The importance of teamwork

One of the originators of the alcohol/drug team model assesses its strengths and aggravations

Multidisciplinary teamwork in the drugs field protects workers against their own strong emotional reactions to patients, helps them resist external pressures, and prevents burnout. However, staff need to be adequately trained and psychologically suited to this way of working. Careful selection, preferably by the team, is essential. Different professional backgrounds and skills can lead to conflicting therapeutic approaches.

Terry Spratley

The author is consultant psychiatrist specialising in alcohol problems at the Mount Zeehan Unit of St Martin's Hospital in Kent. An earlier version of this article was published in Kent Drug News.

MY EXPERIENCE with multidisciplinary teams started when I was a member of the pilot project which in 1975 recommended the general establishment of special multidisciplinary community alcohol teams. In 1978 our book *Responding to Drinking Problems* described our first attempt to develop such a team.

Sadly, our earlier writing has often been misunderstood. We did not recommend that unskilled workers could do this type of work nor that all personalities are capable of this method of working. Nor did we suggest that community teams could dispense with specialised day units for more difficult drinkers.

I worry that the present drug field is repeating the errors made by the alcohol field – sending out poorly selected, untrained and unsupported teams into the community, like lambs to the slaughter.

The most important advantage for me of working in a team is that the team can help me be more objective in working with substance misuse patients. Working with these patients can evoke extremely powerful emotional reactions which can distort clinical judgments and actions. These 'counter-reactions' are common, not just because of the client group, but also because of the extremely difficult circumstances in which we often have to work.

In addition, we ourselves bring psychological vulnerabilities into our working situation. Specialising in the field does not mean that we are free from such self-caused counter-reactions. Many specialists have particularly strong responses to these patients; it is partly because of these that we specialise in the field.

Personal therapy can help us become more aware of our own counter-reactions, but we deceive ourselves if we think it can make us immune to these and free from irrationality in our therapeutic behaviour.

Counter-reactions can lead us to blindness in our assessments, and frequently either to punitiveness or to collusion in our treatment: I believe collusion is more common in substance misuse workers; it is the rule rather than the exception.

Most workers have powerful psychological needs to be liked by, and to give assistance to, their patients. "Even more than the calf needs to suck, does the cow need to suckle." Being collusive is more damaging to patients than being punitive; patients flee the punitive worker but stay with the colluder, who continues to reinforce their self-damaging behaviour.

Worker counter-reactions also frequently result in attempts to over-control the patient's life, or to under-control of the therapeutic setting.

Collusion control

Working in expert teams provides the best protection we can give to patients against our counter-reactions. There should be a tradition of open and regular consultation within the team. Our own team members have all received at least some personal therapy and have had prolonged and systematic training in substance misuse. They usually have the practical and psychological skills to help me and each other become aware of counter-reactions, and thus avoid some of the damage these can do to patients.

The second big advantage of multidisciplinary team work is that it increases the power of each worker. Lone workers are rarely able to resist the pressures that patients, relatives and referral agents place upon them to act against their better judgment. The risktaking behaviour of substance misusers generates much anxiety in those around them; some patients learn to use this anxiety to manipulate situations to their own ends.

A team is much stronger than an individual in resisting such pressures. As a doctor, without the backing of a team I would be unable to resist the pressure upon

me to overprescribe or to over-admit to hospital. Because of these two issues, doctors especially need to work in teams. Substance misuse doctors working without expert team support probably do more harm than good.

For the same reason, recent official encouragement to GPs to use methadone to detoxify opiate addicts could backfire. Without expert team support – which few GPs have – they will be unable to resist the pressures addicts place upon them and will inevitably overprescribe. They thus inadvertently reward this pressurising behaviour, which will thereby be reinforced, and the addicts will escalate their pressure. Eventually, many more GPs will become frustrated, turn punitive, and then reject these patients as a group.

Obtaining workers for these expert teams is difficult. I do not believe there is a large number of unemployed substance misuse experts clamouring to be appointed. In psychiatry, there is a severe shortage of properly trained and qualified applicants, even for prestige jobs; this is almost certainly true for other disciplines. To obtain staff for our own services we try first to appoint workers with potential, and then train them in the necessary skills – easier said than done!

Ideally, teams should appoint their own members, but frequently this is not possible. Often, members appointed by outsiders are then sent to join teams for which they may be unsuited.

