
Staffing	
Programme dimensions	*Examples of recovery standard*
Selection	Staff members are hired based on their knowledge, attitudes and skills in recovery
Training	Staff training includes interaction and interview with individuals who have recovered or are living beyond their disability
Supervision	Promotions, rewards and supervisors' reinforcement reflects staff's ability to demonstrate the knowledge, attitudes and skills necessary for recovery and recovery outcomes

Adapted from Farkas et al. (2005).

acknowledge (e.g. Farkas et al., 2005; Deane et al., 2006; Crowe et al., 2006, 2007) the challenge of translating the prescribed process and isolated professional awareness into widespread cultural change within an organisation necessary to actually incorporate the complex and multidimensional recovery process in a mental health service.

In many cases the challenge may be to manage the recovery treatment of a dysfunctional organisation. Clearly the organisational and management model that produced the dysfunction is unlikely to provide the solution. A communication-based, relational alternative to conventional organisation and management is proposed.

Fostering organisational recovery: a relational approach

The strength of conventional bureaucratic management is its comparative efficiency at operating standardised routines and procedures in stable environments where incremental change is sufficient to maintain a balance between operational capability and stakeholders' expectations (Mintzberg, 1983). When this comparative organisational stasis is disturbed, or pushed beyond equilibrium by the changing organisational environment, the conventional management assumptions and processes may no longer suffice.

The usual reactions will likely be to tighten and heighten conventional managerial controls. This may be evident in increased demand for detailed analyses, and demand for new policies, typically prescriptive procedures and related compliance audits. This reaction is problematic because a loosening rather than a tightening of conventional control is needed so that new knowledge, new ways of responding can be collaboratively discovered, experimented and communicated (Argyris, 1998). The question is, can such loosening be achieved without compromising the quality of current service? In other words, can organisational looseness and tightness be achieved simultaneously?

Mintzberg (1983) suggested this apparent contradiction can be achieved through professional autonomy (looseness) operating within an administrative bureaucracy (tightness). Such organisation was, and often still is, a characteristic of institutions such as universities and teaching hospitals. However, these institutions were designed or evolved for relatively stable environments, not for collaborative change in dynamic and complex environments.

It seems fairly clear that new organisational knowledge is needed and that generating it will require at least an augmented set of organisational processes. The augmentation must not diminish the functional capability to continue standard operations but at the same time must enable experimentation and accommodate ambiguity and not-knowing. It must support new shared understanding and successful collaborative action without compromising conventional bureaucratic action. In other words, the augmented processes must generate a culture that values socially situated knowledge, as contained in and enacted through relationships in addition to what is conventionally available in individuals or in manuals

(Argyris & Schon, 1978; Araujo, 1998; Brown & Duguid, 1991, 2001; Gherardi, 2001).

Such organisational augmentation would typically be attempted as a project managed by a multidisciplinary team to devise, plan and implement the changes. The inter-relationships among various team members and responsibilities allocated would typically be in addition to members' normal functional connections. Such a minor structural modification or a 'rewiring' of the conventional organisational structure is unlikely to generate new culture for transformation. That requires reconceptualisation of the project as a relationally focused rather than a task-focused enterprise. This begins with transformation of project team members' interpersonal communication and then extends to the wider organisation. A communication-based relational strategy is proposed in which mental health workers and managers reflectively adapt and apply recovery values (Farkas et al., 2005) and the contextual factors (see Figure 7.2) to themselves, their inter-relationships and their organisation.

Communication-based relational strategy

Conventional project management is typically task focused. Success depends on the accuracy of the planning and controlled completion of the sequence of tasks.

In a project to achieve transformational change, the exact, objective outputs cannot be known at the outset. They emerge from the project process. The sequence of tasks and events is similarly not known. Success centres not on conventional objective knowing but on knowing the processes that have the highest probability of producing success. It is about processes of continual learning and adjustment to first discern the target and then to reach it. Clearly in such emergence, change will be endemic, necessary, desired, even welcomed in contrast to being dreaded in conventional project management.

The authors suggest that the fundamental knowledge and skills for emergence are in the area of interpersonal relationships and a related set of concepts of organisation and leadership for change:

- organisation as a web of communication relationships rather than structures (Weick & Ashford, 2001)
- organisational knowledge, learning and hence change, being socially situated in relationships (Lave, 1996; Wenger, 2000)
- leadership through cohering frameworks of a widely and deeply shared sense of vision and purpose (Senge, 1990; Senge et al., 1994; Collins, 2001).

A project-based strategy for achieving organisational change in mental health services is proposed. In particular a relationally focused approach is suggested in contrast to a typical task-focused approach to project leadership. A web of purposeful communication relationships should be built rather than conventional reporting structures, mechanisms and task sequences. Collaborative organisational experimentation and learning is encouraged rather than managerially determined

tasks and accountabilities. Furthermore, this should be operated within a widely and deeply shared sense of purpose and vision.

Such approaches have a higher chance of success because mental health professionals typically have strong sense of vocational vision and purpose, understand the central therapeutic value of interpersonal relationships, and generally have skills to achieve therapeutic change. Because task-focused managerial assumptions are endemic in the general organisational environment, especially of large bureaucratic organisations, the project leaders and members will need continual coaching and support to maintain their relational, process focus.

Coaching support is primarily for the project leaders who will likely experience pressure from internal and external stakeholders to abandon the relationally focused strategy in order to achieve early progress on tasks. Task progress is managerially attractive because it is generally tangible, objectively measurable and time saved by early task completion is typically regarded as the best hedge against later unplanned change.

The conventional ideal path to project completion is represented by the straight line in Figure 7.3. The curved upper line represents early attention to tasks, minimising the possibility of unexpected change and accumulating slack time in the knowledge that change unfortunately will probably occur. However, in a transformational change project, the strategy is to enable new ideas, new perspectives and new leaders to emerge. This emergence is enabled and supported through a web of interpersonal relationships and collaborative behaviours that are expressed in the agreed framework of high-level goals and objectives for the project. The best time to build these relationships and behaviours is in the early phases of the project. It is too late in the advanced planning and execution phases when the behavioural climate and trajectory is already 'locked in' by the resources spent.

It is hypothesised that a project with a strongly developed relational network and open, supportive communication climate (the lower curved line in Figure 7.3)

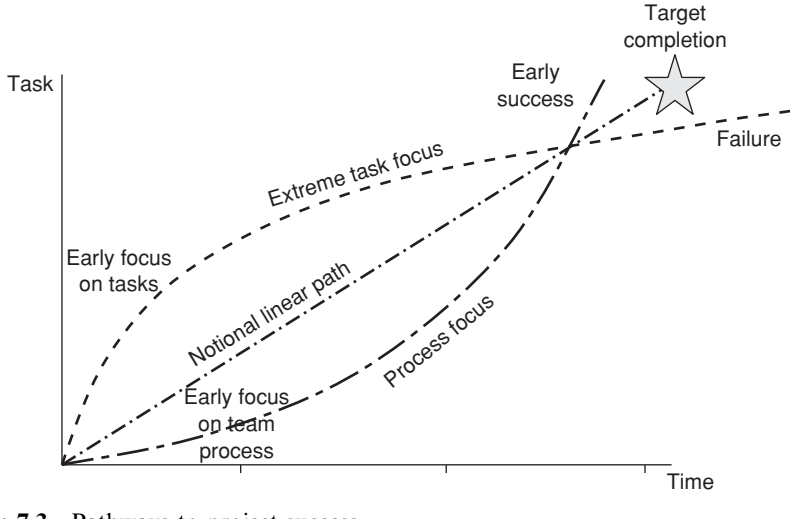

Figure 7.3 Pathways to project success.

is more likely to succeed than a task-focused project with weak relational development because it is more likely to produce and effectively respond to transformative change.

Patterns of change and the role of the project manager

The fruits of transformative organisational change are unlikely to emerge within one, or even two years. Some indicative benefits may appear during the first year but clear results typically take two to five years (Edwards Deming, 1994). Significant progress can be achieved in as little as 12 weeks within particular teams and clusters. These pockets of changed behaviour, though fragile in the midst of unchanged assumptions, practices and behaviours that pervade the wider organisation, are the nuclei around which change grows – a 'strategic termite' model of change (Morgan, 1993).

Given the comparative slowness of the change process, conventional expectations for early outcomes are therefore another pressure on project leaders to truncate the typically messy, complex early project phases. These early phases are where shared understanding is achieved to reduce the chances of persistent misunderstanding and expensive later repair. The early phases are also the critical time where the foundations and relational infrastructure of distributed leadership and responsibility are established.

Project leaders must resist pressure, stemming from others' or their own sense of uncertainty, for early detailed specification, analysis and planning. This pressure will be evident from expectations of superiors and subordinates alike for answers, managerial direction, detail and objective progress. The pressure and expectation is for early resolution of ambiguity. Yet that ambiguity and the related anxiety and uncertainty are key factors in achieving the transformation. The ambiguity is strategically desirable in the change process (Eisenberg et al., 2001), especially the early phases, and the associated anxiety a key indicator of progress.

Rising anxiety indicates progress towards the 'tipping point' (Gladwell, 2000; Kim & Mauborgne, 2006) in a particular transformational change process. The anxiety is both the trigger and the motivation for change in communication and relational behaviour from conventional, largely individualistic behaviours to collaborative behaviours that enable new, experiential organisational learning (Lichtenstein, 1997).

The key to achieving the transformation, to successfully moving through the crisis of the tipping point rather than slipping backwards to conventional status quo, lies in anticipating and recognising the tipping point and seizing the opportunities it presents. The early signs of successful transformation include: previously unspoken ideas are shared; uninterested people show signs of engagement; new leaders and new followers emerge; individuals risk new openness in relationships with colleagues, managers and subordinates; previously hidden talent, skill and aptitude surfaces. In other words the organisation, team by team, cluster by cluster, pocket by pocket, begins to transform with a new widely and deeply shared purpose.

The project is not a managerially engineered, company-wide change programme, the likes of which are evidently one of the greatest obstacles to effecting real change (Beer et al., 1990; Clarke, 1999). It is a raft of collaborative, interpersonal relationships. It consists of a series of mini-projects centred on the relationships and communication that makes up actual organisational life and practice. The overall two-to-five-year change-project can usefully be regarded as cumulative learning through a web of 12-week mini-change-projects. Each has its own particular cycle of anxiety, tipping point and transformation, with the tipping point occurring between the eighth and twelfth weeks. This cycle is driven by the generally acknowledged need to change and is supported by the reflective practice and performance appraisal tools that are described and discussed later in this chapter.

Thus the general purpose of the transformation project, whatever the presenting technical issue, is to achieve change in communication relational behaviour in the belief that dysfunction is healed through collaboratively changed relationships and communication behaviour. Broadly speaking the desired change is from closed, manipulative aggressive/defensive communication (Gibb, 1961) characterised by blaming, shaming and justifying, to assertive/supportive communication. Assertive communication is characterised by open agendas and individuals confidently, openly voicing their perspectives in the robust interaction for consensus-based prioritisation and decision-making; here consensus means unity not unanimity or uniformity.

For instance, assertive communicators typically begin by describing, without blame, the situation as they perceive it. They disclose the observations or data that form the basis of their perception; they then describe their feelings about the situation; then, based on that perception and the data, they say what they want to happen; and finally they ask for others' perceptions, as the following exemplar illustrates.

> 'The proposed key performance indicators (KPIs) *seem to me* to measure compliance with an administrative process that *as far as I know* has no established correlation with successful clinical intervention. For instance *I appreciate* that we need guidelines for [interviewing children] but gauging our professional performance from simple procedural compliance data, to be collected by a junior clerk, *seems to me* to be an unhelpful, unreliable measure of complex professional service.
>
> *I feel* confused and annoyed about this: confused because *I don't know* whether to pay attention to the KPIs or to the quality of my professional practice; annoyed because *it seems to me* that these KPIs have been developed and will now be implemented without adequate thought and design.
>
> *I want us* to collaborate to devise some KPIs that more reliably indicate the quality of our service. What do you think?'
>
> (Notice that this exemplar has the characteristics of Gibb's Supportive Communication Climate, see Table 7.1.)

The project leader's role is to not be the technically expert manager and task master. It is to model, mirror and mentor collaborative relational behaviour. In other words to 'talk the walk' and 'walk the talk'; to model the process of exposing untested assumptions about communication and organisation so that they can be checked, modified and change can begin; to model constructive giving, receiving, and learning from feedback and openly enacting that learning; and to commend, encourage and respond collaboratively to collaborative behaviour.

It requires a project leader with a different set of skills to thus reflect the rising, projected anxiety back to the project team and mentor them in communication and relational behaviour for collaboration. In that sense the project leader's job is to not meet conventional managerial expectations but to operate the recovery approach (Tables 7.1 and 7.2) at the professional and organisational levels. In a managerial sense this is risky territory. Risk-averse, individualistic managers and subordinates will tend to 'cut and run' or disengage when they feel they are losing control or 'getting out of their depth'. Hence the need for experienced external coaching support for the leaders.

Coaching support is probably best initiated by the coach facilitating a one-day intensive interactive workshop to lay the foundations of the developing and growing web of relationships. The intended outputs are shared vision, purpose and high-level goals. This initial understanding will change and develop as the project unfolds. The workshop is more about process than outputs though outputs are important too. Managers are typically surprised at the high levels of congruence and the energy and excitement that a well facilitated workshop produces.

The workshop would probably consist of a sequence of around nine segments.

(1) Revisit core values – an important process for relationship building and for building a sense of shared purpose is to workshop the shared core values of the organisation and its members. This is essentially a brainstorming exercise that includes all members of the immediate organisation. The aim is to achieve a distillate of four or five core values. It is important at this point to identify champions from among the participants, for each of the core values. Their role is to be accountable for maintaining the ongoing visibility of these values in strategic decision making. In a political sense the champions lead the lobbying to ensure the visibility of the values in meetings and conversations, performance measures and recruitment. The champions are accountable for that visibility.
(2) Identify three or four cornerstones of the organisation's purpose – its promise to the people it serves. This brainstorming and distilling process is also important for building a sense of shared purpose. These cornerstones will be congruent with the core values. For instance they might be 'recovery-oriented', 'reliable' and 'accessible'. Try to qualify these terms as a way to discover the various meanings that underpin them. These cornerstones serve as durable reference criteria for organisational decisions (as do the core values).
(3) Generate a shared vision and a challenging long-term (say 10-year) goal on the path to achieving the higher vision. Imagine what could be if all the

perceived barriers and constraints could be overcome. This is an opportunity to visualise beyond the current limitations: a way 'out of the square'. Again, in this process, organisation members are encouraged to learn about themselves and their colleagues and build an awareness and clarity about the natural alignment of purposes within the variety of perspectives.

(4) Break that long-term goal down successively into a medium-term (three-to-five-year) goal and then a one-year goal. Later (below) break that one-year goal into 12-week goals. That's when detail is considered.

(5) Identify the main strengths, weaknesses, opportunities and threats to the group achieving its one-year goal. In brainstorming the possibilities pay special attention not only to their effect on achieving the goal, but also on the *communication and relational behaviours and processes* within and external to the group.

(6) Classify the possibilities into four categories (Figure 7.4) according to their effort and effect required to achieve increased benefit.

(7) Agree on a selection of up to five preferably high value/easy-to-achieve possibilities for attention during the next 12 weeks. Take care not to overlook possibilities in the high value, hard-to-achieve category. Identify a champion for each and determine generally how progress will be apparent and measured.

(8) Establish a schedule for both regular short and long meetings and other information gathering and feedback opportunities. The simplest, shortest, most frequent meetings may simply be each team member in turn briefly telling the others what they are doing that day, what their immediate issues are, and how they feel about the prospects. The core values should be visible and enacted in these regular meetings. One way to explicitly achieve that is to ask members to bring stories about enacting (or not enacting) the core values in their organisational relationships and activities. In mental health services the values that underpin the recovery approach would probably figure prominently.

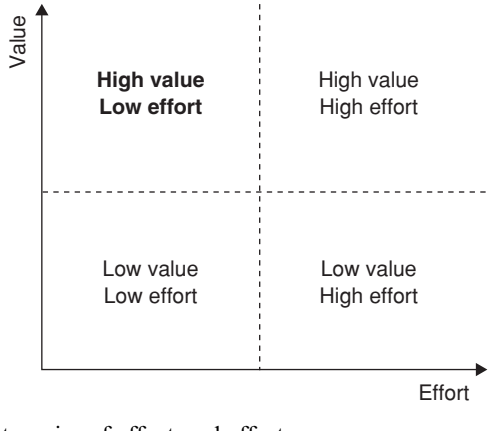

Figure 7.4 Four categories of effort and effect.

(9) Celebrate having completed these initial steps. The key is to maintain the momentum achieved in the workshop through ongoing communication where emergent issues and the change progress can be tracked.

Management tools and systems for change

Two systems are outlined in this section: shared reflection and peer performance appraisal. These are designed to support the project leaders as coaches or mentors of intrapersonal, interpersonal and organisational communication and interrelationship. The aim is to change the way mental health service is organised: to change the mental health practitioners', managers' and administrators' formal and informal communication pathways; their interpersonal behaviours and roles; their assumptions about the way to behave and interact with each other; and other facets of tacit and explicit organisational knowledge. The focus is on changed communication behaviour.

Crucially, communication behaviour and behaviour change are best monitored and managed by peers within individual and group reflective process. These two systems are based on three fundamental values:

- the concept of organisation as communication relationships (Senge, 1990; Senge et al., 1994; Weick & Ashford, 2001);
- the principles of reflective practice (Argyris, 1991);
- the values and attitudes embedded in the recovery approach (see Figure 7.2 and Table 7.2).

Shared reflection

Shared reflection on shared experience of organisational (as distinct from clinical: practitioner–patient) practice and change is the core activity. It is used to reveal assumptions about self, group and organisation; and to discover and utilise valid data (Argyris & Schon, 1978). The performance appraisal system outlined below assists this evidence-informed change process. The quality of reflection is indicated not so much by the scholarly or intellectual content as it is by the depth of interpretation of specific intra- and interpersonal communication behaviour in actual, shared communication events and episodes within the organisational change project.

To encourage personal disclosure within small mentored groups of practitioners, access to shared reflection is restricted to the group members and their mentor. The mentor models and encourages reflection that is personal, specific to particular communication acts (dialogue), insightful, and proposes and monitors plans for personal behaviour change.

For best effect, reflection should be frequent. For example, each team member of practitioners completes a reflection weekly on at least one communication event. A communication event occurs in a particular context and is typically around

an issue, problem, conflict, or a segment of a routine process. The mentor leads discussion on the quality and usefulness of each reflection. The quality standards are indicated by the list 'Environmental factors facilitating recovery' in Figure 7.2.

Virtual, asynchronous communication channels such as electronic discussion boards and blogs can be used to overcome difficulty of sharing reflections and feedback. This is especially because computer-based information and communication technology (ICT) is increasingly accessed by members of mental health service organisations in their work and private lives. Textual, asynchronous communication has the added advantage of providing continuity of narrative plus requiring more thought and explicit care than verbal communication.

