
A Model for Interdisciplinary Collaboration

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Social workers have worked with colleagues from other disciplines since the early days of the profession; yet, they were without clear models to guide this interdisciplinary work. The author uses multidisciplinary theoretical literature and conceptual and research pieces from social work literature to support the development of such a model. First, current trends relevant to interdisciplinary practice are noted to emphasize its importance. The article describes a two-part model. Part one of the model consists of five components that constitute interdisciplinary collaboration between social workers and other professionals: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. Part two of the model consists of four influences on collaboration: professional role, structural characteristics, personal characteristics and a history of collaboration. Implications for social work practice are discussed.

Key words: collaboration; host settings; interdisciplinary teams; interprofessional collaboration; model development

Social workers practice in schools, hospitals, psychiatric clinics, juvenile courts, prisons, police departments, and a range of other settings (Abramson & Rosenthal, 1995; Gibelman, 1995). Current practice demands collaboration between social workers and the professionals who dominate these agencies. For effective collaboration, it is critical to know what constitutes and influences collaboration.

Trends in Social Work Practice Relevant to Interdisciplinary Collaboration

Trends in social problems and professional practice make it virtually impossible to serve clients effectively without collaborating with professionals from various disciplines. Teachers are less able to educate students when larger numbers of them come to school hungry, abused, and unable to speak English. Physicians and nurses are less able to meet the demands of managed care without assistance from social workers, occupational and

physical therapists, and others to support patients in the least expensive setting. These problems are compounded by the limitations of some disciplines, limited understanding of the roles and expertise of other professionals, increased requirements for accountability and documentation, and complex diagnoses and treatment methods.

Practice with Children and Families: Collaboration in Schools

Trends in public education require more collaboration between educators and social workers to educate "the children of today." Many experts cite changing demographics as prompting a national concern with education (Brown & Chavkin, 1994; Hare, 1994; Pallas, Natriello, & McDill, 1989; Schorr & Both, 1991). Pallas and colleagues identified five key indicators associated with poor school performance: minority racial or ethnic group identity, living in poverty, living in a single-parent family, having a poorly educated mother,

and having a non-English language background. Whereas one in four children fit the first four of the five indicators of poor school performance a decade ago, projected figures estimate that our schools will serve 5.4 million more children in poverty in 2020 than they served in 1984, 13 percent fewer white non-Hispanic children, triple the number of Hispanic children, and 22 percent more black children, with similar upward trends in single-parent families, poorly educated mothers, and children with non-English language background (Pallas et al.). These statistics indicate that schools will face more challenges and that these challenges will require expertise beyond "teaching." In other words, there will be a greater need for collaboration between school social workers and teachers. A clearer understanding of "what" this collaboration looks like is a first step in maximizing its occurrence.

Social workers have been active in the school-linked services movement to link health and social services with, and most often within, schools (Dryfoos, 1994; Hare, 1994; Hare, 1995; Pennkamp, 1992). The goal of school-linked services is to develop an integrated system of services for children and families that is characterized by collaboration. Berrick and Duerr (1996) outlined optimal conditions for school-linked services under which teachers and social workers work together to customize service plans to increase attendance, enhance academic performance, and develop creative ideas for managing children's classroom behavior. Supporters of school-linked services hope to achieve overall systems change (Gardner, 1989). They hope that more collaboration between teachers and school social workers can better address needs of students, families, schools, and communities. As Allen-Meares (1996) said, our schools often encourage professional "turfism" and an undermining of "a coordinated approach to equal educational opportunity and the development of our human capital. The need to reform the links between systems is urgent" (p. 538). Collaboration among individual professionals is a first step in developing collaborative relationships among community constituents, agencies, and professional groups.

Interdisciplinary Collaboration in Health Care

Workers in health settings have always been expected to collaborate. Direct social work practice

in healthcare was established in 1905, when social services were introduced at Massachusetts General Hospital (Cabot, 1915). Today, hospital social workers see increasing numbers of immigrants, people in poverty, and patients with limited or no insurance. Schilling and Schilling (1987) argued that this changing population has prompted a move from health care's entrepreneurial emphasis to a focus on clinics and treatment of special populations. Yet, managed care policies increasingly dictate the provision of care, and hospital stays become shorter and rarer. This requires social workers in medical settings to work closely with physicians, nurses, and other medical professionals to ensure that patients and family members have the understanding and tools to maintain gains made in the hospital or regimens prescribed in the doctor's office when they return home (Abramson & Mizrahi, 1996; Carroll, 1980; Cowles & Lefcowitz, 1992; Netting & Williams, 1998; Poole, 1995). Netting and Williams argued that "across the professions over the last decade, psychosocial aspects of health care have been viewed as increasingly critical in intervening with patients and their families" (p. 196).

