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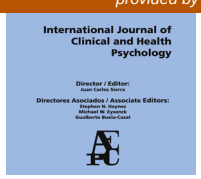

ORIGINAL ARTICLE

Global Collaborative Team Performance for the Revision of the International Classification of Diseases: A Case Study of the World Health Organization Field Studies Coordination Group

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Global mental health;
Multicultural teams;
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Abstract *Background/Objective*: Collaborative teamwork in global mental health presents unique challenges, including the formation and management of international teams composed of multicultural and multilingual professionals with different backgrounds in terms of their training, scientific expertise, and life experience. The purpose of the study was to analyze the performance of the World Health Organization (WHO) Field Studies Coordination Group (FSCG) using an input-processes-output (IPO) team science model to better understand the team's challenges, limitations, and successes in developing the eleventh revision of the International Classification of Diseases (ICD). *Method*: We thematically analyzed a collection of written texts,

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including FSCG documents and open-ended qualitative questionnaires, according to the conceptualization of the input-processes-output model of team performance. *Results*: The FSCG leadership and its members experienced and overcame numerous barriers to become an effective international team and to successfully achieve the goals set forth by WHO. *Conclusions*: Research is necessary regarding global mental health collaboration to understand and facilitate international collaborations with the goal of contributing to a deeper understanding of mental health and to reduce the global burden of mental disorders around the world.

PALABRAS CLAVE
Salud mental global; equipos multiculturales; colaboración internacional; Organización Mundial de la Salud (OMS); estudio cualitativo

Funcionamiento del Equipo Global de Colaboración para la revisión de la Clasificación Internacional de Enfermedades: un estudio de caso del Grupo de Coordinación de Estudios de Campo de la Organización Mundial de la Salud

Resumen *Antecedentes/Objetivo*: El trabajo de equipo colaborativo en salud mental global presenta retos particulares, incluyendo la formación y el control de grupos internacionales integrados por profesionales multilingües y multiculturales con diferentes antecedentes en términos de entrenamiento, competencias científicas y experiencias vitales. El propósito del estudio fue analizar el funcionamiento del Grupo de Coordinación de Estudios de Campo (GCEC) de la Organización Mundial de la Salud (OMS) utilizando un modelo científico de entrada-proceso-salida (EPS) para mejorar la comprensión de los retos, limitaciones y logros del equipo en el desarrollo de la onceava revisión de la Clasificación Internacional de Enfermedades (CIE). *Método*: Se llevó a cabo un análisis temático de una colección de textos, incluyendo documentos del GCEC y cuestionarios cualitativos de preguntas abiertas, acordes con la conceptualización del modelo de rendimiento de equipos de entrada-proceso-salida. *Resultados*: El liderazgo y los miembros del GCEC experimentaron y superaron numerosas barreras para convertirse en un grupo internacional efectivo y lograr exitosamente los objetivos establecidos por la OMS. *Conclusiones*: Se requiere de investigación sobre la colaboración en salud mental global a fin de entender y facilitar las colaboraciones internacionales dirigidas a comprender a profundidad la salud mental y reducir la carga de los trastornos mentales en el mundo.

Working toward the important goal of improving global mental health demands coordinated large scale collaboration. The complexity inherent in addressing the global disease burden of mental disorders calls for a team-based approach that acknowledges the degree to which this challenge surpasses the abilities of any individual health system, research center, or country working alone. It is only through collaborative efforts of diverse and representative teams of researchers and practitioners that the global agenda to improve the understanding and treatment of mental disorders can be advanced.

The World Health Organization (WHO) is a specialized agency of the United Nations that serves as the directing and coordinating authority for global public health efforts and whose mission is the attainment of the highest possible level of health for all peoples (World Health Organization, 2014). The WHO has a unique position as it is historically the only organization with the ability to secure global cooperation and international agreement on matters relating to the initiation and promotion of global health standards. Among the core constitutional responsibilities of WHO, ratified by all 194 WHO Member States, is establishing and revising international nomenclatures of diseases, causes of death and public health practice, and standardizing diagnostic procedures according to these definitions as necessary (World Health Organization, 2014).

The oldest and most influential of WHO's classification systems is the *International Classification of Diseases and Related Health Problems* (ICD), which was originally established as a classification system for causes of death, and beginning in 1948 also incorporated the classification of morbidity (Clark, Cuthbert, Lewis-Fernandez, Narrow, & Reed, 2017). The purpose of the ICD is to serve as an international standard for health information to enable the assessment and monitoring of global public health. The ICD serves as the basis for tracking global epidemics and disease burden, identifying the appropriate targets of health care resources, and encouraging accountability among WHO Member States for public health at the population level (World Health Organization, 1992). In addition, the ICD is increasingly used by Member States to structure health systems and services, providing a key part of the framework

for defining governments' obligations to provide free or subsidized health care, social services, and disability benefits to their citizens (International Advisory Group for the Revision of ICD-10, 2011).

