Working Relationships and Outcomes in Multidisciplinary Collaborative Practice Settings

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ABSTRACT: A multidisciplinary research team of academics and community practitioner partners worked together to design and conduct an investigation into the purposes, processes, and outcomes of multidisciplinary collaborative practice. A review of the literature revealed a confusing array of terminology while also pointing to potential benefits and challenges, models for practice, and suggestions for research. The pilot research study consisted of six case studies set in three different programs. The principal finding was that no single model can be applied to all multidisciplinary collaborative endeavors. The appropriate approach depends on the context and goals of the work and on the organizational structure. This study highlights the process for collaboration and its prerequisites: Shared physical space, opportunities for formal and informal communication, consensual decision-making, team/group coordination, and organizational support. Additionally, the role of specific disciplines appears to be less predominant in the process of multidisciplinary collaboration than the commitment of individuals to collaborating. The benefits reported by practitioners were suggested to far outweigh the challenges associated with the approach to practice. Future research should incorporate a stronger client voice, include investigation of inter-group and interagency collaboration, and extend to a wider variety of practice settings.

In 1994–95 in British Columbia, a formal inquiry was held to review child protective services, policies, and practices. One conclusion of the inquiry was that child protection services must be delivered in a multidisciplinary, coordinated manner. The British Columbia Ministry for Children and Families was formed in the fall of 1996 to bring together child, youth, and family serving programs from five government ministries. Thus it seems inevitable in British Columbia at least, that individuals working with children, youth, and families will be required to do so in a multidisciplinary, collaborative manner.

This study grew out of a desire among academics and practitioners

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in the field to determine why organizations working with children and families would choose a multidisciplinary approach to practice, what the approach actually looks like for the people involved, and to determine if the approach engenders the benefits that are assumed to be associated with the approach. Thus this pilot study of practice in two healthcare settings, employed a phenomenological approach to investigate the lived experience of practitioners and service users. Representatives from two community organizations expressed their interest in the project and joined the project steering committee to assist in guiding the research project. The two research contexts are described in the method section of this article.

Review of the Literature

Although the value of multidisciplinary collaborative work is often endorsed, numerous authors agree that specific studies of how such relationships work and their impact on relationships with clients, service objectives, and outcomes are hard to find (Billups, 1987; Jones, 1997; Lowe & Herranen, 1981; Opie, 1997; Velianoff, Neely, & Hall, 1993). This review of the literature pertaining to multidisciplinary, collaborative practice describes rationales, purported benefits and challenges, the array of terminology used to describe it, models for practice that include factors for effectiveness, and suggestions for future research.

Rationale for Multidisciplinary Practice

A broadened conception of the interrelated nature of human problems and the need for comprehensive approaches to human service delivery is purported to have prompted much of the push for increased collaboration (Abramson & Mizrahi, 1996; Billups, 1987; British Columbia Ministry for Children & Families, 1997). Also, several authors suggest that a mandate for increased collaboration has arisen out of changing economic and social conditions that have prompted more demands for cost-efficient and effective health care service delivery (Netting & Williams, 1996; Abramson, & Mizrahi, 1996; Christ, 1996).

Benefits of Multidisciplinary Practice

Other authors highlight the benefits that a multidisciplinary, collaborative approach to practice affords service users. Billups (1987) suggests that the outcomes of interprofessional team efforts can be considerably greater in scope and value than the cumulative effects of the perfor-

mance of individual practitioners or educators working separately. Christ (1996) states that,

> There exists an expanded and deepened competence that occurs as a practitioner moves back and forth between the depth of specialized practice and the breadth of the generalist knowledge and skill. In fact, the practitioner's understanding of human behaviour and helping processes may become skewed if he or she maintains too singular a focus. (pp. 60–61)

In healthcare, suggested benefits of collaboration extend also to practitioners. Practitioners are reported to enjoy better communication and relationships with their colleagues, the ability to focus on the entire patient, increased efficiency and effectiveness of care delivery (Velianoff et al., 1993), higher productivity, increased satisfaction, and the ability to provide holistic care (Opie, 1997). Bailey and Koney (1996) state that collaboration includes an enhanced potential for resource exchange and a movement toward power parity among members (Bailey & Koney, 1996). Exposure to other professionals allows individuals to expand their knowledge and expertise while providing support, dividing responsibility, and cushioning the effect of failure (Abramson & Mizrahi, 1996). However, Schellenberg (1997) questions whether shared responsibility always translates into shared accountability, especially when things go wrong.

Challenges of Multidisciplinary Practice

Bringing people together usually entails bringing differences together. Sheehan (1996) describes the differences as often being a "clash of cultures" (p. 76) characterized by differences in values, language, problem-solving strategies, and other elements of professional behaviour. To achieve effective collaboration, team members must not resist differences (Poulin, Walter, & Walker, 1994). Ways to use differences for benefit must be a primary consideration in multidisciplinary collaborative work.

Given that each discipline develops a body of knowledge that gives a unique perspective on the phenomena central to the discipline (Knapp, Barnard, Brandon, Gehrke, Smith, & Teather, 1993), different disciplines contribute separate and often competing philosophies, diagnoses of need and pathology, and models of the way the world works. Each discipline alone is not capable of addressing challenges related to the whole individual, complex families, and communities. Thus, cooperation and coordination are required between professionals and between services. Further, the more groups are expected to collaborate closely,

the more they need thorough procedures to coordinate their work (Tjosvold, 1986b).

Terminology of Multidisciplinary Practice

Many different terms (interdisciplinary, multidisciplinary, transdisciplinary, interprofessional) are used in the literature without an understanding of their meaning. Terms are often used interchangeably to mean different things. Literature on collaborative practice often does not state whether it is specific to workers from one or a variety of disciplinary backgrounds.

Orelove and Sobsey (1991) have offered different terms that refer to varying degrees of integration of work among professionals from different disciplines. They describe the transdisciplinary team model as representing the highest level of integration, or the transfer of information across traditional discipline boundaries. They note that "transdisciplinary" practice has been embraced most predominantly by programs serving children with multiple disabilities.

Models for Multidisciplinary Practice

According to Murphy (1995), multidisciplinary, collaborative practice is likely to be strongly characterized by embracing and utilizing individual differences and cooperation and coordination of efforts. Further, multidisciplinary work requires a shared understanding of aims, objectives, and of what constitutes good practice. The components of multidisciplinary collaborative practice most often mentioned in the literature are:

- organizational structure
- cooperation
- roles
- communication
- leadership
- decision-making
- conflict
- attention to collaborative process

The following elaboration of these components illustrates how each influences multidisciplinary collaborative practice.

Organizational Structure. Ovretveit (1993) states that organizational structure is a critical component of team development. Others agree that the structure of the system in which multidisciplinary work occurs

is of key importance to practice effectiveness (Murphy, 1995; Resnick & Tighe, 1997). Teamwork can only occur when it is supported and sanctioned by the environment in which it exists (Lowe & Herranen, 1981).