Social Work Practice in Mental Health

Like medical social work, social work practice in mental health settings began around the turn of the century when Elizabeth Horton was appointed as the first psychiatric social worker to the New York City Hospital System in 1907 (Rossi, 1969). At that time, social work and psychiatry were viewed as having a close collaborative relationship (Deutsch, 1940). Today, social workers are entering the mental health field in increasing numbers. Indeed, mental health is the largest field of concentration for MSW students, and social workers are second only to nurses in staffing mental health facilities (Lin, 1995). Social workers in mental health settings are seeing clients whose lives have been affected by the expanding web of social problems that lead to homelessness and ethnic and language differences that compound medication noncompliance.

More than ever psychiatrists and psychologists in mental health settings are helped enormously in their tasks by social workers' contextual understanding of the person-in-environment. Clients in the mental health system present with more complex symptoms that require the expertise of professionals with diverse educational backgrounds.

Model for Interdisciplinary Collaboration Definition

Berg-Weger and Schneider (1998) defined *interdisciplinary collaboration* as "an interpersonal process through which members of different disciplines contribute to a common product or goal" (p. 698). I use a more positive definition for this article whereby interdisciplinary collaboration is an effective interpersonal process that facilitates the achievement of goals that cannot be reached when individual professionals act on their own (Bruner, 1991). This definition reflects the way interdisciplinary collaboration is written about and increasingly referred to when compared with other closely related interpersonal processes such as cooperation, communication, coordination, and partnership (Bruner; Graham & Barter, 1999; Kagan, 1992; Mailick & Ashley, 1981).

Components of Interdisciplinary Collaboration

I used four theoretical frameworks in the development of the model, including a multidisciplinary theory of collaboration, services integration—the program development model discussed most frequently in conjunction with collaboration—role theory, and ecological systems theory.

Through a review of the theoretical literature and the social work practice literature, I identified components of interdisciplinary collaboration that consistently appear. Although differences exist among disciplines, this model is meant to be a generic depiction of the components of optimum collaboration between social workers and other professionals. Interprofessional processes among one or more professionals from different disciplines engaged in work-related activities should represent five core components: (1) interdependence, (2) newly created professional activities, (3) flexibility, (4) collective ownership of goals, and (5) reflection on process (Figure 1).

Interdependence refers to the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks. To function interdependently, professionals must have a clear understanding of the distinction between their own and their collaborating professionals' roles and use them appropriately. Characteristics of interdependence include formal and informal time spent together, oral and written communication among professional colleagues, and respect for colleagues' professional opinions and input. For example, in

Figure 1

Components of an Interdisciplinary Collaboration Model



a hospital setting a medical professional provides a social worker with an assessment of the patient's medical needs, which the social worker relies on to develop an effective discharge plan.

In the social work literature, frequent references to the importance of interdependence occur in writings about an interdisciplinary "team." The word *team* derived from Old English and referred to "a group of animals harnessed together to draw some vehicle" (Dingwall, 1980, p. 135). Social workers have been parts of teams more than any other professionals (Kane, 1975). A *team* consists of two or more professionals working together. Kane (1980) identified two contrasting patterns of teamwork. *Coordinate teamwork* is characterized by distinct professional roles, designated team leadership, nonconsensual decision making, and little emphasis on group process. *Integrative teamwork* more closely resembles collaboration as defined in this article and is characterized by a belief that group members' abilities to carry out their jobs is dependent on each other.

From their meta-analysis of literature on collaboration across disciplines, Mattessich and Monsey (1992) identified behaviors and attitudes that characterize interdependence as a component of collaborative practice. These include participants' thinking that they have more to gain than lose by collaboration and an ongoing flow of communication among colleagues.