Depending on the assumptions that they bring to this medium members will respond differently. Some may be more reluctant to disclose than by face-to-face, preferring more immediate, dynamic interactions or perhaps because they are wary of written records. Conversely, others may feel freer to disclose and experiment because they prefer to have time to consider their interactions or because shyness, perceived power dynamics or language difficulties constrain them in more immediate, dynamic media. Whatever medium is used, the aim is to provide a variety of avenues to build trust and openness for shared reflection amongst the group.

Peer performance appraisal

Appraisal of communication behaviour is the job of team peers. Appraisal against a suitable set of standard behaviour-based criteria can enable tracking of change and development over time. Such appraisal is a normal part of many comprehensive commercial performance management systems. In such systems, behaviour-based, process-focused performance appraisal by an individual's peers, supervisors and subordinates (360-degree appraisal) balances the typically output-based goal-focused measures used as KPIs. Peer appraisal in commercial systems is usually anonymous whereas an open appraisal within the project team is mentored by project team members.

A set of criteria specifically applicable to the mental health service context could be developed from the list of facilitating environmental factors in Figure 7.2. Each factor can be expanded into a range of specific observable behaviours that indicate different levels of performance. For example the set of four criteria in Figure 7.5 have been derived from the factor 'Enabling participation in meaningful activities'. The objective in designing the appraisal questionnaire is to cover the diverse contributions and levels of competency that individuals contribute to collaborative activity. Figure 7.5 shows a typical appraisal pattern and score, out of 50.

Peer performance appraisals can be consolidated for each appraisee and the individual and consolidated results can be openly shared to further inform the reflective process. Change can be tracked by subscale and total scores. After allowing time for the peers to pilot the system to familiarise themselves with the way the scoring works and building trust and openness, the appraisal system can be

Enabling participation in meaningful activities	Always (5)	Mostly (4)	Often (3)	Sometimes (2)	Rarely (1)	Unknown (0)	Score
Novice: keeps learning Shares new information with the team? (1 ×)	●						5
Intermediate: acts as a coach Offers practical advice, demonstrations and the insight of experience? (2 ×)		●					8
Experienced: increases the team skill base Encourages and supports others take the lead and practice leadership? (3 ×)			●				9
Sophisticated: pushes the team Challenges the team to go beyond the accepted barriers? (4 ×)					●		4
							25

Figure 7.5 Example of items and scores for 'enabling participation in meaningful activities'.

given 'bite' (Collins, 1999) by linking the consolidated results to apportionment of group reward and recognition.

For instance, a team that has achieved a recognised high level of success in, or as a result of, collaborative professional practice, can use the peer appraisal data to identify and acknowledge particular team members for their contribution to building the underpinning relationships. The power in this is that the team, not the manager, decides by systematic process which members to especially recognise or reward. This contrasts and balances conventional processes that are decided by managers and tend to focus on individual performance. It helps stimulate, encourage and reward behaviours that support and enable organisational learning to collaborate more effectively.

Conclusion

The massive pressure and scope for change in mental health services indicates a transformation in practice and organisation. Though the requirements seem well, even widely understood, effective implementation of the espoused change has proved difficult and frustrating.

The roots to this difficulty and frustration lie in the tacit assumptions about organisation that we call culture. For transformation to occur, this tacit culture must be identified, acknowledged, examined and purposefully modified. This is a communication-intensive process where normally acceptable communication behaviours and processes are not effective. A fundamental or driving element of the transformation process is to develop more effective interpersonal and organisational communication behaviours and processes.

A diagnosis of the persistent organisational dysfunction as 'mental illness' suggests that organisational wellness might well be achieved by adaptation of the recovery approach to the professional and organisational levels of change in health services. Transforming the culture of the organisation is thus similar to transforming the health and well-being of the individual.

While such a novel application of mental health knowledge may make intellectual sense, it is expected that this intellectual understanding will not readily translate into behaviour change. Major barriers are organisational and management assumptions, behaviours and processes that produced the dysfunction. They are unlikely to enable and support effective treatment. The transformation project therefore requires a new approach to management, that is, a recovery approach.

Thus we advocate a carefully designed and managed project to transform mental health service organisation from managerial to recovery-based culture to enable the delivery of quality mental health services to clients with mental health problems and the population in general. Two main tools for design and management were proposed: (i) shared reflection on inter-relational communication behaviour and (ii) shared peer performance appraisal to drive, inform and measure the behaviour change. These tools are operated within the overarching values and programme of the recovery approach to achieve the necessary communication and relationship climate for recovery.

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Chapter 8
Clinical supervision

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Chapter overview

Clinical supervision has attracted substantial interest in recent years as a core process in the operation of mental health services (White & Winstanley, 2006; Butterworth et al., 2008). Advocacy for introduction of clinical supervision has been especially strong within the nursing profession (for which it is relatively new) and in the UK, where it has become mandatory in some services (Abbott et al., 2006). This chapter discusses the role of clinical supervision in mental health services. It argues that there is sufficient evidence regarding the benefits of clinical supervision to warrant its utilisation as part of standard operational practice within mental health services. Recommendations are made concerning ways by which service managers can promote, support and monitor clinical supervision. The chapter begins by differentiating clinical supervision from related processes, especially line management and clinical review. The existing evidence base concerning the effectiveness of clinical supervision is then considered, having reference to each of the three domains (formative, normative and restorative) set out in Proctor's (1986) model. An overview is provided of ethical and legal issues that may arise in the context of clinical supervision. The chapter concludes with recommendations regarding processes by which clinical supervision can best be introduced and sustained within a service.

What is clinical supervision and how does it differ from line management and clinical review?

There have been a number of attempts to provide a definitive statement that captures the core characteristics of clinical supervision (Milne, 2007). In this section, rather than providing a single definition, we attempt to differentiate clinical supervision from related processes such as line management and clinical review.

Clinical supervision is a process by which a trainee or professional discusses clinical work with a colleague. Clinical supervision usually involves the sharing of considerable detail regarding assessment and/or treatment of a client but can also involve exploration of the emotional impact of the client on the clinician

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and aspects of the supervisee's work life that are impinging on clinical work. The clinical supervisor will not usually provide direction (except in some circumstances to trainees and junior practitioners, which are considered in more detail below) and may or may not provide advice or recommendations. The role of the supervisor may be simply to assist the supervisee to explore and better understand her or his experience of a client.

Line management is concerned with the allocation of work, review of work performance and provision of general work role support, including assistance with planning for professional development. The line manager is in a position of authority and is accountable (within broad parameters) for the work performance of those for whom they have responsibility. Line managers are often able to provide directions that subordinates must follow. In a clinical setting, line managers will not usually become involved with the detail of the clinical work undertaken by professional staff but rather will monitor broad performance indicators such as caseload, client throughput, complaints and compliments, and compliance with record keeping obligations.

Whereas the line manager is required to make judgements about the quality of a subordinate's work, the clinical supervisor will usually adopt a non-judgemental position. The line manager is likely to have a critical role in professional progress matters such as promotion and will often approve leave and make decisions concerning work rosters or other matters that impact on the work environment of the clinician. This means that the line manager is in a position of power by virtue of authority whereas the clinical supervisor may be in a position of influence but has no formal authority.

Notwithstanding these conceptual and role distinctions, line management and clinical supervision are sometimes performed by the same person. There are different views as to whether or not this is a desirable arrangement and the parameters of this debate are considered later in this chapter.

Clinical review processes also share some common ground with clinical supervision processes. Most mental health services have routine clinical review processes in which client progress is considered in some depth and recommendations are made concerning the direction of the treatment plan. These may occur within the framework of ward rounds or community team meetings. Sometimes they occur in one-on-one meetings between a senior practitioner and the clinician with primary care responsibility. Typically a psychiatrist or other senior clinical professional presides over these clinical review processes.

While clinical review processes are similar to clinical supervision in that they involve detailed consideration of an episode of clinical work, there are important differences. The first is that clinical review processes form part of clinical quality assurance. The primary purpose is to ensure that assessments and treatment plans are appropriate. The second difference follows from this: clinical reviews are a form of clinical governance and have the capacity to override the clinical judgement and decisions of the primary clinician. A third difference is that clinical review processes are often conducted as a forum that enables a spectrum of professional perspectives (the multidisciplinary team) to contribute

to clinical planning and decision making. Clinical supervision may, but often does not, include a contribution from a different professional perspective. Finally, the primary and often entire focus of clinical review is on the client, whereas in clinical supervision the focus may be equally on experience of clinician. While it is expected that clients may be beneficiaries of clinical supervision the value of the process is not contingent on specific client benefits.

In summary, while clinical supervision shares some characteristics in common with line management and clinical review, it can be readily differentiated from these processes. It cannot be assumed that the existence of satisfactory line management and clinical review processes obviates the need for clinical supervision.

What can clinical supervision achieve?

Proctor (1986) usefully classified the potential benefits of clinical supervision as being formative, normative and restorative. *Formative* benefits occur when the supervisee develops new clinical knowledge and skills and forms more constructive attitudes as a result of clinical supervision. This may occur because of direct transmission of ideas, information or techniques from the supervisor to the supervisee or it may occur because the process of discussing a client enables the supervisee to take a fresh perspective and develop new ideas about how to conduct a treatment. *Normative* benefits occur when, as a result of supervision, clinicians practise in a manner which is more consistent with expectations of the service. This may be through practice which is more consistent with service priorities, which is more evidence based or which is more cost effective as just a few examples. By its nature normative practice will depend on the standards, policies and expectations of the service in question. *Restorative* benefits occur when, as a result of clinical supervision, clinicians are better able to manage the stresses and strains associated with mental health practice. This may be evident in a more positive attitude to work and indicated by fewer sick days, reduced staff turnover and greater willingness to take on responsibilities and challenges.

The formative benefits of supervision are those with the greatest potential to flow through to clients through improved assessment and/or treatment by the supervisee. However, a 2002 review of research into the impact of clinical supervision on client outcomes found the field surprisingly sparse (Freitas, 2002). Since then, a randomised controlled trial by Bambling et al. (2006) found that clients being treated with psychotherapy for depression had better outcomes if their therapists were supervised than did those whose therapists were unsupervised. This study also found better therapeutic alliance with supervised therapists. Bradshaw et al. (2007) found that nurses receiving clinical supervision showed an increase in knowledge of psychological interventions compared with peers who were not receiving supervision. They also found that the clients of the nurses receiving supervision showed greater reduction in symptoms. Thus, while the literature is still modest, there is preliminary evidence to support the proposition that clinical supervision has a formative function that can benefit clients.

It is likely the normative effects of clinical supervision occur overtly and indirectly. Overt effects occur through advice or instruction provided by the supervisor. Indirect effects arise through the responses of the supervisor to a case presentation or clinical situation. Some have suggested that clinical supervision should not venture too far into the normative, which is more properly the function of line management functions (Yegdich, 1999; Schulz et al., 2002). However, it is likely that, even when supervision is provided independently of line management, normative dimensions of professional practice will be transmitted through the supervision process. As far as we are aware there has been little if any empirical research into the extent to which supervision has a normative impact.

The restorative benefits of supervision are those associated with the emotional well-being of the supervisee. Mental health practice is widely regarded as stressful because of high levels of responsibility (especially in relation to risk factors such as suicide and aggression) associated with the client population and because of the complex interpersonal issues (such as transference and countertransference) that characterise at least some treatments. Clinical supervision enables some diffusion of responsibility as well as an environment in which interpersonal challenges can be examined with some objectivity. Proctor (1986) argues that the restorative capacity of clinical supervision is its single most important function. It is our view that, when morale is low and there is evidence of negativity or burnout, the priority in supervision is to address these issues. Only then can there be a meaningful focus on normative and formative functions. There is both quantitative (Hyrkas, 2005) and qualitative (Bégat & Severinsson, 2006) evidence to support the restorative value of clinical supervision. However, it should also be noted that some other studies have found benefits to be modest or nonexistent (Palsson et al., 1996; Teasdale et al., 2001; Meldrum et al., 2002; Bégat et al., 2005). It would be unrealistic to expect supervision to solve major systemic problems affecting the morale of clinicians.

Ethical and legal issues in clinical supervision

It is beyond the scope of this chapter to provide a comprehensive guide to the various ethical and legal issues that arise in the context of clinical supervision. However, it is important for managers to be alert to the key considerations. Failure to be mindful of ethical and legal issues not only increases the risk of exposing the service to complaint or even litigation, in the event of problems arising in one or both of these areas, but also may inhibit supervisors from becoming involved in providing clinical supervision. Without guidelines to advise on best practice, senior clinicians may shun the responsibility of supervising juniors (Cutcliffe et al., 1998a, b).

Duty of care

In general we think that all supervisors must accept responsibility for the quality of advice or information they provide to supervisees. In this respect supervision

is no different from the discharge of any other professional responsibility. Negligence occurs when:

- a duty of care is owed
- a duty of care is breached
- harm resulted, and
- the situation was reasonably foreseeable.

In the case of clinical supervision the duty of care is primarily to the supervisee. This means there is a legal obligation to provide the supervisory service in a competent manner. The broad test of competence is whether or not a competent professional in the same role would act in a similar fashion. Ultimately this is normative and there would likely be a range of opinions as to whether or not a particular piece of advice or recommendation (or omission to provide advice or recommendation) is competent. A supervisor would not be likely to be considered incompetent unless the advice (or omission) was clearly out of line with prevailing standards within the profession.

Supervisors will often want to know to what extent the act of supervision implies assuming a degree of responsibility for the conduct of the treatment provided by the supervisee. In other words, does the supervisor have a duty of care to the person the supervisee is treating? We think there is an important distinction between supervision provided to a person whose competence to practise is contingent on a supervisory arrangement and supervision provided to a colleague who is a fully qualified practitioner. Supervisees in the first category include students, practitioners whose registration requires a period of supervision and practitioners who have been required following some form of performance or professional review to practise under supervision. For this group it is implicit in the supervision contract that the practitioner is unable to make sound autonomous clinical decisions and requires the assistance of a more experienced or better qualified practitioner to assist in decision making. In such circumstances, the supervisor is not only responsible for providing sound advice but also for monitoring the implementation of this advice. It is only in this way that the duty of care to the ultimate recipient of the services can be discharged.

However, the focus in this chapter is peer-to-peer clinical supervision. Under this kind of arrangement, the supervisee must be regarded as having capacity to make autonomous clinical decisions, including capacity to make use of or disregard advice provided by a clinical supervisor. The supervisor is in possession only of clinical information provided by the supervisee and any perspective or advice provided by the supervisor is necessarily limited by the quality of information available. Whereas the supervisor of a student will often 'sit in' on clinical interviews conducted by the student so as to both directly observe student conduct and to be in a position to provide informed clinical advice, this is unlikely to occur in peer-to-peer clinical supervision. Finally the focus of the supervision may not be on the implementation of a clinical treatment plan but rather on aspects of the supervisee's emotional experience of the treatment. In this respect clinical supervision is quite different from the clinical review processes discussed above. For these reasons we think it is relatively unlikely that the supervisor will

assume any form of clinical responsibility for the treatment. There are, however, some exceptions that supervisors need to be alert to.

- If the supervisor forms the reasonable view that a supervisee is impaired or, for some other reason, incompetent there is a responsibility to take effective action to protect the interests of clients.
- The supervisor may have legal reporting obligations in circumstances where, for example, there are reasonable suspicions that a client is experiencing sexual abuse (as a child).
- Reasonable concern that a client is at imminent risk of self-harm or a client is likely to harm a third party may impose a secondary duty of care that requires the supervisor to ensure that supervisee is taking appropriate steps to minimise the risk.
- When a supervisor holds herself or himself out as an authority providing direction for the treatment provided by the supervisee, a duty of care may extend to the person or persons receiving treatment from the supervisee.

Dual relationships

Among ethical issues in clinical supervision, the most contentious is that of the dual relationship arising when the clinical supervisor is also a line manager. There has been considerable debate in the literature as to the merits of line managers providing clinical supervision to those for whom they have line management responsibility. For those who oppose such arrangements, the major concern is that supervisees will be unwilling to openly discuss difficulties or situations they handled poorly when the person supervising is also required to conduct performance appraisals and make decisions that impact on career progression (Feltham & Dryden, 1994; Scanlon & Weir, 1997; Consedine, 2000; Kelly et al., 2001; Sloan & Watson, 2001; Cole, 2002; Cottrell, 2002). In other words, the line management relationship is not conducive to the development of a relationship of trust that is essential for open communication about complex clinical issues, especially when such communication may cause a supervisee to be judged negatively.

However, others have taken the view that it is possible to achieve both quality improvement that meets administration goals and lifelong learning within a single supervisory process (McSherry et al., 2002; Howartson-Jones, 2003; Clouder & Sellers, 2004). While the debate has been characterised more by opinion than by evidence, one study (Tromski-Klingshirn & Davis, 2007) found that counsellors were equally satisfied regardless of whether or not supervision was provided by line managers. Furthermore, a majority whose supervision was provided by line managers reported specific benefits or advantages associated with receiving supervision from a line manager.

We think that the evidence suggests that the organisational and even professional context may be important in determining whether or not line supervisors make appropriate clinical supervisors. Much of the argument favouring separation has been from the nursing literature. There is evidence that nurses are more

wary about clinical supervision than some other professionals and supervision through line management may be more problematic for this reason (Wolsey & Leach, 1997; Yegdich, 1999; Kelly et al., 2001). Scanlon and Weir (1997) found that unless the line manager had psychotherapy training, clinical supervision tended to operate as line management.

It is our view that neither broad ethical principles, nor the empirical literature, suggest that the dual relationship involved in line management and clinical supervision is so vexed that it *must* be proscribed. However, we do think that both service managers and clinical supervisors who are line managers must appreciate that it is a dual relationship and that there are significant risks as well as possible benefits that arise as a result. Whether this creates difficulties that are insurmountable will depend on both the culture within the organisation and the specific characteristics of the relationship between line manager/supervisor and supervisee. We can envisage circumstances, especially in implementation of clinical supervision of nurses, where it might be wise to proscribe provision of clinical supervision by line managers in order to build confidence on the safety of the supervision framework. We think that, even when the line manager is not excluded as a supervisor, it is very important that all supervisees have access to a supervisor outside of line management.

Another dual relationship risk arises because discussion of the emotional impact of clinical work on the practitioner is a common and perhaps necessary element of clinical supervision. The risk is that the supervisor may unwittingly assume the position of a personal therapist in this context. The risk is especially great when the impact of clinical work is in some way linked with personal stresses or issues the practitioner is struggling with. Supervisors are often themselves therapists and are required to consciously inhibit an almost automatic tendency to explore emotional issues from a therapeutic perspective.

