Chapter 19

Multidisciplinary Teamwork

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The use of multidisciplinary teams is critically important for the effective treatment of persons with serious mental illness. In many cases people with serious mental illness need a larger variety of different kinds of supports and skills than can be provided by any one clinician, including housing and vocational supports, crisis intervention, psychological supports, and medical/psychiatric treatment. In addition, many people with serious mental illness need more availability than can be provided by any single clinician, no matter how dedicated. Crises often occur outside of normal business hours, and even some scheduled services such as medication monitoring must to be available 7 days a week. Finally, the sharing of clinical responsibility among several people can decrease the burden associated with working with taxing clients and thus reduce subsequent burnout.

The psychiatrist and primary clinician often function as a team, regardless of whether this is formally acknowledged, and case management usually involves some level of shared or team responsibility. Some teams are set up to function as true shared case managers with shared responsibility and

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decision making. At the other extreme are those teams where each clinician has sole responsibility for his or her own clients, with little shared responsibility. Intermediate degrees of shared responsibility can also develop. For example, in some teams each clinician may take responsibility for specific and well-delineated areas such as housing or vocational training. Clinicians working in such a team may refer clients to each other but may have little sense of shared responsibility for clinical decisions.

In this chapter I begin with a general discussion of multidisciplinary teams but focus primarily on teams with case management responsibility. The chapter will concentrate on the relationship between the case management team and the psychiatrist. For reasons that will be discussed later, this relationship is often complicated, as both share overall responsibility for the client's treatment. Some of the potential problems and possible solutions of working within a multidisciplinary team will be addressed.

Multidisciplinary Teams

Multidisciplinary teams exist within the mental health system whenever a group of clinicians or staff regularly works together to meet the needs of persons with mental illness. The teams that exist on a formal organizational chart may be quite different from the informal teams that develop spontaneously when clinicians or other staff work together to meet the needs of a shared client. Teams often include people from different disciplines and may include people from different agencies. The defining characteristics of the team are its purpose, composition, size, and working relationships, including both formal and informal structure. Each of these component parts affects how the team will operate.

Purpose

Teams often define themselves by their purpose. The more specific the purpose of the team and the more all members of the team understand and agree to that purpose, the more likely the team is to be effective. For example, one treatment team in the mental health center of Dane County has responsibility to provide ongoing community-based treatment and rehabilitation for 140 clients who have a serious and persistent mental illness. Another treatment team has the responsibility to provide a 24-hour mobile crisis response, with the specific goal of decreasing the need for hospitalization by providing a range of community options. Other teams can be set up to provide services to a clearly defined geographical area or a population otherwise defined.

Without a clearly defined mandate, different people are likely to interpret the job of the team in very different ways, leading to confusion about who should be served and how staff should be spending their time. For example, some time ago, one of the teams in Dane County was set up to provide day treatment services to persons with serious mental illness. There was ongoing, energy-draining debate both about the purpose of the program and which clients should be served. The program was supposed to provide rehabilitation services, but without a clear definition of what this meant, outcome criteria for the program could not be designed. Without a clear definition of the purpose of the program, it was difficult to agree on the design of the program. The lack of clarity over the purpose of the program made it difficult for the staff to agree on such basic clinical decisions as how much responsibility they should take for clients who stopped coming into the program.

The defining mandate of many teams is too vague to provide a clear focus and direction. For example, when teams are established to provide mental health services to a geographical area, there is often disagreement about whether the team should prioritize people who are most ill, most motivated, most likely to be helped by traditional psychotherapeutic and psychopharmacological approaches, or most visible to other elements of the community. Without a clearly defined purpose, it is more difficult to assess the effectiveness of the team or justify to funding agencies that the team is performing as intended.

