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Synthesizing and Integrating Mental Health Practice: An Interdisciplinary Approach

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by

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Psychology.

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ABSTRACT OF THE DOCTORAL PROJECT

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Research has demonstrated the benefit of interdisciplinary practices in clinical settings, training programs, and research models. This project will review the literature regarding the collaboration of various disciplines in mental health including history, key aspects of integrating mental health as seen through other collaborative efforts, and future direction. In addition, outlining 8 key features that can facilitate more constructive collaboration in the mental health field (Psychological, Psychiatry, Social Work, Marriage and Family, and others). This effort is so we may understand each other's needs and work better together for the overall benefit of our patients.

CHAPTER ONE

HISTORY OF INTERDISCIPLINARY COLLABORATION

The idea of interdisciplinary collaboration is one that has existed for over 100 years. Royer (1978) describes the efforts in India that even prior to 1900 mission hospitals used the efforts physicians, nurses, and “auxiliaries” to provide health services to remote communities. In the 1920, Great Britain produced the Dawson Report which advocated for the need for health care workers to take a team approach. This inspired others like Sidney Kark and his colleagues to implement the concept of multidisciplinary teams in South Africa and later in Israel (Baldwin, 2007). These initiatives around the world later came to influence practices in the United States.

During the Second World War thousands of lives were saved by the collaboration of medical and surgical teams on the battlefield (Baldwin Jr, 2007). With this the United States found its first glimpse of the benefits of having different disciplines working together. Following the war individual achievements such as those of Martin Cherkasky in 1948 New York has been credited with continuing interdisciplinary approaches in the United States (Kindig, 1975). Cherkasky (1949) developed a hospital outreach program that employed a team of physicians, social workers, and nurses to provide care to the impoverished local community. Other great individuals such as Kurt Lewin and his work with group dynamics or the writings of Richard Cabot emphasizing the need for teamwork between doctors, educators, and social workers back in the early 1900's (Baldwin Jr, 2007) have made significant impacts on what we see and do today. In the 1940's and 1950's multidisciplinary teams started to become established in medicine, long term care, burn units, rehabilitation, and mental health among many others (Baldwin Jr,

2007). Since that time these programs have been shown to improve clinical outcomes, health care process, symptom control, length of stay in a hospital, and hospital costs as well as improved levels of satisfaction from families patients, and even staff (Youghwerth & Twaddle, 2011). And the rationale for why this happens is pretty straight forward. Bringing people from many different disciplines together guarantees a cross-fertilization of knowledge and ideas. With each discipline sharing its specialized knowledge and philosophy, all in the group or team can benefit from an expanded understanding (Mellor, Hyer, & Howe, 2002). Basically, that the whole will equal more than the sum of its parts (Drinka & Clark, 2000). That is the interdisciplinary perspective.

Clarifying Terms

It is important at this time make a clarification between interdisciplinary and other terms such as multidisciplinary and transdisciplinary. The reason is because a consistent definition of these terms does not exist in the literature to the extent that interdisciplinary and multidisciplinary have been used interchangeably (Youghwerth & Twaddle, 2011). For clarification it is best to think of multidisciplinary models as being designed like the pieces of a pie. Each discipline is responsible for a particular part of that pie within the team, but there is not necessarily overlap between pieces. For example, if a person breaks there arm in a car crash, a physician is able to set the arm and a psychologist can address issues relating to the traumatic event. On a multidisciplinary team these contribution can be made in relative isolation from each other. Even though both disciplines worked together to address the needs of the patient they were able to do so independently.

Transdisciplinary team models have less defined roles and are made of members

generally from drastically different backgrounds and unrelated disciplines. The purpose of these teams is to use member expertise to blur traditionally held roles and cross discipline boundaries. An example of this could be the creation of a course taught by a dietitian and physicist or a philosopher and a mathematician. By combining at two generally non-relatable topics and trying to understand them in a new way, new perspectives can be created.