To fulfill its constitutional responsibilities, the WHO must periodically publish revised versions of the ICD that synthesize global health information so that the ICD remains consistent with available scientific evidence and best clinical practice (International Advisory Group for the Revision of ICD-10, 2011). The WHO began work on the 11th revision of the ICD in 2005, the first major revision in over two decades, which is slated for approval by the World Health Assembly in 2018 (World Health Organization, 2017b). Revising the ICD is a massive undertaking as it involves updating the classification of all health conditions, including mental and behavioral disorders. The WHO Department of Mental Health and Substance Abuse (MSD) has led the revision of the ICD chapter on Mental and Behavioral Disorders with the overarching goal of developing a revised global mental health disorder classification system that maximizes clinical utility and global applicability, in addition to scientific validity (First, Reed, Saxena, & Hyman, 2015; Reed, 2010). Clinical utility, or the usefulness of medical information for decision-making in clinical settings, and global applicability are both critical to the ICD's function as the interface between health encounters and global health information (Reed et al., 2013). Further, the ICD's utility and applicability significantly facilitates the work of researchers, practitioners, and policymakers in understanding, diagnosing, treating, and tracking mental health disorders around the world.

In 2006, the WHO Department of Mental Health and Substance Abuse appointed an International Advisory Group to provide guidance on all aspects of the development of the Mental and Behavioural Disorders chapter of ICD-11. The Advisory Group oversees the functions and products of numerous working groups on mental disorders that have specific advisory roles as they pertain to the ICD revision process. The Field Studies Coordination Group (FSCG) is one of the working groups reporting to the Advisory Group and the focus of the current paper. The FSCG is a global mental health research team assigned to provide consultation and oversight related to the scientific integrity of studies evaluating the revision and to collaborate in the conceptualization, implementation, analysis, and publication of major global studies related to the ICD-11.

The FSCG, which can be conceptualized as a project-based team (Sundstrom, 1999), employs a collaborative and integrative method to conceptualize critical questions, design scientific protocols, conduct research projects, analyze and interpret findings, and disseminate key findings to researchers and practitioners around the world. Over the course of eight years, the FSCG has conducted a series of large-scale research projects to provide scientific evidence related to proposed modifications of categories, structure, and diagnostic guidelines for specific mental disorder groups (e.g., Evans et al., 2013, 2015; Keeley, Reed, Roberts, Evans, Robles et al., 2016; Reed, Correia, Esparza, Saxena, & Maj, 2011; Reed et al., 2013; Roberts et al., 2012; see the Bibliography, World Health Organization, 2017a, and selected entries at the GCPN website: http://gcp.network). This has included a major international research effort focused on clinical utility (Keeley, Reed, Roberts, Evans, Medina-Mora et al., 2016; Reed, 2010) and addressing the immense task assigned by the WHO to involve a team of international collaborators to develop a globally appropriate classification system for the ICD-11.

Initial FSCG studies, for example, examined how different mental and behavioral disorders were perceived as related to each other and how these classifications might be optimally structured to serve the global needs of the ICD-11 (Reed et al., 2013; Roberts et al., 2012). In each phase of the research sequence, the team reviewed a variety of research methodologies to select the ones most appropriate for the research inquiries posed. Initially, surveys of mental health professionals around the world provided expert input on the utility and organization of these classifications (Evans et al., 2013; Reed et al., 2011; Roberts et al., 2012). Then, a paired comparison approach evaluated clinicians' perceptions of disorders through multi-dimensional scaling statistics (Roberts et al., 2012) and a card sorting task (Reed et al., 2013). Each methodology offered advantages in clarifying some aspects of the classification while balancing the limitations of the others. Thus, as a project-based team, the members of the FSCG collectively and collaboratively raised questions in evaluating these methodologies and established their empirical properties prior to research implementation.

Despite the perceived importance of teamwork and collaboration in global mental health, little research exists that can guide the optimal composition, context, and processes that might result in the successful collaboration of a global mental health team. Stephen and Daibes (2010) conducted a reflective exploration of 14 global health research teams, one of which focused on mental health, through team proposals, annual reports, and interviews as well as a review of the scientific literature. Results suggested that effective global health research teams exhibited competencies such as engaging team members in collaborative and participatory decision-making that promoted the development of working partnerships, communication, and leadership (Stephen & Daibes, 2010).

The input-processes-output (IPO) model of team performance

The IPO model is a longstanding approach to examining team performance using a systems-based methodology that includes broadly identifying *team inputs* or resources (i.e., individual, group, and environmental factors), *team processes* or the interactions that occur among team members, and *team outputs* or their overall effectiveness and deliverables (Hackman, 1987; McGrath, 1984; Steiner, 1972). Given that the FSCG comprises a diverse, high-status global team of clinical researchers, it is useful to describe and evaluate the functioning and outcomes of the FSCG through the lens of performance domains specific to team science in a multicultural, multidisciplinary context.

A case study approach is a useful methodological design to examine novel phenomena like teamwork in global mental health and to assess how well global mental health collaboration fits with current theory on team performance (Hackman, 1987; McGrath, 1984; Siggelkow, 2007; Steiner, 1972). The purpose of the study was to apply the team

science lens of the IPO model to a case study of the FSCG to better understand the team's challenges, limitations, and successes relevant to the revision of the ICD.