Composition

In many treatment systems the formal treatment team that exists on an administrative chart is composed of clinicians who have professional degrees. The functional team, however, may be quite different from this. Often a secretary, clinicians from a variety of different agencies, and staff from a variety of nonclinical backgrounds all actively work together on a regular basis, sharing information and responsibility for common clients, and informally constitute a "team." In some systems a minister, a police officer, or even a very involved landlord may all be part of the functional team, sharing information and acting as part of a cohesive unit.

At the mental health center of Dane County, for example, the program secretaries are seen as integral members of their respective teams. Team secretaries answer the telephone, deal with clients and other outside professionals, and help the teams interface with the outside world. How clients feel about a treatment team may be strongly influenced by the initial reception provided by the secretary. Often these secretaries have important information about clients and other matters that is unknown to other team

members. It is important to ensure that the secretaries' behavior with clients is consistent with the rest of the treatment plan, and that the information that they have is made available to the rest of the clinical team. These program secretaries participate in treatment planning meetings and are involved in a variety of decision-making activities. They are trained and supervised to increase their clinical skills, and their interfacing with the outside world is considered a core clinical function. Most clerical staff who interact with clients have useful information unavailable to clinical staff, and it is a mistake to exclude them from some kind of participation with the rest of the clinical team.

Psychiatrists can either be included or excluded from the multidisciplinary team. Psychiatrists can be included in team discussions and share information with other team members or alternatively can work in relative isolation from the rest of the treatment team. Decisions about medications, like decisions about housing or other aspects of treatment, can be discussed by the entire team or kept as the sole province of a single clinician. There are many factors that influence how the psychiatrist will work with other team members. The interests and skills of the psychiatrist certainly play a major role. Psychiatrists can be interested and knowledgeable about all aspects of a client's treatment or can see their roles as restricted to a narrower focus such as medication. The job description also plays a major role. Psychiatrists may have the time to participate in team discussions or be so busy with medication reviews that any expanded participation is impossible. Even geographical proximity influences the role of the psychiatrist. The psychiatrist who shares office space with the other clinicians on the team will have a different relationship the team members than the psychiatrist who has an office in a separate building.

Size

Groups of 8 to 10 people seem to function better than groups that are much larger. It is difficult in larger groups for individuals to feel that what they do matters much to the group as a whole. Larger groups tend to split off into smaller subgroups. "Teams" of 20 to 30 clinicians are actually an organizational structure that is not likely to act as a coherent team. A common problem is that teams start with a workable number of clinicians, but over time the number of clients and clinicians involved grows beyond a workable number. In this instance, it is often difficult to split a team that has gotten used to working together and sees itself as one unit, even after the realities of growth make the increasing size less efficient. On the other hand, small size is less of a problem. Teams may be quite small and still be effective. In small programs, two or three colleagues working together can form a team with many of the same advantages as larger ones.

Team Process

There are many ways to describe the internal processes of teams. There are three areas that seem particularly important to team functioning:

1. The degree to which the team is more hierarchical or more egalitarian
2. The degree to which responsibility for decisions is shared by all members of the team or divided with each team member having specific areas of responsibility
3. The degree to which a team functions as a single social cluster or multiple clusters

Each of these is discussed below.

Hierarchical Versus Egalitarian Team Structure

Teams can be organized hierarchically with direction coming from a supervisor or senior clinicians to junior staff and aides. An example would be a team in which case managers developed treatment plans and supervised psychiatric aides in implementing these plans. Alternatively, the team can be organized so that different members of the team are clearly identified as having different expertise and information, but each member of the team functions as a full participant. For example, a social worker, nurse, and technician could all work with the client to develop a treatment plan with the understanding that the social worker might be most expert about dynamic issues in the relationship with the client, although the technician might have the most information about how the client actually functions in the community.

The degree to which a particular team functions hierarchically often depends as much on informal as formal structures. A team leader may encourage the entire team to share in clinical decisions. A social worker may encourage a psychiatric aide to function as a professional colleague and support him or her to make independent decisions. Alternatively, a team member with no formal authority might have a dominant role in decision making, either by force of character or by expertise. Psychiatrists, as high status members of the team, often have considerable influence over team relations. The psychiatrist who engages other team members as equals will model egalitarian behavior for other members of the team; alternatively, psychiatrists who assert the presumed perquisites of their profession influence hierarchical behavior by the rest of the team.

