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Promoting mental health through multidisciplinary care: experience of health professionals working in community mental health teams in Ireland

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International mental health policy recommends that community-based mental health care is the optimal service provision marking a distinct departure from institutions. In Ireland, it is envisioned that this care be provided by Community Mental Health Teams (CMHTs), where multidisciplinary health professionals all play a key role in promoting client mental wellbeing. However, recent reports indicate that implementation of the community-based care approach has been less than optimal. This research explored CMHTs' perspectives and experience of community-based care; it also examined their awareness of specific key performance indicators (KPIs) that can monitor their provision of care. A total of 738 health professionals working in 70 CMHTs across the nation were surveyed. The results indicated little multi-disciplinary input from CMHTs in the provision of mental health care. In addition, the findings indicated that having clear KPIs did not represent a priority for a large number of respondents.

Keywords: Community Mental Health Teams, multidisciplinary, key performance indicators.

Introduction

The need to provide clients with multidisciplinary community-based mental health care has been progressively understood at European level (Ozamiz, 2011). This is supported by a large body of evidence that suggests that multidisciplinary community-based mental health care has a positive impact in promoting users wellbeing compared with the care provided in institutional setting (Frank et al., 2008). The term multidisciplinary utilised in this study reflects a non-hierarchical, collaborative working culture, where various health professionals share common goals, in order to provide effective services (Barr, Koppel, Reeves, Hammick, & Freeth, 2005, Blutteau & Jackson, 2009;

WHO, 2010); and community care is used to denote the care provided in the community (as an alternative to institutions) with the final goal of promoting users' recovery and fully reintegrate them into society (McEvoy & Richards, 2007). The launch of the Green Paper for Mental Health (EU, 2005) provided a key milestone at the European level in the provision of multidisciplinary community-based mental health care; it set the European agenda for how mental health care across state members should be implemented. This policy has been enhanced by the launch of the European Pact for Mental Health Wellbeing in 2008 (WHO, 2008), which outlined key priorities in mental health, such as tackling specific population (i.e. young people and elderly), preventing depression and suicide, promoting social inclusion and combating stigma. Furthermore, in 2010, the WHO Regional Office for Europe outlined the importance of community-based mental health care and advocated for empowering service users in their mental health care.

Despite all these recommendations, in 2013, the European Mental Health Action Plan (WHO, 2013) indicated that mental disorders still affected over one-third of the European population clearly directing that much more is required in order to effectively engage with mental health. The European Mental Health Action Plan (WHO, 2013) clearly advocates that individuals with mental disorders must have a voice in their care, and that they should be treated in community-based services by multidisciplinary health professionals who can address their psychological, biomedical and socio-economical needs. Prioritising community-based multidisciplinary care has also been echoed in most national policy in European state members, such as England, Italy, Netherlands and Denmark at many others (Evans et al., 2012).

The Irish context

In Ireland, Community Mental Health Teams (CMHTs) have been established in order to provide users with an alternative to in-patient hospital-based care (Mental Health Commission, 2006). These teams were first recommended in 1984 by the national policy Planning for the Future (Department of Health, 1984), which indicated that mental health care should be delivered in community services by multidisciplinary teams led by psychiatrists, and their key role in secondary mental health care was then stressed by subsequent policy documents, such as in 1995 The White Paper (Department of Health, 1995) and in 2001 by Mental Health Act (Department of Health, 2001). Despite such national policy recommendations, the transition from institutional to community-based care has been very slow and fragmented across the nation. As a result, in 2006, the Expert Group on Mental Health Policy, endorsed a new national policy entitled A Vision for Change [AVFC] (Department of Health and Children [DHC], 2006) in which the Irish government committed itself to

a new mental health strategy framework. CMHTs as envisioned in the [AVFC] (DHC, 2006) are positioned as the cornerstone of the delivery of modern integrated mental health care to service users in their own community. The core functions of the teams are described as, supporting primary care providers to facilitate appropriate referrals; providing timely assessment and access to a range of interventions as well as developing local knowledge to assist service users to access local support networks. As such the CMHT is envisioned as functioning as a single point of contact for service users thereby facilitating integrated service delivery. The multi-disciplinary composition of the team means that a variety of professional perspectives would be evident in case formulation, case planning and service delivery (Burns, 2004). To achieve this, AVFC recommends that each CMHT include input from the disciplines of psychiatry, nursing, social work, clinical psychology and occupational therapy as well as inclusion of access to other specialisms such as counselling, psychotherapy or speech and language therapy as required. The team is envisioned to meet regularly to discuss the needs of each service user in consultation with the service users and their careers. In addition, care plans are to be constructed and agreed with all parties and these include the goals of the user as well as criteria for assessing outcome and user satisfaction.