Method

Data for the case study were obtained from two sources: (1) FSCG documentation (e.g., reports prepared by the FSCG to the WHO MSD Advisory Group, agendas and minutes from the FSCG meetings that occurred between 2010 and 2016, and scholarship produced by members of the FSCG) and (2) narrative responses provided by FSCG members to a brief open-ended qualitative questionnaire asking about various aspects of the IPO framework (e.g., teamwork, team problem solving, challenges and barriers, and leadership) (see Appendix for questionnaire). Fifteen members of the FSCG completed the open-ended qualitative questionnaire. These data coming from the FSCG documentation and open-ended questionnaires were thematically coded and then analyzed for the purposes of this case study by two independent reviewers and were interpreted according to the three IPO categories of team performance (1) inputs, (2) processes, and (3) outputs (Hackman, 1987; McGrath, 1984; Steiner, 1972). Information from the FSCG documentation as well as representative quotations from the open-ended surveys completed by the team members of the FSCG were then used to illustrate the operation of key concepts and reflections pertaining to the collaboration of this global mental health team using an IPO model lens. A quality assurance member check (Lincoln & Guba, 1985) was completed with all members of the FSCG reading the present study's findings and ensuring the credibility of its interpretations. The first author was not a member of the FSCG and was brought on board to conduct this team analysis. The following authors were members of the FSCG. There were no content or editorial constraints placed on the reporting of the findings.

Results

The FSCG: Inputs

The revision of the Mental and Behavioural Disorders chapter of the ICD-11 is a major undertaking requiring an international, multidisciplinary, and multilingual approach to ensure its utility and credibility for stakeholders. The FSCG grew in size over the course of the team's projects with team members possessing capacity in particular areas or in key institutional or regional placements added to the group as its projects evolved. The FSCG eventually consisted of 30 members and consultants from 13 countries, with some pulling back involvement after some time. The FSCG team members were primarily from the disciplines of psychology and psychiatry but also including experts from public health, medical anthropology, neuroscience, and other relevant fields. Members represent all WHO global regions (Africa, Americas, Eastern Mediterranean, Europe, Southeast Asia, and Western Pacific), who live and work in countries with diverse economic circumstances.

The WHO aim of producing a classification system based on clinical utility and global applicability meant that it was explicitly important to include clinical and health systems experts with a wide range of experience related to mental disorders and classification. The inclusion of members from low- and middle-income countries, which constitute more than 80% of the world's population (The World Bank, 2017), was critically important because the intention of the project was to produce a clinically useful classification that would be usable across all Member States. Criticisms of previous ICD versions and other classification systems included overrepresentation of project members from high-income, English-speaking, Western countries. The value of explicitly including multinational diversity among members of the FSCG and understanding how to adjust the framework for the evaluation of excellence across countries with different economic and social circumstances is well illustrated by the quotation below:

> You need to evaluate team members' expertise and accomplishment differently. If you are committed to identifying and working with top global experts, in many countries you can't just Google them or do a PubMed search. In most countries, researchers do not have access to the infrastructure, professional time, and funding that people in the US, the UK, or many countries in Western Europe have. The fact that people in many countries have publications at all often means that they were committed enough to pursue research and scholarship on top of a 60-hour per week clinical load as well as substantial administrative and teaching responsibilities. Not to mention that they are usually writing in a language that is not their own... you need to value people's different experiences and contexts.

Members of the FSCG come from Brazil, Canada, China, France, Germany, India, Japan, Lebanon, Mexico, Nigeria, Russia, South Africa, Spain, and United States. Notably, the Chair was a female psychologist from Mexico and the Vice Chair was a male psychiatrist from Nigeria. The Senior Project Director for WHO was a male psychologist living in Spain and subsequently Mexico working for WHO in Geneva. Team members described the experience of working on this highly diverse team as ''fascinating, exciting, enriching, and educational.'' One team member stated:

> I feel proud and lucky to work in such a diverse team. It's also the feeling of being a representative of one's own country and at the same time a participant of a global process. It is motivating for the progress in work and enriches one's own experience. I feel a great interest in other members of the team, in their professional achievements as well as in their personal life and national traditions, it makes me feel a part of a great team.

Team members identified the unique characteristics of working on such a diverse team:

> Working on a team this professionally, geographically, linguistically, and culturally diverse has been a new experience for me. It was initially intimidating because of my perception that my own world view was limited in comparison to the experience of the others. However, my work on the team has greatly enhanced the scope of my world view, helping me to understand and incorporate broader points of view and considerations. Nonetheless, despite all of our differences, I have been struck by how

> accepting all team members have been. The diversity of the team has been integral to its success, as we have been successful in integrating separate points of view to enhance our outcome, rather than having our diversity create division.

The FSCG was primarily a high-status team, a compositional attribute that has been shown to significantly impact a team's ability to innovate, in that all the members of the FSCG held respected positions in their home institutions and organizations (West, 2001; West & Anderson, 1996). That is, members of this global mental health team were recognized experts in their countries and respected internationally, with important institutional positions and significant experience, which also fostered mutual respect among the members of the FSCG. At the same time, there were a number of junior colleagues who initially began working with the team as consultants or even research assistants on specific topics, who assumed wider responsibilities and developed substantial expertise of their own over the course of the FSCG's work. There were approximately equal numbers of women and men (which also enriched the diversity of the group).

The team context of the FSCG is relevant to consider when seeking to understand the contributing factors of the FSCG teamwork and collaboration. For example, team member affiliation included different types of institutions, including academic, governmental, and non-governmental organizations. These affiliations shaped the context in which the team communicated and collaborated (Salazar, Lant, Fiore, & Salas, 2012). Although all had some type of academic affiliation, many also served in clinical roles in mental health and medical centers. This diversity of daily activities was a direct benefit to the group given its goal of developing a clinically relevant classification system.