Shared Versus Delineated Responsibility

Some teams are structured so that the team assumes responsibility for most decisions, even decisions where a staff person has focal expertise. Other

teams assume that specialists will be responsible for decisions within their areas of expertise. For example, the housing specialist on the team may get information about the client's preferences, develop a list of housing options, do a functional assessment of required supports, and then facilitate a decision about where the client should live. Alternatively, the housing specialist can provide information to the team so that the entire team can be actively involved in working with the client to make the decision.

Similarly, the psychiatrist can make decisions about a client's medication and then inform the rest of the staff about that decision. Alternatively, the psychiatrist can actively involve other staff in medication decisions by seeking staff input about what is going on in the client's life and by involving other staff in weighing the pros and cons of possible medication changes. In all cases the psychiatrist continues to be the expert on psychopharmacology and is ultimately responsible for all medication decisions, but the involvement of the rest of the team can vary enormously.

Single Versus Multiple Clusters Within the Team

In a single cluster team, all staff working with a client function as an integrated unit, freely sharing information and diffusing the decision making across the entire team. A large team can functionally divide into several smaller teams for more efficient functioning, but each would include all of the staff who need to work together to develop an integrated plan. Alternatively, separate clusters can evolve that cut across functional lines. When this occurs, the psychiatrist and nurse are often in one cluster and communicate with each other over medication decisions, whereas other team members form a second cluster that addresses work, housing, and other rehabilitation issues. Often there is relatively little communication among the clusters and still less shared planning or shared decision making.

Although the problems are obvious, solutions are often difficult to devise. There must be coordination among the different components of a treatment system. Staff responsible for developing housing or vocational options for a person with serious mental illness must coordinate with staff who will provide ongoing support, which in turn requires a coordinated treatment planning process, communicating with the prescribing psychiatrist, and involving whatever staff working with the person's family. Especially when working with clients with serious mental illness and extensive needs, case management must be a function of the entire team rather than the responsibility of a single individual. A significant problem is the integration the psychiatrist within the team and, in particular, how the psychiatrist and case management team can develop complementary roles.

The Psychiatrist and the Multidisciplinary Team

There are many sources of potential conflict between the psychiatrist and other members of the multidisciplinary team, including role conflict, ideological differences, and the special problem of medical expertise and responsibility. There are ways of minimizing these potential problems areas, each of which will be discussed below.

Role Conflict: Who Is Responsible for What?

There are inherent conflicts in the roles and responsibilities of the case manager, other clinicians, and the psychiatrist. The nature of the conflict depends on the specific model of case management being considered. Most discussions about clinical case management assume that the case manager will be in a central position in the client's treatment. With access to all relevant information, the clinical case manager has the presumed authority to organize an integrated and coherent treatment plan. Other clinicians, having their own agenda and sense of parochialism, may resist giving up their own sense of primacy to the case manager.

Such conflicts become particularly problematic when one of the involved clinicians is a psychiatrist (Arce and Vergare 1985). Psychiatrists tend to think of themselves in a central position with many of the same attributes as case managers—that is, they tend to see themselves as responsible for the client's entire treatment. The training of psychiatrists in medical school, internship, and psychiatric residency socializes them to assume overall responsibility for the treatment of their clients. The literature on the role of the psychiatrist considers a variety of clinical roles but almost never considers the case manager's central position or the need for the psychiatrist to acknowledge, come to terms with, and support this central role (Langley and Barter 1983).

In turn, the case management literature ignores the reality of having a psychiatrist involved. The psychiatrist not only has special expertise, but also inevitably has legal liability for decisions even if responsibility for those decisions has been delegated to a nonmedical mental health professional. This confusion over who is ultimately responsible is further heightened by administrative policies that require that the psychiatrist supervise and "sign off" on services provided by other clinicians.

