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So Farewell Then, CMHTs

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*So farewell then, CMHTs
'Multi-disciplinary work'
That was your catchphrase
'A seamless service'
That was another*

*Keith's Mum said you were a daft idea
But I reckoned you might be fun*

With apologies to E.J. Thribb, Private Eye.

Since qualifying as a clinical psychologist I have always worked in a community mental health team (CMHT). Some people believe the death knell is sounding for this type of team. In the future, teams will have a designated purpose – be crisis teams, early intervention teams, assertive outreach teams, personality disorder teams, young people crimestoppers teams, or whatever. Little has been written on CMHTs that describes what it is actually like to be in a CMHT. This article, which is based on my own and some of my psychology colleagues' experiences of being members of CMHTs, is my attempt to do this.

In Shropshire nine CMHTs, 5 based in urban areas (Shrewsbury and Telford) and 4 in rural areas (or more accurately, the largest town in each rural area) have existed for 8 years. Each team is jointly funded and managed by the Mental Health Trust and Social Services and, unusually, has the full compliment of professionals: social workers, community mental health nurses, community care workers, admin workers, plus a clinical psychologist, occupational therapist and psychiatrist in each team. Within these teams, some people are friends, some are lovers, some stick mostly with their fellow professional colleagues whilst others have cross discipline friendships and work alliances. Some people do not trust each other; others have at times hated each other. I have worked with people I would never allow near the people who have been referred to me for help, as well as working with people who are more committed, radical and ethical in their work than I have ever been.

The nine teams have suffered from an idea that they should all be the same – be doing the same types of work with the same types of people, have the same policies and procedures, and so on. Managers and members of the teams, as well as higher management, have frequently expressed surprise and alarm when discovering that different teams do things differently. We have all struggled to realise that each team has its own personality, history, set of ideologies, and so on. Enormous amounts of time and energy have been wasted in fruitless attempts to make all the teams be the same, just so they would fit neatly into boxes that only really exist inside managers' heads. It has been hard to accept that such variability is a good thing, even in organisations that recognise that needs in rural and urban areas differ widely.

How things have been traditionally done in a team has a bigger effect than how management (or psychologists) want things to be done. Team cultures have lasted long after the people that helped create that culture have left. This baffles team members; only those who have stuck around long enough can see why things are the way they are. Staff turnover is high. You do not have to stay long to become a senior member of a team – after two years I had gone from being the new boy to the third longest serving member (although it took another 3 years for this to sink in). It has been more effective to sit tight and wait for people I struggled to work with to leave rather than leave myself and join the merry-go-round of staff changes.

The CMHTs in Shropshire each have either a social worker or nurse as manager. My team has had five different managers in six years. Management style has varied from laissez faire (“You are all trained and responsible adults, it’s up to you to see the team functions effectively”) to authoritarian (“I’m the team manager and you will do what I say”). Laissez-faire was much more disastrous than authoritarian and led to disintegration of the team. Managers have been criticised for telling people what to do (“He’s a dictator, he never consults us”) and not doing this (“He’s wishy washy and doesn’t know how to manage”). Onyett and Malone (1990) made multi-disciplinary CMHT management sound a lot easier than people in Shropshire have found it. Very few managers appear to have effective support from outside or inside the team. All are expected to implement enormous documents from the Health Service, Social Services and from their line managers, with only the most confident or disillusioned able to ignore such documents, despite the impossibility of reading let alone implementing all of them.

Within the team I have enjoyed being treated with respect, kindness and trepidation. Some colleagues have grown to trust me and have confided intensely personal information. More difficult has been the paranoia I have sometimes felt as a result of feeling attacked for having my own room, earning the most money and not being a team player. Pointing out that I do not earn the most money (my starting salary was less than the social workers’ salaries, and my salary will always be less than the psychiatrist’s) has not helped. Explaining that my work requires a quiet therapeutic space or that there are enough rooms in the building for people that want their own room to have one has not stopped the sideswipes. I am not a team player even though I have never refused to see someone that a team member has wanted to refer to me and have provided clinical supervision, therapy and crisis support to 90% of the team at any one time. Conversations with team members can seem mad until you get a handle on the dynamics that drive such exchanges.