Cooperation. Personal characteristics have been suggested to have less influence on group functioning (Ovretveit, 1993), although Kline (1995) and Landerholm (1990) contend that individuals must be willing to become multidisciplinary, that is, to share their knowledge and learn from the knowledge offered by other disciplines. Additionally, individuals must strive to understand the roles and responsibilities of others, their feelings, values, perspectives, and motives (Murphy, 1995; Roberts, 1989; Tjosvold, 1986).

Tjosvold (1986b) states that collaboration cannot occur effectively in competitive environments. Such environments are characterized by: a) no concrete, common task; b) no rewards for collective success; c) individuals don't know each other as people; and d) reasons to compete exist.

Conversely, collaborative models build structures and processes around the nature of the task rather than starting with a hierarchical structure and force-fitting the task to it (Kraus, 1980, p. 101). Further, in collaborative organizations, values such as openness, trust, honesty, concern for others, power sharing, and expansion and tolerance for ambiguity influence structures and processes.

Roles. Research also suggests that to work effectively in a multidisciplinary way, team members need to understand, clarify, and manage influences on their roles, especially when conflicting expectations exist (Ovretveit, 1993). Thus team members need to be able to understand and explain their formal responsibilities, to be accountable, and clarify with other members what scope they have to negotiate what they do (Ovretveit, 1993; Peace & McMaster, 1989; Murphy, 1995). Sheehan (1996) supports this in asserting that clear guidelines and expectations about roles must be established. In addition to defining roles clearly, Billups (1987, p. 148) notes that attention must also be given to avoid incompatible expectations in roles ("role conflict") and the inability to meet multiple expectations ("role overload"). Further, as well as understanding one's own role, individuals working in collaborative settings must strive to gain knowledge and understanding of the professional expertise and roles of others (Lowe & Herranen, 1981; British Columbia Ministry for Children and Families, 1997; Murphy, 1995; Netting & Williams, 1996; Orelove & Sobsey, 1991; Sheehan, 1996).

Communication. Researchers on multidisciplinary practice have also noted that the quality of communication within a team is a good index

of its levels of organization and the health of the relationships between members (Ovretveit, 1993). David (1994) suggests that listening skills are a critical factor in effective communication and should be part of training for collaborative teams. Others have pointed out that effective communication requires avoiding the use of professional jargon and establishing clear guidelines concerning information exchange (Kline, 1995; Rutman & Swets, 1995; Sands et al., 1990; Sheehan, 1996). According to Klein (1990), successful teamwork depends on tending to the communication process. Finally, Lowe and Herranen (1981) have suggested that determining the nature of interdependence or who needs what information from whom is an essential part of teamwork.

Leadership. Another dimension of effective, multidisciplinary practice is high quality leadership. Ovretveit (1993) states that more team problems are caused by inadequate leadership than by any other single factor. Problems with leadership usually involve an ambiguous leadership role or one that is not appropriate for the type of team or situation (Ovretveit, 1993). Leadership in teams should aim to help different disciplines to act toward a common purpose (Ovretveit, 1993; Tjosvold, 1986b).

Decision-Making. Along with adequate leadership, productive and balanced decision-making processes are essential to the success of multidisciplinary practice. Decision-making is about determining how the tasks and goals of a team, group, or unit get accomplished (Lowe & Herranen, 1981). Coordination is critical for problem-solving and decision-making (Tjosvold, 1986b). In order to make the most of different skills and perspectives of members, teams must have agreed-upon procedures for making decisions (Ovretveit, 1993). Ovretveit (1993) distinguishes between the types of decisions facing teams: a) decisions about one client; and b) policy decisions about the team's services to all clients and about how the team works. In collaboration, team members' sharing of decision-making power facilitates a functional focus rather than an authority or power focus (Kraus, 1980).

Conflict. An additional dimension of multidisciplinary practice that requires attention is conflict. Conflict occurs most often because of differences in socialization, goal incompatibility, task uncertainty, differences in performance expectations, and resource limitations (Fargason, et al., 1994). Effective conflict management involves problem characterization, acknowledgment of relevant goals and interests, and negotiation when interests are in conflict (Schneider & Galloway, 1994, p. 863). Teams must strive to raise, recognize, and resolve differences (Ovretveit, 1993). Minimizing, denying, or accentuating differences are

all detrimental to team effectiveness. Making use of differences requires the use of clear and effective decision-making processes.

Attention to Collaborative Process. Finally, the literature on multidisciplinary practice suggests that teamwork as a concept must be understood, practiced, and studied in order to fulfill its potential (Lowe & Herranen, 1981). Interprofessional collaboration includes attending to what a team does and how it goes about doing it (Billups, 1987). Thus time and resources must be allocated to facilitate team development and effective team work (Billups, 1987; Iles & Auluck, 1990; Opie, 1995; Opie, 1997; Rutman & Swets, 1995). Allowing time for relationship-building among individuals from different disciplines is important for effective practice (Ministry for Children and Families, 1997; Netting & Williams, 1996).

Gaps in the Literature

The literature provides a number of suggestions for future research: Involving practitioners in research (Jones, 1997), including the client voice in evaluations of practice, and providing evidence for the benefits purported to be derived from multidisciplinary, collaborative practice (Billups, 1987; Lowe & Herranan, 1981; Opie, 1997). Research is also needed that would provide benchmarks for the developmental process of interdisciplinary collaborative groups (Velianoff et al., 1993).

The literature review conducted for this study also highlighted the need for all research in this area to include explicit definitions for the terms used.

Purpose of the Study

This research project responds to the need for an improved understanding of a multidisciplinary, collaborative approach to healthcare practice and its benefits. The lived experiences of practitioners and service users are highlighted in this study in order to give their voices prominence. Due to available funding, this study was designed as a pilot project that would provide some new understandings while identifying key issues for exploration in additional practice contexts. This project was guided by a steering committee composed of representatives from the University of Victoria's Schools of Child & Youth Care, Social Work, Nursing and Faculty of Education, and two community healthcare organizations that have engaged in forms of multidisciplinary practice for more than five years.

Method

Research Questions and Rationale. Four general research questions were developed to guide the investigation of multidisciplinary collaborative practice:

What organizational and program purposes drive a multidisciplinary collaborative collaborative approach to practice?
What strategies are employed in, what meanings are attributed to, and what organizational support exists for multidisciplinary, collaborative practice?
What outcomes do practitioners and service users perceive to be associated with a multidisciplinary, collaborative approach to practice?
To what extent can the process of multidisciplinary, collaborative practice be linked to its outcomes?