There Are No Easy Answers

Many of the conflicts are caused by ambiguity over who is responsible for what. Resolution depends on developing complementary roles for the case

manager and psychiatrist. One extreme position is to make the psychiatrist the team leader and clinical supervisor of all of the other professionals (Leong 1982). Conflict is avoided by putting the psychiatrist in charge and making the case manager subordinate. However, there are multiple problems with this approach. The psychiatrist may be with the team part time or, by virtue of skills or personality, may not be the best team leader. Other clinicians may not agree that the psychiatrist should lead the team, and furthermore, it may not be the best use of the psychiatrist's expertise to lead the team (Tucker 1987). An alternative but equally extreme position is to limit the job of the psychiatrist to prescribing medication and other, strictly medical, tasks. In this case, conflict is avoided by limiting the role of the psychiatrist to a well-defined set of tasks. Unfortunately, this limits the usefulness of psychiatrists and allows only part of their expertise to be utilized. More importantly, it enforces an artificial separation between "medical" and "nonmedical" parts of the client's treatment.

Regrettably, there is ongoing disagreement about the appropriate roles and the relative responsibilities of case managers, psychiatrists, and other team members (Clark 1987). Whereas the roles of various professionals are complementary at some agencies, in other agencies there appears to be continuous friction over who is responsible for what. There are, however, some general principles that seem useful in minimizing these conflicts and increasing the chance for fruitful collaboration and effective treatment planning.

The Client Comes First

It is important for the needs of the client to override personal or guild issues. Unfortunately, in the exegeses of operating in the real world, clinicians often forget to follow this precept. We work in imperfect systems and at times get annoyed with our colleagues—sometimes for good reason. It is difficult to work with another clinician who does not return telephone calls or refuses to collaborate in a shared treatment plan, and a natural tendency is to stop trying. Unfortunately, it is the client who is most often harmed when this happens.

Clinicians need to start by thinking about what their client needs. Then they need to act to get those needs met. This may require that they do things counter to their own preferences. Ideally, a psychiatrist should be an active member of the team, participate in treatment planning meetings, and be part of the informal information net of well-functioning teams. When information needs to be exchanged, the psychiatrist should work as hard to contact the case manager and other members of the team as the case manager does to contact the psychiatrist. Unfortunately, this does not always happen. Part of the difficulty may be structural. The psychiatrist's job description may preclude participation in team meetings, and an office at a site

separate from the team will interfere with informal "touching base" with other team members.

At times, however, the problem is one of attitude. For example, a case manager may keep "forgetting" to give a psychiatrist adequate notice of treatment planning meetings, or a psychiatrist may delay returning calls the case manager initiated. These behaviors are often irritating and are perceived by the injured party as a mark of disrespect or rejection of that party's potential usefulness. Although the behavior may be irritating, the needs of the client must take precedence. The psychiatrist may have to keep pushing for participation in the planning process, even if the scheduled meeting needs to be rearranged, and the case manager may have to pursue the psychiatrist so that necessary information gets exchanged and medications are appropriately prescribed.

It is easier to get consensus on a specific treatment plan for a specific client than it is to come up with an agreed-on treatment philosophy. For example, different professionals, with different views on the role of the hospital, can have endless arguments about whether hospitalization should be used more or less and whether it is useful or injurious. However, when a specific client comes into the office with increasing suicidal ideation, and the historical information, treatment successes, current supports, and stressors are reviewed and discussed by the treatment team, the role of hospitalization usually becomes clearer. Even where there is philosophical disagreement, the specific issues facing a "real client" shape a treatment plan that all involved clinicians can support.

Look for areas of agreement, rather than concentrating on areas of disagreement. Frequently clinicians are so drawn to areas of disagreement that they fail to recognize that areas of conflict may be a fairly minor part of the entire picture. A negotiated team decision usually leads to a better outcome than an imposed decision.