While the concept of CMHT as outlined in the AVFC espouses a model of collaborative working and shared governance, the clinical leadership function resides within the profession of psychiatry for contractual and legislative reasons. This clinical leadership role is seen as articulating the collective vision of the team and ensuring clinical probity. The other key functions of team members are those of team coordinator and practice manager. The team coordinator is envisaged as having both a clinical and administration function with responsibilities around managing referrals and waiting lists, organising team meetings and liaising with GPs and outside agencies and services. The practice manager is seen as an administrative role to include budgeting and managing IT services for the team. In addition, where a service user is under the care of more than one team member they are assigned a key worker who may in principle be any member of the team.

These team roles along with the clinical roles of each of the professionals involved in the team and with the full involvement of service users, their families and advocates were designed to provide an integrated, person-centred, recovery-oriented mental health service. In order to monitor the development of such a service, AVFC recommends that 'Evaluation of the activities of the CMHT in terms of meaningful performance indicators should take place on an annual basis and incorporate service user feedback.' [AVFC] (DHC, 2006, p. 82).

However, reviews of the implementation of the recommendations provided by AFC

indicated little in terms of significant changes (Mental Health Commission, 2009a, 2009b, 2010, 2011 – 2014). Indeed, the Mental Health Commission (2009b) have identified that in practice mental health services frequently are not able to provide comprehensive community-based mental health services and that significant regional variation is evident in terms of quality, availability and composition. Some of the CMHTs continue to engage with both in-patient and out-patient settings (MHC, 2009b). The number of fully staffed, effective CMHTs is very low (MHC, 2008, 2009a, 2009b, 2010 – 2014). The Mental Health Commission (2009a, 2009b) expressly articulates that lack of progress in achieving the national strategy aims are damaging for the dignity of individuals with mental disorders. In addition, despite the fact users agree on the relevance of receiving multidisciplinary community-based care (Mannix-McNamara, Eichholz, Vitale, & Jordan, 2012), they felt that their voice is under-represented and that the type of care provided by CMHTs is still medically orientated (Vitale, & Mannix-McNamara, 2013).

It is in this context that this study was set. The aim of the study was to identify the involvement of various health professionals working in CMHTs in service user assessment, treatment care and treatment care review across the nation. In addition, in line with the recommendations provided by the current policy [AVFC] (DHC, 2006), it aimed to investigate whether health professionals working in CMHTs were aware of positive and negative key performance indicators (KPIs) and whether they used them as indicators of their effectiveness. When examining KPIs Parmenter's (2010) conceptualisation is adopted and thus KPIs are understood as non-financial measures adopted by public and private services to assess their performance with the aim of maintaining specific standards and/or to inform staff how to improve the quality of their work.

Method

Instruments

The CMHT questionnaire was designed specifically for the study after an extensive literature search, which indicated that, at the time of the research, there were no instruments that fit the purpose of the study. The questionnaire was designed with the input of an advisory panel (which included a service user representative, mental health professionals and academics with a mental health background) and was subsequently piloted with selected health professionals working in one community mental health service in the region.

The questionnaire consisted of 19 items clustered in three sections: one section served to profile health professionals working in CMHTs, the next section served to assess their involvement in users'

care and the latter section served to assess respondents' knowledge of positive and negative KPIs for their team. In addition, a bio-form was included to collect demographic information.

Ethical considerations

Ethical approval was granted by the Regional Health Services Research Ethics Committee. During the study, the ethical principles of respect, beneficence and non-maleficence for participants were observed (LoBiondo-Wood & Haber, 2006). The research aims and objective were detailed in the information sheet provided and restated by the researchers involved in the study. Prior to completion of the questionnaire, participants were asked to sign a consent form which stated that participation in the study was anonymous and that they were free to withdraw from the study at any time without prejudice.