Straying into personal therapy is problematic for multiple reasons. A clinical supervisor does not have sufficient objectivity and independence to provide competent therapy. Furthermore, engagement in the complex interpersonal relationship that characterises therapy will almost certainly compromise capacity to provide effective clinical supervision. When a clinical supervisor and supervisee work in the same service, a therapeutic relationship is likely to complicate if not damage a work relationship. For these reasons both supervisors and supervisees must be alert to when the clinical supervision is developing a focus beyond the professional activity of the supervisee. The supervisor might reasonably alert the supervisee to issues better addressed in a personal therapy arrangement but should not be tempted to even explore in depth the need for personal therapy. Managers must ensure that all staff involved in clinical supervision have a clear understanding of the boundary between clinical supervision and personal therapy.

Confidentiality

Confidentiality is another ethical issue that arises in clinical supervision. A sound understanding of issues relating to confidentiality is vital at the commencement

of the clinical supervisory process (White et al., 1998). In general, the supervisory relationship requires that privacy and confidentiality are to be respected at nearly all times. However, as discussed above there are circumstances such as concerns about supervisee competence, imminent risk to clients or the public, and mandatory reporting requirements, when confidentiality must be broken (Nicklin, 1995). One such scenario that invariably results in the disclosure of confidential material relates to dangerous practice that may jeopardise patient safety (Dimond, 1998). Cutcliffe et al. (1998a) suggest that, where possible, the supervisor obtain the consent of the supervisee, be guided by statutory requirements and act in the public interest. When issues of supervisee impairment arise, such as evidence that the clinician is depressed, affected by alcohol or other substances, the supervisor may need to alert the line manager. Ideally, this is negotiated with the supervisee prior to the supervisor taking any action. When the matter has been tested in the courts, breaching confidentiality has been upheld where there is a serious and imminent risk of harm to a third party (*W* v *Egdell* [1989] 1 All ER 1089).

Implementing clinical supervision in a mental health service

Attempts to implement clinical supervision frequently fail (Cottrell, 2002). One of the factors identified as contributing to this is the lack of involvement of all relevant parties, including managers, supervisors and supervisees. Without this, the needs of all stakeholders will not be considered and included in the implementation plan. Clear documentation of the implementation process as it evolves is essential to facilitate a clear understanding of clinical supervision and its implementation (Hawkins & Shohet, 2000).

It is essential that all parties reach agreement in relation to three principles which are crucial to the ultimate success of the process.

- The process of clinical supervision must be given the same priority as other essential quality assurance activities such as regular client review (Arvidsson et al., 2001).
- Health professionals must be provided with the time to devote to clinical supervision sessions and the sessions must be located in an environment free from distraction and well away from work pressures (White et al., 1998).
- Each supervisory service requires supervisors with appropriate skill level and a high level of commitment (Bishop, 1998).

To maximise the chance of a positive response when introducing a clinical supervision programme, a modest size project is initially recommended, as it involves a far lesser financial outlay by administrators working within a confined budget (White et al., 1998). Given that emotional exhaustion and a perception of not being supported are reliable predictors of sickness and absence from the workplace, managers who can establish better support mechanisms for their staff can expect to reduce non-attendance at work (Firth & Britton, 1989).

We recommend that services appoint a clinical supervision co-ordinator (CSC) whose singular role is to establish and implement the clinical supervision service. This role ensures momentum is maintained and links all involved parties. The CSC role is especially important in generating interest and enthusiasm within the clinical team. Approaches by the CSC to staff individually or in small groups provides general information on the plan, establishes levels of interest, and clarifies any misconceptions regarding the process. An active and engaged CSC counteracts the risk that those who require it most are the least likely to attend (Dimond, 1998). While we recognise that some professional associations may mandate supervision we do not recommend that services mandate clinical supervision because of the adverse impact on formation of a trusting relationship (Faugier, 1994). Prescribing supervision as part of a disciplinary process is to be avoided at all costs. This gives the message that supervision is only for those with identified deficits and not for the purposes of professional development (Dimond, 1998).

We think that Proctor's (1986) tripartite model can inform planning and development of clinical supervision within a mental health service. Different stakeholders within a service will attach different degrees of importance to the normative, formative and restorative aspects of supervision. One of the key roles of the CSC is to identify the stakeholders and ascertain which aspect is most salient for them. Engagement is most likely to be successful when discussions concerning supervision focus on the most salient aspect. We think there are three core groups of stakeholders that need to be considered in implementation of clinical supervision: senior management, middle management and clinical staff.

Implementation of supervision depends on management sanction (Yegdich, 1999) and, without active management support, is unlikely to succeed (Butterworth et al., 1996). Discussions with senior administrators are likely to be most productive when the *normative* functions of the clinical supervisory process are identified. Such functions include the role of clinical supervision in enhancing ethical practice, evidence-based practice and effective risk assessment/management. In general, managers are likely to support clinical supervision if it is seen as leading to improvements in service delivery (Wolsey & Leach, 1997). The support of middle managers (team leaders, unit managers) is equally important to ensure clinicians are allowed time and encouraged to attend clinical supervision (Butterworth & Faugier, 1992). While this necessitates a potentially disruptive removal of staff from the available clinical pool, the *restorative* benefits such as improved staff morale and increased professional satisfaction have obvious ramifications for the service through better staff retention, a positive attitude to work (reduced sick leave) and a work environment that favours recruitment of new staff (Darley, 1995).

The most salient aspect of supervision for clinical staff are the *formative* and the *restorative*. We think that focus on the *formative* aspect is likely to be most effective because it appeals to core values and aspirations to be the best possible clinician. Focus on the restorative aspect can be somewhat negative because it carries the implication that clinicians are stressed or burnt out. Even where this

is the case, clinicians may not want to acknowledge it and may not be comfortable in a process which is seen as having a 'therapeutic' dimension. The restorative value of supervision is best promoted when staff have either individually or collectively identified that there is a problem with morale or stress in the workplace.

Promoting ownership of supervision among clinical staff

While the role of the CSC is vitally important, it is equally important that clinical supervision is owned by the people who will be using it. In our experience this can be achieved through group processes facilitated by the CSC. The CSC invites interested clinicians to participate in a group consultation that focuses on the concept of supervision, its process and its potential benefits. An important early objective is to ensure that potential participants understand the distinction between clinical supervision and supervisory activities concerned with quality control or line management and the distinction between clinical supervision and personal therapy (Kelly et al., 2001). The group is encouraged to think about ways by which supervision could assist them personally, with a focus on *formative* aspects unless there is clear evidence of stress or burnout, in which case *restorative* aspects should be equally emphasised.

The group formulates its own definition of supervision, reflecting their collective viewpoint having previously become familiar with other definitions from the literature, and arrives at a consensus of 'What clinical supervision will be' in that given service (Hawkins & Shohet, 2000). A working agreement is drawn up by the group, outlining the rights and responsibilities of both the supervisee and supervisor within clinical supervision (Bond & Holland, 1998). Issues such as punctuality, openness, honesty, boundaries, lines of communication and confidentiality are included. In short, a clear outline of the expectation of all involved is generated from a service user perspective.

This process ensures that clinical staff commence their experience of supervision with a clear framework, reasonable expectations and free of unnecessary fears of being judged or criticised or 'therapised'. Because it is a framework they have actively contributed to, it is less likely to feel like something imposed.

Finally, Cleary and Freeman (2006) argue that successful implementation of clinical supervision can only occur when there is a 'learning culture' within the service. This means that there must be a service-wide commitment to staff development and to supportive and restorative processes that will foster staff development. This takes us beyond the scope of this chapter but is an important reminder that clinical supervision cannot be considered in isolation from the wider system within which it occurs.

Conclusion

There is growing recognition of the role of clinical supervision in mental health services. Clinical supervision provides potential benefits to individual clinicians

and to the service as a whole that are over and above those produced by related but different processes of line management and clinical review. While the empirical literature is limited, there is evidence to support the proposition that it has formative, normative and restorative attributes. Service managers can reasonably expect that clinical staff will seek opportunities for clinical supervision. Successful implementation of clinical supervision requires an understanding of ethical and legal implications as well as appreciation of cultural and systemic factors within the service. A commitment to the process is required at every level within the system if clinical supervision is to flourish and endure as a successful component of a mental health service.

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Chapter 9
Performance appraisal and personal development

Hazel Bassett

Chapter overview

When I recently spoke with my new team members about their upcoming performance appraisal and development plan, great sighs and groans were heard. This is a common experience for managers who are responsible for the performance appraisal and development plan of staff, and its review. Staff are often sceptical of the process and see it a 'paper exercise', while managers see it as one of the most difficult aspects of their work (Chandra & Frank, 2004). Yet when the performance appraisal and development planning process is performed effectively, both staff and managers see it as beneficial and valuable (Spence & Wood, 2007).

The aim of this chapter is to define performance appraisal and development and consider how it fits into performance management in the mental healthcare setting. We will then examine the main ingredients of performance appraisal and how to formulate a development plan that is supported by and supports the performance appraisal process. Strategies for conducting performance appraisal and the accompanying development plan will then be explored. Managing some of the more difficult staff issues that arise or are identified in the performance appraisal process will be discussed. Finally, benefits of the process for all stakeholders will be identified.

What is performance appraisal?

Performance appraisal is defined as the process undertaken by managers to analyse and assess a staff member's range of professional knowledge, skills and attitudes which impact on that staff member's performance in fulfilling his or her duties within the work environment (Bromwich, 1993). It also can provide an avenue for identifying strengths and correcting performance imperfections as well as promoting career planning (Chandra & Frank, 2004; Fulmano, 2004). It has been noted that individual performance is a joint function of ability and motivation thus dictating that performance appraisal has as its goal motivating a staff member to improve his or her performance (Roberson & Stewart, 2006). For successful performance appraisal, however, a number of things must be clear including (Arnold & Pulich, 2003):

- which performance standards the staff member's performance is being assessed against
- how these standards are defined
- what are the requirements of the standards
- how feedback on the staff member's performance will be given
- the exploration of how to improve performance.

When staff members are motivated to improve their performance, the organisation as a whole benefits (Chandra & Frank, 2004). For the manager, it is important to remember that performance appraisal is about motivating staff to improve performance and to perform at the optimal level (Hoban, 2003) rather than it being seen as a disciplinary process. Budgetary matters while important should not be the main focus of performance appraisal, even when performance may be related to monetary rewards (De la Cour, 1992). Relating the review process to the reward process can be detrimental to staff morale (Curran, 2004). Performance appraisal has at its essence the desire for staff to maximise their potential in their chosen field of employment. In doing this, the manager, through performance appraisal as well as other performance management strategies, will develop an effective workforce (Chandra & Frank, 2004).

If the performance appraisal process identifies areas of improvement and also identifies areas for career development, then a development plan can be devised. This plan can focus on the provision of education, training and experiences that will improve performance as well as assist the staff member to develop skills that will provide further career options. When the development plan relates to the performance appraisal, opportunities for further education and skill development can be supported by management. This in turn empowers the staff member to see value in and, therefore, participate in the performance appraisal process. He or she will no longer see it as a 'paper exercise' but rather see it as a way to improve his or her career options (Chandra & Frank, 2004).

How does performance appraisal fit into performance management?

McConnell (2004, pp. 273–274) defines performance management as:

> 'The art and science of dealing with employees in a manner intended to positively influence their thinking and behaviour to achieve a desired level of performance.'

In other words, performance management is the primary responsibility of the manager. At all times, the manager should be managing staff so that what needs to be done gets done and at an appropriate standard (McConnell, 2004). Part of the performance management process is the performance appraisal, but performance management is more than just the appraisal. Performance management requires the manager to be aware of what extrinsic obstacles might be impeding staff performance. Sometimes these can be an organisational process (the duplication of paperwork); the process may be resource based (a lack of resources such

as equipment, computers, etc.) or personnel based (personality conflict in the workplace). As McConnell (2004) has noted, the manager has the role of addressing obstacles to staff performance so that staff can perform at their best. Therefore, it can be seen that the role of the manager can be a complex one.

Organisations are now beginning to recognise that star performance in the technical field does not equate to star performance in the management field (Martin, 2004). The manager needs to have 'people expertise' which includes knowing how to motivate others and how to provide an environment that encourages optimal performance. Chandra and Frank (2004) have identified an effective manager as one who creates an environment that motivates others. The manager, they believe, needs to be a coach, a teacher, a guide and a supporter if the best environment for staff performance is to be created. Staff members want a manager who sets clear expectations, yet can teach them how to achieve what is required including competencies that will improve their career prospects (Martin, 2004). When that kind of environment exists, then people will want to work in that environment and substandard performance will not be tolerated (Simmons, 2005). In fact, having a culture of excellence where high performance is a non-negotiable condition will assist in retention of staff (Martin, 2004). In this kind of environment, performance appraisal is seen as one tool of managing performance rather than being the only tool of performance management.

When an issue surfaces in this environment, the manager is able to address it in a positive way providing whatever coaching, counselling and training is necessary to assist the staff member to improve his or her performance (McConnell, 2004). Umiker (1994) notes that feedback, which is an integral part of this process, is more effective when given frequently rather than when it is only given at the yearly or semi-yearly performance appraisals. Managers need to have frequent contact with their staff. Performance appraisal is not enough for managing performance in the complex field of mental health. Managers need to be seen by staff as being involved in the work area and having an intimate knowledge of staffing issues. Such managers are then seen as having the kudos for overseeing a fair and equitable performance appraisal process (Roberson & Stewart, 2006).

What are the main ingredients for performance appraisal?

In considering what goes into making a performance appraisal process successful, one needs to consider the manager and the organisation, the staff member being appraised, the appraisal process and the outcome of the appraisal.

The manager and the organisation

The most important ingredient of the appraisal process is the setting of clear goals for the staff member to achieve. Curran (2004) noted that the most successful organisations have designed staff positions (or job descriptions) that clearly state the responsibility and desired outcomes of the position while allowing the

staff member flexibility and creativity in how those responsibilities are fulfilled and outcomes achieved. Therefore, it is the responsibility of the organisation to have job descriptions that outline exactly the expectations and the required outcomes of the role. This is essential if optimal performance is to be achieved. Without this, it is difficult for the staff member to know what is required of him or her.

The organisation also needs to have clearly defined criteria regarding the performance appraisal process in the workplace (Hayworth, 2006). The criteria should be set out in the orientation or employee manual. It should include the aim of the process, how the process should occur and what to do if the staff member is unhappy with the process or feels he or she has not had a fair and equitable appraisal. The organisation should also be prepared to evaluate the process and receive feedback on the process from the staff member (Chandra & Frank, 2004; Roberson & Stewart, 2006). This feedback can then be used by the organisation to improve the appraisal process and make it more 'user friendly'.

Another issue for the organisation is the use of rewards. The organisation must decide how it will reward appropriate performance. These rewards need to be in line with the values of the organisation and can include monetary rewards (Curran, 2004). However, rewards can come in many different forms and the creative organisation will set up a variety of reward systems with which to reward staff members who are achieving acceptable levels of performance or who are performing at a higher level than required.

Another important aspect in the process of performance appraisal is the way the manager views the process. Too often the process can be undervalued by the manager as the need to complete 'the paperwork' becomes all consuming (Bromwich, 1993). For the process to be successful and to achieve the best outcome for both the manager and the staff member, both need to be committed to the process and need to have an understanding of what the process can offer in the way of guidance in the workplace. Paperwork is important in the sense that it guides the process, but the value of the performance appraisal is the direction and clear understanding it gives the staff member of what is expected in his or her role and the guidance it gives the manager in knowing how to measure the staff member's performance (Bromwich, 1993). If the manager does view the process as 'a paper exercise', then that is all it will be.

Another important element of the appraisal process for the manager is that confidentiality needs to be maintained (Bromwich, 1993). If corrective action is required, and it will necessitate involving someone other than the manager and the staff member, then the staff member should be made aware of the person's involvement and what will be made known to the third party. Staff members' performance appraisal should not be the topic of discussion around the managerial lunch table. The most likely person who will be involved in this process would be the professional senior of the staff member. Ideally, the professional senior would not be the line manager. This person would also be the person who provides clinical or practice supervision for the staff member, thus having some understanding of the workplace and the performance required of the staff member. It is beneficial to involve the professional senior in the appraisal

process in case professional practice issues are identified. Again, all people involved in the process need to maintain confidentiality.

This leads to a discussion of the qualities required in a manager who is engaged in staff performance appraisal. McConnell (2004) makes it clear that the manager who models the behaviour he or she expects in the workplace will gain respect, agreement and compliance from staff. The manager needs to lead the way in the behaviours required (Fulmano, 2004). By doing this, the manager then earns the right to speak to staff about behaviour. The successful manager will also recognise that the good parts of the staff member's performance needs to be acknowledged (Curran, 2004). The manager who is prepared to verbally reward good performance by the staff member is more likely to see that behaviour occur again. Spence and Wood (2007) have noted that praise, feedback and direction given in a respectful way will not only assist in the professional growth of the staff member but will also improve job satisfaction and retention of staff.

Also, a successful manager builds one-to-one relationships with each staff member and takes an interest in each member's contribution. The wise manager has learnt that there are times when their mind needs to open and their mouth to be closed (McConnell, 2004). Some of the best ideas for improvement come from those who have to work within the system.

Finally, to successfully lead a productive performance appraisal, the manager needs to be appropriately trained in performance appraisals (Bromwich, 1993). While this may seem obvious, a number of managers receive little or no training in how to conduct a successful performance appraisal. One of the goals in the manager's own performance appraisal needs to be training in performance appraisal and then attendance at regular refresher training. Training will assist the manager in keeping a clear focus on the purpose and usefulness of the performance appraisal. If the manager values the process and sees it as important, it will impact on staff's view of the process. Instead of being a chore that is to be endured, the process will be viewed as a useful and valuable tool in the workplace.

The staff member

The attitude the staff member has towards the performance appraisal process will also impact on its success or otherwise. Some staff members can be quite defensive about the process. This is usually linked to an experience where the appraisal was used only as a performance correcting tool. One way to overcome this defensiveness is to encourage the staff member to take an active role in the appraisal process. This is because appraisals are much more effective and achieve better outcomes when the staff member takes an active role (Lawler et al., 1984). One way to do this is to have the staff member do a self-appraisal (Chandra & Frank, 2004). Involving staff in the process enables the staff to identify strengths and weakness and to brainstorm ways of improving performance in light of these (Arnold & Pulich, 2003). By allowing a staff member to have a voice in the process, they are more likely to own the appraisal and any suggested improvement thus increasing the likelihood of positive changes occurring. This then becomes a win-win situation for the manager and the staff member.

The appraisal process

As stated earlier, the appraisal process needs to be clearly set out so that both the manager and staff member are clear about what to expect. Processes that are unclear can lead to inequitable appraisals (Roberson & Stewart, 2006). The aim of the process needs to be clearly defined and mechanisms for challenging the process need to be readily accessed by all.