Lastly, the interdisciplinary model refers to a synergistic approach requiring greater collaboration between disciplines. These interdependent interactions take the ideas, backgrounds, and expertise of each member and uses them to create new ideas and perspectives. Unlike multidisciplinary teams that can almost work independently, interdisciplinary teams require much more collaboration. A great analogy for interdisciplinary team work is the human hand. With each discipline representing a finger we see that individual fingers have different functions, abilities, and dexterity. However, they can achieve much more by working together than any one of the fingers could accomplish alone (Youghwerth & Twaddle, 2011). This is the perspective used when discussing interdisciplinary practices.

History of Integrating Mental Health

As Interdisciplinary practices become a more accepted philosophy the prevalence of interdisciplinary programs will continue to grow over time. However, it has not always been easy to get individuals with such varying backgrounds to work together. To highlight some of these difficulties in mental health it is worth looking at one of the earliest examples of mental health disciplines trying to work together.

In 1950 the American Psychological Association (APA) and the American Association of Psychiatric Social Workers (AAPSW) began negations to explore the relationship between their two professional groups and discover a means of improving mutual inter-professional contributions (Mitchell, 1955). During this process there were found to be three main difficulties. The first difficulty was regarding the definition and responsibility of each profession. According to the by-laws at that time a psychiatric social worker had to have a direct relationship to psychiatry and work in a clinic or team setting. However, almost half of AAPSW members were not presently employed in a clinic setting (Mitchell, 1955). This gave APA members pause because they could not be sure exactly who these other AAPSW members where and what their skills may be. Additionally, since the AAPSW was not adhering to their own by-laws and allowing membership to individuals who did not meet the definition, the psychologists had no clear understanding who they were getting involved with. The issue of defining who belonged to each group and what their responsibilities where lasted for more than 3 years (Mitchell, 1955). In many ways issue still exists today in other professions like psychiatry, psychology, marriage and family, and social work who are all trying to find their place when there is so much overlap in responsibility. This can certainly make it difficult to work smoothly together for a common goal.

The second difficulty had to do with the perceived roles that would be taken if both sides started working together. The AAPSW felt that their contributions would be seen as less valuable by psychology as they were “being relegated to a junior partnership with psychology” (Mitchell, 1955). Open communication from both sides was able to deal with this problem but highlights well how our perceptions of our own profession and

that of others will impact relationships. This idea of feeling pushed underneath another discipline becomes know in the research as a cultural or professional hierarchy. Referring to our cultures tendency to place objects and people into a hierarchy and assign value to each position. A useful strategy in most situations but can serve to damage group cohesion if some members are forced to be seen as less valued.

The final difficulty had to do with training methodology. The basic difference in philosophy at the time was that graduate psychological training emphasized research methods whereas social work focused primarily on meeting individual needs of the people. These different philosophies and backgrounds made it difficult for either side to find common ground together. For quite some time no side was willing to compromise on their beliefs. Fortunately, after a long standoff a psychologist at the meeting was quoted as saying “A vast area of communication between psychology and social work has been recently opened by the latter's increased interest in research” (Mitchell, 1955). The AAPSW took a step to better understand where psychology was coming from and as a result were better able to enter dialogue and work together. This is seen in other areas today as well. Though most psychologists cannot prescribe medications, by simply having an understanding of them can help bridge some gaps with psychiatry by fostering more educated dialogue. As more disciplines become willing to step out of their comfort zones and try to understand another’s perspective, more prosperous collaboration can occur.

CHAPTER TWO

MODERN PROGRAMS OF INTERDISCIPLINARY COOPERATION

The previous example from 1950 gives good reference to the issues that were and still are important today. These are issues that arise when two or more different professions with different backgrounds try to work together. Since that time countless individuals and organizations have tried to combine different professional groups together from private clinics to government run institutions such as state and VA hospitals. Each venture presenting new challenges and successes. Through research an understanding of these issues will allow for smoother and more efficient collaboration in the future.