Procedures

A letter of invitation was sent to all CMHTs' Managers nationally (75 in total). They were asked to forward the information provided in the letter to all professionals working in their team, and to discuss its content at their next team review meeting. Two weeks after sending the letter, a follow-up phone call was made to ascertain whether the CMHTs were willing to take part in the research. In order to maximise health professionals' participation, it was suggested that the date for administering the questionnaire overlapped with one of the teams' review meetings. All team members of each CMHT were surveyed simultaneously. Each participant was asked to read an information sheet, then to sign a consent form and finally to complete the CMHT questionnaire.

Qualitative data analysis

Participants were asked through an open format whether they were aware of specific KPIs used in their CMHT. Because this yielded qualitative data the analysis was conducted in two consequent cycles (Saldana, 2009). First, structural codes were constructed: that is, for each respondent, large segments of texts on broad topics were identified and these were then compared across participants to determine their frequency (MacQueen, McLellan-Leman, Bartholow, & Milstein, 2008). A second coding cycle was then conducted using evaluative coding, as this method is particularly effective when dealing with populations scattered across different sites (Saldana, 2009); this type of coding is also recommended when dealing with policy research to describe and compare data in order to

make grounded recommendations (Patton, 2002). After the evaluative codes were identified, they were clustered into themes. Direct quotations were taken from the data in order to exemplify each theme.

Results

Out of 75 CMHTs who were invited to take part in the study, five declined yielding a response rate of 93%. The reasons cited for not taking part in the study were 'not having time' (three CMHTs) and 'not feeling comfortable with the research study' (two teams).

The average response rate within each CMHT was 82% (with a range between 43% and 100%).

Overview of the sample

As is possible to observe from Table 1, most participants were Irish (85%); female participation was much higher (65%) than male (35%). Participants' age range varied, with the highest frequency in the 46 – 55 years group (34%). Almost half of the sample was represented by nurses (49%), followed by doctors (19%), psychologists (9%), social workers (8%) and occupational therapists (7%); addiction and 'other' therapists were equally represented (4%).

Participants' involvement in users' care

Participants were asked to indicate their involvement in users' assessment, treatment and discharge plan (i.e. 'none', 'some' and 'full'). As it is indicated in Table 2, psychiatrists represented the professional category with the highest full involvement in the three stages of user care (i.e. 87% in the assessment, 88% in the treatment and 92% in the discharge plan). These rates were followed by the full involvement of trainee doctors (i.e. 71% in the assessment, 65% in the treatment and 64% in the discharge plan) and by the full involvement of nurses (i.e. 40 % in the assessment, 40% in the treatment and 39% in the discharge plan). Overall, the full involvement of other health professionals in users' care was extremely low.

Table 1. Participants' profile. N ¼ 746.

Gender	Female: 65 % Male: 35 %
Nationality	Irish: 85 % Other: 15 %
Age range	18–25 years: 3 % 26–35 years: 24 % 36–45 years: 26 % 46–55 years: 34 % 56–65 years: 10 % - 65 years: 3 %
Tenure	- 1 year: 20 % 1–2 years: 21 % 3–5 years: 23 % 6–10 years: 23 % 11–15 years: 6 % 16–20 years: 5 % - 20 years: 2 %
Profession	Nursing: 49 % Doctors: 19 % Psychologists: 9 % Social workers: 8 % Occupational therapists: 7 % Addiction Therapists: 4 % Other therapists: 4 %

Table 2. Health professionals' involvement in users' assessment, treatment and discharge plan.

N ¼ 746 Professional category	Assessment %			Treatment %			Discharge plan %		
	None	Some	Full	None	Some	Full	None	Some	Full
Psychiatrists (N ¼ 67)	0	13	87	0	12	88	0	8	92
Trainee doctors (N ¼ 79)	2	27	71	1	34	65	5	31	64
Nurses (N ¼ 343)	11	49	40	8	52	40	13	48	39
Psychologists (N ¼ 65)	3	85	12	0	88	12	10	81	9
Social workers (N ¼ 57)	18	65	17	4	78	18	9	79	12
Occupational therapists (N ¼ 49)	13	77	10	0	83	17	4	86	10
Addiction therapists (N ¼ 24)	0	92	8	0	77	23	4	76	20
Other therapists (N ¼ 27)	56	26	18	52	33	15	48	37	15

Positive KPIs (N 5 373)

A total of 373 participants (50%) indicated positive KPIs. The themes and sub-themes related to the positive KPIs are described in detail in the following sections.

