# Barriers and Bridges:
# Interdisciplinary Collaboration in Addiction and Mental Health Care

**By**

**Amber Risha Turner Mitchell**
**B.A., University of Victoria, 2006**

**A Thesis Submitted in Partial Fulfillment**
**Of the Requirements for the Degree of**

## MASTERS OF ARTS

**In Dispute Resolution, School of Public Administration**
**Faculty of Human and Social Development**

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## ABSTRACT

The objective of this thesis is to explore the factors that enhance collaboration in the interdisciplinary environment of front-line addiction and mental health care. This research will explore these factors by posing the question, *What do mental health and addiction professionals report as determining the success of an Inter-Disciplinary Collaborative environment?* Using McCracken's Long Interview (1988) and principles drawn from Flanagan's Critical Incident Technique (1954) the participants discuss their experiences with collaboration in the interdisciplinary environment of integrated addiction and mental health care. The findings are presented according to three overarching themes: 1) Interpersonal and Group Relations, 2) Organizational Supports, and 3) Challenges / Sources of Conflict. Finally, a dispute resolution perspective is taken in order to discuss the findings according to implications for practice, dispute resolution, and leadership and policy.

TABLE OF CONTENTS

## LIST OF ACRONYMS

ADR – Alternative Dispute Resolution

CD – Concurrent Disorders

CIT - Critical Incident Technique

IDC – Interdisciplinary Collaboration

VIHA – Vancouver Island Health Authority

# ACKNOWLEDGEMENTS

I would like to acknowledge and thank the Vancouver Island Health Authority for their participation in this study. I would especially like to extend my gratitude to the participants who volunteered to share their time and experiences with me.

I would also like to thank the British Columbia Ministry of Health who, through the Pacific Leaders Graduate Fellowship, funded this research. I do hope this study will be of use to you as you plan and design future care in our province.

Finally, I would like to thank my supervisor, Dr. Mary Ellen Purkis, committee member, Dr. Lyn Davis, and past program advisor, Louis Pegg, for their combined dedication and assistance. Without the gracious support of all of you my experience with the MADR program would not have been the same.

# DEDICATION

I would like to thank and dedicate this work to my family. Derek, Grayson, Wesley, Tweety - without your support I could not have accomplished this goal. The greatest reward is hearing you speak of mom's 'ceesus' with such pride.

# Chapter 1 – Introduction

The principle aim of this thesis is to explore the factors that enhance collaboration in the interdisciplinary environment of front-line addiction and mental health care. A key focus of the thesis will be to elicit moments that interdisciplinary group members report as successful experiences of interdisciplinary collaboration, and to garner an understanding of what skills and factors may have played a role in the positive outcome despite the inherent conflicting differences in professional identity, education, background, and values present in the individuals involved. This includes an examination of how group members attempt to navigate and manage these differences as they arise. This research also attempts to further explicate some of the inherent challenges present in the interdisciplinary group environment of integrated mental health and addictions care, with the goal of further understanding and supporting the interdisciplinary group process. This research will explore these factors by posing the question, *What do mental health and addiction professionals report as determining the success of an Inter-Disciplinary Collaborative environment?*

## Why this site for the research?

Enhancing services and treatment for those with concurrent mental health and addiction issues is listed as one of the top priorities in the 2007/2008-2009/2010 Strategic Services Plan produced by the Ministry of Health (Ministry of Health, British Columbia, 2007b). The Government of British Columbia has also indentified the need

to “enhance mental health and addiction services across the province” in the ‘Five Great Goals’ established as overarching goals to guide the work of all ministries in British Columbia (Ministry of Health, British Columbia, 2007a). The importance of this integrated treatment approach has certainly been established, what researchers, policy makers, and front line workers are now navigating is how to effectively treat concurrent mental health and addiction issues in an integrated environment that often demands collaborative practice between multiple disciplines.