It is important for all members of the treatment team to support the client's relationship with other members. Team members may differ in their approach to treatment, but embroiling the client in this conflict runs the risk of increasing the client's stress and symptoms (Stanton and Schwartz 1954). Supporting a consistent treatment plan is almost always more beneficial to the client than feuding over whose approach should be followed. As there is often no "right" answer in treatment, the different team members can usually discuss and offer the client a range of options. Presenting options is very different from having professionals, on whom the client is dependent, fighting over the "correct" course of action.

Team members must be willing to gather and present the data for their respective positions, rather than falling back on authority, familiarity, or

unexamined feelings. The psychiatrist, case manager, and other team members should support their positions with information or expertise that can be shared and considered by the other clinicians. For example, it is not very useful for the psychiatrist to issue the edict, "I am the physician, and I feel that John should be on more medication." Similarly, the case manager cannot justify his or her decision by relying on the assumption that "I know the client best!" A much more useful approach is demonstrated in the following two vignettes.

A case manager was concerned about the side effects caused by raising a client's medication. The psychiatrist explained that she felt the increase was necessary because the client seemed more disorganized and bothered by intrusive, auditory hallucinations. The psychiatrist also referred to the client's similar exacerbation the year before and improvement after the medication was increased. Given the history, the case manager was able to support the decision to increase temporarily the dose of antipsychotic medication. At the same time, the discussion increased the psychiatrist's sensitivity to the problems caused by the side effects and led to a decision to add another medication to treat them. The case manager worked with the client to develop a set of target symptoms to monitor both exacerbation of symptoms and side effects, which provided the psychiatrist with better information for future medication adjustments.

A psychiatrist believed that a particular client needed the supervision of a group home, whereas the case manager wanted to support the client's request for a supported apartment. The case manager pointed out that the client would live alone, but would have staff dropping by several times a week to monitor the client's functioning and to assist with shopping, budgeting, and other realities of living. An inventory of the client's specific skills (he made friends easily and could ask for help) and specific deficits (he was unable to budget money, cook, or organize any complicated task) led to a discussion of the client's previous trials in independent living and group homes. This shared information made planning the client's independent living trial easier and more success oriented than previous trials. The discussion also led to a clearer understanding of the risks involved (he might cause a disturbance and get himself evicted, but he was unlikely to be dangerous or get himself into serious trouble). By the end of the treatment planning process, the psychiatrist, case manager, housing consultant, and client were able to agree on a plan that was different from any that each of them would have come up with independently. The client was supported in living in his own apartment and in turn was willing to accept closer supervision than he might have preferred.

A critical element in developing a shared treatment approach is shared responsibility. It is rarely useful to criticize a plan if a better one cannot be

derived. For example, when there is disagreement on the need for hospitalization, the clinician who believes that hospitalization is unnecessary has the responsibility to develop ideas for an alternative that can be discussed and examined by the other clinicians working with the client. On the other hand, the clinician who thinks that hospitalization is needed has the responsibility to develop specific goals for the hospitalization and an idea of what is going to happen after discharge.

It is equally ineffective to come up with a plan requiring another clinician to do more work or take more responsibility than he or she is willing to assume. For example, a psychiatrist suggested that a decompensating client should be treated in the community rather than with a hospital admission. After some discussion about the specific needs and behavior of the client, the team involved in treatment planning quickly agreed that treating this client in the community would require several home visits a day for the next few days. It also became clear that the case manager did not have the time to do this, and although other staff could help, the staffing needs of the proposed treatment plan could not be met. Instead, a 2-day hospitalization was arranged that helped to stabilize the client and give staff time to organize better coverage for when the client was discharged.