The facilitation of such a range of diversity can impact functionality and knowledge integration within the team (Salazar et al., 2012; West, 2001). Composing teams that are demographically diverse on a variety of surface-level (e.g., age, gender, race) and deep-level differences (e.g., discipline, values, abilities) might result in some difficulties in making progress on project tasks. However, in the case of the FSCG, the need for diverse perspectives was intrinsic to the task set forth by the WHO and not a distraction or an obstacle to be overcome. Despite differences in surface and deep-level characteristics of team members, there was no evidence that these interfered with the work of the FSCG. The parameters of the project to produce an *international* classification may have diminished the negative influence of these characteristics. More specifically, team members may have had an a priori rationale for thinking there would be country or cultural differences in the context of a mental disorder classification system.

The composition of a multidisciplinary scientific team has significant relevance to the deep-level differences in the composition of the FSCG and its collaborative efforts. Given that the FSCG included both researchers and clinicians from different fields, disciplinary differences arose occasionally during collaboration within the team. However, despite any disciplinary allegiances, team members noted that FSCG leadership set firm boundaries such that condescension or disrespect based on such biases was unprofessional and unacceptable team decorum. The collaboration of such a diverse multidisciplinary team also brought about additional team compositional factors such as differences in ways in which team members were trained and the approaches with which team members were accustomed to solving problems and conceptualizing knowledge in their respective fields (Salazar et al., 2012; West, 2001). The compositional diversity of the FSCG played a significant role in how the team worked together during the collaborative process and ultimately led to an enriched outcome. For example, team members possessed varying levels of experience in working with different patient populations and contributed knowledge to inform a variety of research methodologies during project development and implementation. Further, the range of theoretical orientations, regarding both ideal mechanisms of change and scientific approaches to be used in mental health service and research, of the FSCG provided opportunities for dialogue that helped to improve the quality of team performance more than if a singular team leader or team member had dictated decision-making.

Team science researchers have made substantial gains in understanding key attributes that define teams and the complexity of teamwork. According to Salas and colleagues, team leadership is a central component of the teamwork process. Given that teamwork involves the facilitation and coordination of team members' abilities, thoughts, and feelings to promote team performance (Salas, Sims, & Klein, 2004; Salas, Sims, & Burke, 2005), team leadership occurs when a member of the team is appointed to the role of providing organization and support to harness the team's talents and guide its projects and eventual outcomes. Team leadership principles were enacted in the context of the FSCG through the appointment of a FSCG leadership team, which consisted of the WHO Senior Project Officer alongside the FSCG Chair and Vice Chair. The FSCG leadership team members aided in instilling a common vision amongst all members of the larger team and centered the team's focus on defined, measurable goals and expectations throughout the collaborative process. Evidence for this is well articulated by one team member, who stated,

> The WHO Senior Project Officer is an excellent example of team leadership. One of his greatest talents is bringing people together from diverse backgrounds and setting them towards a common goal. He is excellent at identifying a piece of talent he needs for his team, and integrating that person into the group. Part of the success of this team is our collegial relationship. Each meeting feels like a family reunion. That is not accidental, but a byproduct of our leader's intentional integration of the team.

A relevant component of team leadership that occurred in the context of the FSCG was the application of collective leadership (Friedrich, Vessey, Schuelke, Ruark, & Mumford, 2009). Collective leadership can be defined as a team contextual factor in which a single person is not the only individual appointed as the leader during the collaborative process, but rather leadership opportunities are distributed or shared among different members of the team, frequently based upon team members' areas of expertise (Friedrich et al., 2009). This expertise-approach to sharing leadership roles to members of the FSCG was frequently capitalized

upon using project-based leadership delegation. For example, for each of the team's major research projects, team members were delegated leadership roles to prepare and present research proposals to the team for group discussion.

In addition, other team members were also assigned leadership roles of reviewing and facilitating group discussion about each proposal presented during team meetings.

The FSCG: Processes

The processes that were utilized to instill and manage collaboration among the members of the FSCG greatly influenced their interactions with one another and their overall performance as a team. The FSCG's ability to instill effective group processes to facilitate teamwork and communication among its members came from their leaders' ability to inspire shared team objectives and an overarching vision for the immense task of revising the Mental and Behavioural Disorders chapter of the ICD-11. The first way in which this goal was addressed was how members were selected and recruited to the FSCG. The recruitment of potential FSCG members explicitly addressed the WHO's goal to bring together individuals from a wide range of countries from diverse professional backgrounds. Therefore, it was at the point of team member recruitment that the process of integrating an attitude of team orientation began to take place. Team orientation can be defined as a characteristic of team members that allows them to work well on a team and enhance the performance of others (Salas et al., 2005), an attribute that was specifically cultivated on the FSCG. The team's goals and values were explicitly outlined for them by the FSCG's mandate and leadership (International Advisory Group for the Revision of ICD-10, 2011; Reed, 2010), and team interactions regularly reinforced the importance of these guiding principles.