Soler and Shauffer (1993) also affirmed interdependence as a component of collaborative efforts in their exploratory research. They examined efforts to coordinate children's services across the country to elucidate factors that make them work. They found that successful efforts relied on highly effective communication that spanned professional boundaries. This finding parallels Kagan and colleagues' (1995) study of service integration initiatives in four states, which found that successful collaborations among service providers in programs for children and families were characterized by clear avenues of reciprocity and communication among key actors.

A frequently cited advantage of teamwork is that merging the expertise and knowledge from different disciplines maximizes creativity with today's complex problems (Lonsdale, Webb, & Briggs, 1980; Webb & Hobdell, 1980). A related support for collaboration is rooted in the belief that reliance on others for certain tasks and resources allows collaborators to spend their time

doing what each knows and does best (Abramson & Rosenthal, 1995).

Billups (1987) identified a solid professional identity as an important component of successful teamwork. Mattessich and Monsey (1992) found that successful collaborators had clearly understood roles. Both of these qualities are precursors for interdependence; professionals need to be secure in their own roles to know what they can offer and, in turn, what they can rely on others to provide.

Newly created professional activities refer to collaborative acts, programs, and structures that can achieve more than could be achieved by the same professionals acting independently. These activities maximize the expertise of each collaborator.

Kagan (1992) identified newly created professional activities as a critical component of collaborative work when she defined *collaboration* as an act by which "an identifiable durable collaborative structure is built" (p. 60). Melaville and Blank (1992) echoed this, characterizing collaborative initiatives as creating fundamental changes in the way services are designed and delivered.

Mattessich and Monsey (1992) identified this factor as a component of collaboration when they noted that collaborators create unique purposes for their endeavors that do not replicate those of individual professionals or professional groups.

Kagan and Neville's (1993) application of systems theory to service integration emphasized how individual people and programs linked together have the opportunity to create that which they cannot create when acting independently. Kagan and colleagues' (1995) study of service integration in four states found that successful collaborative efforts involved mechanisms for "broad-based reform that affects clients, programs, policy, and organizational bureaucracy" (p. 145). In other words, reform involving collaboration extends beyond the individual collaborators and their direct services to clients. Such reform may be observable in new structures, policies, and service delivery systems. These new structures can be found in schools where teachers and social workers develop staff in-service programs collaboratively. They can be seen in hospitals where a structure is created for medical and social work interns to pair together to work with patients and families.

Flexibility extends beyond interdependence and refers to the deliberate occurrence of role-blurring.

Behavior that characterizes flexibility includes reaching productive compromises in the face of disagreement and the alteration of role as professionals respond creatively to what's called for. Hospice social workers illustrate flexibility when they use knowledge gained from working in teams with nurses and physicians to answer patients' simple questions about palliative medical care.

Mattessich and Monsey (1992) argued that flexibility is a critical component of collaboration and noted that successful collaborators exhibit adaptability, even under changing conditions. Case studies of collaboration and service integration emphasize the importance of flexibility (Hord, 1986; Lieberman, 1986; Soler & Shauffer, 1993; Wimpfheimer, Bloom, & Kramer, 1990). Billups (1987) identified flexibility, especially with regard to team goals, as a process characterizing interdisciplinary team interactions in which social workers engage.

Toseland, Palmer-Ganeles, and Chapman (1986) surveyed professionals in a variety of disciplines and interdisciplinary teams in psychiatric settings. They found one of two major areas of disagreement to be whether team members should have equal power. As a component of collaboration, flexibility in role demands less hierarchical relationships. Abramson and Mizrahi (1986) viewed this from a perspective that did not attempt to alter power, but rather circumvent it. They argued that social workers have greater success working with physicians when they view their role as being a resource as opposed to a role in an "equality-based collaborative" (p. 2). To have the kind of integrative teams that Kane (1980) wrote about, some deliberate role blurring and flexibility are required. Roles taken should depend not only on a professional's training, but also on the needs of the organization, situation, professional colleagues, client, and family.

Collective ownership of goals refers to shared responsibility in the entire process of reaching goals, including joint design, definition, development, and achievement of goals. This includes a commitment to client-centered care whereby professionals from different disciplines and clients and their families are all active in the process of goal attainment. To engage in collective ownership of goals, each professional must take responsibility for his or her part in success and failure and support constructive disagreement and deliberation among colleagues and clients.