Theme 1: Being part of a team. As is possible to observe in Figure 1, Being part of a team represented the theme with the highest frequencies and with the most sub-themes.

A total of 34% respondents indicated Teamwork as one of their team’s positive KPIs. One participant specified ‘Good team working and team discussion for service users’ treatments’ (P. 290), whereas another stated ‘Working in a collaborative fashion, which supports each other’ (P. 663). In addition, 27% participants specified that Teamwork related to Cross-communication among health professionals. For example, ‘Communication between team members, sharing information’ (P. 115), and ‘Every member has a say in patient care’ (P. 515). In turn, Cross-communication led in 10% of cases to having Cross-referrals and also, in 7% of cases to sharing integrated files within team members. The importance of Respect (10%) also emerged from the analysis. For some participants this was related to Support from team members (7%) and/or being Open to changes (4%). For instance, ‘Willingness of team members to improve team functioning’ (P. 662). Clear roles (15%), Cohesion (18%) and being able to maintain a Friendly atmosphere (8%) also emerged as sub-themes.

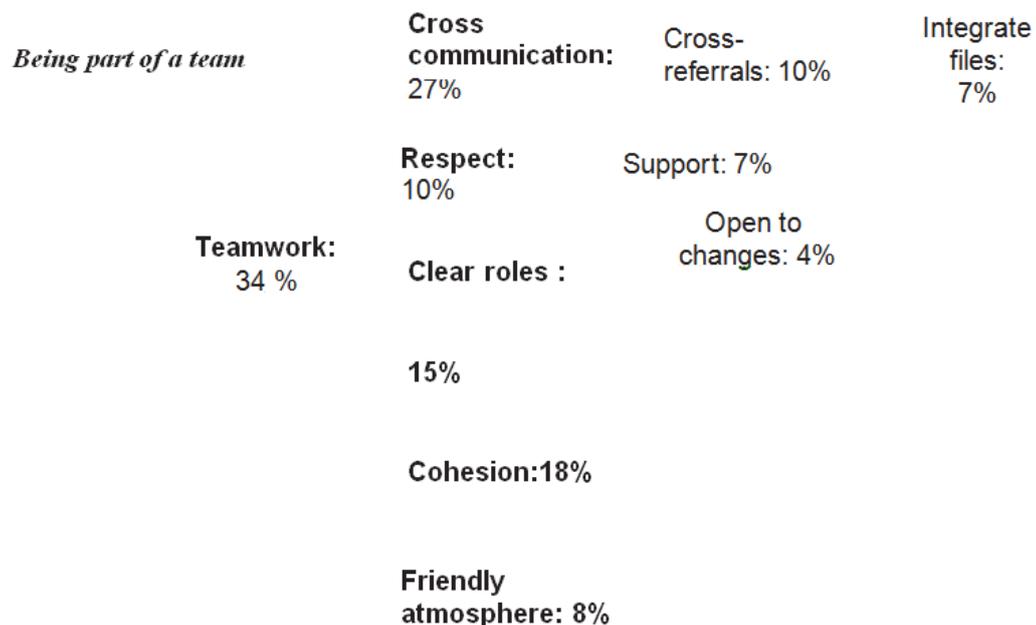


Figure 1. Theme 1: Being part of a team.

Theme 2: Professionalism. Professionalism was also indicated by respondents as one of the main positive KPIs (Figure 2). For 43% of respondents, this was related to having skilled professionals. In this regard, ‘Having a good range of experience and skills’, (P.84) was cited, and variety was appreciated ‘dedicated workers, variety of therapies, experience, professionalism’ (P. 150). A total of 25% of respondents suggested Commitment as one of their positive KPIs; for instance for one

participant (P. 40) this meant 'All interested in providing a quality service'. Finally, a small percentage of participants (8%) indicated receiving Training as part of their positive KPIs.



Figure 2. Theme 2: Professionalism.