There are several differences in the kinds of interdisciplinary teams that can be created in clinical settings. An example of one such team is the Sure Start program in the United Kingdom. This program was created to move past old professional and agency boundaries and work together in a new way to more successfully meet the needs of the community. Later becoming known as the Referral and Allocation Program or RAP, this program brought together individuals from public health, social work, education, and clinical psychology.

Some specific goals of RAP were to make sure that referrals were allocated to the most appropriate team members, promote creativity, accountability, and ensure regular reviews to determine if interventions were working. In the beginning of this process there were considerable delays and confusion regarding almost all aspects of this venture. There was confusion regarding individual's roles and responsibilities. Some individuals

did not expect to change their roles while others felt it would not work unless each member's role did change. When meeting were held there was no agreed format, a lack of clarity regarding chairing and the minutes of the meeting, no single record keeping system, and family history and dynamics where held in different formats by each professional (Marrow, Malin, & Jennings, 2005). This made efficient and effective communication difficult between the 33 member staff.

Within the first year there were signs of improvement. Staff reported feeling more confident about approaching each other and receiving a greater understanding of each other's roles. Meetings were also becoming more organized setting a limit on the number of cases to be discussed in a meeting (4 cases per 2 hour meeting). However there were still problems to face. Meetings were not seen as a priority and many individuals would simply not show up to the meeting. There were also expressions of professional anxiety in challenging or disagreeing with other professionals relating to the hierarchy. This perceived hierarchy was reported as a strong influence in meetings ultimately slowing down the progress that could be made by the group. For example, having valuable patient information not discussed because of the fear of speaking up. Over time from 2001-2003 the sure start program and RAP were able to successfully handle over 100 cases, but their early difficulties made it all but impossible to be successful from the beginning.

Additional Barriers to Success

Bokhour (2006) also saw a lack of communication as a primary reason for failure. She examined transcripts from interdisciplinary team meetings and found that only 32% of meetings used what she defined as collaborative discussion. This was defined as

conversation between multiple disciplines making joint decisions about patient care allowing for team members to collaboratively solve problems. This means that nearly 70% of the time there was no discussion of collaborative patient care where meetings consisted of giving reports and writing down information about their patients. Since the entire purpose of the meetings is for interdisciplinary discussion, these meetings appear to be falling considerably short of expectation.

It was observed that for collaborative discussion to take place it almost always required a team member to challenge the report of another. And as previously discussed with perceived hierarchy it is difficult to create an environment where someone is comfortable enough to speak freely. Our organizational culture seeks to put things into a hierarchy which unfortunately leads to poor collaboration and negative patient outcomes in primary care settings (Youghwerth & Twaddle, 2011). It is important that we find a way through this cultural barrier.

Specific language and jargon can make communication difficult as well. Each discipline holds its own professional language and shorthand, which to any person that is unfamiliar with it could find confusing. For example, the term “support system” to a social worker or psychologist is likely to mean a patient's network of family and friends who can provide support in times of need. To a nurse “support system” is considered life supporting equipment such as an IV or respirator. Also medical and pharmacological terms, discussion of particular theories, and abbreviations like PRN may be confusing to different professionals (Mellor, Hyer, & Howe, 2002). Without clarification in the room it can be very difficult to follow a conversion with other disciplines.

Another barrier to effective cooperation is that of Turf Wars. Dosser et al (2001)

describes how professionals who work very hard at creating their professional identity have, “hard won turf to protect”. For example, several states and institutions have been trying to get prescription privileges for psychologists which can help with cost and create more available treatment for patients. However this has been the turf of psychiatry since the beginning. Having to work closely with one another it is likely that the relationship would become strained, feeling a sense of competition or disrespect. The same is true for psychology that has long held psychological assessment as its turf. Now with school psychologists performing evaluations and marriage and family therapist being trained in assessment holding onto ones turf is becoming much harder. Other issues such as working together in limited space, cross-disciplinary tension, conflict, and competition are all likely to be seen. This is particularly true in related mental health fields such as MFT, psychology, and social work where turf is still at times poorly defined (Mendenhall, 2006). This can also lead to a lack of respect between disciplines. Fortune and Fizgerald (2009) noted that lack of respect for the roles taken by each discipline is a significant factor in the withdrawal of key staff and a lack of support received in collaborative situations.