Another important aspect of the process is that there should be no 'hidden' surprises or agendas for the staff member (Hoban, 2003). Rather the process should consolidate any action plan for dealing with issues or problems that should have already been raised with the staff member. This is essential if the process is to be seen as transparent and equitable. The process should be characterised by three features (Erdogan et al., 2001):

- adequate notice that it is happening
- a fair hearing that identifies how the assessment was made
- judgement based on evidence and without bias.

When the appraisal is seen to be based on feedback that is considered to be coming from an accurate source, then acceptance of the feedback is more likely and improvement of performance will have more chance of occurring than if the source is seen as inaccurate or biased (Roberson & Stewart, 2006).

One possible source of information is peer review. One benefit of peer review is that it allows the input of those who work closely with the staff member, particularly if the manager is not always present in the workplace (Arnold & Pulich, 2003). For those working in community mental health, peer review might provide a good source of information for the manager about a staff member's performance. However, this kind of process needs to be used wisely. There is scope for personality differences to influence such a review. Therefore, the peer review should not be the only source of information used in evaluating a staff member's performance (Chandra & Frank, 2004).

Another possible source of input is consumer satisfaction with the service provided. Again this source of information needs to be used wisely in the mental health workplace as certain factors (such as the Queensland Mental Health Act 2000 conditions, personality differences, etc.) may impact on the perception of the service received. Nevertheless, it can be a valuable source of feedback for the staff member and is one that is rarely considered in the performance appraisal process.

Outcome and follow-up of performance appraisal

The outcome of the appraisal process should be twofold: it should guide future performance by clarifying areas for improvement; and it should acknowledge achievements made over the appraisal period (Taylor, 2005). Acknowledging achievements is the easier of the two outcomes. Giving positive feedback is a pleasant experience for all involved. However, giving feedback on how to improve performance requires that deficits in performance are identified and acknowledged. It also requires a plan to be put in place to address performance

improvement (McConnell, 2004). In these cases, the plan should contain all possible approaches to positively elicit the improvement required. This might include refresher training, modelling and/or work shadowing. The staff member needs to be involved in the process of deciding the methods to be taken for facilitating improvement (McConnell, 2004). The wise manager will only use criticism when absolutely necessary and will always use it constructively by giving the staff member suggestions for correcting his or her performance (McConnell, 2004).

Only after all positive responses to the issue have been exhausted should the manager engage in corrective processes (McConnell, 2004). Such processes include: diminished work performance (including monetary implications such as decreased pay), written performance expectations that are quantifiable and assessed on a weekly basis, transfer, or in the worst case scenario, termination. The organisation will determine the process and the corrective measures to be used. The staff member needs to understand why the process is being enacted, what the process is and what is required from him or her (Roberson & Stewart, 2006). At this point the manager would be wise to engage the human resource management of his or her organisation to be sure that proper process is followed in case the staff member starts litigation proceedings against the organisation and/or manager.

The development plan

The performance appraisal has as its goal the identification of areas requiring improvement as well as identifying possible career directions for the staff member. Therefore, no appraisal is complete without a development plan. The appraisal helps the manager to identify the development needs of the team as a whole and of individuals within the team (Hoban, 2003). Armed with this information, the manager can devise development plans for both the team and the individuals which will enable them to achieve the goals set out in the performance appraisal. In this sense, the development plan needs to be tied to and support the performance appraisal. Staff members need to be given the opportunity to access whatever developmental programme will assist them in improving their performance and being able to develop skills that will assist with their career development (Bromwich, 1993). The development plan should aim for improved functioning within the workplace (Simmons, 2005). The development plan should contain both short-term and long-term goals and the creative manager will include a wide range of activities rather than just educational activities.

Staff development needs to be based on planned activities with a definitive aim rather than sending staff haphazardly to a variety of study days (Bromwich, 1993). The development activities need to be focused, anchored to and justified by the appraisal process. As stated earlier, development activities are not just exclusively education sessions. There are a variety of ways that staff can be helped to develop skills. The creative manager will consider educational and training

activities as well as activities such as work shadowing, opportunities for acting in higher positions, taking on some simple managerial activities, leading in-services and journal clubs, and opportunities for secondment to other areas within the organisation. For those attending educational or training activities there should be an expectation staff will share with other staff (usually through in-service opportunities) the information learnt (Bromwich, 1993).

Staff development plans, when designed properly, will assist in retention of staff by anchoring them through the ups and downs of the everyday work life (Rollins, 2006). Staff feel valued by the organisation when time is allocated and is quarantined regardless of the everyday needs of the workplace (Chandra & Frank, 2004). This leads to greater job satisfaction and better staff retention rates (Martin, 2004).

Practical steps for conducting a performance appraisal and developing a development plan

Having considered the theory of the performance appraisal and development plan process, we now should examine the practical 'nuts and bolts' of how to actually make one happen.

Beginning the process

The appraisal process should be a cycle that is continually occurring within the workplace. Therefore, staff members need to be aware of the process and where they are in the process. When a staff member is recruited, the performance appraisal process should begin as part of the orientation process. Within a month of starting employment, a staff member should have met with the manager to set out performance goals for the year ahead and identify any developmental needs. Then at least every six months – if not every three months – the manager and staff member should meet to review the goals and development needs and check if these are being addressed.

To begin the appraisal process and any subsequent review, it is important that the staff member is given plenty of notice that a review meeting or formal performance appraisal is occurring (Hoban, 2003). The organisation should clearly set out a timeframe for this. A possible timeframe is one week's notice, with the staff member being given relevant paperwork for the appraisal (Hayworth, 2006). Paperwork might include the job description, a copy of the previous review with performance goals identified and the development plan. The manager might want to include a list of questions designed to prompt thought and discussion about 'where to now', for example:

- What have you achieved since we last met?
- In what ways do you think your performance has improved since the last review?
- What do you enjoy about your position?

- What things do you not enjoy?
- What skills have you developed since we last met?
- What are your future goals (are they still the same as in the last review)?
- What can the organisation do to assist you to achieve those goals?

As a manager, you might wish to use a routine list of questions or you might wish to develop individual questions for each staff member. A routine list means that you cannot be accused of targeting a staff member on performance issues. An individual list, however, allows you and the staff member to focus specifically on his or her performance and development.

Once the time for the appraisal has been set and the appropriate paperwork given to the staff member, the manager can then prepare for the appraisal. Firstly, the manager needs to familiarise him or herself with previous reviews and identified performance goals of the staff member. The manager should then identify: any extra responsibilities taken on by the staff member; any achievements by the staff member since the last review; and any specific issues that have arisen since the last review (Bromwich, 1993). The manager needs to prepare feedback on performance. Feedback needs to be accurate, thoughtful, balanced and true with regards to the performance goals set previously and not just a knee-jerk reaction (Martin, 2004). When feedback is accurate and able to be backed up with specific examples, staff members are more likely to trust and value the feedback and the manager giving it. This feedback also needs to be in line with feedback given between appraisals and reviews. As stated earlier, there should be no surprises for the staff members. Any performance issues should have already been raised and processes put in place to address these. The manager, who prepares for the performance appraisal process, will be able to stay on track and will not be waylaid by side issues.

At the time of the appraisal or review, the manager needs to create a welcoming environment. Several researchers have commented on the need for the appraisal to occur in a relaxed setting (Bromwich, 1993; Hoban, 2003; Taylor, 2005). Taylor (2005) even suggests that the appraisal meeting should not be conducted in the manager's office – a neutral relaxed interview room away from the actual workplace is the best option. He also suggest that the furniture needs to be arranged in a way that underlines a lack of status differentiation (i.e. do not sit behind a desk) and minimises confrontation.

The manager and the staff member also need to set aside the appropriate amount of time for the appraisal to be carried out without interruption. Taylor (2005) suggests that a period of two hours allows time for the appraisal, for development plans to be put in place and evaluation of the process, and for the manager to make notes about the session.

The process

To begin the process, the manager will need to employ all the skills he or she has developed in building rapport with people. Taylor (2005) suggests starting

with small talk and checking out the expectations of the staff member. Remember to ask open questions that allow the staff member to reflect on his or her own practice enabling him or her to then identify strengths and weaknesses openly and honestly. Remember McConnell's (2004) sage advice and keep your ears and mind open and your mouth closed as much as is possible. People are more likely to own and try solutions that they have formulated themselves than pat responses from their supervisors. Use reflecting and summarising skills to their best advantage (Taylor, 2005).

Remember to balance praise and criticism – do not lose sight of the positive contributions that the staff member has made over the review period. While performance in one area may be an issue, Martin (2004) challenges managers to not allow the need for performance improvement to overshadow the person's value. Always focus on the behaviour not the person, and when focusing on deficits also explore possible solutions for dealing with the deficits. Staff members should walk away from the process encouraged and with an action plan for improvement.

The staff member needs to be encouraged to take an active role in the process. Self-appraisal is not an easy task but is more likely to bring about change behaviour if deficits in behaviour are identified (Bromwich, 1993). Positive achievements also need to be identified and acknowledged in an appropriate way. Overall the staff member should emerge from the process feeling encouraged and acknowledged for his or her strengths and achievements, while feeling motivated to lift performance to improve areas identified as needing improvement.

Areas that the performance review should focus on should have been defined by the organisation and should be clearly set out in the performance appraisal guidelines. Possible areas for discussion include: clinical performance and skills; approach to work; team skills; management skills (Bromwich, 1993). The staff member's level of experience and role within the workplace will define the focus on the above areas. It is also important to spend time identifying likes, dislikes and frustrations experienced. This can help guide the manager and the staff member in considering future career development. Martin (2004) points out that when managers identify people's likes and encourage engagement in tasks that encompass those likes, they are creating ideal positions for staff.

It is also worthwhile discussing with the staff member if there are any skills that he or she has that are being underutilised in the workplace (Bromwich, 1993). Identifying these and ensuring ways that skills or expertise can be used within the workplace will not only empower the staff member but will also benefit the workplace and the organisation. Discussion should also include career direction and any learning or workplace experience that would aid the staff member's development in that direction.

Time is also needed to define performance goals for the next appraisal period. The goals need to be clearly defined with appropriate development plans in place to maximise the potential for the staff member to succeed.

Thus by the end of the process, the staff member should have a clear understanding of how he or she is performing against the set criteria for his or her

Table 9.1 Performance appraisal and development plan.

Job description descriptor	Target behaviour	Performance indicator	Development plan
Provides appropriate occupational therapy (OT) assessments for mental health consumers	Competent in the area of functional assessments	Presents three different OT functional assessments reports e.g. Domestic and Community Skills Assessment (DACSA), Allen Cognitive Levels (ACL) and Brookvale Living Skills Assessment	Attends workshop on the use of and report writing for the ACL assessment

position. He or she should know against what performance criteria he or she will be reviewed for the next appraisal. The staff member should also have a clear understanding of performance goals and also any development plans that are in place to assist with achieving those goals. In other words, the staff member knows how he or she is performing so far, what is expected in the future and how the organisation will support the person in achieving those expectations. Table 9.1 outlines a possible way of setting out the performance appraisal and development plan.

Continuing the process

Having engaged in the formal appraisal process, it is now the manager's responsibility to see that recommendations from the process are not placed aside and forgotten. The manager needs to follow up with development opportunities and encourage staff members to make the most of these opportunities. The manager also needs to encourage performance improvement. The skilful manager will do this in the least threatening and most collegial way. The wise manager will role model the behaviours required while spending time in the workplace. Use of praise and constructive criticism will be a part of the manager's repertoire. The staff member will receive feedback that is fair and true throughout the review process. By the manager investing time into staff, workplace performance will improve and the work environment will be seen as positive and supportive. Not only does this have excellent outcomes for the staff and manager and the organisation as a whole, but this will also have benefits for the consumers who access the service.

Difficult issues

When staff are performing well in the workplace, everyone is happy. However, there is usually at least one staff member who is not. This person needs to be

managed or he or she can have a negative influence within the workplace. To begin the management process, the manager needs to clarify what the issue is. The manager needs to consider if the issue actually sits with him or herself. Arnold and Pulich (2003) identified four possible influences the manager may be under.

- '*Similar to Me' effect*: the manager rates the performance as higher or lower depending on how much the person is perceived to be like the manager, i.e. same characteristics and beliefs.
- *Halo effect*: the manager generalises one positive characteristic of performance to all areas therefore resulting in an overall high rating.
- *Horn effect*: the manager generalises one negative characteristic of performance to all areas therefore resulting in a low overall rating.
- *Recent behaviour bias*: the manager remembers a recent behaviour, recalling it clearly and rating overall performance based on that behaviour rather than on the behaviours evident throughout the performance period.

If these are evident, it is the manager who needs to improve his or her performance. Hopefully, the manager can explore these and the solutions to the problems that arise in his or her own supervision sessions and performance appraisal with his or her manager.

If, however, the issue lies with the staff member, the manager needs to use the performance appraisal mechanisms to give the person every opportunity to improve his or her performance. This might including breaking down the target behaviours into specific tasks with clear behavioural components that the staff member will be expected to meet. This removes the possibility that the staff member does not understand what is required (McConnell, 2004). It may also be necessary to increase the number of reviews, either three monthly or even monthly instead of six monthly. The development plan also needs to be specific, with specific activities in which the person is expected to engage. If all else fails to bring about the behaviour changes required to lift the person's performance into the realm of acceptable, then it will be necessary to engage performance management strategies that are more corrective in nature such as diminished work performance (where salary is impacted by poor performance and remains so until performance improves). Whenever it gets to this point, it is important for the manager to engage his or her operational manager in the process and to also engage someone from human resource management of the organisation in the process. This can be a difficult time for both the manager and the staff member and it is important that both have support through the process.

Benefits of performance appraisal and development

The benefits of effective performance appraisal and development can be enjoyed by the staff member, the manager, the organisation and the consumer. For the staff member, effective performance appraisal motivates improved practice, provides job satisfaction and assists with career development (Spence & Wood,

2007). For the manager, there are many benefits including (Alban-Metcalfe et al., 1989):

- being aware of the staff member's job satisfaction, frustrations, needs, strengths and weaknesses
- setting objectives for the workplace
- improving communication and working relationships
- documenting processes.

For the organisation, having staff members who are performing to an acceptable level and are in fact improving and developing means that the organisation can function and provide the service that is required of it. Also, when staff feel valued and are encouraged to grow and develop their skills, they are more likely to stay in that employment. This means that recruitment and retention is more effective and less time and resources are used continually recruiting. Finally, there are benefits for the consumer, including improved and appropriate service, and better outcomes of the service provided by the staff.

Conclusion

Performance appraisal and development is an important aspect of performance management. When performed effectively, all stakeholders in the process benefit. When it is poorly carried out, it builds frustration and resentment and becomes nothing more than a paper exercise. The wise manager will engage the process as a way to develop his or her staff and to improve the service that is provided to the consumer. In doing this the manager will build a workplace culture that is built on respect, problem solving, mutual support and team performance (Curran, 2004). Staff will be attracted to the workplace and excellence will be the order of the day. Therefore, it can be seen that performance appraisal and development when carried out properly can be an effective staff management tool.

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Chapter 10
Dealing with stress and burnout

Chris Lloyd and Robert King

Chapter overview

Since the mid-1980s, there has been increasing interest in the issues of stress and burnout in the human service professions. Job stress can have a detrimental effect on the person, the workplace, and society. The construct of burnout has been linked to job stress and is thought to be a unique response to frequent and intense client interactions. This chapter explores stress and burnout and offers some strategies for minimising the effects that stress and burnout have on the individual and his or her workplace.

Stress

Occupational stress has been identified as affecting 28% of all European Union workers and being responsible for 50–60% of all lost working days (Ryan et al., 2005). Minimising stress and responding effectively when it is identified is therefore a key component of effective workforce management.

Stress has been defined as (Sutherland & Cooper, 1990, pp. 23–24):

> 'the interactions between, or misfit of, environmental opportunities and demands, the individual needs and abilities, and expectations, elicit reactions. When the fit is bad, when needs are not being met, or when abilities are over or undertaxed, the organism reacts with various pathogenic mechanisms. These are cognitive, emotional, behavioural, and/or psychological and under some conditions of intensity, frequency or duration, and in the presence or absence of certain variables, they may lead to precursors of disease.'

Potential sources of stress include stress from the job itself, work roles, relationships with others, career development, and the organisational structure and climate (Sutherland & Cooper, 1990; Dunn & Ritter, 1995; Moore & Cooper, 1996). Two stressors specific to a health environment include financial cutbacks and the rationalisation of services and the shift from hospital-based services to the community (Fagin et al., 1996). Response to stress is the product of the situation and the person, taking into account the factors that influence a person's resistance to stress or increase his or her vulnerability. Potential moderators and mediators to the response to stress can include personality traits and behavioural characteristics, physical conditions, and life-stage characteristics of the individual

(Tyler & Cushway, 1995; Moore & Cooper, 1996). Individual vulnerability to stress is dependent on a large number of complex factors, including personality, personal history, needs, wants and coping strategies adopted. Supervision, training and relationships at work (support from colleagues and supervisors) are considered buffers to stress.

Definition and characteristics of burnout

Breaking down the three components of burnout as described by Maslach and Florian (1988), emotional exhaustion refers to a depletion of one's emotional resources and the feeling that one has nothing left to give to others at a psychological level. Depersonalisation refers to the development of negative and callous attitudes about the people with whom one works. The last aspect of burnout is a negative evaluation of one's accomplishments in working with people. Specifically, workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job. Healthcare professionals' work often involves close contact with people who can be emotionally difficult to manage on a continuing basis. For health professionals who experience burnout, there may be a gradual loss of caring about the people with whom they work, as over time they find they cannot sustain the level of personal care and commitment required of them (Maslach et al., 1996).

According to Maslach et al. (1996), burnout differs from occupational stress in that it is specific to work that requires intense involvement. The defining feature of occupational stress is an imbalance between occupational demands and available coping resources. The burnout concept integrates a feeling of exhaustion with staff members' involvement in their work, especially the people with whom they work, and their sense of efficacy or accomplishment. Burnout is usually thought of as the outcome of chronic stress (Cushway et al., 1996).

Unmet job expectations in general and specific aspects of job experiences are associated with burnout. It has been suggested that there is a prevalence of unrealistic job expectations among human service professionals and that this mismatch between expectations and reality is a major contributor to the stress that they experience (Jackson et al., 1986). It has been suggested that two types of employee expectations are implicated as possible causes of burnout. These are achievement expectations about what one will achieve with clients, and organisational expectations about the nature of the job and the systems within which one operates as an employee and a professional (Jackson et al., 1986).

The person who burns out is unable to successfully deal with the emotional stress of the job, and this failure to cope can be manifested in a number of ways, including low morale, impaired performance, absenteeism and high turnover. A common response to burnout is to change jobs, move into administrative work or leave the profession entirely. In addition, burnout is correlated with various indices of personal dysfunction. Emotional exhaustion is often accompanied by physical exhaustion, illness, psychosomatic symptoms, increased use of alcohol

and drugs, and increased marital and family conflict. As a result of these factors, the quality of care that service recipients receive may deteriorate.