Theme 3: Meetings. For 14% of respondents having CMHT Meetings was one of their teams' KPIs. For instance, participants indicated: 'Frequency of team meetings, (there is an) opportunity to communicate ...' (P. 204); 'Good structure of the meetings' (P. 215); and 'Team meetings chaired by different disciplines' (P. 704). However, from the analysis of the qualitative data, it was not possible to identify whether participants referred to team clinical meetings or team management meetings.

Theme 4: Leadership of the consultant psychiatrist. A total of 13% participants indicated the Leadership of the consultant psychiatrist as one of their teams' positive KPIs. For instance, participant specified 'Good consultant' (P. 730); and '(A) dynamic, approachable consultant' P. 433.

Theme 5: Service users' care. Overall, Service users' care was the theme with the lowest frequency (i.e. 4% in total). Comments included 'Understanding service users' needs' (P. 136); 'Good work relationship with patients' (P. 293) and 'Service users' needs are a priority' (P. 371).



Figure 3. Theme 6: Not being part of a team.

Negative KPIs (N 5 415)

A total of 415 participants (56%) specified negative KPIs in their CMHT. The themes and sub-themes related to the negative KPIs are described in detail in the following sections.

Theme 6: Not being part of a team. As indicated in Figure 3, within the negative KPIs, Not being part of a team was the theme with the highest frequency.

Specifically, 18% participants indicated a Lack of multidisciplinary work as one of the negative KPIs in their team. As one participant indicated 'People are not willing to work in a collaborative fashion' (P. 275). A small percentage of participants stated that a consequence of the Lack of multidisciplinary work was Not having integrated files (i.e. 8 %). Another sub-theme emerging from the analysis was Interdisciplinary conflicts (19%).

For instance, P. 381 indicated 'Members (of the CMHT) believe that one profession is more important than the others', whereas P418 stated 'Conflicts between disciplines ... lack of support from other members'; and P.721 identified 'Some disciplines are not as highly regarded as others'. For some respondents, Interdisciplinary conflicts led to a Lack of respect (i.e. 5% of cases). For instance, P. 165 indicated 'Lack of respect or value for other discipline at work'; P. 561 said 'Lack of respect within the team' and P. 654 stated 'Non polite dismissive comments'.

A total 37% respondents indicated Lack of communication as one of their negative KPIs. For instance, for P. 34 this meant a 'Lack of clarity and communication around decisions', and for P. 95 a 'Lack of open communication between disciplines'. Furthermore, for 13% of respondents this led to a Lack of clarity in roles. This was well- summarised by P. 171, who indicated 'Little understanding of roles, standards and responsibilities', and by participant P.600 who specified that there was a 'Misunderstanding about each other's roles'.

Theme 7: Inability to provide adequate care was indicated in some cases as one of the negative KPIs (see Figure 4). This meant in 33% of cases having an Excessive caseload. For 17% of participants it was rather related to a Lack of locum cover. For instance, participant P. 20 indicated that ‘(There have been) a lot of changes in terms of consultant psychiatrist in the last 10 years so this has been difficult, past issues remain unsolved’, whereas participant P. 93 indicated ‘Changing staff frequently, especially junior doctors’ as one of the negative KPIs. For 8% of participants, their team’s Inability to provide adequate care was related to Personnel rotation.

Theme 8: Lack of adequate resources. A total of 53% of respondents indicated Lack of resources, as one of their negative KPIs.

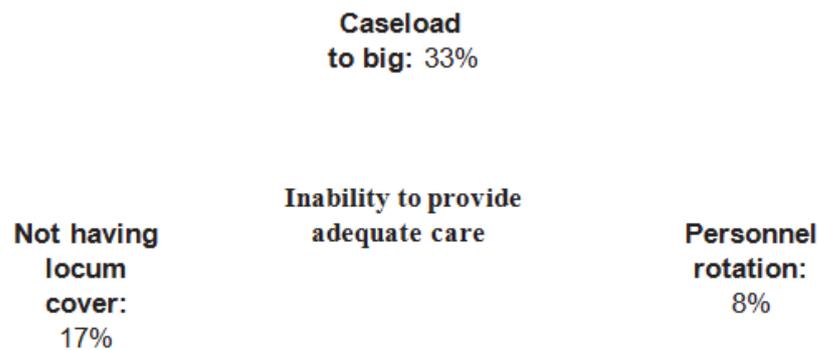


Figure 4. Theme 7: Inability to provide adequate care.