Terminology Used in the Project. The use of specific terminology proved to be a contentious issue in this study. During project development, the term "multidisciplinary collaborative practice" was agreed upon by the steering committee and then used in the investigation. For the purposes of this research project, the term "multidisciplinary collaboration" was defined as individuals from more than one discipline working together in some concerted way. Through our discussions it became clear that workers in the field might feel judged by the terms we chose to use. The community representatives on the steering committee suggested that some workers were familiar with the work of Orelove and Sobsey (1991) and believed themselves to have moved beyond a "multidisciplinary" level of integration in their work. We decided that we must clearly articulate in our interviews that we were using the term "multidisciplinary" in a loose way, and that it was not intended to reflect any assumptions about the particular degree of integration of work. Further, we expressed our desire to have the approach in each context defined by its workers and service users. Therefore, as part of the research we asked both workers and clients to offer the meanings that they attribute to the practice they experience. In this way we hoped we would uncover the breadth and depth of the individual approaches and their outcomes.

Throughout this report the term "practitioner" is used interchangeably with "worker" and "client" with "service user" or "family." Again, the use of these terms generated considerable discussion among steering committee members. The different practice contexts involved in this study had their own terminology. Steering committee representatives from the two contexts ensured that the terminology used throughout the study reflected the terminology used in their work settings.

Another issue involving use of terminology arose when we moved into our analysis phase and attempted to compare our findings to other collaborative models. Alternative descriptors for practice were discussed and agreed upon during that phase of this study in order to better reflect the approach to working with children and families in the community health center.

Research Contexts. Interviews and observations were conducted at two community sites located in Victoria, B.C. One site is a children's health center that offers programs and services in the area of mental health, health promotion, family education, rehabilitation and support, pediatrics, and assessments for children and families on both an outpatient and residential basis. The other site is a community health center offering health services, family resource support, home support, and community development services. Practitioners/workers at both sites worked in a collaborative manner with others from a variety of disciplines.

Research Participants. Six case studies each were conducted in three programs at the two collaborating sites in this pilot study. Case studies 1 and 2 were conducted in a preschool program affiliated with the first setting. Case studies 3 and 4 were conducted in a child and family and adolescent inpatient program also affiliated with the setting housing the preschool program. Case studies 5 and 6 were conducted in a family resource center affiliated with the second setting. Each case study involved one client and all relevant workers who had been involved with the family. Table 1 shows the practitioners involved in each case study.

The steering committee representatives from the community sites approached their staff to request volunteers for the study. Three "teams" volunteered to participate. Their respective coordinators facilitated the involvement of their team members and suggested potential volunteer clients. The research project coordinator contacted these on-site coordinators frequently throughout the project to inquire about team meeting dates, arrange and confirm interview schedules, and provide transcripts for participants to review.

The program coordinator (case studies 1 and 2), the program director (case studies 3 and 4), and the supervisor (case studies 5 and 6) approached potential families for participation in the study and provided the project coordinator with parent names and contact numbers when their consent was obtained. Participant families were selected based on their willingness to volunteer, their involvement with the majority of the team members, and their current involvement with the center.

Table 1
Practitioners Involved in the Study on Multidisciplinary Practice

Case Study 1	Case Study 2	Case Study 3	Case Study 4	Case Study 5	Case Study 6
1. Occupational Therapist 2. Physiotherapist 3. Social Worker 4. Psychologist 5. Physician 6. Speech-Language Therapist 7. Community Integration Person* 8. Ministry Social Worker	*Same individuals as Case Study 1 with three additional interviews:* 1. Community Integration Person *(new) 2. Daycare Provider 3. Speech Language Therapist**	1. Occupational Therapist 2. Social Worker 3. Psychologist 4. Psychiatrist 5. Speech Language Therapist 6. Teacher 7. Primary Worker (Nurse) 8. Secondary Worker (Nurse)	1. Occupational Therapist 2. Social Worker 3. Psychologist 4. Psychiatrist 5. Teacher 6. Primary Worker (Child & Youth Care) 7. Secondary Worker (Nurse)	1. Public Health Nurse 2. Physician 3. Nurse Practitioner 4. Worker (Teacher) 5. Worker (Nurse) 6. Supervisor (Counsellor) 7. Volunteer Coordinator (Property/people management)	1. Volunteer (Nurse) 2. Teacher 3. Physician*** 4. Youth Worker****

*For Case Study #1: the Community Integration Person has a disciplinary background of Early Childhood Education combined with Special Needs training.
For Case Study #2: the Community Integration Person has a disciplinary background in Education in Early Childhood and Anthropology.
**Audio-tape from interview with second Speech/Language Therapist for Case Study 2 was defective and not used in the data analysis.
***Physician requested interview not be taped, so information from this interview was from interviewer notes only.
****Youth Worker interviewed was unavailable to consent to transcript use, therefore it was not included in the data analysis.

Instrumentation. The steering committee worked together to develop interview questions that would elicit answers to the four general research questions posed. The wording of questions posed to practitioners differed slightly from those posed to service users but covered the same information elements. Interview guides are attached in the Appendix. Researchers focused their observations during team meetings on group processes and dynamics. For example, observers noted who spoke, to whom they spoke, how often each person directed their speech toward another individual or toward the group in general, the types of exchanges (i.e., directive, clarification, confirmation, questioning), leadership behaviours, and nonverbal gestures (indicating agreement, disagreement, comfort, discomfort).

Procedures. In this study, interviews with practitioners and service users were between 45 and 60 minutes in length and were conducted by the project coordinator. An interview guide was used to ensure that important topic areas were generally covered in each interview. Interviews with all participants were tape-recorded except one (as noted in Table 1) when the participant requested no recording. In addition to interviews, observations were conducted for the purpose of gaining insight into interactions and dynamics among team members/workers (see Table 2).

Analysis. The process for data analysis was inductive. The data was studied to reveal dynamics, process, meaning, effect, organizational support, and outcomes of multidisciplinary, collaborative practice. The analyses involved the use of systematic, formal, and logical procedures

Table 2
Observations

Case Study	Observation(s)
#1 and #2	Case Review Meeting*
#1	Assessment Conference
#2	Assessment Conference*
#3	Follow-up Conference
#4	Review Conference
#5 and #6	Staff Meeting

*These meetings were observed by a second investigator (in addition to the Project Coordinator).

to generate categories relative to the identified research questions and to determine relationships among them. Procedures used in analysis followed those outlined in Goetz and LeCompte (1984) and Stewart and Shamdasan (1990) and included scanning data for categories, using constant comparison to note instances of responses, and generating conceptual categories or "themes" that emerged in the data.

Steering committee members shared in the analysis of interview and observation transcripts. Each transcript was reviewed by at least two investigators and sometimes three. This served as a form of triangulation. During analytic induction, initial cases of relevance to the research questions were determined and compared with those identified by the other analyst(s). Two day-long meetings were held to discuss emergent themes in the data. The varied disciplinary backgrounds of steering committee members added richness to the analysis.

Preliminary findings were shared with research participants through an oral presentation to each team. Feedback on the findings was requested and while few changes were suggested, interesting discussions arose from these sharing sessions.