Client-related factors

In human service occupations the worker must deal directly with people about issues that may be problematic. Maslach et al. (1996) suggested that as a consequence of this, strong emotional feelings are likely to be present in the workplace and that this chronic emotional stress can induce burnout. Client characteristics and contact are a defining factor in burnout among human service providers.

Caseload

Higher rates of emotional exhaustion and depersonalisation and lower rates of personal accomplishment are related to having a larger caseload (Maslach et al., 1996). The larger the ratio of clients to staff, the less liked their job and the more they said they would change their jobs if given an opportunity. McLeod (1997) found that 80% of community nurses working with severely mentally ill people had a caseload higher than the national average, with some staff having as many as 60 clients in their caseload. Seventy-five per cent of the community nurses reported that having too many referrals and a large caseload were the most significant stressors.

Case type

The higher the percentage of people with schizophrenia in the client population, the less job satisfaction staff members expressed. The findings from McLeod's (1997) study of 60 community psychiatric nurses in the UK revealed that higher levels of stress were experienced by community mental health nurses working with severely mentally ill people than those working with people with a range of diagnoses (affective, anxiety and adjustment disorders). Potentially threatening clients were found to be a major source of stress for mental health nurses, with staffing shortages putting them at physical risk because of the nature of their client group (Schafer, 1992). Violent or aggressive clients have been found to be a source of stress for social workers.

The type of client problem has an effect on staff stress and burnout. Some clients may have problems that are far more emotionally stressful for staff than others. If the interaction with clients is particularly upsetting, depressing or difficult in some way, then staff burnout may be more severe and/or occur more quickly. Related to the stressfulness of the client's problems is the probability of successful change. It may be more difficult for staff to work with people and see few changes over time. Another stressor has been found to be the client's reaction to staff. It is common to receive more negative than positive feedback from clients.

Contact level

Savicki and Cooley (1987) found that high work pressure related to high levels of emotional exhaustion and that high contact workers showed higher levels of depersonalisation than low contact workers. Maslach et al. (1996) reported that doctors who spent most of their working time in direct contact with clients scored high on emotional exhaustion. Rogers and Dodson (1988) found that the number of direct client contact hours was positively correlated with the intensity dimension of emotional exhaustion and the frequency dimension of depersonalisation for occupational therapists. The frequency and intensity of these feelings may be exaggerated by increased client contact.

Work-related factors

Work environment

Work environments associated with high burnout are those that demand high personal adherence to work through restriction of worker freedom or flexibility and that de-emphasise planning and efficiency for the task at hand. Other work environments related to higher levels of burnout are those in which job expectations are vague or ambiguous, in which management imposes extensive rules and regulations, and in which support and encouragement of new ideas and procedures are low.

Key stressors for ward-based mental health nurses were found to be staff shortages, health service changes, poor morale, lack of consultation from management, and not being notified of changes before they occurred (Fagin et al., 1996). Schafer (1992) identified that, for community mental health nurses, the principal stressors related to the perceived inadequacies in management and perceived need for supervision. Some of the stressors for British psychologists working in the National Health Service (NHS) included pressure of workload, lack of resources, conflict in relationships with other professionals, and poor organisational communication and management (Cushway & Tyler, 1994).

A possible explanation for the high stress levels may be the impact of enforced reorganisation involving major changes in service delivery and supporting systems with deadlines for implementation. Jones and Novak (1993) suggested that social work practitioners seemed demoralised, exhausted, and overwhelmed by constant change. The way the department is managed was a significant source of dissatisfaction among social work staff and managers. Job dissatisfaction in relation to organisational structures and processes has been related to high turnover of social workers (Bradley & Sutherland, 1995). Issues relating to how clinicians spend their time are also associated with stress. For example, it was found that being unable to reach planned work targets, and other caseload factors such as having too much administrative and paper work appears to be strongly associated with high measured stress for social workers (Collins & Murray, 1996) and occupational therapists (Leonard & Corr, 1998).

Work location

With the downsizing of psychiatric hospitals and an increase in community-based services, the nature of mental health service delivery has changed greatly. There has been ongoing concern about whether community mental health teams have adequate resources, including staff, to provide a service for all people with severe mental illness living in the community (Prosser et al., 1996). Concerns have also been raised about the lack of day facilities, supported housing and appropriate hostels with skilled staff (Reid et al., 1999). Reid et al. (1999) found that lack of resources was the third most frequently mentioned source of pressure at work. Another cause of stress appeared to be the lack of inpatient care for those clients in acute distress (McLeod, 1997). Mental health nurses indicated that the stress of working with difficult clients was associated with a lack of resources (Cushway et al., 1996). Insufficient resources and a lack of alternative facilities to which to refer clients have been identified as two of the top stressors for a number of professional disciplines, including community mental health nurses (McLeod, 1997), occupational therapists (Leonard & Corr, 1998), psychologists (Cushway & Tyler, 1994) and social workers (Bradley & Sutherland, 1995).

Role-based stress

These organisational stressors include role conflict, role ambiguity, role overload, and the responsibility associated with the role of the individual (Moore & Cooper, 1996). Reid et al. (1999) found that community mental health social workers expressed more concerns about role conflict and role ambiguity than any other professional. This study also found that 75% of doctors, all team leaders and 33% of the social workers had difficulties managing multiple demands on their limited time. An increased level of responsibility following the introduction of new legislation was found to create additional pressure at work for community nurses and occupational therapists (Reid et al., 1999).

Table 10.1 presents a summary of workplace stressors.

Stress can be very costly in both human and economic terms for individuals and for society. Health professionals may have a profound effect on peoples' lives. Stress in health professionals may have far-reaching effects on the clients with whom they work (Cushway, 1995). It is clear that a critical first step in managing stress is acknowledging the problem. What can be done about it?

Dealing with stress and burnout

Given the range of sources of stress and the complex demands of mental health work, it can be expected that team leaders, professional seniors and unit managers will frequently have to assist colleagues who are affected by stress. It can also be expected that they will themselves be affected by stress. The following sections aim to assist with responding effectively to others' stress as well as appropriate self-help.

Table 10.1 Workplace stressors.

Factors contributing to workplace stress	Type of stressor
Client-related factors	Caseload
	Cast type
	Contact level
Work-related factors	Work environment
	Staff shortages
	Health service change
	Poor morale
	Lack of consultation from management
	Lack of supervision
	Time management
	Work location
	Role-based stress

The obligations of the supervisor

Supervisors have a duty of care in respect of those staff members for whom they are responsible. Stress is a workplace health and safety issue and supervisors must identify and minimise risks and assist anyone affected by stress. This means both being aware of potential sources of stress and also being receptive to staff at an interpersonal level. If the first time a supervisor learns about stress is when a team member takes sick leave, it usually means that something has been overlooked. However, the duty of care does not provide a licence to intrude into the personal life of team members. Unless there are clear indications of impaired work performance the correct position of the supervisor is clear communication of availability and willingness to assist. Stress often results from a complex mixture of personal and work factors and the team member may prefer to address sources of stress outside the workplace. In these circumstances the role of the supervisor is to assist with referral where required and monitor, in a general way, the effectiveness of any external support provided.

Levels of intervention

Management and supervisory response to risk or actuality of workplace stress has been conceptualised (Cottrell, 2001) as operating at three levels: primary, secondary and tertiary (see Table 10.2). Another way of conceptualising this is prevention (introducing measures to reduce risk of stress), intervention (providing active assistance during a stressful event or experience) and postvention

Table 10.2 Matrix of organisational stress management interventions.

	Prevention	Intervention	Postvention
Community Mental Health (Individual perspective)	Caseload monitoring and management	Healthy lifestyle	Counselling
	Caseload characteristics monitoring and management	Reflection	Psychotherapy
		Clinical supervision	Occupational health interventions
	Assertiveness	Mentorship	Physical wellness: diet, exercise, addictions
	Communication skills	'Buddy' systems	Lifestyle work
Inpatient Services	Psycho-education	Relaxation	
		Home/work interface	
		Support mapping	
		Biofeedback Imagery	
Both Inpatient and Community Services	Effective team functioning	Group development, diagnosis and intervention	Availability of critical incident debriefing
	Thoughtful and consultative rostering		Access to counselling/ psychotherapy
	Clinical supervision	Clinical team supervision	Access to career planning
		Dependency/skill mix	
		Workload analysis and review	
Organisation (Systems perspective)	IPR	Workload management	Therapeutic consultancy
	PDR	Mission clarification	Reorganisation
	Job descriptions and Role	Risk analysis and management	Organisational transformation programmes
	Clarification	Employee participation	Employee Assistance Programmes (EAP)
	Participation and empowerment		Process redesign
	Schemes		Cultural change work, e.g. combating 'presenteeism'

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(providing assistance in the aftermath of stress). Managers must have effective strategies in place at each level and also need means of monitoring the effectiveness of these strategies.

Workload and work quality

Supervisors can and should monitor workload and work quality (Meldrum & Yellowlees, 2000; King et al., 2004). Workload factors may include hours of work, travel time and non-clinical duties in addition to caseload size and characteristics. While there may be no clearly defined benchmarks as to what is an acceptable workload, it is not difficult to gauge whether a practitioner has workload that is higher than normative. Client factors are especially relevant to work quality. Acute, suicidal, violent and unresponsive clients increase the stress associated with clinical work, and a disproportionate number of such clients can significantly increase risk of stress or burnout (Meldrum & Yellowlees, 2000). Clinicians who work with victims of abuse are at increased risk of vicarious trauma, which is a form of stress (Thomas & Wilson, 2004). It is not uncommon for clinicians to develop a specialist interest in groups of clients who have such risk factors. While this has potential benefits (see below) because it capitalises on the development of specialist clinical skills, it is important that such clinicians are monitored to ensure that there are no unintended effects, such as vicarious trauma.

Burden of responsibility

The evidence that clinicians working in community settings are probably under greater stress than clinicians working in inpatient settings presents a challenge for the team leader or service manager in these settings. As discussed above, workers in such environments often attribute stress to inadequate resources such as access to inpatient beds, emergency housing or after-hours support. While these may be legitimate concerns, they are often not under the control of the team leader. This raises the question of what can the team leader do to minimise stress associated with these kinds of environmental deficiencies?

One reason that the absence of resources is so stressful for community-based clinicians is because of feelings of responsibility resulting in a burden of care. When clients are unstable or acutely unwell, clinicians look to inpatient services, respite services and other community supports to relieve their burden of care. In the absence of such services, they feel overwhelmed by responsibility for the well-being of the client. In this respect, clinicians may be in an analogous position to that of family and carers. It is important that community-based workers are not left to deal with this burden on their own.

The most important resource for a community-based mental health clinician is a supportive team. A team can share responsibility for decision making and also allocate additional resource to ensure that a single case manager does not have to provide all the care in a crisis situation – or at least knows that help can be provided if needed. The team leader has the responsibility of managing

the team and ensuring that the team processes are supportive – that individuals have the opportunity and are encouraged to present challenging cases, that the team deals with the issues respectfully and thoughtfully and that the team mobilises its collective resources to develop a plan for which it will assume responsibility. When a team has a consultant psychiatrist or other senior clinician, that person will usually provide ultimate clinical accountability for team plans.

Sometimes community services comprise single individuals or just a couple of individuals. In these circumstances, clinical supervision is a key component of prevention of stress associated with burden of care (Edwards et al., 2006). The responsibility of the service manager is not necessarily to provide the supervision but to ensure that each practitioner has access to appropriate support.

Work–life balance

The evidence suggests that problems outside the work environment and difficulties achieving a satisfactory balance between work and non-work life demands cause stress as much as experiences within the workplace (Bolger et al., 1989). Most members of the contemporary workforce struggle to balance workplace responsibilities with responsibilities to partners, children, parents or others and with recreational activities or community services. The team leader or service manager can be a positive or negative force in respect of these challenges.

Rostering of after-hours duties is an example of an administrative responsibility with high potential to impinge on work–life balance. Inpatient services and many community services require 24/7 or extended hours staffing. This means that many clinicians will be required to work evenings and/or weekends, imposing limitations on time available for shared activities with family and friends. Rostering is a sensitive issue, partly because it impinges directly on the work–home balance issue (Clissold et al., 2002) and partly because it can easily be perceived to be a means by which management exercises control and provides benefits for those who have the 'ear' of management and disadvantages for those who do not. Rostering can be a source of chronic discontent.

While management may not have capacity to eliminate extended hours work, there are some general principles which, if consistently used, reduce the risk of roster-induced stress and discontent:

- Ensure there is a need for extended hours services. Demand should be monitored and alternative ways of providing services investigated. Rostering staff to provide after-hours services that are not really necessary is not only expensive but may unnecessarily promote grievances.
- Use rostering systems that maximise staff autonomy and decision making and adhere to principles of transparency and fairness. Self-rostering is an example of an established approach with a track record of increasing staff satisfaction (Wortley & Grierson-Hill, 2003; Jennings, 2005; Pryce et al., 2006).
- Regularly monitor rostering systems using confidential satisfaction surveys. Anonymous surveys are more likely to elicit meaningful information than

informal face-to-face feedback. When staff feel vulnerable, they are reluctant to provide honest feedback that may be unwelcome.

Stress antidotes

While mental health professionals report moderately high levels of emotional exhaustion, they do not typically report lack of satisfaction with their work with clients (Hannigan et al., 2000). Clinical work is often experienced as highly satisfying and there is evidence that clinicians want more opportunities to deploy their professional skills in work with clients (Lloyd et al., 2004). Service managers and team leaders can actively contribute to employee work satisfaction by maximising their opportunities to deploy their clinical skills and capacities. This means maintaining a strong awareness of the clinical interest and expertise of team members and ensuring that, wherever possible, they have opportunities to work with clients in a way that will utilise these capacities. This does not mean that clinicians should be supported to provide any form of intervention that interests them. Considerations such as efficacy and cost-effectiveness remain relevant. However, clinicians should be granted as much autonomy as is consistent with operation within an evidence-based practice paradigm (see Chapter 12) and within the resource limitations of the service. Transparency concerning these issues will encourage clinicians to develop and utilise interventions that are personally satisfying as well as beneficial to clients.

Supporting clinician autonomy as a strategy for stress prevention is consistent with research that suggests that enhancing the degree to which a worker has control in the job, including discretion and choice, reduces work-related stress and associated phenomena such as absenteeism (Bond & Bunce, 2001).

Staff training for stress reduction

While there is evidence that stress reduction courses, whether provided one-on-one or in group settings, can be effective (Edwards & Burnard, 2003; Marine et al., 2006), it is less clear as to whether there are benefits in providing staff training designed to prevent or reduce stress. Kagan et al. (1995) reported positive results of psychoeducational interventions for emergency medical staff. However, the multisite OSCAR project (Ryan et al., 2005) found otherwise. This group provided a four-day staff training programme for mental health staff that focused both on recognising and managing stress at individual, team and organisational level and on responding to client crisis and violence. Unexpectedly, stress increased rather than reduced following the training. The authors concluded that these paradoxical results may have been due in part to increased staff expectations that were not fulfilled because organisations were unwilling or unable to respond to identified needs. Both Edwards et al. (2003) and Marine et al. (2006) concluded that methodological problems made it difficult to evaluate the findings of the identified studies that had evaluated stress management interventions in mental health staff and healthcare workers, respectively.

Post-incident stress debriefing

Considerable controversy surrounds the role of debriefing following a work incident or other trauma likely to be stressful, such as an assault or accident causing or threatening significant harm or death (Everly & Mitchell, 2000). Critical Incident Stress Debriefing (Mitchell, 1983; Mitchell & Everly, 1997) is a process designed to assist people affected by trauma to psychologically process the experience and to recognise and respond effectively to trauma-related stress symptoms.

A Cochrane review (Rose et al., 2002) identified nine studies using an experimental or quasi-experimental design with broadly similar interventions and study populations. The review concluded that there was no evidence that debriefing was superior to no intervention and that there was some evidence that it may increase risk of depression or trauma. Likewise, van Emmerik et al. (2002) concluded from a meta-analysis that natural recovery was as effective as any kind of debriefing after trauma. Proponents of debriefing have, however, continued to argue that it is effective when applied in an appropriate fashion to the populations for whom it was intended (Everly & Mitchell, 2000; Jacobs et al., 2004).

There is little basis, given the current state of knowledge, for the use of mandatory debriefing procedures when staff are exposed to traumatic events. Voluntary debriefing may or may not be helpful as a preventive measure. While it is important to provide psychological support for staff who are distressed following exposure to a traumatic event, it may be more important to ensure that targeted interventions are available to people who are showing signs of a stress reaction (Rose et al., 2002).

Conclusion

Stress is connected to the job itself, work roles, clients, relationships with others, career opportunities and organisational structure and climate. The person who burns out is unable to successfully deal with the emotional stress of the job. Stress is very costly in both human and economic terms. Team leaders and other people in a management role will frequently have to deal with people affected by stress. Some strategies for assisting managers to identify and deal with stressful situations have been outlined in the chapter.

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Chapter 11
Quality improvement

Frank P. Deane and Vicki Biro

Chapter overview

> 'Performance monitoring and readjustment . . . does not in and of itself create a commitment to quality; it only serves that commitment. A genuine, persistent, unshakable resolve to advance quality must come first. If that is present, almost any reasonable method for advancing quality will succeed. If the commitment to quality is absent, even the most sophisticated methods will fail.'
>
> Donabedian (2003, p. 137)

In this quote and in his writings Donabedian highlights one of the most important foundations of quality improvement, the need to have genuine commitment to quality that is internally motivated and not just a response to external pressures or demands. Furthermore, he argues that the commitment needs to be by everyone at all levels of an organisation (Donabedian, 2003). Herein lies one of the first challenges to managers in mental health – the capacity to develop and nurture an environment in which others in a service value quality and the ability to demonstrate it.

Defining quality improvement

Quality improvement and quality assurance have been used somewhat interchangeably in the past. Quality assurance has been defined as 'all actions taken to establish, protect, promote, and improve the quality of health care' (Donabedian, 2003, p. xxiii). However, the term assurance has been criticised because of the sense of guarantee that is implied. Instead, quality improvement or continuous improvement has been suggested as better alternatives because they imply an ongoing process of quality enhancement activities (Donabedian, 2003).

Goh (2007) further elaborates that quality assurance involves the consistent delivery of standards of care. One of the difficult aspects of this definition is that specifying appropriate standards is not always straightforward. A standard has been defined as 'a specified quantitative measure of magnitude or frequency that specified what is good or less so' (Donabedian, 2003, p. 60). Many stakeholders are involved in deciding standards, and the notion of appropriate or good standards from the perspective of clinicians, hospital managers, politicians and

consumers is likely to vary considerably. Despite this, there is some consensus that meeting the needs of consumers is an important consideration in setting standards. The point is that there are many drivers of what is considered to be an appropriate standard of care. For many clinical managers the most frequent formal demands for quality improvement activities often occur in the context of accreditation or quality reviews.