The multidisciplinary literature on collaboration identifies the collective ownership of goals as a core component for successful collaboration (Bruner, 1991; Mattessich & Monsey, 1992). Mattessich and Monsey implied collective ownership of goals when they noted that successful collaborative efforts include clearly defined, realistic goals; a shared vision; agreed-on mission, objectives, and strategy; broad-based involvement in decision making; and collaborators with the ability to compromise. The literature on services integration parallels this in recognizing the importance of clearly identified goals (Kagan et al., 1995; Soler & Shauffer, 1993) and client and family involvement in planning (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996; Soler & Schaffer).

Billups' (1987), in his article on social workers' collaboration with other professionals, defined the central dynamic of the interprofessional team process as

a form of consensus among team members that reflects neither the extreme of perfect unison nor that of unbridled conflict. This central dynamic more often has attributes of a democratically-oriented flow of transactions that makes possible free communication, reasonably full participation, and a sufficient level of agreement to lead to a concerted series of collective decisions and actions (p. 148).

Billups emphasized two subprocesses of collaboration that are particularly related to the collective ownership of goals: identifying and assessing problems to be addressed, setting goals, and developing action plans; and negotiating and implementing the action plan and engaging in necessary follow-through.

Abramson and Rosenthal (1995) argued the importance of collective ownership of goals when affirming that greater inclusiveness in decision making leads to "a wider base of ownership of the process and increased support for implementation" (p. 1482) and that broad-based interdisciplinary support for change has a better chance for success than a solitary effort. In an ethnographic sociolinguistic study to understand how "professionals and professionals-in-training learn about becoming a team member," Sands (1990, p. 4) examined one social worker's development as a team member over time. She found that a key aspect of socialization to the interdisciplinary team

process included the worker's increased involvement in team processes, including discussions and decisions.

Connaway (1975), Compton and Galaway (1984), and Mallick and Ashley (1981) discussed the social worker role of client advocate as potentially being in conflict with collective team goals. An example in the school could occur when a school social worker perceives a teacher as impeding the progress of a child or family. How does the worker advocate for his or her client in a way that does not compromise a collaborative relationship with the teacher? In a larger way, Dingwall (1980) cautioned that "better teamwork might only increase the power of professionals in relation to their clients and many would argue that that imbalance was already too great" (p. 135). Inclusion of the client and his or her family in goal setting and achievement as part of a definition of interdisciplinary collaboration attends to the importance of the clients voice in all aspects of service delivery (Graham & Barter, 1999; Seaburn et al., 1996).

Reflection on process refers to collaborators' attention to their process of working together. This includes collaborators' thinking and talking about their working relationship and process and incorporating feedback to strengthen collaborative relationships and effectiveness.

Soler and Shauffer's (1993) study identified successful service integration as incorporating a commitment to self-evaluation. Billups (1987) included openly addressing intrateam conflict and use of feedback to reflect on collaborative interactions as critical components of successful interdisciplinary teams. Kane (1980) defined an *integrative team* as one that allocates time for "reflecting on process." Last, Abramson (1984) identified guidelines for team actions and specified the importance of a procedure whereby teams examine the ethical dilemmas that confront them and how these dilemmas are approached.

Influences on Interdisciplinary Collaboration

Inclusion of influences on interdisciplinary collaboration places the model in context. After a model exists to describe collaboration, and if collaboration is deemed an important component of practice, an understanding of what aids and what presents barriers to collaboration is needed to increase its occurrence. Areas noted as influences on interdisciplinary collaboration include professional role, structural characteristics, personal

characteristics, and a history of collaboration (Figure 2). The presence of each supports interdisciplinary efforts, whereas their absence presents barriers to its occurrence.

Professional Role. A strong sense of professional role includes holding the values and ethics of the social work profession; an allegiance to the agency setting; an allegiance to the social work profession; respect for professional colleagues; an ecological, holistic view of practice consistent with the social work profession; and a perspective that is similar or complementary to collaborators' perspectives.