Results

The key findings reported here address the four research questions that form the basis of this project.[1] Before addressing the research questions, it's useful to begin with the meanings that workers attributed to "multidisciplinary collaboration." Distinctions between terms associated with multidisciplinary, collaborative practice were largely unimportant to workers. All the workers were able to clearly articulate a personal sense of what it means to "work collaboratively," indicating their understanding of how they work with others. Most commonly, "working collaboratively" was described as working together as "equals," valuing and utilizing the perspectives and expertise of others in working.

What Drives the Approach?

In each context examined, the context of the work was found to drive the approach to practice. At the children's health center, the multidisciplinary, collaborative approach to practice was described as being necessitated by the complexity of cases to which practitioners were required to respond, a mandate for holistic and comprehensive services, and responsiveness to needs and goals identified by families. When asked why they work in a collaborative way with people from different disciplinary backgrounds, practitioners said:

The type of kids that we treat . . . are so multi-faceted.
These are cases where people don't know what to do . . . these questions are so complex you need specialized disciplines to look at it from different knowledge bases . . . it's not unlike peeling off layers of an onion.
[It enables us to] do a core group of things in one place rather than have it done over a 7-year period with all these different players elsewhere.

At the community health center, the approach to practice was described as being necessitated by a mandate to facilitate connections for community members that involves constant change and the need to be consistently responsive to needs identified by the community.

> It's continuing, it's ever changing, it's forever increasing. There is always something new happening. . . . It doesn't have a finish. It's just going to continue on being, meeting the needs of the community, whatever that means from one day to the next, from one year to the next.

Practitioners/workers appear to have a general sense of organizational missions, viewed largely as a shared philosophy, but note that in practice, they are driven more by program goals ("how to" statements) and personal values such as a commitment to collaborating and caring.

The "context" for practice seems to prompt a collaborative approach. Specifically, individuals are viewed within a family "system" or other "system" (i.e. community) and the system as a "whole" needs to be looked at in addition to looking at the individual within the system. Looking at the "pieces of the whole" is best done by bringing a number of people with varying perspectives, abilities, and knowledge together to assess and respond to the "whole."

Practitioners/workers at both sites recognize their role as part of a larger piece of work; they recognize the limitations of their own knowledge and abilities and recognize the benefits of collaborating with others to work towards achieving goals. Information shared in the interviews reflected valuing the input and participation of others in working together. Workers described their contribution to the team as providing one piece of many required to put a whole picture together.

The Process

In looking at findings across the case studies, we found that some elements of multidisciplinary collaboration figure more prominently in the process than others. We found that some of the elements deemed most important in the literature were not deemed as important in our research contexts. The elements we investigated were:

- disciplinary roles
- communication, decision-making, problem-solving, and conflict
- leadership
- coordination
- composition of the "team" and involvement of families/clients
- organizational and personal inhibiting and facilitating factors

The key findings pertaining to these elements are detailed separately below.

Disciplinary Roles. While disciplinary titles distinguished practitioners in the first context (Case Studies 1–4), these distinctions contributed little to understanding the collaborative process. It seems that each team/working group must determine on their own "how" they are going to work together. The process of collaborating across disciplines requires coordination, frequent communication, consensual decision-making, non-authoritarian leadership, shared values, personal commitment, and facilitative support from the organization.

The role of individual disciplines seems to be less predominant in the process of collaboration than the commitment to collaboration that is required by the individuals involved in the process. However, workers had all been involved in collaborating for some time (approximiately 12 years, on average), and this study was not able to uncover the evolution of disciplinary roles and contributions throughout the collaborative process. While the organization must espouse a philosophy consistent with a multidisciplinary, collaborative approach and can facilitate the process by providing structure and a facilitative atmosphere, the commitment of individuals to collaborating is critical to effective collaboration.

Communication, Decision-Making, Problem-Solving and Conflict. A commitment to communication was reported to be essential for effective collaboration, but because it is also time-consuming, the commitment must include an understanding and acceptance of the time requirement. In order for effective communication to take place, a lot of communication between individuals must occur, but it can be structured formally or occur largely informally. A worker at the children's health center, involved with case study 1, described formal communication and decision making in her team, this way:

> I wrote down on the chalk board all the possible things that we could ever hope to do as a team . . . we put everyone's initials by all the things we were really interested in doing and could contribute and that helped, doing that, sort of identifying, taking it beyond role, or profession . . . we look at all these things that we can do, we can't do them all, but just to

> show that there was room for all of them. And that she could do this and that was fine with me and I wouldn't be trying to encroach on her territory or whatever.

Practitioners told us that decision-making must be shared among group members and needs to occur on different levels. Individuals may make day-to-day decisions on their own or in consultation with one or two others, while other decisions are made in group meetings. The process of decision-making and problem-solving needs to be consensual. Individual differences are expected and accepted differences of opinion are shared and must not be viewed as "conflict."

Below are two examples from the second context, the community health center, in which communication and decision-making happens more informally between workers and between workers and the center's participants/users.

> We're not really big on being structured and I think that's partly . . . the kind of people we probably all are and it's also the nature of the work where you have people drop in. You know . . . it would be totally futile to have a formal intake and referral process for teens who cannot make an appointment and keep it . . . and similarly with the drop-in programs. People will be on their way out the door putting their jacket on their child and bundling somebody into the stroller and saying, "Oh, by the way, I am really worried about so and so," and so then you say, "Well come on down to my office and I have a handout on this, maybe that would help.". . . So I think it's informal partly in response to the nature of how things come to us.

A parent involved in the community health center's programs and activities (Case study 5) reported being aware of the effects of communication between workers, although she did not report observing them communicating:

> I think there is a lot of interaction because I know when I first went there, I went to [one worker] and found the other person, another person seemed to know that I had health problems, and then a volunteer came and asked me if I needed some help. So . . . I got a sense that they really communicate with each other a lot. And they always knew my name, so I think that helped. Like they were very attentive.

Leadership. Elements of leadership were not readily apparent in the data. Interview questions did not explicitly address leadership issues. However, insights gained from observations suggest that leadership can be shared among a collaborative group and that it is most likely facilitative in style, encouraging collaborative efforts among individuals. Additionally, leaders have a key role in modeling the equal valuing of input from everyone involved in the collaborative process.

Coordination. Workers reported that is essential for multidisciplinary, collaborative working groups to have someone fulfill a coordinating role. Individual schedules must be coordinated for meetings; someone needs to have a sense of the overall picture of who is going to do what and when it will be done.

Each team had an appointed individual who worked to facilitate individual members' participation in the collaborative process:

- the program coordinator in case studies 1 and 2 encouraged collaboration among team members and worked to coordinate and communicate priorities of team members;
- the team leaders in case studies 3 and 4 oversee the needs of workers and clients and coordinate workers' schedules on their units;
- the family center supervisor in case studies 5 and 6 receives suggestions from workers for input into meeting agendas and facilitates worker participation in staff meetings.