Along with the process of developing a shared vision for the creation of the team, the development of a team mental model was an inherent component of the FSCG's collaborative process and the ability for its members to agree upon the purpose of the team and dynamics of team member roles. The FSCG's shared mental model can be defined as the ways in which members of the team organized their understanding of their responsibilities, tasks, and performance expectations both individually and as a team to respond in a strategic and adaptable way with one another to achieve the team's goals. One team member described this shared mental model by stating,

> There was a shared understanding of WHO's mission. The role of the FSCG was clearly defined and our team members had similar values that were aligned to WHO's mission. Decision making was democratic in intent, and individual members' developmental needs were considered.

It is important to note that cross-cultural collaborations can lead to differences in team members' understanding of a team's mental model; therefore, the ways in which FSCG team members viewed team roles and goals may have diverged (Salazar & Salas, 2013). Contrary to this prediction, the team remained cohesive in its vision by having members regulate each other by offering reminders of the team goals when an individual's viewpoint drifted.

A unique process-related attribute to teamwork and collaboration in global mental health can be seen in the FSCG's establishment of shared mental models centered on the idea of collaboration for the common good. Dibble and Gibson (2013) discussed the idea of collaborating for the common good, and the challenges and adaptability it requires. The FSCG fundamentally relied on its team members adhering to a mental model that accepted that their collaborative efforts would not be as successful in the confinement of a monolingual, monocultural organization that supplied immense monetary resources or prestigious rewards. Rather, the shared mental model of the FSCG promoted collaboration that would be multicultural and exist temporarily in an informal team environment, with substantial time and resource constraints and involvement in the experience being the only immediate reward (Dibble & Gibson, 2013). One team member highlighted the degree to which collaborating for the common good came into play:

> Multiple times we had to take a different tack related to our research program. It was frustrating at times for some of the collaborators who had invested in a particular strategy that did not advance. Overall, members of the team were okay with such adjustments, accepting that it was for the greater good.

Given the unique challenges of joining a global mental health team that promotes the importance of multicultural and multidisciplinary collaboration (Dibble & Gibson, 2013), the FSCG frequently faced the need to enact considerable adaptability in their teamwork process:

> It seems that we are always having to adapt our plans and flexibly re-align our roles. Because of our shared responsibility for specific projects, often someone is in a leadership role on one piece of work while simultaneously being a helper on another. However, the roles for each project are always well defined, and I have never experienced any confusion or strife within the team.

By frequently instituting a team process of adaptability, the FSCG was able to identify potential barriers and adjust team members' roles and personal expectations to accomplish the team's goals. As one FSCG member reported:

> I think there were times when it was clear that our secondary and tertiary goals were a bit overly ambitious (some data analyses or writing project) that could potentially obscure or distract from the primary goal (viz., of creating the ICD-11 document and research base). Some interesting ''side'' projects got put onto the ''back burner'' in order to move the primary project forward. These extra/side projects either were completed on a separate time schedule or some were fully stopped (maybe for later fulfillment).

Adaptability in the process of collaboration in the FSCG also positioned professionals from a wider range of countries in leadership roles based on their unique expertise and experience, supporting them in making equally strong contributions to those of professionals from more highly resourced environments. In recognizing the leadership taken by one FSCG core team contributor, another team member noted:

> He did a wonderful job of shepherding the group through the development process of the. . .studies. He graciously took over the lead on developing it. . .when the project was not moving quickly enough. He put in substantial hours of work to produce a sacrificial document for the group to dissect, which was a necessary step for us to work through the details of the project. He did an excellent job of gathering and integrating feedback from all parties in a non-defensive way while maintaining everyone's sense of contribution.

Notably, however, the core team contributor stated with some irony that his initial succinct protocol of 14 pages became 140 pages long with the input of the FSCG, an example of individual adaptability when working in a team-based context.

According to Salas and colleagues (2005), mutual performance monitoring is one way in which teams may facilitate their collaboration with one another. In relation to the FSCG, mutual performance monitoring was utilized throughout the collaborative process to instill checks and balances to the team's collaboration and to ensure everything continued to run smoothly and in a timely fashion:

> There were expectations for individual's performances to respond to the task requirements. Sometimes people could not do what they volunteered to do (for a variety of reasons, often understandable), either those tasks did not get done or were picked up by others. Through the tenure of the team project, we experienced each other as humans in the course of life. We experienced each other's children's births, illnesses, divorces and marriages, deaths in immediate family, job changes, promotions, etc. We developed a sense of caring for each other while also contributing to the team activities. Then not wanting to disappoint others on the team seemed to motivate the most. Remember, the team members were mostly volunteers, and the team members had ''day jobs'' in that their paying positions required time and attention.

For example, the FSCG utilized a peer review process within the team to evaluate the progress of team projects and provide feedback pertaining to project-based pressing needs to sustain productivity and the effectiveness of the team. One team member described the way this peer review process facilitated collaboration and team performance:

> The team is excellent at providing feedback to each other on individual projects. We have purposefully established a peer-review system for most of our work, so that a set of independent team members review the work of others. This process has always resulted in a superior outcome, because of the diversity of the team. Someone always has a different perspective, and that point of view helps enhance the quality and inclusivity of the product. Also,. . . the collaborative nature of the group has greatly enhanced its productivity. Because we care about each other, we want to produce the best result we can for the good of each other. Our accountability to each other helps us to strive for our best work continually.