Funding is another barrier that deserves a notable mention. Even in 1950 the APA and AAPSW had difficulty agreeing on financial responsibilities for their collaboration (Mitchell, 1955). It was argued that the APA had a more solid organizational structure and was better able to generate and more efficiently spend funds. So what aspects of the process would each side be financially responsible for? Most likely, as in this case one side is able to bring more to the table generating concerns about responsibility and fairness. This was noted by Mitchell (1955) as a cause for considerable tension. We saw

even back then it is important for interdisciplinary efforts to work out financial issues.

In a University, the allocation of resources has to do greatly with the discipline itself. Therefore, working with other disciplines within the University means that certain groups are likely to have more to offer. Also most departments budget priorities are to teach competencies and courses that meet the requirements for obtaining their specific professional credentials. Meaning less time and money will likely be spent modeling, mentoring for other disciplines, and creating interdisciplinary coursework and practicums (Dosser, Handron, McCammon, Powel, & Spencer, 2001) even though we know they work. The issue of funding may seek to discourage any departmental interdisciplinary efforts.

CHAPTER THREE

INCORPERATING SOULTIONS

Looking at the before mentioned barriers we see many aspects that need to be overcome. Definition of roles and responsibilities, competency and turf battles, perceptions of professional hierarchy, communication and difficulty speaking to perceived authority, Professional not buying into interdisciplinary approaches, Funding to create teams, differences in training, culture, and background, down to the basic organizational elements of running a meeting. Despite these barriers in the last 20 years there has been a clear emphasis toward developing programs and training opportunities that incorporate multiple disciplines and teamwork. With a belief that if we can negotiate these barriers, our patients and patient outcomes will significantly improve by allowing more specialized knowledge and different philosophies to guide their treatment (Mellor, Hyer, & Howe, 2002).

There have been studies on the benefits of making decisions through teamwork (Cook, Gerrish, & Clarke, 2001; Miller, Freeman & Ross, 2001) as well as the characteristics in an effective team (Mandy, 1996; Molyneux, 2001). Unfortunately most studies rarely address how they can be achieved (Marrow, Malin, & Jennings, 2005). More recently authors are trying to shed light on how to effectively make an interdisciplinary team.

Redman (2006) describes 3 essential characteristics for being on an interdisciplinary team. The first is that a team member must be willing to learn about and understand the expertise, knowledge, and values of each member. By being educated about the other discipline issues such as communication barriers and issues of respect can

be addressed. Second, learning how to work cooperatively and collaboratively with other disciplines and professions. Being successful at this characteristic can increase trust between team members. Lastly a team member must have skills to function in a group, including ability to assess group dynamics, communication, negotiation, and conflict resolution skills. Having the ability to be able to compromise when needed can also build trust and respect within the group. If each member is able to think of themselves as part of a larger system a more effective team can take shape.

Another aspect that can bring about positive solutions regarding communication is by providing adequate opportunity to dialogue about issues. This has been done in several ways. Fortune and Fitzgerald (2009) described an open forum where whole teams are encouraged to focus on their patients from the perspective of other disciplines. This way a person can gain respect and understanding for a viewpoint they may not have considered. Allowing for questions can also help members gain a more complete understanding of the patient. Fullan (1993) describes the important of whole-team evaluations and feedback sessions. These sessions allow for each member to speak up and ask questions creating respect, group cohesion, and understanding between the disciplines. This also helps create an atmosphere where it easier to talk to other disciplines and there is less influence from perceived hierarchies. When that happens a more trusting environment is created where team members begin to feel they can rely on each other. This is important because building trust that has been shown significantly important to support team building and growth. (Perreault et al, 2009).