"Team" Composition and Involving Clients in Collaboration. In this study, two aspects of multidisciplinary collaboration were different at each of the research sites: The shape which "team" can take and the extent to which clients are involved in the collaborative process. The teams at the children's health center possessed a distinct membership and maintained partnerships or cooperative relationships with external agencies or individuals. At the community health center, collaborative working groups change membership based on a composition of individuals best able to respond to the needs of the client. Thus "team" is not static; rather, membership in any collaborative group is open. When changes in membership occur, new members must possess a commitment to the collaborative process and personal characteristics required for collaborating across disciplines.

At the community health center, workers stressed that their approach involves working "with" people and includes a blurred distinction between "worker" and "others." The focus of the work is to help people get their own needs met through offering opportunities and resources and facilitating the development of supportive connections.

At the children's health center, parents and families of children in the programs are involved according to a formal process that begins with requesting input and soliciting parents' goals for their child. Parent participation in therapy is strongly encouraged. Workers value and strive to empower parents through learning opportunities and a caring approach. The primary contact with families can be determined either by the amount of contact with family through the course of program participation (case studies 1 & 2) or by designated roles (case studies 3 & 4).

A practitioner in the second team at the children's health center (case study 4) described family involvement with the team as "Putting together the different ideas and saying, 'Okay, is this working, is this realistic, is the expectation too high, how is it going?' . . . That's not only with the team but that's also including the family and the child in this."

Commitment to collaborating includes a commitment to communicating with others and the acceptance of the time required to do so. Personal characteristics include being flexible, respecting others, being able to express limits around one's work and abilities, accepting individual differences, and being reflective in one's own practice.

Organizational and Personal Issues That Facilitate and Detract from a Multidisciplinary, Collaborative Approach to Practice. There was a high degree of consistency between the factors that workers in the three teams identified as facilitating and detracting from a multidisciplinary collaborative approach to practice. These factors cover both what the organization and the individual contributes to the process (see Table 3).

The data was examined to determine the extent to which the following elements of organizational structure proposed as required for effective collaboration (Lowe & Herranen, 1981) were present in the work of the three teams:

- support
- the goals and objectives must be consistent with those of the organization
- space must be arranged to be conducive to collaboration
- communication must occur between the team and organization
- there must be an appropriate reflection of the organization's authority structure within the team

Workers at the second research site reported feeling supported by the organization in their work. While workers at the first setting reported feeling supported by their teams, they reported that support from the organization was more questionable. This lack of support pertained to high caseloads and inadequate resources.

All practitioner/worker groups reported consistency between team goals and organizational goals. However, reports of inadequate resources to support best practice suggests a difference between which goals teams adhere to and those which the larger organization or funding bodies support.

Practitioners in all three teams reported aspects of their space arrangements that facilitate collaboration. However, the degree of offsite practice by therapists visiting community daycare centers and

Table 3
Organizational and Individual Factors That Act as Detractors and Facilitators to Collaborative Practice

	Detractors	Facilitators
Organizational Factors	• high caseloads • low resources • climate of uncertainty around reorganization • lack of administrative support to coordinate/plan meetings and schedules • hiring staff without experience with collaborative approaches • lack of a formal communication structure	• having a team structure • protecting team meeting times (individuals are expected to attend) • maintaining a philosophy that mandates family/ client involvement in collaboration • allowing choices re: collaboration process • providing a non-competitive environment
Individual Factors	• not sharing work • not being able to express limits • needing to control others • needing to work autonomously • needing to have own opinion accepted	• flexible • self-aware/reflective • committed to collaboration • value others • accept individual differences • good communication • develop and value personal relationships with co-workers • understanding others, their roles and contributions • educating others about self, own role, and contributions

preschools in the preschool program at the first setting makes frequent informal communication and coordination of scheduling more challenging.

There appears to be regular and in-depth communication between the program workers and the organization at the community health center. At the children's health center, which is a much larger organization with more layers of management and administration, it seems

there are some challenges to communication between the team and organization. This was evidenced in reports of:

- not feeling there is anyone to turn to with concerns, to get information, and to provide input into plans for reorganization, and
- not being involved in some important organizational decisions.

At the second setting the manager has frequent interaction with team members and participates in monthly staff meetings and staff development meetings. In the preschool program at the first context (case studies 1 & 2), the authority structure present in the team is uncertain. Only one or two practitioners mentioned the existence of a program manager in their interviews, but this person's role in the team and interaction with the team remains unknown. In the program at the first setting (case studies 3 & 4), a program director is actively involved in weekly team meetings and has regular interaction with team members. The director appears to serve as a link between the team and the larger organization, although his role in representing/communicating organizational information to the program teams was not explored in this study.

Outcomes

While all three participating groups reported a variety of challenges associated with multidisciplinary collaboration, they also reported believing that the benefits to clients and workers justify the effort expended and minimize the importance of the challenges.

Benefits. The benefits were similar across the three teams. Table 4 summarizes the benefits described by practitioners in their interviews. One parent (case study 5) reported feeling strongly supported by the team at the children's health center.

> She supports [me] by making suggestions on things I can do . . . I was talking about getting into low income housing and she said that she could help me . . . also the issue with the Big Brother for [my son], which was really nice. There was another thing where she had gone into I guess a clothing room and picked up a bunch of coats that the kids needed and stuff like that and to me it was like REALLY nice . . . I mean, that's not what she had to do at all . . . introducing me to another person that she thought might be able to give me some information on my dental work and stuff like that . . . definitely good, very excellent support.

These two workers from the second program at the children's health center note how working in a team has facilitated their own learning and growth.

Table 4
Benefits to Service Users and Workers

Participating Group	Benefits to Service Users	Benefits to Workers
Children's Health Center Preschool Program	• more comprehensive, holistic services • increased ability to work with family as "client" • support within team enables extension of support to families • more opportunities for learning/increased empowerment for families	• reduced stress through support in team • increased professional satisfaction through enriched work environment, enhanced problem-solving ability, learning opportunities from other disciplines, and belief in affording the most benefits to clients/ families
Children's Health Center Adolescent Program	• more comprehensive, holistic services • children feel safe, nurtured and enjoy the attention • more opportunities for learning/increased empowerment for families • best opportunity for tailoring services to unique needs of individual families	• reduced stress through support in team • increased professional satisfaction through learning opportunities from other disciplines, and belief in affording the most benefits to clients/ families
Community Health Center Family Resource Program	• more comprehensive services • social supports and relationship building • personal development • family growth • community connectedness • learning • empowered—enabled to meet own needs	• support • increased professional satisfaction through learning opportunities from other disciplines, and a belief in affording the most benefits to clients/ families

> [I work with] skilled folk who I know and trust will give you feedback to help you improve your work.
>
> The growth that's occurred in the last ten years because of the families and the people that I work with has been life-altering . . . my co-workers as well as the families, make you look at your own life, your own issues and address your own issues.