This behavior facilitated collaboration among the FSCG as it allowed team members with different types of training and expertise to support one another in completing tasks imperative to the goals of the team:

> Members have come from diverse backgrounds in regard to both clinical and research experience. Persons with more experience have often been asked to provide some form of mentorship to others with less experience. This has been the case especially in regard to the preparation of manuscripts and reports. Opportunities for presenting drafts of manuscripts are created during meetings and these opportunities are used to provide support on completing tasks.

The FSCG: Outputs

The evaluative mechanisms and rewards utilized by the WHO in relation to measuring the performance and effectiveness of the FSCG are important considerations when seeking to understand teamwork and collaboration in global mental health. The primary way in which the WHO evaluated the performance of the FSCG occurred through the reporting of the WHO Senior Project Officer to WHO leadership and periodic attendance of the Director of the WHO Department of Mental Health and Substance Abuse at the FSCG meeting. Otherwise, the team was primarily accountable to itself. Team members regularly set goals publicly, and team members held each other accountable for meeting project deadlines.

There are several incentives relevant to FSCG member participation. While there was no explicit monetary compensation for the team member's participation, team members' expenses were paid for travel to the meetings. Another incentive for being a member of the FSCG that was frequently cited by team members was the ability to participate in a large, global endeavor that would leave a legacy. One team member described this intrinsic reward by stating, ''At the conclusion of my career, there will be five things I will be most proud of and being a part of the ICD-11 revision will be one of those things.'' Another member added, ''Working on the FSCG has been one of the highlights of my career as an academic.'' Research has shown that recognition may serve as one of the most highly motivating incentives to team-based performance and team member satisfaction (Peterson, 2007). Further, authorship is the ''currency of the realm'' of academia and publications, even when one's name is included in a listing of multiple authors, gave recognition to scholarly contributions that were respected at the team members' institutions. Some junior members of the team received promotions that were at least partially based on publications and involvement in the project.

In regards to measurable outcomes derived from the teamwork of the FSCG team, the ICD revision process, including the FSCG efforts, has produced a substantial body of scholarship; over 300 publications with multiple authors representing the multidisciplinary, multilingual, and multicultural team have appeared in peer-reviewed journals (e.g., Evans et al., 2013, 2015; Keeley, Reed, Roberts, Evans, Robles et al., 2016; Reed et al., 2011, 2013; Roberts et al., 2012; see the Bibliography, World Health Organization, 2017a, and selected entries at the Global Clinical Practice Network (GCPN) website: http://gcp.network). As a part of

the work performed by the FSCG, this team of global clinical researchers successfully developed the Global Clinical Practice Network (Reed et al., 2015), the largest practice-based research network ever developed, now comprising over 14,000 professionals from more than 150 countries. The FSCG developed and implemented complex psychologically-based research protocols via the network. The FSCG also developed a network of International Field Study Centers around the world involved in more intensive clinic-based studies with real patients. This effort has fundamentally shaped the development of recommendations to the WHO for the ICD-11 revision.

Facilitators and barriers to team performance within the FSCG

The FSCG leadership and its team members overcame numerous barriers to become an effective international team and to successfully achieve WHO's goals. These barriers posed substantial challenges during the initial phases of the collaborative process as professionals confronted cultural, disciplinary, and stylistic differences related to perspective and approach that influenced team dynamics. A part of the success of the team has been to achieve its goals with extremely limited resources by facilitating collaboration via finding ways to creatively support its projects financially, through both local funding and contributions of personal time and effort in extraordinary ways.

Frequent barriers to collaboration among multicultural teams include issues with direct and indirect communication, linguistic barriers due to language fluency and accents, different attitudes and perspectives pertaining to the authority and the hierarchy of the team, and conflicts in team dynamics during group decision making (Brett, Behfar, & Kern, 2006). All these barriers to multicultural collaboration were experienced by the team members of the FSCG. For example, even the preparation of this paper illustrates the process of collaboration in an iterative process, yet requiring participation across time zones, language, styles, and perspectives.

Despite efforts to facilitate and support the diversity of the members of the team, some members still reflected that they saw the need for improvement in the team's ability to collaborate if not in ''equitable'' ways then in ways that further gained the unique perspectives and expertise of the different members of the group given the resources available. The success of this project required the professionals' input from different cultures and settings.

> The lion's share of expert roles was given to individuals from developed countries, especially those in North America, owing to their demonstrated track record and because the greater handholding needed for experts from [some] developing countries could interfere with timely development and completion of projects. Things would have been different, if despite the time pressure, project development could be spread further, with experts from developed countries taking a mentoring position akin to what they did for trainees from developed countries.

Additionally, some appreciation of cultural and personal differences in modes of behavior was needed, perhaps more than was provided at various times.

The multinational and multicultural nature of the FSCG also led to the composition of a highly multilingual team of collaborating professionals. Although English was the common language for communication, most team members were themselves proficient in at least one language other than English. Linguistic diversity among team members in the FSCG was described thusly,

> It is also hugely important to be able to tolerate the different levels of comfort and skill that people have expressing themselves in English. I have now had the experience of having to give talks in a language that wasn't my first language, and at first it was really painful and embarrassing. You have to be really brave and tolerate the inherent awkwardness. This increased my empathy a lot. So, in the team I usually start from the assumption that if somebody is making the effort to communicate something to the group it is important and necessary to understand what it is, even if they are sometimes not able to express it as smoothly as a native English speaker might.