Determining priorities

In most Western countries, national mental health plans and national standards for mental health services have been developed and probably drive decisions about which standards are important at any particular point in time (e.g. Australian Health Ministers, 1996, 2003). Where there is mental health reform there are likely to be a set of performance indicators that reflect progress toward achieving reform goals (e.g. McEwan & Goldern, 2002). For example, the Department of Health (2006) in the UK has specified increased access to computerised cognitive behaviour therapy as part of its goal to provide better support for mental health and emotional well-being. The Australian National Mental Health Plan (Australian Health Ministers, 2003) highlights the need for services to become 'recovery-oriented' and provides definitions of what that means. Similarly, New Zealand has a blueprint for mental health services that also highlights a recovery approach (Mental Health Commission, 1998), a set of national standards for providing care (Ministry of Health, 1997) and a set of recovery competencies for New Zealand mental health workers (Mental Health Commission, 2001). While such documents may provide some direction for prioritising quality improvement activities, typically there are many more potential targets (goals, standards, competencies) than can be measured in most services.

At a more local level such as a community mental health service, changes in service delivery, specific problems or complaints may drive which set of standards will be targeted or prioritised. For example, a project integrating psychiatric rehabilitation into a managed healthcare structure, identified desirable consumer outcomes as 'personally satisfying role functioning in the client's social, residential, educational or occupational status' along with increased ability to function independently as key quality assurance targets (Ellison et al., 2002, p. 387). Other factors may be problem related such as an increase in rates of suicide attempts or injuries to staff that require quality reviews that have a more occupational health and safety focus.

Different professional organisations also specify competencies and professional standards for their clinicians (e.g. Coursey et al., 2000; Scheiber et al., 2003). Such competencies are also likely to have bearing on standards of care. There are many standards to strive for and we will provide a case example and other suggestions about considerations in determining which standards to assess. However, there are also usually multiple ways of determining whether such standards have been achieved. A variety of measurement tools may be used to gain

information about standards and practices of the healthcare service and include both quantitative and qualitative measures. The measurement of whether particular goals or standards are being met is an important part of quality improvement activities. The use of performance indicators and monitoring techniques are common elements of measurement. But, as with establishment of standards, what, how, when and why particular measures are taken varies widely depending on context and the issues driving particular quality goals.

Quality measurement

Quantitative measures provide a form of information that can be compared across different studies, populations and over time such as the frequency or duration of an event. Quantitative measures include things such as the number of treatment contacts or hospitalisations, duration of direct treatment contacts or length of stay in hospital. Other quantitative measures might be scores on particular questionnaires or rating scales. Qualitative measures tend to provide a context for quantitative measures and may highlight an issue or area of concern not directly measured by a specific quantitative measure. Qualitative data may be derived from case studies, interviews, focus groups or review of notes from files. Both measures may be used effectively in combination or separately, and are valid tools for monitoring and evaluating service activities and projects (Goff et al., 2001). The use of performance indicators and performance measures are helpful tools in quality improvement systems. In addition, activities that can provide information about the provision of quality of care and services may include incident review and monitoring, complaint monitoring, use of clinical indicators, review meetings, audits and surveys.

A study of quality measurement in substance abuse and mental health services across 434 managed care organisations found 70% used patient satisfaction surveys, 73% used performance indicators, 74% used practice guidelines for behavioural health and 49% assessed clinical outcomes (Merrick et al., 2002). Although consumer satisfaction surveys are relatively frequently used, there is not always a clear association between satisfaction and clinical outcomes. This requires the need to consider a range of quality measures. Increasingly, mental health services are introducing minimum mental health datasets to assist in quality measurement (Clarkson & Challis, 2002). For example, routine outcome assessment in Australian mental health services using the Health of the Nation Outcome Scales (HoNOS) and Life Skills Profile (LSP) is now well established (Eagar et al., 2005), and these scales have the potential to be used in quality improvement activities.

Key performance indicators

Key performance indicators (KPIs) are variables (e.g. number of staff contact hours) that are assumed to reflect how well a service is performing in important

areas related to quality of services. They are termed 'indicators' because they do not guarantee quality, but *probably* reflect quality; they are used to screen or flag processes or outcomes for review. For example, clinical indicators are usually rate based and demonstrate trends or variations within results thus highlighting areas that may need addressing (Australian Council on Healthcare Standards, 2006a). As a clinical manager, you may not always have a lot of choice about which KPIs are requested. However, wherever possible you should try to be involved in decisions about the selection of KPIs and the discussions leading to their selection.

Goff et al. (2001) recommend that when developing performance indicators, managers and evaluation teams should ensure that they relate directly to the goals, outcomes and objectives of the activity or initiative. They go on to recommend that consideration be given to the performance indicator in terms of whether it provides a logical link between the available evidence and whether it has demonstrated the capacity to measure change within a given timeframe. Other considerations are: whether the performance indicator is achievable, measurable and affordable (cost–benefit); whether it is clear, concise and understandable for relevant stakeholders; and whether it measures a specific aspect of behaviour, attitude, condition or status that relates directly to the objectives, outcomes and goals of the initiative/activity.

By way of example, Sorensen et al. (1987) described 25 KPIs to support managers and policy makers in assessing the performance of their programme relative to others. The focus was on community mental health organisations. The initial set of indicators had an efficiency orientation (use of resources) while the later ones had a focus on effectiveness (attainment of goals). In addition, KPIs were blocked into the four groups of revenue, clients, staff and service. Sorensen et al. suggest that before comparing with external sources, the organisation's own trends should be considered and this involves calculation of percentage change from previous year to current year. Use of medians was suggested to avoid effects of extreme mean values. These median values can then be compared to appropriate comparison groups (specific to organisational needs, national or state). For example, an area health service may choose to benchmark against other area health services with similar population or geographical characteristics. The authors suggested locating organisational data in quartiles compared with comparison groups. For example, those organisations in the first quarter would be among the lowest 25% of organisations on a particular measure (Sorensen et al., 1987). It is recommended that at a minimum, cautions should be made for special circumstances that may lead to accurate but potentially misleading conclusions (for example, special projects occurring within a service that may influence results). Examples of managerial applications of the data are provided with the suggestion that KPI measures that fall in the first or fourth quartiles are 'potential areas of managerial inquiry' (p. 242) (i.e. we may have a problem).

Of the 25 KPIs in Sorensen's list many were heavily weighted toward revenue or financial consideration. For each KPI an operational definition is provided

along with uses, limitations, potential problems in data collection and advantages. Although this was an attempt to suggest a set of KPIs given the emphasis on revenue and efficiency indicators (the ability to lower the cost of care without reducing health outcomes) these appeared more relevant to managers with strong fiscal responsibilities. However, clinical managers may be more concerned with acceptability of care such as the extent to which patients' preferences and expectations of treatment are met (Donabedian, 2003). Thus, there is usually some need to make decisions about what to monitor and this can be influenced by external factors (e.g. required by government) or internally (e.g. routine problem identification within a team or by consumers of a service). The following case example illustrates how one mental health service approached prioritising and selecting KPIs to be monitored.

Selecting KPI priorities

In a local area mental health service project 87 KPIs had been identified by service management as relevant for monitoring progress toward achieving the goals of the service strategic plan. Achievement of these KPIs was then passed to clinical managers with the view that they would monitor and report these on a regular basis. However, the large number of KPIs necessitated some way of prioritising and organising them so as not to overwhelm both the clinical managers and the administrative and other frontline staff.

Initially, these KPIs were organised into six target goal groups: safety of service (20), effectiveness (19), efficiency (8), access (29), appropriateness (4) and participation (7). This process allowed decisions about which domains appeared to have more indicators which might suggest some redundancy. As recommended by Sorensen et al. (1987), there was a need to provide an operational definition for each KPI, the system source of data and its uses. As part of this process and in order to make decisions about which KPIs should be prioritised, limitations of the KPI, potential problems in data collection and advantages were considered and listed.

In prioritising the KPIs to be collected and reported, several criteria were used. The first block, listed below, relate to 'ease of collection' while others focused on the ability of the KPI to provide meaningful data in relation to goal achievement.

- Are the data already being collected and reported?
- Are the data already being collected but not collated and reported?
- Ease and cost of collection and reporting.
- Capacity of one KPI to address more than one strategic goal or standard.
- What are evaluation priorities of key stakeholders (especially consumers, carers, general practitioners (GPs), etc.)?
  - What are meaningful indicators to stakeholders?
  - What are their strategic goal priorities?
- Which KPIs will tell us whether a strategy has been achieved (i.e. how close do the KPIs link with achievement of strategic goals)?

- Is a KPI amenable to implementing change in the organisational system (i.e. will measuring the KPI lead to change, or can it be interpreted in a way that allows change to occur to achieve a specific strategic goal)?
- Do KPIs overlap such that they provide redundant information?

For the 87 KPIs in our case study, 17% were already being collected, aggregated and reported usually for the local clinical governance executive committees, quality council, state, or accreditation organisation. Twenty-eight per cent had data that were available in various forms (e.g. medical records, accounting, human resources, etc.), but would require additional systems and resources in order to be collected, aggregated and reported.

Thus, 45% of the KPIs did not require data generation procedures in addition to data collection. However, many of these KPIs were generated as a function of standard state-wide data collection and reporting requirements. As a result they largely reflected the priorities of the state centre for mental health or management. Without elaborating the process fully, it can already be seen that several of the KPIs could be selected based on relative ease of data collection. Clearly, there is a need to continue the process to be sure that the KPIs are also relevant and meaningful in terms of the targeted goals. However, while these issues are important considerations in selecting KPIs there is also a need for input from other stakeholders about preferences or meaningfulness of different KPIs.

Stakeholder considerations in prioritisation and selection of measures

Wilkerson et al. (2000) described an accreditation system and its performance indicators project. Performance indicators were identified using a consultative approach to the accreditation survey process and gave service providers and stakeholders guidance in gathering and interpreting data on outcomes so that these were completed in a uniform way.

Consideration of consumer or other stakeholder preferences can be achieved in many ways. There may already be consumer representation within the organisation (e.g. consumer review groups). Alternatively, there is the possibility of contracting external consumer review. The goal is not to generate strategic direction since this has presumably already been accomplished through an extensive process of consultation. Instead the goal is for a consumer group to review the existing strategic goals and provide recommendations about what would be meaningful indicators (measures) of the achievement of these goals. In addition, it might be possible for this consumer group to review any existing list of indicators (e.g. the list of 87 indicators) to provide feedback about which in their view have the potential to reflect or inform achievement of strategic goals. It is important to have a set of consumers with some evaluation sophistication for these purposes because there is often a gap between goals and 'indicators' that are not always readily apparent. For example, understanding how and by whom indicators are reported may be important to determine the extent to which they

capture goals. Often strategic documents are written in general terms with varying degrees of specificity with regard to criteria of goal achievement. Similarly, there are often multiple KPIs that will provide data regarding the achievement of a single goal. Often 'indicators' are not direct measures. For example, the KPI 'percentage of active consumers with a current care plan' does not indicate the quality of the care plan, how meaningful the plan is to the consumer, nor how actively or collaboratively the consumer and clinicians are working together using the plan. Where relevant to the strategic goals being addressed other stakeholders may need to be consulted (e.g. access to services by referrers may involve carers, GPs or the police).

Other criteria for considering priorities for monitoring include: patient welfare; meeting externally imposed requirements; risk reduction; institutional enhancement; attempts to get a representative sample (statistically); fairness and feasibility (e.g. organisational readiness) (Donabedian, 2003).

Selecting an approach for measuring performance

From some of the examples above it can be seen that there are multiple methods for collecting data. Donabedian (2003) provides a three-part structure in selecting an approach to assessing performance.

(1) *Structure*, which includes material and human resources (e.g. equipment and number, variety or qualifications of staff) and organisational structures (e.g. supervision, training, funding mechanisms).
(2) *Process* relates to the activities that make up mental healthcare (e.g. diagnosis, treatment, etc.).
(3) *Outcomes*, such as changes in mental health status or satisfaction of consumers and carers about care received.

All three components can provide information from which quality can be inferred. However, Donabedian argued that quality can only be inferred when there is a predetermined relationship among the three components and suggests a simplified linear relationship as:

Structure → Process → Outcome

Between each of the components the arrows represent causal probabilities rather than certainties. Often KPIs are provided that can potentially fall under Structure, Process or Outcome. It is useful to locate where KPIs fall in this system in order to better understand what parts of performance they are mostly capturing but as we will see this process also helps clarify what might be done to improve performance.

You can also see from Table 11.1 that in this service more than one KPI may relate to the same sequence of Structure–Process–Outcome (example 1 in Table 11.1). Thus, the process of organising KPIs (or other measures) may also allow integration and remove redundancy. In addition, the examples highlight

Table 11.1 Examples of KPIs located in Structure–Process–Outcome categories.

	Structure	Process	Outcome
Example 1	**KPI** 'Number of clinical full time equivalent vacancies'	Sufficient staff are available to deliver care	More clients have access to appropriate care **KPI** 'Number of complaints from *consumers and carers* relating to poor access to services'
Example 2	**KPI** 'Number of full time equivalent staff who completed child protection training in the past 12 months'	Appropriate screening and identification of children at risk of abuse	Prevention of abuse and negative mental health outcomes for children
Example 3	Staff receive training in how to engage consumers in collaborative care planning	**KPI** 'Percentage of active consumers who signed their own care plan'	Consumers will have greater satisfaction with care. Specifically, collaborative approach
Example 4	Computers and information system to streamline referral procedures	Referral information received and entered by administrative intake worker within four hours	**KPI** 'Number of complaints from *referrers* relating to poor access to services'

the probabilities that are implicit between each of the components and how these vary.

If we take example 4 in Table 11.1, the probability that provision of computers and an information system (structure) leads to referral information being entered (process) could be viewed as fairly moderate to high. However, the probability that referral information being entered leads to fewer complaints (outcome) from referrers may be lower because there is probably a range of other uncontrolled factors that lead to complaints being made and variances that impact on efficient referral processes and outcomes. In addition, there are methodological issues associated with the measurement of this outcome. It is possible that the frequency of complaints is coming from a relatively low baseline and it may be that this measure is not sufficiently sensitive to detect any changes as a result of the structural changes made to address the problem.

Donabedian (2003) also offers guidelines for how to choose outcomes as an indicator of quality. The outcome should:

- be relevant to the objectives of care
- be achievable with good care (i.e. methods are available to mental health system)
- be attributable to healthcare or the practitioner delivering care

- consider duration and magnitude
- have information about the outcome available (i.e. it must be obtainable)
- consider consequences of taking an action and also not taking an action (i.e. is the outcome able to detect effects of inaction?)
- consider the means used to achieve the outcome.

It is likely that for most quality assurance projects a combination of Structure–Process–Outcome approaches will be used. One advantage of this is that where inferences about quality differ between the approaches, this may indicate problems with either measurement accuracy, timing or faulty assumptions about the sequencing (Donabedian, 2003).

Identifying standards

Table 11.1 also highlights how the role of 'standards' operates in quality assurance. For example 2, the standard for training in child protection (Structure) may be 100% of staff within 12 months of commencing employment. The standard for appropriate screening and identification of children at risk of abuse (Process) might be not less than 90% use of specific oral screening question and use of structured questionnaire following positive screen. The standard for prevention of abuse (Outcome) may be no more than 5% of children who screen positive go on to have documented abuse.

As noted, earlier standards are often defined by government policy, professional organisations and other stakeholders. Wherever possible, good practice and standards should be based on empirical research. In practice this can at times be a complicated process (see Chapter 12). However, there are many accessible sources of information to help establish standards if these have not already been provided. For example, practice guidelines for the treatment of anorexia nervosa reveal that 50% of patients get better (Haliburn, 2005). These data have the potential to serve as a standard for outcomes. Similarly, there is a range of practice guidelines for disorders such as depression (Ellis, 2004) and schizophrenia (Lehman et al., 2004; McGorry, 2005). These guidelines offer further opportunities to identify standards for use in quality assurance activities (e.g. for schizophrenia, 'Clozapine should be used early in the course, as soon as treatment resistance to at least two antipsychotics has been demonstrated', McGorry, 2005). Zaenger and Al-Assaf (1998) specified other methods for setting standards such as identifying and conferring with experts, literature reviews, benchmarking (normative comparisons), and reviewing past experiences within an organisation.

Obtaining information

There are many sources of information that can be used in quality assurance and improvement activities. As noted, in the review of KPIs, consideration should

be given to how accurately the information reflects the target behaviour or performance being assessed (validity). In addition, consideration should be given to how well the sample of information represents most or all occurrences of the behaviour or performance (generalisability). The third major consideration is whether the information can be collected reliably. This can have several implications. For example, if data are being extracted from clients' medical records in some form of audit, reliability might refer to whether the specific data extracted by one person is the same as it would be if a second person were to complete the same review. It may also refer to how complete the data are, it is possible that 90% of data is collected from one community mental health centre, but only 50% is able to be located from a second. Such variation may be a function of incomplete data recording by clinicians or administrative support staff at the different settings.

Records and electronic databases

There are several potential sources of data and the practical difficulties and effort in actually obtaining it will also vary considerably. Medical records are increasingly becoming electronic and while in theory this offers potential for relatively easy access, this will depend on how 'user friendly' the system is or the availability of technical support. Concerns about completeness, reliability and validity of medical record information have been voiced by others and as a consequence there may be occasions where there is first a need to improve the quality of information in records. Improving the completeness and quality of information in records may involve simply insisting that existing requirements be completed (e.g. through team meetings) or may require the provision of additional training of clinical or administrative staff.

There is potential to supplement medical records in order to obtain quality data but there is a need to be sensitive to the extra burden this may place on staff. A compromise to this is to identify selected clinicians who agree to participate in the quality activities and to obtain the extra information. Such a strategy needs to balance the loss of representativeness with improved completeness and accuracy of information.

Many healthcare organisations have electronic information systems that have the capacity to collect and report activity within the organisation (e.g. length of stay, bed occupancy, occasions of service). Strategic development and resource allocation is required by the organisation to ensure reliability of the data entered into the system, ease of accessibility to the information stored in the system, efficient management of data storage and timely reporting of statistical data and trends to relevant managers and service providers.

Another form of record that is frequently used in quality activities are financial records. Financial records are used particularly when assessing the efficiency of care. Efficiency is 'defined either as the amount of medical care for a given cost (where more is better care) or similarly as the lowest costs incurred to provide a given level of medical care (where less is better)' (Benneyan & Valdmanis,

1998, p. 186). The structure and detail of financial management systems will vary in their ability to support resource allocation decisions. From our case example, KPIs that might access financial records to determine costs are: 'Hours per month per employee spent in supervision', 'Average days per annum spent by staff on study leave', 'Number of shifts covered by overtime'.

It should be noted that fiscal or economic information can also be assessed using surveys and this is particularly useful when collecting patient information (e.g. resource usage, work absences, etc., see Gournay & Brooking, 1995).