Members of CMHTs (including psychologists) are liable to struggle with the kinds of group dynamics that characterise all work groups – envy, scapegoating, subgrouping, transference reactions to the group leader, sibling rivalry, dependency, fight/flight, etc. My team has struggled with the group wish for everyone to be the same and the conflict this creates when individual differences come to the fore. The wish for psychologists to be the same as all other team members appears to mostly surface when team members do things they do not like (e.g. duty) and wish to inflict it on everyone. Having commitments outside the team (e.g. to provide training, conduct research, provide supervision for non-team members) enables me to avoid things I do not want to do (often laborious form filling). Psychology management justifies this by saying I am paid too much to do admin work or duty. This works fine except for the

terrible feelings, expressed or unexpressed, that contort the atmosphere in team meetings whenever such privileges are alluded to. As Anciano and Kirkpatrick (1990) stated, having clear role differentiation and psychology line management that emphasises the differences between clinical psychology and other professions helps, but it does not stop these issues arising, especially at times of tension.

Although the team is described as multi-disciplinary, all members act as key workers and ‘case manage’ their clients. Team members may provide emotional or practical support to each other but the fact that we come from different disciplines and have had different training often seems irrelevant. Whether the team works effectively seems to be dependent on the personalities of the people involved, not on our professional backgrounds. I have yet to witness the multi-disciplinary work that senior managers refer to in their presentations on the success of CMHTs. For the first three years no-one in the team was willing to help me with my client work even though both I and the client had identified areas where we thought a social worker, for instance, might be better trained, more experienced and more helpful. “Why don’t you do it yourself” was a stock reply. Willingness to work together and take on different roles with a client, rather than work in a multi-disciplinary way, has been more crucial.

What are CMHTs for and who are we employed to see are questions that never get resolved. The only group task we have been able to agree on is that it is our aim to keep people out of the psychiatric hospital. Managers want this in order to save money; I want it because being admitted to hospital is such a damaging experience for some people. Of course the creation of the teams has led to even more people being admitted to hospital than was the case in the early 1990s. This is because CMHTs bring psychiatry into the community, and sectioning and admitting people to hospital are things that psychiatry does. The team members provide lots of things that are beneficial to the people of Shropshire: they help with benefits, assist people to get back to work or go to college, find people better housing and put people in contact with community groups, talk things through with families, provide counselling and psychotherapy (sometimes covertly – social workers have been explicitly told they are not counsellors by senior management), and offer support, solidarity, and encouragement to a wide range of people who have often had terrible lives and have very few means of support. However, despite the non-medical staff outnumbering the medical staff, the team is infused with psychiatric thinking. Conversations over lunch draw upon a wide array of factors that we feel affect people and lead them to be identified as mad, whereas team meetings tend to be characterised by narrow talk about illness, diagnoses, medication, treatments and Mental Health Act Assessments. As the only team member who offers an explicit alternative to psychiatry and works exclusively from a position of informed consent (before seeing me people are sent a leaflet explaining what I do and describing the kind of person I am, and then it is up to them whether they get in contact), I am frequently drawn into arguments based on profound ideological differences. The interplay between social control, paternalism, informed consent, and individual choice, and the difference between having a responsibility *to* and being responsible *for* someone, make for lively but at times wearying debates, and I often fantasise of fleeing to a group who’s beliefs and practices overlap more with mine.

Allocation meetings vary between teams. By far the most common is the 'looking at your feet syndrome' whenever someone new has been referred. Some teams have the opposite, a 'feeding frenzy' with competition to see the most people or take on the most difficult sounding situations. Prospective clients are sometimes spoken of without much humanity, whilst other services are maligned as the team looks for reasons why someone should not be seen. I have sat in terror wondering whether people in the waiting room could hear what was being said. Decisions are made on the barest of information. People are processed through a system and are invariably rejected as not fitting into an ever-shifting criterion for acceptance. Unless someone has a 'severe and enduring mental illness' (something no-one has been able to define except "You know what we mean Guy, people with long term schizophrenia") they have tended not to be 'let in'. Only they are: when you actually look at people's caseloads they consist of a wide variety of people with a whole host of problems. This is a closely kept secret that everybody knows.