Language diversity has shown to influence both the socialization and trust-building practices inherent to teamwork and collaboration among international team members (Henderson, 2005). More specifically, research has indicated that when international teams use English as their primary language of communication among both native and nonnative speakers, as was the case for the FSCG, substantial challenges may arise in regard to team members' ability to interpret and perceive one another's perspectives and intentions. However, perhaps because of the FSCG's mental health training, group members may have been skilled at clarifying the meaning of others when misunderstandings occur.

In addition, it is important to note that linguistic diversity is not necessarily equivalent to cultural diversity, as team members of the FSCG that were from countries speaking the same basic language (e.g., Spanish) sometimes used different dialects and idioms, requiring consultation for proper communication, and had quite different cultural perspectives. Differently accented English and variants of idiosyncratic phrases and concepts sometimes required clarification even when proficiency was present (e.g., English spoken in the US, India, and South Africa). This highlights the importance of considering the diversity of team composition broadly and acknowledging that teamwork and collaboration in the field of global mental health is impacted by a variety of diversity-related compositional challenges. It is likely that the high degree of diversity within the relatively small group of the FSCG could have limited the potential development of cohesive subgroups, thus promoting increased motivation and effort on the part of individual team members in the larger team to understand each other within the team despite linguistic and cultural barriers.

Another important contextual barrier to FSCG teamwork was the geographic distance between team members, who were located all around the globe. A FSCG team member discussed the relevance of this contextual factor,

> The team has done an excellent job of communicating at distance. We only had the opportunity to meet face-to-face twice a year. Those meetings are incredibly productive, and we outlined much of what needs to be done. However, the bulk of the work is done when we are separated by thousands of miles and several time zones. People have been very flexible with their schedules in order to find times for phone or Skype calls, meeting late at night or in the wee hours of the morning. They have flexibly rearranged their own (often personal) time to prioritize the work of the group.

Given that a substantial proportion of communication and collaboration of the FSCG was performed virtually, it is important to acknowledge the challenges of a virtual team working model, where virtual interactions have been shown to lead to decreased team member satisfaction (Warkentin, Sayeed, & Hightower, 1997) and a breakdown of trust among team members (Rocco, 1998). This is especially relevant in the context of virtual collaboration among global teams where cultural diversity has been shown to influence interpersonal conflict and performance among virtual team members (Kankanhalli, Tan, & Wei, 2006). To mitigate against these factors detrimentally influencing productivity among FSCG members, the FSCG leadership often coordinated these meetings directly and explicitly managed the interaction. Additionally, the biannual face-to-face meetings were orchestrated to facilitate global communication and collaboration among the team members and diminish the challenges associated with using a strictly virtual global team working model.

Limited financial resources and timeline to implement team goals served as a recurrent obstacle to the teamwork and collaboration executed by the FSCG. Throughout the implementation of the FSCG's field study research projects, team members contributed significant in-kind resources such as their own time and other, often significant, staffing support from their respective countries and employers to work on the team's projects. The team members worked together to generate additional funding through donations and sponsorship from various affiliated universities, government agencies, and professional organizations to sustain their level of productivity and continue their projects over the course of eight years. Each team member was responsible for identifying potential funding opportunities to increase the team's access to resources. The challenges associated with limited resources on such a large-scale project are reflected in the following quote:

> The biggest obstacle was the lack of resources available to do a major project with global scope over a period of several years. We had to seek in-kind resources constantly, which we did very successfully and with tremendous financial efficiency, spending maybe 10% of what other organizations have spent on similar projects. But this isn't necessarily the best way to run a railroad. Sometimes there was an obstacle related to the discrepancy of resources across Centers. We set up systems, sometimes based on financial support from our funders, to make more resources available to Centers that didn't have them, but there are always feelings and group dynamics associated with this.

Resource scarcity has been shown to be an influential factor when considering the context of a team working on large projects and complex problems (Wiest, 1967). Activities associated with scheduling large projects with the constraints of limited resources can delay the start date and progress of large tasks and increase the likelihood of experiencing time pressures or dropping ideas for additional research investigations proposed by team members. For example, at least one study had to be abandoned partway through its development because of the lack of personpower to complete the project, and the lack of individuals with the certain technical skills (i.e., computer programming). Another member of the FSCG described how time pressures impact collaboration among diverse individuals,

> When there is so much time pressure and so many work tasks, sometimes it is easy to fall back on familiar patterns of working most closely with people who are more similar to you because they speak your same language or have a more similar educational and social background because it is more efficient. Inclusiveness and distributed leadership is sometimes especially a challenge in such high-pressure situations.

Another important consideration to the mediation of potential conflict during collaboration of the FSCG has to do with managing the issue of authorship on manuscripts produced by the team. Authorship agreements were actively discussed among FSCG leadership and team members throughout the team's collaboration, with significant attempts to award equitable authorship in terms of the distribution of the number of authored publications as well as author order. A formal data-sharing plan was prepared after discussion at a FSCG meeting. During the biannual meetings, publication plans for papers were outlined with identified lead authors and commitments for assistance. Data collection by all FSCG affiliated groups was expected. Data analysis was distributed where resources and expertise were identified but much was centralized. Various writing projects were similarly distributed but due to resources and available time, also were centralized on occasion with participation by all in design, interpretation, and editing the final products. Despite focus on the participation of certain team members at times, the overriding goal of having the ICD-11 widely tested and approved by the numerous participants and constituencies required contribution and collaboration by all to the degree these could be provided. Despite these efforts, some concerns over authorship occurred and FSCG leadership continued to instill the importance of the team's shared mental model that team members were devoting their time and energy for a common goal of contributing to a large global research endeavor. One team member explained the challenge of these tensions,

> There was also some tension between allowing more organic structures and processes to emerge based on what worked well for the group and having clear understandings about some things. We did a pretty good job with this, but there were some struggles. In retrospect, it would have been useful to have some more clarity about some things like publications policies, given that these can have fairly high stakes in people's own professional settings and in their careers.