Surveys

Surveys or questionnaires are a commonly used form of data collection. There is a whole set of specialty skills associated with the development of surveys and it may be helpful to consult with colleagues, consultants or academics who have experience in the design of such measures. If you do not have access to this support then try to identify an existing measure with established reliability and validity. For example, there are many consumer satisfaction questionnaires ranging from a few items to many that cover a wide range of service elements. These can usually be located through library database searches such as Psychinfo or Medline. If you need additional help with this you should contact your institute's librarian. Other sources of information about potential questionnaires can be found on government health department websites and publications (e.g. Stedman et al., 1997).

Surveys can be administered to patients, families, populations or practitioners. Practitioners may include those within the organisation or those external to the organisation who have a collaborative working relationship (e.g. GPs who are a major referral source). Population or community surveys need particular care and planning with regard to representativeness. Usually, clear specification of the target subset within the community is needed (e.g. youth 16–24 years, older people, poor, etc.).

As noted earlier, many countries now have mandated routine outcome measures in mental health services that are completed by clinicians and consumers (e.g. Eagar et al., 2005). These are typically entered into databases, and there is the potential to access this information to reflect amount and rates of improvement for particular client groups or service types.

Observation

Direct observation is another method of gathering information although this can often be a relatively expensive approach. Using the Structure–Process–Outcome structure various approaches to observation can be used. For example, there may be a desire to improve the intake procedures and experience of consumers attending community mental health services. It may be useful to observe first the physical *Structure* of the various waiting areas across several centres. Other structural elements might include the number of administrative staff available,

availability of medical records and forms used in the intake procedure. *Process* observations might involve watching as patients arrive at the centre, how they are greeted by staff, recording their wait times and also time in the initial intake interview with clinical staff. Process observations could be made of the actual intake interviews by having clinical supervisors or colleagues sit in on intake interviews and rating specific behaviours. It may be possible to audiotape or videotape the intake interviews for rating at a later date. Clearly these strategies require the consent of consumers. *Outcome* related observations in this context might involve recording whether patients return for a second visit. The assumption being that having a positive initial intake experience increases the probability they will return for future visits. This could be supplemented by a brief questionnaire asking them how satisfied they were with their initial appointment experience.

Clinical review activities

Service providers can gather information about the quality of care provided to consumers through a range of clinical review activities. These activities may include incident monitoring and sentinel event management. An incident monitoring system facilitates the identification, processing, analysis and reporting of incidents with the purpose of minimising or preventing their recurrence. Effective incident monitoring is dependent on a commitment by the organisation to act on the information that arises from the review process and to facilitate improvements to care and services. Sentinel events are occurrences that have a serious adverse outcome such that an individual investigation is warranted. Circumstances surrounding the event are investigated by the healthcare organisation in order to understand the underlying causes and system vulnerabilities contributing to the event. The product of the sentinel event review and analysis is an action plan that identifies strategies for the implementation of system changes to reduce the probability of the event occurring in the future and to measure the effectiveness of these actions (New South Wales (NSW) Health, 2001).

Reviewing data, feedback and change

Once information has been collected there is a need to make sense of it. As a frontline manager responsible for quality improvement activities, you may not have extensive experience with data analysis. Analysis will be dependent on the type of questions asked and data collected. However, at a minimum, frequencies, percentages, means and medians provide important descriptive data. When attempting to determine whether improvements occurred following some kind of service change, it is likely that statistical analysis will be needed in addition to descriptive data in order to determine whether the change is of sufficient magnitude to be considered reliable and replicable. This provides some reassurance that improvements are not entirely due to chance. For most quality improvement activities basic descriptive data are often sufficient.

There is a need to feed back these results to those in the system who are responsible for implementing any change that may be required or to sustain improvement. Feedback of quality information serves several purposes. It offers staff the opportunity to provide some comments on interpretation of results. It often helps those who are sceptical of information gathering activities to see how their efforts are put to work. Feedback is the initial part of the process that starts to bring staff on board in preparation for making change. It is often preferable to provide frontline staff with opportunities to problem solve around how improvements might be made in relation to specific areas of performance and in relation to the data provided. Where possible a negotiated and agreed strategy for behaviour change should be developed since this is more likely to lead to commitment to change. The preparation for change and attitudes that support this commitment to quality starts at the beginning of the quality improvement process when decisions about which aspects of performance are being determined.

Again, the Structure–Process–Outcome strategy is helpful in determining what behaviour changes might be needed to improve quality. This strategy proposes causal linkages between each of the components and these offer insights into where, when and how change might be made. For example, it may be that there are insufficient human resources (structure) leading to poor performance. It may be that the resources are sufficient, but the skills of staff need to be improved (process) in order to improve quality. The capacity to address particular problems with these components will also vary. It may be that there is no more immediate funding available to increase staffing (structure), so this may become a longer-term target for change whereas improving staff skills may be able to be addressed more immediately through educational and motivational strategies. It is possible that other structural changes, such as provision of better information systems, may clear staff time such that they are able to reallocate human resources to more direct patient care.

An essential part of the quality improvement cycle requires that any changes and actions implemented should in turn have their effects monitored in order to determine whether the changes lead to improvement. Continuous quality improvement is contingent on the organisation ensuring mechanisms are in place to sustain improvement. Sustaining improvement may involve (NSW Health, 2002):

- standardisation of systems and processes for performing work activities
- documentation of associated policies, procedures and guidelines
- ongoing measurement and review to ensure changes become part of routine practice
- training and education of staff to support changes to practice and service delivery.

Quality improvement and accreditation

A number of organisations are involved in both quality improvement monitoring and accreditation. For example, the Australian Council on Healthcare Standards

has a major role in promoting quality and safety in healthcare through the continual review of performance, assessment and accreditation using the Evaluation and Quality Improvement Program: EQuIP (Australian Council on Healthcare Standards, 2006b). The Australian Council on Healthcare Standards uses a set of national standards for health services and also includes an in-depth review of mental health services using the National Standards for Mental Health, 1996. The Australian standards for mental health services pertain to: access, continuity, appropriateness and effectiveness of care, patient safety and the extent to which the service is consumer focused (Goh, 2007).

EQuIP is a four-year quality assessment and improvement programme for organisations that focuses on patient care and service provision. Organisations undertake yearly self-assessments to review and evaluate their performance against national standards and participate in biennial on-site surveys by an external team of accreditation surveyors. Surveyors provide independent assessment of the organisation's performance against the recognised standards. Recommendations from on-site surveys enable the health service to undertake an improvement process that meets professional and practice standards through ongoing monitoring and review (Australian Council on Healthcare Standards, 2006b).

The EQuIP standards focus on issues considered important in providing quality and safe healthcare and are grouped into related areas such as clinical, corporate and support functions. Within each standard there are mandatory and non-mandatory criteria that describe key components of meeting the standard and elements that identify what should be in place within the organisation to meet each criterion. Accreditation of an organisation requires a minimum level of attainment of all the mandatory criteria. This level of attainment demonstrates the health service is evaluating and monitoring key components of each standard.

The clinical function focuses on care delivery processes and systems, access to services and provision of appropriate and safe care and services that include consumer participation. The support function concentrates on performance in areas such as clinical and corporate risk management, information systems, human resource and workforce management and research. The corporate function focuses on leadership and governance of the organisation including its strategic direction and safe environment.

While not required for accreditation, reporting of standardised clinical indicators to the Australian Council on Healthcare Standards and participation in a national comparative report may be used by healthcare organisations for internal and external benchmarking using trended analysis and comparative reports. Through this process they can also demonstrate how they are monitoring and evaluating services for the accreditation process.

Preparing for accreditation in mental healthcare, as with any health service, requires commitment from the organisation to quality improvement and the processes that support performance monitoring. Structures, systems and resources should be in place that support the organisation's self-assessment using the EQuIP standards, criteria and elements and thereby enable services to identify what they are doing, how well they are doing it, what evidence they have to

Table 11.2 Example of addressing an EQuIP standard and related criteria.

EQuIP Function – Clinical	
EQuIP standard	*Consumers/patients are provided with high quality care throughout the care delivery process*
Mandatory criterion	The assessment system ensures current and ongoing needs of the consumer/patient are identified
Levels of attainment	
Awareness level (LA)	Assessment guidelines, policies and referral systems are in place within the mental health service
Implementation level (SA)	Mental health presentations are assessed in timely manner; assessment processes and outcomes are documented in the medical record; at-risk patients are identified, managed and referred to appropriate services; multidisciplinary team approaches are co-ordinated within the mental health service
Evaluation level (MA)	Assessment, referral, care management and discharge processes are evaluated and improved, using, for example, waiting times in emergency departments, audit of medical record documentation, and incident and complaint monitoring and review, and initiatives to improve problems identified in the evaluation of services and systems are undertaken
Excellence level (EA)	Internal and external benchmarking and comparison of systems of care and assessment practices that facilitate practice improvement can be demonstrated
Leadership level (OA)	The mental health service can demonstrate they are a leader in assessment of mental health service provision

demonstrate it and to provide a gap analysis to use for ongoing planning and quality improvement activities. In doing this, the organisation also provides the external survey team with information that facilitates a good understanding of service systems and allows a more efficient verification process. By way of illustration Table 11.2 shows an example using an EQuIP standard and mandatory criteria to highlight the accreditation and quality assurance requirements.

The challenge for mental health programmes and services through the accreditation cycle is to:

- identify what services, processes and systems are in place to address both EQuIP and National Standards for Mental Health through the self-assessment process
- ensure there is evidence to support statements pertaining to service delivery and performance

- demonstrate implementation of quality improvement activities and the use of performance monitoring information to evaluate service activities and implement change.

Steps in quality improvement processes

A number of authors have provided steps in the quality improvement process but these tend to be very broad overviews of the process. We briefly summarise two, since most overlap considerably.

Lavender et al. (1994) described several stages in their approach:

- commitment to service principles and a quality review strategy by service management
- selection and training of quality reviewers
- quality review by consultant in collaboration with staff
- goal setting and action plan by staff and submission of quality report
- monitoring of achievement and further review in a cycle.

Furthermore, they identified a schedule for their quality review that covered environment resources, external links, working practices and service provision.

Goh (2007) provides a practical outline of the quality improvement process that involves five steps. The first involves *preparing the team* by identifying a project, choosing a leader and facilitator, orienting the team, defining roles, and stating a problem and objectives. Step two, *problem investigation*, is similar to Donabedian's (2003) Structure–Process–Outcome framework and involves analysing the effects of the problem on consumers, describing the processes and theorising the causes. This step also gathers data and considers alternative solutions to the problem. Step 3 focuses on *process improvement* by implementing change and a trial of new procedures while measuring the results of this trial. Step 4, *return or rest*, reflects the cyclic nature of the process and refers back to steps 2 and 1. The final step, *close*, involves documentation of the project, recognition and disbanding the team.

Conclusion

A major practical issue for most organisations and managers is that quality improvement activities require commitment and time. As outlined in this chapter, there are a number of steps to be considered in determining appropriate targets and indicators of quality (e.g. KPIs). It takes time to review and consult around these issues. It also takes time to establish systems to collect data and time to maintain and support these systems. Engaging and maintaining staff involvement in this process also requires considerable skill. Further to this, after data has been collected, analysed and conclusions and suggestions for change have been made, the quality review cycle 'begins' again. For very specific problems that become the focus of quality concerns, it is sometimes possible to draw

in other resources or support. For example, specific funding to address service issues may be available to support quality activities. It may be possible to link with local universities. The challenge of providing effective, efficient and sustainable quality healthcare is of great interest to many academics. There is usually overlap between quality improvement, programme evaluation and research activities. While research often requires higher levels of specificity and control in their methods, these demands vary a great deal from project to project and it may be possible for formal research projects to support and contribute substantially to quality improvement activities. The role of a clinical manager in such situations might be to focus on providing feedback in order to improve services since this is not always a primary consideration in research projects (Lavender et al., 1994). However, as noted at the beginning of this chapter, no matter whether quality improvement is driven as a function of formal research projects, complaints by consumers, or accreditation process, the key to success is a genuine and persistent commitment to quality.

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Chapter 12
Evidence-based practice in mental health services: understanding the issues and supporting and sustaining implementation

Robert King and Frank P. Deane

Chapter overview

The purpose of this chapter is to assist service managers to support and promote evidence-based practice (EBP) in mental health services. EBP is, from a service management perspective, a key service quality issue. When a service is operating within an EBP culture both service users and the wider public can be confident that the highest quality and most appropriate clinical services are being provided. When a service operates outside an EBP culture there is risk that clinical services are outdated, idiosyncratic or simply ineffective. The chapter begins by clarifying what is meant by EBP and then considers practical means by which service managers can monitor the extent to which EBP provides the framework for service delivery and can advance EBP within the service. The focus is on psychosocial interventions but the general principles apply equally to biological interventions – although, determination as to whether or not a psychosocial intervention is evidence based may sometimes be more complex and challenging.

Understanding the issues

Defining evidence-based practice

The American Psychological Association (APA), in August 2005, adopted as policy the statement:

> 'Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.'

This is broadly consistent with a widely quoted earlier definition applied by Sackett et al. (1997, p. 2) to evidence-based medicine: 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'.

The APA definition arose out of a period of highly contentious debate within the profession (APA Presidential Task Force on Evidence-Based Practice, 2006).

One way of understanding this debate is to view it as a debate between researchers and practitioners. Researchers attach high levels of importance to the results of clinical trials and tend to the view that clinical outcomes will be best when practitioners conduct their treatments in the manner of a clinical trial. By contrast, practitioners are suspicious of clinical trials and fear that clinical judgement will be replaced by a straitjacket of highly standardised treatment protocols. The consensus definition, like the Sackett et al. (1997) definition, is an attempt to accommodate the values and concerns of both groups.

Both definitions suggest that practitioners and service administrators must consider three questions when determining whether or not EBP is in operation:

- Are clinical decisions and interventions informed by the best available research evidence?
- Is the application of research evidence tempered by thoughtful and conscientious clinical assessments and judgements?
- Have the characteristics of clients (including preferences and culture) been taken into consideration in clinical decision making and implementation of clinical interventions?

If the answer to each of these questions is yes, then EBP is being used. If the answer to any of the questions is no, then something other than EBP is in operation. This means that there is much more to EBP than the application of 'empirically supported treatments' (ESTs). An intervention might have strong empirical support but be either inappropriate for application in the specific clinical circumstances of a client or it may have both empirical support and application to the client but may be culturally unacceptable or in some other respect unpalatable to the client.

What is the 'best available evidence'?

The term 'best available evidence' accepts that the quality of evidence underlying a practice is not always exemplary. Sometimes there will be no evidence at all and the APA Presidential Task Force (2006) points out that lack of evidence does not mean that an intervention is ineffective. However, when there is a choice between using an intervention for which there is higher-quality evidence and an intervention for which there is lower-quality evidence or no evidence, the former would usually prevail, unless inconsistent with clinical judgement or client preferences. Furthermore, the burden would be on the service or clinician to make the case that clinical judgement and/or client preference factors outweigh evidentiary factors.

Evidence for the effectiveness of an intervention may come from one or both of two sources:

- published evidence of effectiveness with analogous populations
- evidence of effectiveness in this specific treatment.

The literature on EBP is dominated by the former category – interventions that are sometimes described as 'empirically supported treatments' (ESTs). However, there is growing interest in the second category of evidence and there is evidence that feedback to practitioners regarding the effectiveness of a specific treatment with a specific client can improve the effectiveness of the intervention. Both sources of evidence are considered here. We discuss them under two broad headings: ESTs and Emergent evidence.

Published evidence: empirically supported treatments

There is a very substantial (and constantly growing) literature reporting on the effectiveness of psychosocial interventions for people with severe mental illness. The challenge both for practitioners and for service managers is to determine when evidence of effectiveness is sufficient for an intervention to be considered as being 'evidence based' or 'empirically supported' for application in a mental health service.

Flay et al. (2005) suggested that for evidence to be sufficient to warrant dissemination of an intervention, there should have been reported at least two trials that meet five requirements: defined samples from defined populations; psychometrically sound measures and data collection; rigorous data analysis; consistent positive effects; and at least one long-term follow-up showing sustained effects.

Dissemination is a highly relevant concept for service managers. Whenever managers advocate use of an intervention, introduce training in an intervention or introduce a programme based around an intervention, they are engaged in dissemination. They are also potentially overriding the judgement of specific practitioners. This is good practice when the effect is to improve services to clients, especially when services result in improved outcomes or more cost-effective service delivery. However, dissemination requires confidence that the mandated intervention is in fact at least as effective as (and preferably more effective than) standard care.

The requirements specified by Flay et al. (2005) ensure that idiosyncratic, 'one-off' findings do not provide a basis for dissemination of an intervention and that the reported findings are from studies that meet minimum scientific standards. They also protect against the risk that an intervention has only transient effectiveness.

We think that there is reason to add three further requirements: there is no reason to suspect that the evidence no longer has validity; it is reasonable to assume treatment effects derive from treatment-specific factors, and the intervention is robust in the face of fidelity violations (Box 12.1).

The reason for the sixth requirement ('no reason to suspect that the evidence no longer has validity') is that the effectiveness of some psychosocial interventions may be contingent on specific contextual requirements. An example is intensive case management (ICM). King (2006) showed that, whereas studies published prior to 1999 typically showed positive ICM impact compared with usual care, more recent studies showed little or no advantage for ICM. He concluded

Box 12.1 Eight requirements for a treatment to be regarded as empirically supported for purposes of implementation in a mental health setting (assuming at least two published studies).

- Defined samples from defined populations
- Psychometrically sound measures and data collection
- Rigorous data analysis
- Consistent positive effects
- At least one long-term follow-up showing sustained effects
- No reason to suspect that the evidence no longer has validity
- It is reasonable to assume treatment effects derive from treatment-specific factors
- The intervention is robust in the face of fidelity violations

that the most likely reason for this was that the clearest ICM effect in earlier research was on inpatient admission days and a trend towards briefer admissions meant that there was much less scope now to achieve relative reductions. One of the strongest arguments for ICM was that it was cost-effective because of admission offsets and this argument was seriously weakened by the results of more recent studies. The evidence that ICM caused symptomatic and/or functional improvements relative to standard care was always weaker and more recent studies suggest that such benefits are unlikely.

The reason for the seventh requirement ('it is reasonable to assume treatment effects derive from treatment-specific factors') is that the effectiveness of psychosocial interventions can be attributed to some combination of treatment-specific factors and what are usually termed 'common' factors. This is analogous to 'active agent' and 'placebo' effects in drug treatments. Psychosocial interventions are often evaluated against 'no treatment' comparisons. When this is the case, it is not possible to determine what treatment effects can be attributed to treatment-specific factors and what treatment effects are the result of common factors such as positive expectation, alliance with the therapist and active participation in recovery-oriented activity. A good example is the psychological treatment of depression. It was once thought that treatment-specific factors in the cognitive behaviour therapies were critical to positive outcome but it is increasingly clear that a wide spectrum of treatments are equally effective, probably as a result of the overwhelming importance of common factors (King, 1998; Wampold et al., 2002; Parker, 2007). There is a strong likelihood that any purposeful psychological intervention designed to alleviate depression will be effective so long as it activates the common factors. It is therefore difficult to argue that any specific treatment has a stronger evidence base than any other, even though intervention in general is clearly superior to no intervention.