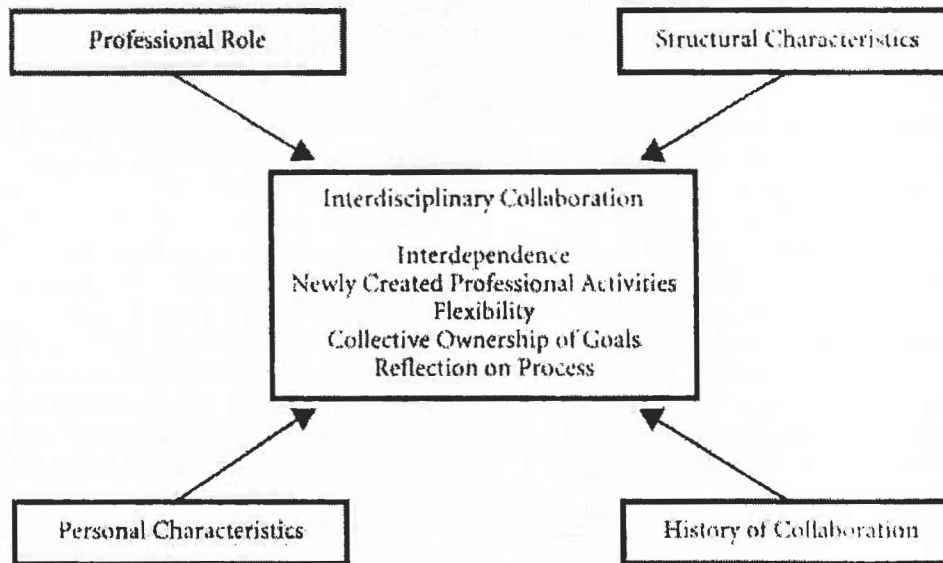
Role theory informs an understanding of how socialization into a professional role occurs and how a person is able to interact with others in his or her work. Critical issues in understanding the influence of professional role on social workers' collaboration with others includes the effect of socialization, the settings, and status and hierarchy.

Each profession socializes its members differently with regard to role, values, and practice (Abramson, 1990), and the differences among the professions are compounded by the high value each places on autonomy, holding the ability to be self-directed as an "ideal" of professionalism (Waugaman, 1994). This sense of autonomy, professional identity, and skills develop through the process of professional socialization. Understanding the socialization, and with it the role expectations and heritage of a profession, are prerequisites for understanding a group of professionals' skills, attitudes, and abilities to collaborate with other disciplines (Lee & Williams, 1994; Waugaman). Sometimes, the diverse cultures, norms, and language of each profession make the process of interdisciplinary collaboration resemble the bringing together of inhabitants from foreign lands.

Social workers take on an endless number of roles on interdisciplinary teams and in their dyadic interdisciplinary relationships. Several studies note that successful teamwork may be hampered by allegiances that lean too strongly toward a workers' profession or department (Abramson, 1990; Hoch, 1965; Kane, 1975, 1980) or too strongly toward the interdisciplinary team (Abramson, 1990; Kane, 1980). A strong sense of professional role as prerequisite for interdisciplinary collaboration involves an allegiance to both. Because interdisciplinary relationships differ for a discipline and its status in the setting, a competent

Figure 2

Influences on Interdisciplinary Collaboration



professional role that can promote collaboration requires reciprocal respect regardless of the profession's status in the setting.

Structural Characteristics. Structural characteristics relevant to interdisciplinary collaboration include a manageable caseload, an agency culture that supports interdisciplinary collaboration, administrative support, professional autonomy, and the time and space for collaboration to occur.

Hord (1986) reviewed the experiences of a wide spectrum of collaborators in human services, education, academia, and management and identified some of the structural barriers to collaborative activity. These include insufficient time for negotiation and exchange, personal investment, and the financial commitment necessary to sustain collaboration. Mattessich and Monsey (1992) found that collaboration is supported when agency leaders advocate for it and when an adequate financial base exists.

Structural characteristics that influence interdisciplinary collaboration include ways that an organization and supervisor allocate resources

and assign work that either supports or poses barriers to collaboration. Hughes and colleagues (1973) noted that it has always been difficult to separate social work as a profession from the organizations in which social workers practice. Smalley (1965) extended this view, saying that "social workers are trained to work within an institutional framework, and to make some agency's or institution's purposes usable by the clientele served for their own and the community's welfare" (p. 63). As far back as the 1930s, Gulick and Urwick (1937) argued that the greatest dangers to organizations' working together was the "lack of co-ordination and danger of friction" that "occurs between departments, or at the points where they overlap" (p. 33).