Another solution relating to communication is that of language and jargon across disciplines. Interdisciplinary cooperation is challenging and complex requiring time to

learn the language and perspectives of the people involved (McCallin, 2006). By having workshops, symposium, and other face to face opportunities provided time for these lengthy process to take place (Marrow, Malin, & Jennings, 2005). Learning a new way of thinking or language in a professional setting will no doubt take time. But by cultivating professional situations such as those mentioned it can speed up the process of learning and understanding other disciplines. Unless of course that learning has already taken place.

Understanding the perspective of another discipline or having training in that discipline is a major factor in interdisciplinary success. So the issue of education is very important. In a study done by Thomas (2012), 4 known factors that assist in inter-professional collaborative practice were explored. The study looked at measures of trust, teamwork, communication, and education (academic and inter-professional). In a regression analysis this elements accounted for 25% of variation in inter-professional collaborative practice. However, Education accounted for 20% of the variance on its own (Thomas, 2012). This indicates that one's educational background and understanding of other disciplines is a significant predictor of effective collaboration between disciplines.

One final area of importance has to do with mutual respect. Just as a lack of respect for other disciplines can be a barrier to success, having appropriate respect and commitment can be helpful. Issues such as friendliness, optimism, humor, and setting high standards for the group have been recognized as way to foster respect between members (Youghwerth & Twaddle, 2011). Sennett (2003) describes how mutual respect and self worth can create bonds even across perceived inequality. This provides yet another way to push through the barrier created by professional hierarchies.

CHAPTER FOUR

ADDITIONAL LESSONS FROM THE LITURATURE

Lessons from Interdisciplinary Training Programs

Interdisciplinary training is an important part of student growth and understanding. Even though this is a widely held belief, since the 1970's few programs can claim they have transgressed the borders between disciplines in a theoretical and methodological manner allowing for new synergies to emerge (Pavlidou, 2012). This is made difficult by traditional teaching strategies. In graduate education a student's disciplinary identity is a focal point. Great effort is placed on initiating the student into the disciplinary culture while preparing them to accept the professional identity, roles, and responsibilities that their discipline demands (Dosser, Handron, McCammon, Powel, & Spencer, 2001). This is an important aspect of any training program, but makes interdisciplinary training difficult as students develop a particular way of thinking and professional identity.

Because interdisciplinary collaboration is not a focus at many training sites, providing practicum or internship opportunities that promote interdisciplinary collaboration is difficult to find and create. Also, when integrated programs are created they pose a threat in some cases to departments who fear new collaboration and integrated curriculum. These new curriculum may threaten long standing and accepted ones. In addition there may be fear about job security as well as loosing students who are seeking more integrated programs. This can put strain on their profession increasing the likelihood of trying to slow further progress (Charny & Friedlander, 1996)

One of most critical issues to why it is difficult to move forward can be summed

up in a question. How can students contend with existing traditional paradigms while advocating for and practicing a non-traditional collaborative paradigm of service without putting their job at risk (Dosser, Handron, McCammon, Powel, & Spencer, 2001)? This is a difficult question to answer, but the truth is most providers still see the need for collaborative interdisciplinary practice in healthcare and mental health care (Brandon & Knapp, 1999). It seems worth the effort to try and challenge some aspects of traditional teaching to reach that goal. By doing so, each success would provide valuable information that will help create future programs capable of teaching students to think and work more effectively with other disciplines. And many programs are already taking that chance.