Challenges. Workers reported more challenges than did clients. Among the challenges reported were:

- coordinating work schedules among team members
- finding time for the additional communication required for collaboration
- working with different personal styles of individuals
- integrating the work and contributions of individuals

Workers at the community health center said that,

> It's hard to organize your day unless you . . . [have] those looser bits of time. So that's probably the downfall of that, is that I am not sitting on my own and doing my own little thing. . . . I'd be much more efficient that way.
>
> The bigger the team gets to be . . . the more . . . goal displacement can happen; when you end up looking after your organization rather than looking after what started out to be your work. . . . If you start out, my work is to see clients individually, but suddenly you are going to performance appraisals committee meetings that take half a day because you are trying to develop a performance appraisal that will fit for everybody from very different disciplines, and then some of your energy has gone out of your original work.

Discussion

In this section, we examine the findings of this pilot study in relationship to the current literature on multidisciplinary collaborative practice.

What organizational and program purposes drive a multidisciplinary collaborative approach to practice? The purposes behind a multidisciplinary collaborative approach described by practitioners in the study were consistent with those suggested in the literature. Multidisciplinary, collaborative practice is designed to respond to complex problems (Orelove & Sobsey, 1991) and solve problems which are beyond the scope of any one discipline (Klein, 1990).

What strategies are employed in, what meanings are attributed to, and what organizational support exists for multidisciplinary collaborative practice? All practitioner participant groups noted that communication was critical to effective collaboration. This is consistent with views espoused by Klein (1990), Lowe & Herranen (1981), and Ovretveit (1993).

Leadership that is facilitative in style and serves to help others to act towards a common purpose has been identified as positively contributing to multidisciplinary practice (Ovretveit, 1993; Tjosvold, 1986b). These previous findings were borne out in the pilot study in that all three organizations reported working to realize an overall sense of who is doing what, with whom, and when amongst the collaborative group.

However, while Ovretveit (1993) indicates that decision-making requires agreed-upon procedures, the results of this study neither confirm not contradict this. Practitioner teams/groups report a shared perception of the decision-making process as consensual but the data did not address the development of the process or whether procedures for decision-making were explicitly articulated for or by team/group members. Therefore, future research could further explore the decision-making process of multidisciplinary collaborative teams.

Ovretveit (1993) also suggests that teams need to raise, recognize and resolve differences. Workers' readiness to accept differences of opinions and their views that interpersonal conflict is distinct from professional conflict suggests that the teams/groups in this study had perhaps integrated workable strategies for dealing with differences and, thus, rarely experience escalating conflict situations.

While Billups (1987) states that attending to the collaborative process is important in teamwork, group maintenance functions were not readily observed as occurring in the teams/groups studied. The intensity of the work at the program involved with case studies 3 and 4 was reported to interfere with the team's ability to attend to its own issues at times. Still, a high degree of reflective practice on the part of practitioners was evident in most of the interviews. It seems that while there may be little time for groups to explicitly review and contemplate their group process, individuals regularly engage in reflection regarding their own experiences in the collaborative group. The extent to which practitioners agreed upon organizational and personal issues affecting outcomes of practice seems to support Opie's (1995) contention that discussing perceptions of factors which contribute to and inhibit the effectiveness of collaborative efforts is another component of effective teamwork.

The literature suggests that rates of professional development and attitudinal readiness for collaboration may vary, depending on personal styles, personalities, philosophies, or particular training experiences (Billups, 1987; Kline, 1995; Krueger, 1990; Landerholm, 1990; Pappas,

1994). These scholars suggested that personal styles, personalities, and philosophies were deemed to be critical in the collaborative process. However, Krueger (1990) contends that teamwork has to be taught and cannot be learned from experience alone. A lack of relevant training experiences reported by participants in this study would indicate that specific training is less critical to the process. Most of the practitioners at the sites studied had more than a decade of experience working in collaborative teams/groups, and appear to have "learned by doing," not by being trained.

Perhaps what is most important is being afforded the opportunity and support to determine through first-hand experience that collaboration is useful and effective.

Accepting individual differences was reported as key to multidisciplinary, collaborative functioning by Poulin et al. (1994), and Krueger (1990). Learning to understand others was reported to be equally important in collaborative efforts by Lowe and Herranen (1981), Murphy (1995), Roberts (1989), and Tjosvold (1986). Building personal relationships with other team/group members was also described as important and is consistent with Tjosvold (1986b), Ministry for Children and Families (1997), and Netting and Williams (1996). All three teams/groups of practitioners interviewed in this study reported awareness of the importance of accepting individual differences, learning to understand and respect others, and building personal relationships with fellow team members in collaborating.

Practitioners/workers reported shared values and common goals as essential to collaborative relationships. This assertion appears similar to Murphy's (1995) description of shared vision in collaboration.

Coordination is essential according to Tjosvold (1986b). Practitioners in this study seemed to bear this out as all three program groups had a person(s) designated to fulfill this function.

Some information contained in the literature was contradicted by the results of this study. Kraus (1980) indicates that a non-hierarchical structure is required for collaboration. The team involved with case studies 3 and 4 at the second context operate under a clearly hierarchical structure but manage to collaborate effectively across disciplines. The hierarchical structure is overcome by the following:

- The psychiatrists ("ultimate authority") are committed to equal responsibility for collaboration within the team and interpret their own role as that of an equal member.
- Workers accept that professional acts dictate the authority accorded the psychiatrist.
- Individual members or team groups feel comfortable approaching the psychiatrist when they disagree with an intended course of action and requesting further discussion to reach consensus.

What outcomes do practitioners and service users perceive to be associated with a multidisciplinary, collaborative approach to practice? If time for collaboration is protected but other resources are not in place to support that time, some elements of services risk being compromised. When this happens, the approach to practice loses its capacity to produce the optimal outcomes.

A multidisciplinary, collaborative approach to providing services to children and families is more than "one-stop-shopping." When a variety of disciplines work out of the same facility and do not collaborate, the benefits derived by clients and workers are not realized. It is the collective effort that produces the benefits; it makes the "whole" much greater than the sum of its parts. Clients are reported to benefit from the variety of expertise and perspectives different disciplines bring to the collaborative team. Workers are also reported to benefit from the variety of expertise and perspectives and describe these as contributing to a work experience that is enriched by learning from others, sharing responsibility, and affording clients optimal benefits.

Practitioners at the first setting (case studies 1–4) reported that for some time, high caseloads have forced workers to share work, but that recently caseloads and reductions in services have increased to the extent that they threaten the collaborative approach to practice and its related beneficial outcomes. Pappas (1994) agrees that particular circumstances such as funding cutbacks can hasten collaborative team development by creating an occasion for collaboration or hinder it by setting up barriers (Pappas, 1994).