In our team, we try to organise appointment committees so that we at least have the right of veto. Normally we spend a whole day interviewing and involve every member of staff and some patients. We interview in a one-to-one situation, followed by a group, and also include a psychotherapeutic interview.

Roots of the drug team

The current network of drug teams at regional and district level is based on the recommendations of the Advisory Council on the Misuse of Drugs in their 1982 *Treatment and Rehabilitation* report. In that report, the council explained that it aimed to develop a structure "very similar... to that which has been developed for... problem drinkers".

In turn, the community alcohol team model was based on the work of the Maudsley Alcohol Pilot Project led by the author of this article, which reported to the government in 1975. Their recommendations were taken up by the Kessel committee and implemented in the alcohol field.

Following the appointment and a period of observation in the day unit, we send the new member on a year's part-time course in alcohol counselling. This course has a very strong emphasis on supervised clinical work, skills training and counter-reaction work, as well as the usual academic component. After this basic training the new worker begins to feel part of the team – someone whose opinion is of value, to whom other team members might be happy to refer patients, and with whom they might consult.

> ***"Substance misuse doctors working without expert team support probably do more harm than good"***

Providing the importance of mutual emotional support is recognised, the team approach also protects against the well known burnout syndrome. Workers have a right to expect their own team members to help them deal with the pains that working in the field brings. This need not be intrusive nor would it take away all the pain, but rather entail helping the worker to understand the pain and then to use it to learn and grow.

Conflict and challenge

Teams bring together a great range of specialised knowledge and skills and very different conceptual frameworks. These can be very enriching, but can also pose complex difficulties in communication and practice.

Our most interesting examples come from our family team. When we started many years ago, most of us shared a simple view that understanding and working with the family would help all concerned. As team members trained and studied more deeply, conflicts began to emerge.

One important difference was between 'traditional' conceptualisations, which saw the alcohol or drug problem as located *within* the patient, and newer 'systemic' models which saw the 'illness' in terms of its *function* in the family or in wider social systems. For these models, changing the *system* rather than the *individual* was the focus of therapy – an approach difficult to reconcile with traditional approaches when applied to the same patient.

Furthermore, implementing the team approach meant members had to face challenges to deeply held values. I will try to make this concrete by example.

At times when I came out of a therapy session to consult with the family team behind the one-way screen, the team would ask me to say things to the family that I could not even understand, never mind agree with. I was prepared to accept this as I knew that in the heat of therapy it is often difficult for the therapist to understand fully what is happening. I also knew that interventions made on a systemic model were often successful in very entrenched family situations.

But many systemic interventions raised for me worrying moral and legal problems. In situations where drinking is a response to an over-controlling spouse, encouraging the spouse to attempt to get the partner to drink *more* rather than less can certainly be a very effective way to disrupt the status quo. But what of the legal and moral issues involved in such interventions? And how does that intervention fit in with the values of the rest of our services? These values stress the importance of staff being non-manipulative, and of clearly explaining treatments to patients so they can make informed choices.

Non-systemic thinking by team members causes equally serious, but opposite, problems. For example, a non-systemic team member can localise the pathology of the problem within the individual patient and exclude all others. It can then become very difficult for team members to include other people relevant to treatment, such as family, employers or referral agents.

Leadership is the issue which causes the most difficulties to teams. The leadership question is especially difficult for many consultant psychiatrists. There are issues of tradition, power, status, remuneration, and legal difficulties involving the doctor's responsibility for 'their' patient.

Our deeper fears are also of great importance. Like many colleagues, when under threat, I seek to control. Most of the time I am entirely unaware of this until it is pointed out to me. I have had to learn instead to trust and ask for help from the team. When I do, the team usually recognises my needs and helps me. Freeing staff from my over-control encourages their own growth and development.

I recommend great flexibility in organising leadership in teams. There can be rotating leadership, leadership based on external hierarchy, and leadership determined by the needs of the paymasters or clients. A team can have different leaders for different tasks.

THE WAY LEADERSHIP is organised in the substance misuse field is probably of less importance than the ability of the group mutually to cooperate around their common tasks. This ability depends less on structures than on individual psychological maturity and shared values. Nonetheless, leadership of some kind is necessary for the optimum efficiency of any team activity. ■