The clinician can often achieve a good outcome by continuing to be reasonable, even when other clinicians seem unreasonable. Although this is often hard to do, it is surprisingly effective when achieved. If another clinician becomes dogmatic, authoritarian, or avoids a shared decision, there is a complementary pull to become equally unreasonable. There may also be a pull just to avoid working with this other clinician. Either way, the client typically loses. If, in the face of this dilemma, the responsible clinician continues to look for areas of common agreement, consider seriously the view of the other clinician, and examine the available client data, there will be a strong reciprocal pull for that other clinician to respond in turn and thus look for areas of compromise and potential agreement.

Consider the Needs of the Other Clinicians

It is important to consider what the other clinicians need to adequately perform their jobs. For example, an emergency department at a nearby hospital had an administrative rule that required discharge clearance by a psychiatrist whenever a client was seen following a suicide attempt. Even if an experienced case manager assessed the client and recommended discharge, there was a need for at least telephone clearance from a psychiatrist. The case managers were annoyed that they were required to review each case with the on-call psychiatrist and felt as though the psychiatrist was "second guessing" their professional assessment. In discussing this annoyance, case managers were

asked what kind of information they would want if they were placed in the role of the psychiatrist and had to take responsibility for releasing a client from the emergency department. Considering the psychiatrist's needs and responsibility helped the case managers understand and accept the detailed questioning.

Familiarity Breeds Solutions

Knowing each other helps. All too often, informal networks of community support staff do not include the psychiatrist. The case managers and other staff meet to discuss joint clients, visit agencies, and thus know each other as real people. The psychiatrist, on the other hand, exists only as a voice on the telephone or as a set of cryptic medication notes. This lack of familiarity is unfortunate and often discourages integrated treatment. To counter this, psychiatrists should attempt to establish personal relationships with other members of the team. Psychiatrists should regularly invite other team members to confer about shared clients and to participate in joint meetings. Although the initial relationship building requires face-to-face contact, much of the communication, including conference treatment planning calls, can be done over the telephone after these personal ties are formed.

Developing these personal ties is often difficult and may even seem risky. Clinicians are busy, and it is awkward to begin a connection with a stranger. Moreover, there is always the risk that attempts at closer collaboration will expose hidden conflicts and make the working relationship more difficult rather than easier. These anxieties often lead the involved clinicians to believe there will be less conflict if the relationship between the psychiatrist and the case manager is allowed to remain more distant, even though this is clearly not in the client's best interest.

Different Ideologies

Just as potential problems are caused by conflicting roles, there are potential problems caused by different ideologies. The psychiatrist and the other team members often talk different languages and have different ideologies. This goes beyond the previously discussed conflict over who is responsible for what. It has more to do with different ways of viewing the world, different ways of conceptualizing problems, and different kinds of goals. These differences are most evident when the treatment team is part of a rehabilitation program and the psychiatrist is part of a treatment program. Rehabilitation

programs have generally stressed the differences between rehabilitation and treatment (Anthony et al. 1984; Cnaan et al. 1988). Such programs have typically been based on the belief that treatment services (including psychiatric services and medication monitoring) are important but should be clearly separated, or at least put at some distance and not allowed to "contaminate" rehabilitation. It is all too easy for case managers working in such programs to feel that psychiatrists are trying to impose a traditional, paternalistic, and illness-based orientation. Psychiatrists, in turn, are often uninformed about rehabilitation programs and do not understand the importance of maintaining a rehabilitative perspective.

Even case managers working from a more traditional treatment orientation often see themselves as having a different focus from that of psychiatrists. Regardless of whether this focus is truly different, the perception of difference and the use of a different language sets up barriers that accentuate professional rivalries, concern about dominance, and turf issues. The decision about whether to use the word *consumer, client,* or *patient,* and the underlying view that each represents have led to monumental struggles in some mental health systems.

These ideological conflicts are accentuated in journal articles and academic discussions and appear less relevant at the level of direct service workers. This seems particularly true in those settings where psychiatrists and case managers have good working relationships. Just as there are general principles that can help resolve role conflicts, the following principles can help resolve conflicts resulting from ideological differences.