Barriers to collaborative treatment are many, and each barrier produces an exorbitant cost to the Province of British Columbia, in financial loss, human life and provincial potential. The Centre for Addiction and Mental Health (CAMH) in Toronto conducted a study involving Mental Health and Addictions workers, finding that the two predominant issues identified as barriers to workplace productivity, (e.g. effective and positive treatment of their mental health and addiction clients), were poor inter-personal communication and inter-personal and inter-group conflict (Kinross 2003). Extensive research has been done on integrated management, yet the predominant focus has been on best practices and clinical guidelines for care (Baker, 1991); (Canadian Mental Health Association/ Ontario Division, 1997); (Hood, Mangham, McGuire, & Leigh, 1996); (Ries, 1994). Little research or knowledge has aimed to address the gap in our understanding of how best to facilitate collaboration and co-operation across these diverse and culturally different disciplines, including the myriad of front line individuals involved in the concurrent treatment of addiction and mental health needs (Garland, Harrison, & Schwartz, 2007); (Health Canada, 2002); (Standing Committee on Social Affairs, Science & Technology, 2006). There is an urgent need to address inter-

professional conflicts and increase coordination and collaboration of these diverse systems (Baker, 1991); (Canadian Mental Health Association/ Ontario Division, 1997); (Hood et al., 1996); (Ries, 1994).

## What assumptions frame the Research?

There are a number of assumptions that have been made from the outset of this research. Many of these assumptions arise from the complicated nature of research into health care collaboration and its effectiveness, an area of research that is very difficult to contain and categorize due to myriad contextual factors and multiple levels of possible outcome measurement[1]. Perhaps most significant is the broad assumption, present not only in this research but also in much of the research and policy in the area, that collaborative, integrated mental health and addictions services and care will indeed mean improved outcomes for clients. Recent research offers evidence that these integrated systems and programs are indeed more effective, and yet the majority of research simultaneously highlights the multiple policy, clinical and consumer barriers that frustrate and hamper implementation and maintenance of these integrated systems and programs (Minkoff, 2001); (Mohr, Curran, Coutts, & Dennis, 2002) Drake, Essock, Shaner et al 2001; Sciaccia 1997). We may assume then, that although integrated, collaborative care has become an evidence based practice in addictions and mental health care, the rhetoric may at times outpace actual practice. Evaluation and judgment of the integrated system and/or programs is simply beyond the scope of this research.

Moreover, there is an assumption in operation throughout this thesis and

[1] For an excellent in-depth review of past studies and literature, please see (Lemieux-Charles & McGuire, 2006)

research as a result of my own disciplinary experience and history. That is, as a dispute resolution student I am quick to assume that enhanced collaboration and a reduction of group conflict will indeed improve the ability of group members to deliver care and therefore enhance client outcomes. But the client outcome is simply too far removed from the group relationship and carries too many co-related factors to be brought directly into the research paradigm or outcomes. This thesis, then, aims to explore how collaborative practice unfolds in the addictions and mental health environment rather than provide evidence of enhanced client care and causal factors. This being said, my location as a dispute resolution student means that I strongly believe in the value of productive conflict and enhanced collaboration, in both personal and professional settings.

There are also a number of assumptions that have gone into the design and framing of the research. These include assumptions that the research methodologies, methods and framework of analysis are the most appropriate ways in which to explicate the desired detail from the participants, resulting in the most genuine representation of the interdisciplinary relationship. Moreover, I assume that in choosing mental health and addictions integration as a locating site for my research on interdisciplinary collaboration, that my analysis and study will subsequently be beneficial and valuable to others attempting to navigate the actualities of integration and the inevitable interdisciplinary group relationships that present.

It is also very important to note the assumption that the research and concepts discussed within this thesis, particularly those from the fields of conflict analysis and alternative dispute resolution, focus on general processes and it must be understood

that each individual, organization, community, institutional or societal setting is unique and requires analysis to understand and explicate the multitudes of interactions present before any form of suggestion or management process is implemented. Furthermore, it must be said that these processes come from *minority world* social science research and as such must be altered or modified with understanding and knowledgeable assistance and direction in order to be applicable in other cultural settings.