At the Sharp Healthcare Family Practice Residency in San Diego, CA a biopsychosocial model of consultation was developed bringing together a psychiatrist, family therapist, family therapy interns, and family practice residents. (Edwards, Patterson, Grounds, & Groban, 2001). This facility offers family therapy in conjunction with medication management in a training environment. Students and trainees have the opportunity to work on interdisciplinary teams to help understand patient needs and create the best possible treatment plans. This process can help groom students into more effective providers that can learn from other disciplines (Edwards, Patterson, Grounds, & Groban, 2001). As mentioned before, that level of education and understanding of disciplines is one of the most important aspects of working successfully on interdisciplinary teams. And many programs are trying to do exactly that.

Another important aspect derived from training programs is the importance of learning activities involving faculty and mentors from different disciplines. It allow for a

focus on different key ideas inviting an opportunity to reflect on issues that would have been otherwise overlooked (Perreault et al, 2009). Also in a training or educational setting, when research is presented along with modeling and role-playing skills students tend to learn interdisciplinary collaboration more effectively (Selle, Salamon, Boarman, & Sauer, 2008). So there will often be a mix of factors that promote the best interdisciplinary outcomes in training programs.

Lastly, looking at various training programs we see a reemergence of aspects that were important to clinical programs as well. Communication and developing a common language and knowledge base has been shown to be important in the training process (Domino, Smith, & Johnson, 2007). Without this component, communication and the ability to understand and relate to each other can stall all attempts at progress. This is true in a clinical settings, research opportunities, as well as training programs. By seeing these issues come up again in different kinds of scenarios can help solidify our understanding that indeed communication and related aspects will be crucial to address in any future interdisciplinary endeavor.

Lessons from Interdisciplinary Research

Conducting interdisciplinary research is similar in many ways to working together in clinical settings or training programs. They each demonstrated similarly what components are needed to be successful. Still there are lessons that can be learned from research studies that efficiently brought together the work of multiple disciplines.

One team of researchers explored ways to use interdisciplinary behavioral rehabilitation to treat pain-associated disability. This was a large research undertaking

that required interdisciplinary cooperation. At John Hopkins University, a biopsychosocial model was used that brought together physical, occupational, and recreational therapy, medicine, nursing, pediatric psychology, neuropsychology, psychiatry, and social work (Maynard, Amari, Wieczorek, Christensen, & Slifer (2009). This is a lot of disciplines to bring together for a single study. They did not track specifically the issues that arose trying to get them all to cooperate, but their research methods gave good insight into helpful practices.

One of the most valuable issues to consider that was made apparent in early history is that of definition and role responsibilities. Some professional responsibilities in the study were easy to define. Physical and Occupational therapist used the WeeFIM a functional status measure, medicine provided medical charts and monitored medication for the study, and psychology, psychiatry, and social work all provide assessment and observational data when needed (Maynard, Amari, Wieczorek, Christensen, & Slifer (2009). These responsibilities are fairly strait forward. However, when disciplines share responsibility it can be difficult to know what specifically each team member is responsible for. That is something this study defined well.

For example, psychology's function within the team was to “provide individual therapy and address psychological stressors, and to differentiate distress from pain or other somatic symptoms” and to “provide ongoing support and education for family members.” Social workers “monitored family caregivers' coping, and reinforced behavioral recommendations that allow children to experience developmentally appropriate independence” (Maynard, Amari, Wieczorek, Christensen, & Slifer (2009). These are areas that either a psychologist or social worker would be able to do. For

example, a psychologist could monitor family caregivers' coping, but having such well defined job descriptions it prevented disciplines from stepping over each other.

Other roles such has who completes the comprehensive mental health assessment, who is in charge of cognitive-behavioral pain management training, who is monitoring medication usage, who evaluates sleep patterns, who monitors for any additional therapeutic needs are all defined. This could have been confusing due to the overlap in ability between mental health providers, but because of a comprehensive definition of roles and responsibilities they were able to provide effective treatment for pain-associated disability. Using an interdisciplinary behavioral rehabilitation approach they saw improved functioning through physical performance, increase in school attendance for children, improved sleep, use of active coping strategies, reduced medication usage, and an apparent reduction of future over-utilization of healthcare resources (Maynard, Amari, Wieczorek, Christensen, & Slifer (2009). These results have been replicated in several additional studies (Hooten, 2011; Vincent, Omli, Day, Hodges, & Vincent, 2011; Gersh, Arnold, & Gibson, 2011).