There was strong agreement between practitioner groups regarding the existence of considerable benefits to themselves and clients through engaging in a multidisciplinary, collaborative approach to practice. Several authors agree that such benefits as shared responsibility among workers, the provision of more comprehensive or holistic services, increased staff satisfaction, and mutual support among team members are outcomes of the approach (Abramson & Mizrahi, 1996; Bailey & Koney, 1996; Billups, 1987; Opie, 1997; and Velianoff et al., 1993).

While some authors suggest that multidisciplinary collaboration results in increased efficiency and effectiveness (Opie, 1997; Velianoff et al., 1993), practitioners interviewed in this study argue against the approach being efficient in the short-run because of the time demands, but fully support the approach as being more effective.

To what extent can the process of multidisciplinary collaborative practice be linked to its outcomes? Organizational and personal issues have strong influences on the potential for multidisciplinary collaborative practice to be effective. Attention to elements which facilitate and detract from the ability to collaborate effectively across disciplines is

essential if benefits are to be derived from the approach to practice. Organizations can facilitate a multidisciplinary, collaborative approach to practice by protecting times for formal communication, by maintaining a philosophy which values the involvement of clients/families in collaborating, and by providing adequate resources and ensuring optimal caseloads. Individuals must be committed to meeting the demands of collaborating with others from varied disciplines and especially must be prepared to learn about and respect the roles and contributions of others while simultaneously educating others about ones own roles and potential contributions.

Effective collaboration and its associated benefits can be construed to be an outcome. Improved relationships between workers and the support they derive from the collaborative process changes their ability to hear and respond to the needs of clients/families. Future research could explore further the notion that effective collaboration results in an increased "climate of caring." The caring, concern, and support described by clients was a key element of the benefits they derived from their experience. The parents report the social-emotional aspect of the support is what they value most. This is important to note when reorganization in healthcare currently is focusing on cost-efficiency; the time and process required to enable caring is in threat of being deleted from service in organizations.

The caring climate evidenced by all three practitioner participant groups seemed to make an important contribution to the overall success of the practice explored at both sites. This was attributed largely to the support workers derive from collaborative relationships. However, the experience workers possess as caregivers to children may contribute to their comfort level in working with conflicting goals and welcoming the challenges of change. Ruddick (1989) describes the task of caregivers as working to "maintain mutually helpful connections with another person . . . whose separateness they create and respect. Hence, they are continuously involved with issues of connection, separation, development, change, and limits of control" (p. 131).

Models for Collaboration. A primary finding from this pilot study is that people do multidisciplinary, collaborative practice in different ways. Approaches taken by various teams appear to develop to fit the focus of their work and their organizational structure. There is no apparent cut-and-dried model to point to, but it is possible to point to the process of multidisciplinary collaboration and its prerequisites as described above. The literature describes collaboration as occurring along a continuum of degrees of integration (Pappas, 1994; Orelove & Sobsey, 1991). The data from this study suggest that each of the three teams/collaborative groups reflect varying degrees of integration on the vari-

ous elements of collaboration. This is not surprising given that collaborative behaviours mature over time (Pappas, 1994) and that the desired degree of integration will depend on the objectives of any given program (Opie, 1995). While all three teams share a similar orientation to people which includes seeing co-workers and clients alike as capable and valuing their input, the sites have different expectations for the length of involvement of clients or families. Table 5 outlines the elements of multidisciplinary collaborative practice along the continuum of integration from multidisciplinary through transdisciplinary.

Based on the data obtained in this study, the degree to which the practice of the participating program teams reflects elements along the continuum is proposed in Table 6. The descriptors used in Table 5 were derived from research on working with children with multiple disabilities and therefore more closely resembles descriptors of practice at the children's health center than at the community based health center. Therefore, replacement descriptors were suggested to facilitate interpretation of the community health center's fit with the proposed models (see Table 7).

Table 6 reflects how the authors believe examples of practice from this study relate to the collaborative elements proposed in the above models for collaboration. The interpretation indicates that the collaborative approach demonstrated by each of the participant "teams" includes varying degrees of integration across the elements of collaboration.

Summary and Conclusions

In summary, this pilot study has resulted in confirming multidisciplinary collaborative practice: Its purposes, the process of doing it, and perceived outcomes associated with the approach to practice. The finding that could be argued as most interesting is that there are different forms of collaborative practice and that the models proposed in the literature may be too stereotyped, suggesting instead that multidisciplinary, collaborative teams generally follow consistent degrees of integration across elements of collaboration. There appears to be no one model for collaborative practice involving different disciplines. This study suggests that multidisciplinary, collaborative teams can reflect varying degrees of integration across elements of collaboration and that the desired degree of integration will be dependent on the focus and goals of the work and the purposes and length of client involvement.

While we can not point to one specific model for collaborative practice, this study has effectively highlighted the process for collaboration and its prerequisites. Shared physical space, opportunities for formal and

Table 5
Models for Practice

Element	Multidisciplinary	Interdisciplinary	Transdisciplinary
Assessment	separate assessments by team members	separate assessments with consultation	team members conduct comprehensive assessment together
Parent Participation	parents meet with individual team members	parents meet with team or team representative	parents are active and participating team members
Service Plan Development	team members develop separate plans for disciplines	team members share separate plans with each other	team members and parents develop plans together
Service Plan Responsibility	individual team members are responsible for implementing their section of the plan	team members are responsible for sharing information and implementing their section of the plan	team members are accountable to each other for how primary service provider implements plan
Service Plan Implementation	team members implement part of plan related to their discipline	team members implement their section of plan and incorporate other sections where possible	a primary service provider is assigned to implement plan
Lines of Communication	informal lines	periodic case-specific team meetings	regular team meeting with ongoing transfer of information, knowledge and skills shared among team members
Guiding Philosophy	team members recognize the importance of contributions from other disciplines	team members willing and able to develop, share and be responsible for providing services that are part of the total service plan	team members make a commitment to teach, learn and work together across discipline boundaries in all aspects to implement unified service plan

Table 5
(*Continued*)

Element	Multidisciplinary	Interdisciplinary	Transdisciplinary
Staff Development	independent within each discipline	independent within as well as outside of own discipline	an integral component of team meetings for learning across disciplines and team building

Note. From Woodruff, G., & McGonigel, M. J. (1988), p. 166.

Table 6
Flexible Models for Practice

Element	Children's Health Center: Preschool Program	Children's Health Center: Adolescent Program	Community Based Health Center: Family Resource Program
Assessment	multidisciplinary to transdisciplinary	interdisciplinary to transdisciplinary	interdisciplinary
Parent Participation	multidisciplinary to interdisciplinary	multidisciplinary to transdisciplinary	transdisciplinary
Service Plan Development	transdisciplinary	transdisciplinary	transdisciplinary
Service Plan Responsibility	interdisciplinary	transdisciplinary	interdisciplinary to transdisciplinary
Service Plan Implementation	multidisciplinary to interdisciplinary	transdisciplinary	transdisciplinary
Lines of Communication	transdisciplinary	transdisciplinary	multidisciplinary
Guiding Philosophy	multidisciplinary to interdisciplinary	interdisciplinary to transdisciplinary	interdisciplinary to transdisciplinary
Staff Development	multidisciplinary to transdisciplinary*	transdisciplinary*	transdisciplinary

informal communication, consensual decision-making, team/group co-ordination, and organizational support contribute to facilitating the collaborative process.