## Situating Myself: Social Constructivism

This research is designed and conducted under an emergent theoretical perspective in order to allow for the unique perspectives and experiences of the participants as the research is conducted. This is in keeping with my own epistemological views of knowledge, and my positioning as a *social constructivist.* Social constructivism assumes that knowledge is experiential and subjective, meaning that there are multiple 'realities' experienced by each individual in a constantly evolving continuum of human and environmental interaction (Winslade & Monk, 2000). Constructivism has become popular lexicon in many social science fields as these researchers often "share the goal of understanding the complex world of lived experience from the point of view of those who live it" (Schwandt, 1998, p. 221). Therefore, social constructivism is frequently aligned with research that as much as possible relies "on the participants' views of the situation being studied" (J. Creswell, 2003, p.8). The adoption of a social constructivism standpoint also mirrors the research subject matter in this study, as constructivism posits that meaning making is

constructed as an external, intersubjective process, just as the interdisciplinary relationship is also an external, intersubjective process.

**Background to my field of study: Alternative Dispute Resolution (ADR)**

Alternative dispute (conflict) resolution (ADR) refers to the wide variety of methods employed in the management and resolution of disputes (conflicts) other than traditional litigation (Goss, 1995). As a growing field, ADR has evolved from beginnings in mediation and arbitration processes used within the court system to a broader field; actively employed across many legal and non-legal arenas including government, policy, social services and non-profit. Historically, the roots of ADR processes can be seen in some of the early labour disputes of the 20th century however it was not until the legal reform measures taking place in the second half of the 20th century that ADR processes became a part of our legal system, introduced as a means to ease the cost and time involved in litigation (Mayer, 2004; Goss, 1995). As the number of scholars and practitioners interested in these alternative processes grew, so too did the legitimacy of ADR as a serious field with an increasing amount of tools to understand and manage conflict, including mediation, arbitration, mediation-arbitration, and the design and orchestration of collaborative decision making models between multiple stakeholders.

ADR maintains a close theoretical and practical relationship with the field of conflict analysis. Both theorists and practitioners have attempted to analyze and classify conflict situations with the hopes of learning more about the fundamental psychological roots that seem pertinent to understanding and managing conflict effectively. Most of

these classifications of conflict can be loosely grouped into three ‘dimensions’ or ‘constructs’ as identified by LeBaron (2003): material-structural, communicative-relational, and symbolic. Whether the conflict in question is an interpersonal, intergroup or international conflict many of the same questions arise as to the motivating factors and actions of those involved. Although there are many different but equally valid outlines proposed by different scholars, for the purpose of this paper, I will follow the outline of psychological processes as proposed by Morton Deutsch, as presented in The Handbook of Conflict Resolution: Theory and Practice (2000). This typology is helpful in understanding and categorizing conflict, and assists individuals and practitioners in analysis of conflict towards successful management.

It must be understood that none of these processes are mutually exclusive but rather they interact, playing both a causal and escalating role in the perpetuation or management of a conflict scenario. Deutsch outlines these processes as follows:

- **Social Justice**. When all parties involved have a different conception of what ‘fair’ resolution would look like. Each believes the other is, or represents, a perceived injustice.
- **Cooperation-Competition**. Refers to the orientation in which individuals approach a conflict. A competitively orientated individual will be seeking a win-lose resolution, whereas a cooperative orientation seeks a mutually beneficial solution, often referred to as a win-win agreement.
- **Motivation**. Often parties to a conflict have stated positions, but knowing the reason behind this position - their needs or interest - is crucial. Understanding and exploring the motivation behind an entrenched position can facilitate constructive progress

towards resolution and management.