The FSCG leadership also promoted a ''check your ego at the door'' philosophy throughout the team's collaborative pursuits in that team members were expected to contribute to the team's products without a guaranteed status in the authorship order. This policy violated the disciplinary norms for some FSCG members but was more typical for others. As a result, some team members may have felt more confusion regarding authorship agreement decisions, whereas others may have more inherently adopted the team's ''check your ego at the door'' policy and contributed significantly more towards the team's manuscripts, regardless of authorship order.

Discussion

Although the research behind professional understanding of multicultural and multidisciplinary teamwork and collaboration is strong, there is still much left to explore regarding the facilitation of teamwork, specifically in the field of global mental health. While team science inputs, processes, and outcomes were selectively presented in relation to a high-status, diverse team of multidisciplinary researchers and practitioners that comprised the WHO FSCG, our discussion could not be comprehensive, which indicates the need for further empirical research in this topical area. More specifically, team science researchers have argued that the IPO model of team performance does not sufficiently address the nonlinear nature of team performance and the numerous factors that may contribute towards team performance but cannot be defined as a process or procedural team variable (Ilgen, Hollenbeck, Johnson, & Jundt, 2005). Therefore, it is essential that more empirical data be collected regarding the functioning of global mental health teams in order to better understand the complex underlying factors that influence their performance. This report presents a generally laudatory view of the FSCG team processes and products. Perhaps team members may have shaped their response to the questions in a rosy cast and others did not respond if holding negative perceptions. We also recognize that projects resulting in success often generate positive perceptions; and if the project had been less successful, the organizational analysis might have generated more critical comments to explain the failure.

In addition, findings based on the present case study provide several key recommendations for future work on global mental health teams. First, we recommend that when researchers are studying diversity among global mental health teams, diversity should be defined broadly. Multiple components of diversity should be studied at length to gain a better understanding of which diversity compositional factors have the greatest influence on team outcomes. Second, we recommend that empirical studies be conducted on specific tools or interventions that may facilitate teamwork and collaboration in global mental health, as the only evidence we have pertaining to addressing team-based challenges derives from multicultural and/multidisciplinary team science research that does not consider relevant components of global teams of mental health researchers and practitioners. Some processes may not have served all members equally in the FSCG).

As the initial questions posed by the WHO to the FSCG were answered, additional tasks for the team directed team members' attention to extant research needs. The initial time to the overall ICD completion calculated by the WHO was too ambitious and due dates for World Health Assembly review and final approval kept getting pushed off (though not because of the portion of the revision effort related to Mental and Behavioural Disorders). If the total amount of time the project would take had been known at the start, the FSCG team leadership might have set up more formal governance structures or might have been able to give attention to other parts of the team process. For example, if the project had been defined from the beginning as one with a timeframe of nearly a decade, additional attention could have been devoted to providing more instruction and support for advanced skills development in research, data analysis, and report writing, particularly for junior team members or those from lower-resource countries who had not had access to these opportunities. More financial and person-power resources would have helped the team to benefit from all team members' skills and facilitated their country colleagues' entry into the research enterprise more fully. Nonetheless, the WHO Senior Project Officer had an assignment to do and developed an initial plan for how to accomplish the job through an international team of scientists and professionals and evolved the plan to expand and adapt over time. The fulfillment of this vision has been greater than anticipated. Being able to submit the MBD chapter for the ICD-11 in a timely way has been the major accomplishment; developing an international cadre of researchers and the largest clinical practice network developed to date, producing a significant evidence-base of publications and knowledge is clearly the outcome of a dynamic team process.

Conclusion

The basis of the team science literature has considerable depth and breadth relevant to the study of teamwork and collaboration of multicultural, multidisciplinary teams. However, more systematic investigation is needed to specifically address teams of global researchers and practitioners in the public health sector that are working to make international health-based discoveries and harness the talents and knowledge of multinational parties to alleviate the burden of disease on a global scale. To accomplish equitable and effective international collaborations in global mental health, investigators need to continue to study the challenges and limitations as well as the successes of global mental health teams to progress closer towards achieving the highest level of health for the entire global community.

Appendix

1 What was it like to work on a highly diverse team?
2 What obstacles did this team face when trying to collaborate? What could have been done differently when trying to overcome those obstacles?
3 What were the most important processes that your team engaged in to reach the goals set forth by the WHO?
4 Can you think of any specific examples of team leadership?

5 Was there ever a time that members of the team monitored one another's performance and progress? How did the team respond?
6 Can you think of any specific examples of times in which team members coached one another or provided support on completing a task?
7 Was there ever a time that the team had to adapt or deviate from defined roles or plans? How did the team respond?
8 Can you think of any specific ways in which the team tended to enhance individual performance through collaboration, coordination or evaluation?

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