This was related in 15% of cases to Lack of space, in 40% of cases to Lack of CMHT staff, for 14% of participants to Lack of administrative staff and in 22% of cases to Lack of funding and in 9% to Lack of headquarter. This is summarised well by participant P. 527, who indicated ‘CMHT not fully/adequately staffed, lack of space in building, lack of funding to ensure activities for patients’. The overall findings for this theme (including frequencies and sub-themes) are summarised in Figure 5.

Theme 9: Lack of CMHT meetings. A total of 17% participants indicated Lack of adequate CMHT meetings as one of their negative KPIs. For instance, P. 325 indicated ‘Some members can dominate the meetings’, whereas P. 31 outlined ‘Isolated from monthly team decisions’; P. 207 stated ‘Not all

team members being able to attend team meetings due to clinic duties, sometimes are too busy’ and P. 418 stated ‘Weekly meetings interpreted by phone calls’.

Theme 10: Poor leadership. A total of 12% respondents indicated Poor leadership as one of their negative KPIs. For instance, one respondent (P. 600) indicated that ‘Decisions (are) made without consultation with the team’, whereas another (P. 503) simply indicated that there was a ‘lack of leadership and direction’; and P. 641 outlined ‘Sometimes dictatorial leadership, without consultation’.

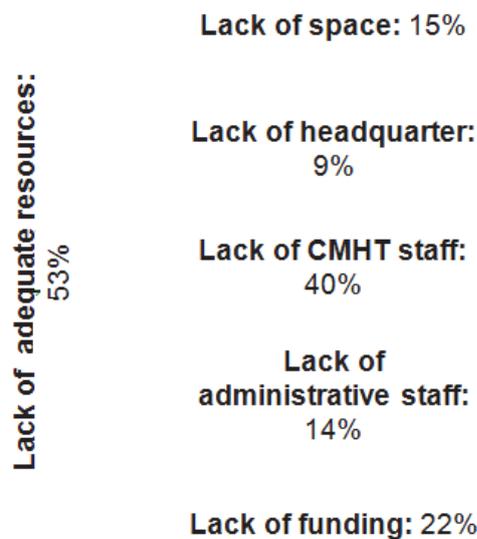


Figure 5. Theme 8: Lack of adequate resources.

For some of these teams, respondents stated that their leadership was too medically orientated. For instance, P. 497 stated ‘Leadership very medically orientated, results in other perspectives having difficulties being heard’.

Discussion

This research aimed to explore health professional’s provision of multidisciplinary care within their CMHT, and also their awareness of positive and negative KPIs to assess their work. The data from the study illustrate that the contribution of members of CMHTs to users’ care was uneven and it was mostly medically orientated. Specifically, the analysis of the results indicate that the professional category mostly involved in users’ different aspect of care (i.e. assessment, treatment and discharge plan) were psychiatrists, followed by trainee doctors, and by nurses. The involvement of the remaining health professionals was rather quite limited. This confirms that, despite the

recommendations of AVFC (DHC,2006), CMHTs in Ireland remain under-resourced, precluding them from providing optimal multidisciplinary care. It also confirms the findings from recent reports from the Mental Health Commission (MHC, 2009a, 2009b, 2010 – 2014), which state that service users' access to different health professionals working in CMHTs is poor because community-based services are not adequately resourced. In addition, it reflects the perspective that medical expertise is the prevalent form of treatment in mental health care and this is difficult to change (Vitale & Mannix-McNamara, 2013; Davidson, O'Connell, Tandora, Styton, & Kangas, 2006; Dunne, 2006). Furthermore, these findings are also reflective of service users' view that medical and nursing staff are the most involved in their mental health care in general, and in the care provided by CMHTs (Vitale & Mannix- McNamara, 2013). The lack of multidisciplinary care in these CMHTs is contrary to the recovery model, which suggests a holist approach to service users in order to promote their full personal development, enhance self-esteem and to regain a meaningful role in the society (Allot & Loganathan, 2002). Recovery represents moving away from pathology, illness and symptoms and emphasises the entire wellness (Davidson, 2005; Shepherd, Boardman, & Slade, 2008). Each professional working in CMHTs should be able to provide their unique competencies, skills training and clinical experience attached to their specific role in order to provide service users with a range of skills that are necessary to be fully equipped for effective reintegration into the society (Iqbal, Rees, & Backer, 2014).