Concentrate on Common Goals

The clinical interventions involved in making a diagnosis, prescribing medication, meeting with families, and helping clients to handle stress or obtain a job are all interrelated. All of these interventions are aimed at helping the client improve his or her quality of life. For the most part, getting a client to come for an appointment or to take medications are not ends in and of themselves; they are designed to decrease symptoms, increase functional capacity, and improve overall quality of life. These are goals that practitioners from all disciplines and community programs can share. Once we realize that our long-term goals are shared, it becomes easier to question ourselves about whether a particular intervention helps.

Become Informed About the Ideology of the Other Clinicians

It is important for the psychiatrist and the case manager to learn about, listen to, and understand the ideology of one another. Many arguments over

alternative ideologies are caused by having a simplistic view of the alterna tive point of view or by confusing bad practice with a particular orientatio Nonmedical professionals often rail against a "medical model." In fact, sophisticated medical model stresses a holistic approach that includes cor sideration of psychological and social factors along with biological one What is generally criticized in these discussions is not this kind of compre hensive medical model, but rather medical dominance or attempts to lim consideration of the client to biology. Psychiatrists, in turn, sometimes ste reotype nonmedical mental health professionals as being unable to mak accurate assessments or appreciate the importance of medication. Althoug this is certainly true for some nonmedical clinicians, it is no more represer tative of many social workers or psychologists than is the representation tha psychiatrists prescribe medications and do nothing else.

At times disagreement is based on an accurate appraisal of havin different tasks. A rehabilitation expert might not pay much attention to DSM-IV diagnosis or even be concerned as to whether someone is mentall ill (American Psychiatric Association 1994). The expert's focus of concer is on a functional assessment and a plan to overcome functional limitation This does not mean that the rehabilitation expert dismisses the reality o mental illness or the importance of another professional taking an alterna tive treatment approach to the client, but only that the rehabilitation profe sional approaches the client's problems from a different perspective.

Psychopharmacology and Other "Medical Topics"

The psychiatrist's exclusive expertise regarding medication and other med cal topics can be a source of significant role conflict between the psychiatri and nonmedical members of the treatment team. Often team members wh are actively involved in most other major issues in their clients' lives abdica involvement in medication decisions. There are many reasons for this. On is the mental health system itself. It is often unclear what role, if any, th nonmedical members of the case management team should have in dec sions about psychotropic medication.

Other reasons why nonmedical clinicians are removed from medicatio decisions involve knowledge and responsibility. Many case managers are no particularly knowledgeable about such medical topics as psychopharmaco ogy. Involvement in medication issues is particularly intimidating if the psy chiatrists are not in the practice of working collaboratively with othe clinicians. Perhaps more importantly, many case managers do not see "med cal" decisions as part of their responsibility and do not feel an obligation t become knowledgeable in this area.

Psychiatrists often participate in keeping case managers and other team members out of medication decisions (Samuelly 1986). Some psychiatrists feel that all of the responsibility for medication management, including assessment, prescribing, and monitoring, should be left entirely to physicians. Many of these psychiatrists have defined their role so narrowly and rigidly that they prescribe medication without thinking through the repercussions of those medications on the overall treatment plan or on others involved in the client's care. Other psychiatrists would be willing to use case managers in some way but do not know the system well enough to know how to include the case manager in this aspect of care, or they believe that case managers and other nonphysicians can inform the psychiatrist about how the client is doing, but should have no direct input in any medication decisions, thus putting the case manager in a distinctly peripheral role.

This lack of integration continues despite the reality that other team members are often in a better position than psychiatrists to evaluate the effect of medication changes on a client's functional ability. The case manager and other team members usually see a client more often and in a wider variety of settings. Therefore, they are in a better position to recognize subtle medication side effects and early signs of decompensation. In addition, other team members are often in a good position to monitor whether their client is taking prescribed medication. Clients often have a close relationship with their clinical case manager and may tell them about noncompliance. Lastly, the case manager has contact with the client's support system and can utilize this to help monitor medication when clinically appropriate.