As in other services (see Osborne-Davies, 1996), fantasies of what I and other psychologists do abound. One A-grade psychologist who asked a team member what they thought she actually earned was told "Over £100,000 per annum, and you're not even full time." Team members often think that what I do is mysterious and magical. When I explain that I meet with people, ask them what has led them to want to see me and what help they are looking for, and then see if I can provide that, team members have commented: "Well that's what I do, how come you get paid so much?" or, "You just do all the easy work". I often have sympathy with this, when hearing how the paternalistic role they feel they have to take leads to them being verbally and physically abused by people who do not want to see them and do not like the treatments that have been prescribed for them.

If you want to know what it's like in a CMHT I recommend watching the film Brazil. Ever changing and ever increasing requirements to have everything written down, to be accountable to higher management and government (rather than the people we should be accountable to, the clients), to monitor rather than help people, and to back-cover in case of being sued mean people spend more time sitting at their desks than meeting people. Filing cabinets are jam-packed full of empty forms, let alone completed ones. Escaping from requirements on the team to monitor and keep records on people (rather than help people) is an exhausting process.

Even after being in the team for six years I find it hard to gauge what impact I have had on the team's ethos, ethics and practices. However, when I stopped going to meetings, team members said they missed having an alternative voice to the usual discourse. In particular they found it valuable to have someone who brought up issues such as confidentiality, consent, the effect of compulsion on people's motivation and willingness to engage, alternatives to hospitalisation and treatment (including the option of leaving people alone who do not want to receive psychiatric services). The psychologist having no formal role under the Mental Health Act was seen as a good thing for the team and its clients, in direct contradiction to some arguments being forwarded in the profession that becoming 'clinical supervisors' under a new Mental Health Act would give psychologists more ability to improve the system and help people.

My top dozen tips for psychologists in CMHTs (or any multi-disciplinary team) would be:

1. Work *into* rather than *in* teams, having a base outside and line management with a psychologist.
2. Get lots of support from outside the team (psychologists in Shropshire CMHTs met for six years on a fortnightly basis to discuss their difficulties working in the teams).
3. Be clear about what you will do and even clearer about what you will not do.
4. Ensure you have a room, one with adequate sound-proofing, to see people and have some peaceful thinking space, before accepting a contract to work in a team.
5. Find a sub-group within the team of like-minded people irrespective of their profession.
6. Refuse to talk about clients in corridors, kitchens or the admin area.
7. Do not go to meetings where bureaucratic requirements are explained.
8. Be prepared to say the same things over and over again (e.g., "Saying this person has schizophrenia/personality disorder gives me no information regarding what the person is actually like"; "You've said a lot about this person, but what kind of help did they say they were looking for?"; "Is it possible that this person's behaviour might just have something to do with their environment?").
9. When talking about the team use "we" rather than "you" even when what you are saying does not seem applicable to you.
10. Develop close and effective working relationships by providing regular clinical supervision rather than irregular and unsolicited advice or consultation.
11. Have modest expectations of changing your team through attendance at meetings and away days.
12. Go to all the leaving and Christmas doos and get drunk.

When I was interviewed for the job I said I wanted to work in a CMHT because I liked teamwork and thought I would work well with and have a lot to learn from the social workers and community mental health nurses. I remember the team manager interviewing me, who left before I took up my post, laughed out loud. A much more experienced psychologist, also being interviewed for a CMHT post at the same time, when asked what she thought the role of a psychologist was in a CMHT, replied, "To absorb the projections of the other team members." I guess, like her, after six years in post, I have just about got the confidence to give my opinion on what it is really like. Even so, writing and publishing this has felt as frightening as speaking my mind within the team. We might soon be saying farewell to CMHTs, but I imagine we will not be saying farewell to the frustrations, confusion, fear and no small amount of fun that is a feature of this type of, so called, multi-disciplinary work.

References

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