The data also suggest a few exceptions: participants did not seem very familiar with the concept of KPIs as they often interpreted them in terms of positive and negative aspects of working in a CMHT. This is not entirely surprising, as Parmenter (2010) argues that very few organisations in public and private sectors are capable of identifying specific KPIs and to adopt strategies to successfully monitor them. Practitioners' lack of awareness and/or implementation of KPIs is contrary to current national policy [AVFC] (DHC, 2006) and also to international trends of healthcare organisations, which suggests that developing KPIs to measure and benchmark performance is a precondition for effective model of care (Lauriks, Buster, As de Wit, Arah & Klazinga, 2012). This notwithstanding, the data showed that one of the main themes that emerged from respondents specific to positive KPIs was Being part of a team, and this was in part linked with sub-themes such as Cross communication, Respect (having clear role) and Cohesion. Clearly, these are all important aspects of working in CMHTs that are essential and therefore they need to be strengthened. Conversely, Not being part of a team represented the main themes for the negative KPIs, with sub-themes such as Lack of multidisciplinary work, Interdisciplinary conflicts, Lack of communication and Lack of clear roles, and these are key issues that can significantly interfere with the provision of adequate care in CMHTs.

In particular, lack of clear roles leads to confusion, tension and potential rivalry in health-care settings (Larking & Callaghan, 2005; Miller et al., 2008). In addition, when interdisciplinary practice is not established in teams, there is a tendency to withdraw into one's own discipline in order to seek support and encouragement rather than dealing with issues (Deady, 2012). Health professionals need to be able to work in a collaborative, non-hierarchical working culture (Blutteau & Jackson, 2009). Because being part of a team is essential for the provision of safe and quality patient care, and is a cornerstone of CMHT provision, clearly there is need to support CMHTs in Ireland to develop effective team working strategies. Indeed, Iqbal, Rees, and Backer (2014) advocate that in order to provide adequate care, each team member needs to be the ambassador of their professional discipline and they should also recognise the value of the input of other professional categories; thus effective team work and communication is clearly essential.

Professionalism represented another relevant theme that emerged from the analysis of the positive KPIs; this was related to (having) skilled professionals, commitment and, with much lower frequency, with training. However, this was overshadowed by lack of resources because these can negatively interfere with being able to provide professional care. Specifically, respondents complained about lack of staff, and this of course is problematic on several levels not least of which is that good mental health services delivery requires sufficient as well as competent staff (WHO, 2013). Lack of resources was also related to lack of headquarters, which is also problematic in that lack of shared premises can mean informal and less frequent contacts between team members. Frequent contact with team members has been identified as important in facilitating a positive working relationship (Cook, Gerrish, & Clarke, 2001; Molyneux, 2001). This is also linked to Lack of meetings, which also emerged in the data. Lack of meetings requires urgent consideration as it is a central priority in the team communication process, that is: members need to engage in face-to-face interactions in order to develop cooperative activities (Larking & Callaghan, 2005).

It was of interest in the data that Service users were mentioned rarely in connection with KPIs, particularly because assessment of users' needs and planning of the individual care is one of the main KPIs in health-care settings (Sugarman & Watkins, 2004). Health professionals should aim at empowering service users and help them to regain their mental wellbeing (WHO, 2013). Service users' satisfaction is recognised as national and international strategies to improve mental health [AVFC] (DHC, 2006; WHO, 2005, 2009) and their participation is fundamental for a recovery orientated model of care (Davidson et al., 2006). One might surmise from this omission that more consideration of the service users' perspective at the heart of CMHTs practice might be of value.

Conclusion

The experience of health professionals involved in this study indicates that despite the recommendation from national and international policy, CMHTs in Ireland are currently challenged in their provision of multidisciplinary care. The medical model still appears to be the most dominant in the provision of care. In addition, health professionals working in CMHTs had limited knowledge and competency in specific KPIs to monitor the quality of their care. Of those who were aware of having positive KPIs for their team, providing adequate care to service users did not represent a key priority and this is particularly worrying.

Disclosure statement

No potential conflict of interest was reported by the authors.

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