All team members have a professional obligation to be concerned with medication, just as they should be concerned with other major aspects of the client's life. They need to know what medications might be useful for their clients, what prescribed medications their clients have, what medications their clients are actually taking (which is often different from what is prescribed), and what impact and side effects those medications may have. Although this might seem like an intimidating prospect, it is actually less difficult than it would seem on the surface.

Psychiatrists have an obligation to inform team members (and the client) about psychotropic medications, their indications, and their side effects and to enlist the aid of the team in monitoring the effects of medication. Psychiatrists should teach their nonmedical colleagues about medication, not for the purpose of prescribing, but to monitor beneficial and side effects appropriately. This teaching can involve formal minicourses or lectures. An even more important aspect of the learning process occurs when the psychiatrist involves the team in the decision-making process. Team members learn nothing about the effects and side effects of a medication if the only

involvement is being told that a client started a particular medication a particular dose. Much more information is transmitted and remembe when the psychiatrist and the rest of the team jointly consider the pattern the client's symptoms, look at the therapeutic indications for different me cations, and discuss the pros and cons of each.

Case managers and psychiatrists must work together to connect me cation issues to the rest of the client's life and to the client's own goals a agendas (Diamond 1983, 1985). All too often, medication prescription something that is done "to" clients instead of "with" clients. Clients almc always have their own goals and agendas. One client may miss playing ba ketball but be too paranoid to leave his apartment. Another client may wa to get a job but be too disorganized and too bothered by voices to follc through. Still another client may want to keep his own apartment, but h late night yelling and talking to himself may lead to threats of eviction. each case medication can be presented as something that will help the clie achieve what he or she wants. For example, it is often more effective present medication as something that might help the client become less afra so that he can play basketball again rather than as something that will hel with the more abstract concept of decreasing symptoms. Making concre connections requires considerable information about clients, their need and their own goals.

Lower medication doses can be used when the entire treatment team involved in the monitoring process. In most public mental health systems, cl ents meet with their psychiatrist for a brief session at relatively infrequent inte vals. The psychiatrist cannot monitor day-to-day or even week-to-wee fluctuations. Moreover, the psychiatrist typically observes the client in one se ting: the office. The other members of the team, on the other hand, have infor mation from a variety of settings. With careful monitoring, prodromal relaps symptoms can be identified at an early stage, thus allowing medications to b increased before hospitalization is needed. In addition, careful monitoring ca allow some clients to be maintained on a targeted medication strategy in whicl medication is only used for relatively short, targeted periods when symptom reemerge. All of this becomes much more difficult when the psychiatrist and th rest of the treatment team work in isolation from one another.

Information Sharing

A conscious effort is required by the psychiatrist, case manager, and othe caregivers to ensure that the psychiatrist has enough information about the

client's life and treatment to prescribe and monitor medication effectively and to resolve crises. Too often the psychiatrist ends up outside the information net. To facilitate the inclusion of the psychiatrist in the information net, the case manager and the psychiatrist must decide what kind of information they need to share and how this will occur.

Summary

Treatment of persons with serious mental illness requires that many clinicians work together. This is true whether treatment takes place in the hospital or in the community. The hospital, however, has a long tradition of teams with a clear role for each of the team members. There is much more ambiguity in roles and responsibilities in community settings. In the community, clinicians may have different goals and different treatment ideologies and may operate out of different settings. The potential for role conflict is increased because of poorly defined and overlapping responsibilities. These problems are usually most evident in the relationship between the psychiatrist and other members of the treatment team, but the potential for conflict and communication breakdown is present throughout the team.

These problems can be resolved. It is possible for the psychiatrist to be a fully integrated member of the multidisciplinary team and to work with other team members to develop a comprehensive approach to treatment. It is important for all members of the team to understand the need for an integrated approach to treatment. In doing so, all members of the team must understand the role of the other members and must define their complementary roles. This is actually not difficult once all team members recognize they are involved in the shared task of improving the clients' quality of life.

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