Further, this study indicated that while organizations can mandate collaborative work across disciplines, the role of the organization in supporting collaborative work rests with facilitating the "doing" of the work. The commitment to collaboration rests most strongly on the "grass roots" level of the worker. Thus organizations can create the space and an environment conducive to collaboration but cannot impose collaboration amongst individuals. A multidisciplinary, collaborative approach to practice asks a lot of an individual and includes a commitment to communication and the time it requires, acceptance of individual differences, flexibility, reflection in practice, and valuing the input and participation of others (clients and co-workers).

Workers spoke confidently about the numerous benefits they believe are derived from a multidisciplinary, collaborative approach to practice. Although workers experience challenges in working collaboratively, the benefits they believe are afforded to clients and themselves as workers were reported to outweigh the challenges endured in the process.

This research study, like any, involved some limitations and has served to highlight questions worth exploring in future research endeavours. The case study methodology employed in this pilot study proved an effective means for understanding collaborative practice from the perspective of workers but did not provide for an independent understanding of client effects. Further, although it was the intent of this study to speak to the extent to which a linkage is present between

Table 7
Reworking Terminology for Models for Practice

Descriptor Used Above	Appropriate Replacement Descriptor
assessment	observations of people's needs, determining potential
service plans	offerings/opportunities
parent	client or program participant
primary service provider	worker having primary relationship with client or participant

process and outcome in multidisciplinary practice, the case study methodology also did not provide a forum for evaluating such a link other than in a broadly descriptive fashion. More work is needed to incorporate a stronger client voice into the understanding of a multidisciplinary, collaborative approach to providing services to children and families. More work is also needed on the process outcome relationship.

Additionally, the study did not include a thorough investigation of collaborative relationships that the participating "teams" have with other groups within their sites or with agencies or organizations beyond their sites. This is worthy of further exploration because external organization environments and the support relationships they can afford are of great significance in their ability to undo collaborative practice or obstruct its development.

Aspects of the process of collaboration that warrant further exploration are the discipline/role, communication in group meetings, decision-making processes, leadership, team membership, cultural beliefs within teams/groups, and additional collaborative practice models. New insights into multidisciplinary collaboration could be gained by research that includes different settings and also collaboration amongst individuals who are not located together. Despite information lacking in the areas noted above, this pilot study provides a lot of material that could be used in course development and training in multidisciplinary collaboration. The findings of this study especially support training that would highlight engaging in the process rather than teaching multidisciplinary collaboration as a finished product.[2]

APPENDIX
Interview Questions for Site Practitioners

I. PURPOSES

a) Organizational Mission/Strategic Plan

i) What is your sense of the organizational mission statement/strategic plan for services?
ii) How, if at all, do you think the organizational mission/strategic plan addresses a need for people to work together?

b) Program Goals and Objectives

i) What is your understanding of the goals and objectives for your program?

ii) How, if at all, do you think these address a need for people to work together?

II. PROCESS

a) Strategies

i) What is a typical work day like? How do you organize your time and prioritize your activities?
ii) What aspects of your work require you to work alone?
iii) What do you do with other disciplines/team members?
iv) What is it like to work with others? What do you think about it? How does it make you feel? What does working with others provide you?
v) In working with others, what has your experience been like in communicating, solving problems and making decisions?
vi) In what ways do you involve service users?

b) Meaning

i) What does working collaboratively mean to you?
ii) What does multidisciplinary practice mean to you?
iii) What does integrated practice mean to you?

c) Organizational Support

i) What time is protected by your organization to allow you to work with others? In what other ways does the organization facilitate your working with others?
ii) Have you received any training relating to working with others? What was it like?
iii) In your experience, what are position advancements, appointments, performance increases, or pay increments based on?

III. OUTCOMES

i) What difference do you think working with others has on service users? What benefits does the approach afford them? How does it make them feel?
ii) What is your sense of organizational purposes being achieved?
iii) What is your sense of program goals being achieved?
iv) What are the strengths of this approach to practice?
v) What are the weaknesses of this approach to practice?

Interview Questions for Clients or Parents

I. PURPOSES

a) Organizational Mission/Program Goals and Objectives

i) What is your sense of how people work together here? Do you have a sense of why things are done the way they are?

II. PROCESS

a) Strategies

i) What was your first contact like? How did you feel afterwards?
ii) What were your next few visits like and how did you feel afterwards?
iii) In your experience, to what extent have therapists/workers involved you in the care/service(s) received by you/your child?
iv) Have you been involved with a number of different therapists/workers? What has that been like? How were you treated on a personal level?
v) Who communicates with you regarding the services you/your child uses? How does communication occur?
vi) In what ways or areas do therapists/workers seek your input? If so, what did they do with it?
vii) Have you seen or heard anything that you disagreed with? If so, what did you do?
viii) Have you had experience in a setting where people worked together in a different way than they do here? If so, what was that experience like for you? How does it compare to your experience here?

b) Meaning

i) What interested you about this study/why did you choose to participate?

c) Organizational Support

i) In what ways, if at all, does the organization make it possible for you to be involved in planning and providing services? Do you attend meetings?
ii) Have you been asked to attend a meeting with a group of therapists/

workers? If so, what was that like for you? What did you get out of it and how did it feel to be part of it?

iii) Do you have one contact who communicates methods of services and means for providing services to you?

iv) If you attend meetings, are you helped to understand meeting processes and purposes before meetings begin?

v) Are you provided with child care while attending meetings?

III. OUTCOMES

i) How do you think practice that involves people working together effects those who provide services? How do you think they feel about what they do?

ii) In your experience, what difference has this approach to practice made to you/your child? How are things different for you now than before you came here?

iii) Did you come here with specific goals for yourself/your child? What were they?

iv) Has your experience met the goals you had for yourself/your child?

v) Has your experience included any obstacles/problems in meeting the goals you had for yourself/your child in the program?

vi) What have you valued most from your involvement here?

vii) What have you liked least about your involvement here?

Notes

1. Funding support for this project came primarily from the Queen Alexandra Foundation for Children and the School of Child and Youth Care, University of Victoria. In-kind support was provided by the Child, Family and Community Research Program of the School of Social Work, University of Victoria.

2. Copies of the full research report can be obtained for a cost recovery fee of $10.00 Cdn. by writing to Sibylle Artz or Andrew Armitage, Faculty of Human and Social Development, University of Victoria, P.O. Box 1700, Victoria, BC V8W 2Y2.

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