The reason for the eighth requirement ('the intervention is robust in the face of fidelity violations') is that real-world services often make modifications to standardised treatments to tailor them to the specific requirements and resources of the service. Researchers, and especially those who develop interventions, do

not like this, and refer to such changes as loss of fidelity. Poor performance of intervention is often attributed to low fidelity implementation (Clarke et al., 2000; Duan et al., 2001). However, loss of fidelity is a fact of life in actual service delivery, even when the aim is to maintain fidelity as best as possible (McGrew et al., 1994). Interventions worthy of dissemination into practice environments are those that retain their effectiveness despite compromises with fidelity (Burgess & Pirkis, 1999; Duan et al., 2001; King, 2006).

What this means in practice is that management would be on shaky ground when advocating implementation of an intervention that failed to meet these eight standards (see also, Messer (2004) and Westen et al. (2004) for additional discussion of problems and limitations associated with the EST approach). Managers could, however, reasonably recommend use of interventions that do meet these standards and the burden would be on the clinician to justify an alternative intervention, having reference to sound clinical judgement and/or client preferences (culture).

Effectiveness of a specific treatment: emergent evidence

It may be that the 'best available evidence' is not evidence pertaining to ESTs but rather evidence about the effectiveness of the treatment that is actually being provided to a specific client. In this section we consider the means by which evidence concerning the effectiveness of current treatment can be obtained and utilised in EBP. We also examine research that suggests that routine use of such evidence might in fact enhance treatment effectiveness in itself.

The Outcomes Measurement Project in Australia's mental health services (Pirkis et al., 2005) provides an example of a national initiative designed to ensure that some emergent evidence of clinical effectiveness is available to practitioners and service managers. Under this initiative, services are required to routinely administer standardised measurements of client symptoms and disability at fixed intervals (three-monthly) or when there are major events such as inpatient admissions. Comparing scores from interval to interval shows whether the client is improving, deteriorating or maintaining a steady course. Services and individual practitioners can use these data to track progress and modify interventions when progress is unsatisfactory.

There are, however, several limitations associated with use of routine outcome measures as a tool in achieving EBP. One is the challenge of compliance (ensuring practitioners actually implement the measures in a timely fashion). This issue will be considered below, when we discuss challenges and solutions in implementing and sustaining EBP. Aside from compliance, there are two more fundamental problems. The first is that outcome measurement scores, and especially changes in outcome measurement scores, have to be interpreted. The practitioner or service manager needs a means of determining when a deteriorating score is significant and requires reconsideration of current treatment or when an improvement is sufficient to warrant consideration of discharge. In other words, someone has to make a decision as to whether or not a score is within normal limits given

measurement error and the expected recovery trajectory for the client. The scores do not in themselves ensure correct interpretation and without correct interpretation it is hard to be confident that any clinical response arising will be superior to clinical judgement alone. The second is frequency of measurement. When administered at three-monthly intervals, outcomes measures are not sensitive to week-by-week changes and, by the time practitioners or service managers become aware of a problem, the optimal time for change of intervention may well have passed.

These two problems were addressed by Lambert et al. (2005) in research designed to improve psychotherapy and counselling outcomes that has potential application in the broader spectrum of clinical services. Lambert's approach is based on high-frequency application of a single standardised measure with scores interpreted automatically having reference both to measurement error and to empirically based trajectory of client recovery. The practitioner receives an alert whenever scores hit a threshold that indicates client progress is poorer than expected. The practitioner is also alerted when recovery targets are attained. The evidence accumulated by Lambert's team (Lambert et al., 2005) suggests that this kind of feedback does enhance clinical outcomes independently of the kind of treatment deployed.

There are a number of obstacles to implementing this approach in mental health services. First it is important to have measures that are in fact sensitive to the kinds of client changes that should trigger review of treatment. It is not clear that the measures used in the Australian Outcomes project meet this requirement. The second is that it is necessary to have accurate information about client recovery trajectories so as to enable meaningful alerts about progress. The diversity of recovery trajectories in severe mental illness and the uneven progress of recovery makes this more difficult than in the kind of population that Lambert's work is based on. However, the process of systematically assessing and measuring outcomes is part of EBP in the sense that it attends to fundamental criteria of trying to using psychometrically sound measures and data collection along with rigorous data analysis.

So, how does a manager decide whether clinicians are using the best available evidence in routine practice?

Whether a service relies on use of ESTs or emergent evidence or some combination of both, it is clear that there is no simple pathway to determining the best available evidence. It is incumbent on a service manager seeking to operate within an EBP framework to grapple with these issues and to monitor use of ESTs and use of emergent evidence in the service. We provide some recommendations and guidelines for managers later in this chapter when we look at implementing and sustaining EBP. However, an essential starting point is that the manager has a framework for a sophisticated and constructive dialogue with clinicians about the use of the best available evidence. An understanding of the issues discussed so far should assist in the development of such a framework.

Clinical judgement and client preferences in EBP

In relation to the related concept of 'clinical expertise' the APA Task Force (2006, p. 2) stated:

> 'Clinical expertise is used to integrate the best research evidence with clinical data (e.g., information about the patient obtained over the course of treatment) in the context of the patient's characteristics and preferences to deliver services that have a high probability of achieving the goals of treatment.'

The Task Force further stated that:

> 'Many patient characteristics, such as functional status, readiness to change, and level of social support, are known to be related to therapeutic outcomes.'

Among other patient characteristics pertinent to the application of clinical expertise are (APA Task Force, 2006, p. 2):

> 'personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, and treatment expectations).'

Finally, the Task Force (2006, p. 2) stated that:

> 'A central goal of EBP is to maximize patient choice among effective alternative interventions.'

What this means is that EBP is not a 'one size fits all' approach to treatment. Nor is it a paternalistic application of the principle that the practitioner knows what is best for the client. Rather it implies careful assessment of client goals and priorities and sensitivity to cultural background and values as they relate to treatment. This provides the basis for a collaborative process by which the practitioner and client make decisions about treatment in the light of goals and preferences.

The implication for the manager is that EBP is not occurring unless treatment planning and implementation of treatment is consistent with these principles. It is not enough to take an interest in the extent to which practitioners are having reference to evidence in planning and implementing clinical interventions. The manager must also ensure that sound processes are in place to ensure the proper place of clinical judgement and client preferences.

Implementing and sustaining EBP in mental health services

Establishing a positive climate for EBP

Any attempt to implement EBP in clinical settings and services needs to consider individual attitudes and organisational culture and climate. We have many examples of attempts to introduce EB practices that have failed, even though practitioners accept that recommended approaches are effective and even that

they have the skills to implement that but nonetheless state, 'I just don't work that way'. Statements such as these reflect underlying beliefs or attitudes regarding how one practises. For some individuals, these beliefs can be difficult to shift. Service managers need to anticipate difficulties and objections that practitioners are likely to raise and be able to respond to them in a reasonable and balanced fashion. More than 10 years of EBP debate plus research into the attitudes of practitioners means that anticipating the objections will be the easy part. Managers are likely to encounter a mixture of 'in principle' objections and concerns about practical issues.

A focus group study involving 19 clinicians working in community mental health centres in the mid-west in USA identified themes around challenges to implementing EBP (Nelson et al., 2006). The main challenges identified were that most evidence-based treatments were too long to be effectively implemented in community practice. They required substantial training to become competent and the practitioners believed that the research supporting most EBP was not applicable to their settings (i.e. highly controlled trials with restrictive sample characteristics). Further to this highly controlled studies were described by some as 'irrelevant'.

The practitioners repeatedly indicated that their heavy caseloads did not allow them the time to learn new approaches and that they did not have the training or supervision needed to implement EBP. Client characteristics added to these barriers including complex client presentations with multiple diagnoses, client resistance to some procedures, and poor attendance at sessions. The practitioners also identified the characteristics of EBP that would make it more desirable – specifically, flexible approaches which are easy to implement. Hearing about or seeing positive experiences using the new approach were also considered important to uptake. Not surprisingly, many participants highlighted their preference for treatments that emphasise the importance of the therapeutic relationship (Nelson et al., 2006).

These concerns reflect many of the concerns unleashed when the APA Task Force provided criteria for empirically validated treatments and a listing of those treatments with documented efficacy (APA, 1995). It was argued that the research on the basis of which these decisions were made was not relevant to practitioners because the samples excluded patients with multiple problems and tended to focus on narrowly circumscribed disorders. Practitioners argued that in clinical practice most of their clients had multiple co-occurring problems. Much was made of the 'politics' of science and its influence on what was considered EBP. For example, it was argued that a large number of research studies were discounted because they did not meet strict 'gold standard' design criteria (Henry, 1998). There were concerns that the treatments that were identified as empirically validated over-emphasised technique whereas a great deal of psychotherapy research confirmed the importance of common factors such as therapeutic alliance.

Some commentators in the USA worried that the managed care organisations' desire for highly specified and quantifiable approaches to treating specific

disorders would overly influence which treatments were 'accepted'. It was argued that the requirement of manualised treatment protocols excluded some treatment approaches where it was more difficult to clearly specify the approach in manualised form (Henry, 1998). Further, for some psychotherapies such as humanistic approaches the assumptions of the criteria for establishing evidence were considered inappropriate. Many humanistic therapists argue that the goal of humanistic approaches is not to cure disorder but to create a therapeutic relationship and environment that facilitates self-reflection and promotes personal growth. The emphasis is on making new meaning, focusing on future goals and personal development rather than reducing symptoms (Bohart et al., 1998). As such, there may be something of a philosophical objection to EBP whose evidence is based on assumptions that symptoms will be eliminated and disorders will be cured. There are many other elements of debate about EBP that are beyond the scope of this chapter, but these are critically and thoroughly elaborated in Norcross and colleagues' (2006) excellent book.

The ultimate achievement of the APA Presidential Task Force (2006) has been to steer a path through these complex and difficult issues and adopt a position that creates an imperative for practitioners to have regard to evidence without creating inappropriate constraints on practice. We think that managers who develop a clear understanding of the APA position will find that it readily translates into multidisciplinary mental health practice and addresses the 'in principle' concerns that they are likely to find practitioners expressing.

Managers who want to take a more formal reading of the readiness of the workforce to practise within an EBP framework might consider the use of the Evidence Based Practice Attitude Scale (EBPAS), developed by Aarons (2004). This assesses four dimensions of attitudes toward adopting EBP: appeal, requirements, openness and divergence. In a sample of 322 clinical and case management mental health service providers for children, adolescents and their families, Aarons (2004) found higher educational status, less experience and working in inpatient settings were all associated with more positive attitudes toward EBP. In the same sample, the association of organisational culture and climate on EBP attitudes was also explored (Aarons & Sawitzky, 2006). It was found that workers in organisations considered to have more constructive cultures and workers earlier in their professional careers had more positive attitudes towards adopting EBP. However, the predictors accounted for only 8.6% of the variance in attitudes, suggesting many unmeasured factors also account for attitudes. The authors argued that 'having a positively perceived local opinion leader who can influence organizational culture and who can introduce and guide change in practice may facilitate receptivity to change in provider behavior' (Aarons & Sawitzky, 2006, p. 68).

Managers will often encounter acceptance of EBP as a principle or practice ideal but with minimal commitment to practice change. In a survey of 649 occupational therapists in Australia, 88% agreed or strongly agreed that EBP improved client care (Bennett et al., 2003). However, 39% had rarely or not at all relied on current research evidence in their practice over the previous two

months. Further, research evidence was used to inform clinical decision making for an estimated average of only 42% of the time. A quarter of those surveyed agreed or strongly agreed that EBP was of limited value in occupational therapy because there was not enough research evidence. Almost a third thought that although adoption of EBP was worthwhile it placed too many demands on their workload. Consistent with these findings, the main barrier to implementing EBP was a lack of time (92%) followed by not enough evidence (63%). Lack of skills for locating evidence, lack of computing resources and poor access to research were all endorsed by at least half of respondents as often or very often being barriers to implementing EBP. A lack of skills for understanding research was endorsed by 45% of participants. Although a third had already received training in EBP over half felt that further training was needed. Most (82%) felt that short in-service presentations and workshops would be useful training format along with brief written information (79%) and web-based resources (76%) (Bennett et al., 2003).

Strategies and activities to promote EBP

So, what is the evidence base for successful implementation of EBP in mental health services? While there is a great deal of strong evidence for particular treatments for mental health problems (e.g. Drake et al., 2005; Goodheart et al., 2006) there is relatively little evidence about what the most effective strategies are for implementing EBP in mental health services. To our knowledge there have been no randomised controlled trials testing EBP implementation strategies. However, the studies outlined in earlier sections of this chapter do provide us with some guidance, as does research from other areas of health. The general medical literature suggests that the use of multiple strategies to overcome barriers to implementation is likely to be more effective than a single intervention (e.g. Grimshaw & Russell, 1993). Changing complex practice behaviours is likely to be more difficult than changing relatively simple behaviours (Torrey & Gorman, 2005). Several studies have addressed what is needed to transfer training into practice and these too provide some guidelines (e.g. Milne et al., 2000; Deane et al., 2006). For example, the following increase the probability of transfer success: support from management at all levels; new practice is not too dissimilar from prior practice; changes are clearly communicated, cued, checked and positively reinforced (Deane et al., 2006).

Panzano and Herman (2005) described a simple formula for thinking about factors that determine the success of implementing new practices. Implementation success is viewed as 'a function of know-how, motivation, and the opportunity to learn' (p. 265). Staff need the opportunity to develop new knowledge and skills. They need to have either internal (e.g. work satisfaction, values) or external motivations (e.g. success stories, respect from peers, promotion) to implement the behaviour change. Finally, the opportunity to implement a particular EBP may require overcoming barriers such as lack of time or other resources (e.g. transport, equipment, staff). Managers in leadership positions have a major

role in all three components of know-how, motivation and opportunity. Panzano and Herman (2005, p. 268) summarise leaders' tasks as:

- communicate a vision
- guide stakeholders through the decision process
- articulate goals
- develop and implement a plan to work towards goals
- monitor progress towards goals
- implement education and training programmes
- establish reward structures to keep staff motivated
- remove barriers to day-to-day implementation.

In addition to these leadership tasks, research related to staff attitudes and perceived barriers suggests other activities that managers might also consider in introducing EBP (Box 12.2).

Box 12.2 Strategies for promoting an EBP culture.

- Create a culture by initiating conversations about evidence. This can begin informally during team meetings, case reviews, etc.
- Introduce routine client progress measurement and ensure that results are readily available to clinicians
- Be sure to nurture workers early in their professional careers toward EBP not only because they appear to be more open to this, but also because there is risk that they will fall into the 'custom and practice' of an organisation which may or may not follow EBP
- Model critical consideration of evidence in your own clinical work (e.g. by referring to evidence when reviewing cases. Doing this creates a culture of openness)
- Educate about the role of clinical judgement and client preferences in EBP (see earlier section). Staff are likely to be less resistant to EBP when they appreciate that these two factors are important components
- Ensure that staff have access to information and resources that will support EBP (see suggested resources below). Arrange appropriate access to resources to do this ahead of time and ensure that staff have both sufficient training and sufficient access to utilise internet-based resources
- Anticipate attitudinal and practical barriers to implementation of EBP and avoid rigid or unnecessarily prescriptive responses. Allowing some flexibility in implementation will most likely result in clinicians viewing a strategy as 'useable', however, it is important to ensure that flexibility does not result in loss of fidelity to a degree likely to compromise the effectiveness of an intervention
- Start with small changes to practice to help establish a culture of responding to evidence, then move to more substantial projects if needed
- Continue to emphasise the importance of therapeutic relationship in conjunction with implementation of EBP
- Reinforce EBP through direct praise and highlight success stories
- Where training to develop EBP is needed allocate appropriate resources so this can be achieved. Advocate to make funding available if needed

Sources of information about EBP

In the focus groups by Nelson et al. (2006) practitioners were asked where they got their information about treatments. The most common source of information was from professional colleagues and supervisors. This was typically an informal process. Workshops and other training sessions were also frequently cited sources. Books were also frequently used but a major difficulty was finding sufficient time to read them. Information on the internet was often mentioned but little detail about specific search strategies was provided. The practitioners generally found the literature overwhelming in its volume and complexity and wanted more accessible summaries, particularly those that emphasised how to translate findings into different clinical settings.

Although practitioners indicate that in-service presentations and brief summaries of research evidence are valued (e.g. Bennett et al., 2003), passive educational approaches alone are unlikely to lead to practice change (Torrey & Gorman, 2005). There is a need for active, participatory approaches which include practice, direct feedback, and ongoing supervision, support and/or incentives. One powerful incentive is seeing positive change in clients and it has been recommended that 'telling success stories' is a strategy to support implementation of new behaviours in practice (Torrey & Gorman, 2005).

Below are a range of specific resources or sources of information that can support EBP (Box 12.3). However, there is a need to make sure these resources are tied to an ongoing process of active education, implementation and review.

Box 12.3 Resources to assist in implementation of EBP.

- In-service presentations or workshops on EBP
- Brief written summaries of evidence in particular domains
- Bibliographic databases such as Medline, Psychinfo, CINAHL (Cumulative Index for Nursing and Allied Health). PubMed is a bibliographic database freely available over the internet and contains Medline as part of its content
- Tutorials to learn how to use these bibliographic databases (e.g. CINAHL, www.mclibrary.duke.edu/training/cinahlovid, accessed 17 March 2007)
- The *Database of Systematic Reviews* in the *Cochrane Library* online
- Relationships with university academics or other health providers with interests in EBP
- Journal clubs (small groups that meet on a regular basis to discuss recent publications in areas of shared interests)
- Synthesised one-page summaries, which are available from some journals e.g. *Evidence-based Medicine*, *Evidence-based Mental Health*. The Cochrane database also provides one-page abstracts of reviews with a 'Plain language summary'
- Online tutorials on EBP (Duke University)
- An excellent chapter on the research process and steps for practice to become evidence-based can be found in Mueser & Drake (2005)

Conclusion

The use of EBP is a key element of service quality improvement and a means both of fulfilling our professional obligations to clients and the wider public and also of ensuring professional development of our staff. Developing, promoting and supporting a culture of EBP is a core responsibility for mental health service managers. Implementing EBP is much more complex than implementing ESTs and managers need a sophisticated understanding of EBP. We think that this is best achieved through consideration of the APA formulation. The introduction of ESTs forms part of EBP, but managers need to ensure that any EST introduced as a service-wide intervention meets the eight requirements we have set out in this chapter. Managers can play a key role in developing EBP but need to be aware of both the resource requirements and the more subtle cultural and interpersonal issues that are likely to be critical to success or failure in development of a service with a strong EBP culture.

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