CHAPTER FIVE

KEY COMPONENTS TO SUCCESS

As difficult as it seems to bring about cooperation between different disciplines it does not have to be. For some they find themselves in the perfect situation where collaboration across disciplines is “easy and natural” (Shinn, 2006). When the right combination of elements exists successful interdisciplinary practices can be achieved. The following are 8 key components to successful interdisciplinary cooperation that research has indicated to be helpful when confronted by barriers. It is likely that if each of these 8 factors are addressed prior to and throughout the creation of an interdisciplinary program the chances of success, efficiency in reaching goals, and overall productivity can be achieved.

Buying into the Importance of Interdisciplinary Practice

As described in the Sure Start Program there was a lot of problems in the first year regarding attendance and seeing team meetings as a priority in their program (Marrow, Malin, & Jennings, 2005). Also there were reports here and in other studies of staff questioning the rationale of these meetings. Before any team is likely to work, each member needs to understand why the structure is changing and how working with other disciplines is worth the extra time and energy patient outcomes.

Organization

In the RAP example meetings contained no agreed format, a lack of clarity regarding chairing and the minutes of the meeting, no single record keeping system, and

family history and dynamics where held in different formats by each professional (Marrow, Malin, & Jennings, 2005). As a result people became frustrated and withdrew from the process loosing valuable time and energy. Even issues such as group size need to be addressed beforehand. Research indicates that smaller team size can encourage greater participation and team effectiveness (Youghwerth & Twaddle, 2011). If organizational elements are not addressed before or early in the process there is little chance of being successful quickly and efficiently.

Defining Roles and Responsibilities

When confusion and poorly defined roles are allowed to be a part of team meetings, there have been examples of literal years being wasted as evidenced by Mitchell (1955) and Marrow, Malin, & Jennings (2005) previously. This speaks to the importance of addressing these issues early in the process. By doing so their also needs to be willingness on the part of team to be flexible or even change the definitions of roles if needed for the betterment of the group (Perreault et al, 2009). This may be the most difficult aspect of interdisciplinary team building. But as Maynard, Amari, Wieczorek, Christensen, and Slifer (2009) demonstrated, with clear and at times very detailed definitions of roles and responsibilities interdisciplinary ventures can be highly successful and more efficient compared to when this component is not met or minimally addressed.

Mutual Respect

Each member needs to feel valued and though skill sets may be different, teams need to foster a sense of equality and value to each skill set. Sennett (2003) describes

how mutual respect and self worth can create bonds even across perceived inequality. Considering how powerful the cultural and professional hierarchy can be, any element that can help break through that barrier will be of critical importance.

Trust

If a true interdisciplinary team is to be successful it will require the most important part of any team. Trust is one of the defining qualities needed for any team building experience to the point that no team can function efficiently and to its full potential without trust among its members (Mandy, 1996; Molyneux, 2001). Therefore it is also an integral part of interdisciplinary team success (Perreault et al, 2009).

Shared Language and Education

Each profession has its particular jargon, methods of record keeping, priorities in an interview, and how to get and relay information to a patient. It will take time to learn the language and the perspectives of the people involved but are essential to working smoothly together (McCallin, 2006). In addition, when a misunderstanding does occur related to these issues it is important to proactively deal with the situation (Domino, Smith, & Johnson, 2007). Not doing so can lead to resentment among team members and even increase the gap in the perceived hierarchy.