The importance of structural factors in interdisciplinary collaboration is noted in the social work literature. Billups (1987) argued the importance of being able to maximize the benefits and minimize the constraints of environmental and agency influences on interdisciplinary practice. Brown (1995), in his social work dissertation,

sought to identify factors that support or pose barriers to interdisciplinary collaboration in health care. He found that a sense of a common mission facilitated collaboration. He also found that the structural factors unclear mission, insufficient time, excessive workload, and lack of administrative support were barriers to collaboration.

Personal Characteristics. Personal characteristics relevant to interdisciplinary collaboration include the ways collaborators view each other as people, outside of their professional role. Mattessich and Monsey (1992) revealed that personal characteristics are extremely significant components of successful collaborative endeavors. In studies they reviewed relevant personal characteristics included trust, respect, understanding, and informal communication between collaborators. Maslow's (1965) humanist perspective that undergirds service integration efforts also argued that trust is a critical base for successful collaboration.

Abramson and Mizrahi (1996) surveyed social workers and physicians and found that both of these groups felt that collaboration was enhanced by respect, a positive quality of communication, and similar perspectives. A well-understood role and quantity of communication were more valued by social workers, whereas a "capable" collaborator and one who "kept you informed" were more highly valued by physicians. Brown's (1995) study of factors that present barriers to or support collaboration in health care found that the following personal characteristics were relevant to successful collaboration: positive attitudes toward collaborators, respect, and comfort with collaborators' personal behavior.

History of Collaboration. A history of collaboration refers to earlier experiences in interdisciplinary settings with colleagues. This factor emerged as an indicator of successful collaboration in many of the studies reviewed by Mattessich and Monsey (1992). Lonsdale and colleagues (1980) noted that the long tradition of specialization and fragmentation in the social services as a whole presents obstacles to successful collaborative practice. In addition, positive experiences with interdisciplinary collaboration in paid and internship settings have been shown to be linked with current levels of successful collaboration (Bronstein, 2002).

Conclusion and Implications for Practice

Social workers face the challenges of increasing social problems such as rising numbers of families

in poverty, new immigrants, and people who are aging, and decreasing resources make efficient practice essential. Interdisciplinary collaboration whereby colleagues work together and maximize the expertise each can offer is critical. Yet, without a model of interdisciplinary collaboration, its practice needs to be continually redefined. The model of interdisciplinary collaboration put forth elucidates the components of this social work skill, which is now an imperative for professional practice. A high-quality level of collaboration may occur in an elementary school when a school social worker decides to accommodate parents' requests for help with their children's homework, and the social worker elicits teachers' input for how to structure a homework club to maximize participation and results. In a rehabilitation hospital, optimal collaboration may occur when an interdisciplinary team of social worker, doctor, nurse, and speech therapist meets regularly for case conferences that each looks forward to as a place to find solutions for clients that they have been struggling with alone. In an inpatient unit of a community mental health center, collaboration occurs when a family member calls the unit with a request that any of the professionals feel comfortable responding to in a way that makes the family members feel respected and a part of the team.

The second part of the model, the influences on collaboration, offers workers areas to pay attention to in maximizing collaborative work. For example, if social workers feel that their collaborative work is not as effective as they would like, they can look to areas outlined in the model such as their supervisor's support, their colleagues' and their own commitment to agency and profession, and their personal relationships for improvement. When collaborating with professionals of higher status, workers can acknowledge this difference (Abramson & Mizrahi, 1986) and attempt to clarify their contribution and unique role. Workers can be proactive by providing interns with positive collaborative experiences in field placements and allocating time for collaborators to confer.

As Seaburn and colleagues (1996) noted, "A culture of collaboration does not just happen. It must be formed and fashioned by many hands" (p. 23). The model put forth is intended to serve as a map for the creation of such a culture. The next step is to use this model to examine whether interdisciplinary collaboration is being carried

out. If it is, then does it echo what our literature and practice wisdom indicate and lead to the critical work of our profession, improving the lives of the clients we serve? ■

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