Whole-Team Evaluation

Fullan (1993) describes the important of whole-team evaluations and feedback sessions. These sessions provide an open forum and opportunity for staff and other

professionals to express their opinions and concerns. By allowing all members to help develop the shared vision the overall team is far more likely to be successful (Pearson & Spencer, 1995). In addition this added face to face time can serve to build respect and foster trust between disciplines (Perreault et al, 2009).

Commitment

The path to successful interdisciplinary teamwork is not easy and requires time and dedication to work through differences (Marrow, Malin, & Jennings, 2005). This is particularly true for mental health. Different disciplines work off of different traditions, theories, styles of teaching, methods of evaluation, experience, and as Dosser et al (2001) describes, “hard won turf to protect”. It will take a strong commitment and great attention to developing these relationships to bridge all the required gaps to interdisciplinary collaboration.

CHAPTER SIX

FUTURE DIRECTIONS

Their have been numerous writings on the benefits of interdisciplinary work in mental health and how critical it is to the survival of healthcare and mental healthcare alike (Maton, Perkins, & Saegert, 2006). Approximately 75% of all primary care visits involve at least some mental health component and many who need mental health service often seek help initially from primary care (Westheimer, Steinley-Bumgarner, & Brownson, 2008). It is evident that different disciplines need to learn to work and talk together. With a clear need for interdisciplinary approaches, where does future research need to look to continue to propel itself forward?

At the present time, there appears to be 4 deficiencies in the research that if addressed could dramatically change how interdisciplinary teams are created, understood, and utilized. The first issue revolves around the clarification of terms used in the research. Specifically, looking at the terms interdisciplinary, multidisciplinary, and transdisciplinary and how each are defined. As described earlier, each term or model has its own meaning that plays a significant role in how they are understood. Unfortunately, at this time a consistent definition of an interdisciplinary team is lacking in the research. Many publications are even using the terms multidisciplinary and interdisciplinary interchangeably causing confusion among many researchers (Youngwerth & Twaddle, 2011). Since a team's structure can vary greatly depending on which model is used, consistently applied definitions and a proper use of terms is critical in future research so that issues impacting each model can be appropriately understood.

The second deficiency in the research is related to how to implement successful

team building. There is plenty of research indicating what factors make up a good team and how good team chemistry can promote a variety of positive outcomes. Unfortunately most studies rarely address the process of how those factors are achieved (Marrow, Malin, & Jennings, 2005). It would be beneficial if future interdisciplinary research would go into greater detail of how to achieve respect, trust, creating open forums, organization, and the other factors identified as playing a role in strong interdisciplinary teams.

The third deficiency is related to the kinds of studies that exist in the literature at the present time. Case studies of interdisciplinary programs make up much of the research base. The majority of articles describe a particular program that tried to employ interdisciplinary models, what made it difficult, and how they tried to deal with those problems. What seems to be lacking most of all is a focus on quantitative research. Thomas (2012) took a great step in trying to understand interdisciplinary issues in this way. This research attempted to take the variables of teamwork, trust, communication, and education and perform analysis to see what variables are most involved in interdisciplinary collaboration. Few others have tried to understand interdisciplinary cooperation in this way. There is a need to further operationalize the other components identified in the research to more concretely understand how they play a role. Variables such as buying into interdisciplinary practice, respect, commitment, use of open forums, and organization should all be studied to determine how much each is involved in interdisciplinary collaboration. Doing so would give program directors and interdisciplinary team leaders more specific ways to address barriers and which areas are the most influential so more effective strategies can be employed.

The final issues of concern for future research is to continue to uncover the variables involved in creating successful interdisciplinary teams. As Thomas (2012) found 25% of the variance in interdisciplinary collaboration comes from trust, teamwork, communication, and education. This is a great start and an important shift in how we are thinking about interdisciplinary issues. However, there still remains 75% of the variance that exists as unknown or unaddressed factors. To truly develop an understanding of what is going on in interdisciplinary teams future research should invest in uncovering what those unknown and unaddressed variables are. If successful the study of interdisciplinary collaboration can have a more complete understanding.

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