- **Trust**. Lack of trust is common in conflict situations. Attention to factors which give rise to distrust, as well as those that repair or foster trust is crucial in ongoing management of conflict.
- **Communication**. Communication often plays a cyclical role in conflict that is miscommunication often breeds conflict which then further breaks down effective communication. Thus the importance of developing effective communication skills, as both listener and speaker.
- **Persuasion**. In most conflict situations, each party spends a considerable amount of energy and time focused on how to persuade the other of the validity of their own position.
- **Power**. The distribution of power (including power drawn from economic advantage, physical power or weaponry, knowledge and information, status or position, historical advantage etc.) among conflict parties and how this power is employed during the conflict can considerably influence the outcome.
- **Violence**. Manifest conflict that escalates into violence, or the threat of violence, necessitates specialized intervention and practitioners with experience and understanding of factors that contribute to the likelihood of continuing, or escalating, violence and retaliation.
- **Personality and Identity**. Unresolved inner conflict and individual personality characteristics including personal values, ideology, and social identity have tremendous effect on conflict, as both root and escalating factors.
- **Culture**. The social and historical culture(s) in which an individual has developed,

and is currently immersed, are of particular importance to the conflict theorist hoping to understand the roots and continuance of conflict. There are a number of questions raised when attempting to understand the role of culture in conflict, especially as these pertain to the role of the practitioner or theorist. How can intractable conflicts, often involving cultural differences, be handled? Is intervention appropriate, particularly when the intervention and management is usually led or coordinated by a minority world, Western academically trained ADR practitioner? Is conflict theory, largely developed out of minority world academic environments, applicable in other cultural contexts?

This thesis will focus largely on group processes within the health care arena, specifically the analysis of the factors which lead away from a competitive orientation towards a group cooperative, or collaborative, orientation for professionals employed in an interdisciplinary addictions and mental health care environment (Deutsch & Coleman, 2000). Inter (between) group and intra (within) group conflict analysis has grown in importance as group decision making has become increasingly recognized across both private and public organizations and general society. It is now common to have multiple groups with a varied level of decision making influence and authority: management teams/groups, rotating project groups, stakeholder groups, et al. It is clear that conflict may be expected at some point in these groups, as multiple individuals, with diverse backgrounds, disciplines, values, interests and ideas, attempt to come together. It is difficult to surmise what the definitive outcome of these conflicts may be; how and why in some situations conflict has the ability to be a productive and constructive process that contributes to a group ongoing decision making and cohesiveness. Too

often, however, these conflicts result in a decrease in communication, animosity between individuals, and hamper the productivity and motivation of the group as a whole (S. Fisher, 2000). The purpose of this research study is to explore this unique phenomenon from the perspective of those directly involved and try to locate, from the individuals involved, what skills and interactions contribute to successful group relations, despite the differences and conflicts inherent in all interdisciplinary group relationships.

# Chapter 2 – Literature Review

## Inter-Disciplinary Collaboration (IDC) in the Concurrent Disorders Literature

Inter-disciplinary collaboration (IDC) refers to individuals with distinct professional training and education working together for a common purpose, each making complementary contributions to patient care (Leathard, 1994a). Other terms, such as multidisciplinary, interprofessional, and transdisciplinary, are frequently used and attempts to define and delineate between them in the health literature have been both abundant and futile (Leathard, 1994; J. Ovretveit, 1996). Leathard (1994) grouped terms such as inter-disciplinary, interprofessional, collaboration and partnership according to concepts and processes. Others such as McCallin (2001) have pointed out that the individual contextual nature of service delivery alters both the concepts and definitions as they are applied. Sorrel-Jones (1997) offers a simple definition that maintains applicability in multiple contexts, and the one that will be used for the purposes of this review and study:

> Inter-disciplinary describes a deeper level of collaboration in which processes such as evaluation or the development of a plan of care are done jointly, with professionals of different disciplines pooling their knowledge and skills in an independent manner (p.22).

Therefore, inter-disciplinary emphasizes the collective action towards care rather than the individual's task of work as a part of care.

There is a definitive gap in the research literature regarding collaboration in the

concurrent disorders (CD) environment. This gap has been largely filled by consensus conferences and discussion papers highlighting the need for integrated treatment, systems, and programs without specific details of the strengths, skills, and relationships needed to effectively deliver and sustain these new proposed working environments. This literature review will present and critique past research dealing with inter-disciplinary professional collaboration in the concurrent disorders environment. I will focus on concurrent mental health disorders literature where there is a recognition that representatives of many different professional groups make a contribution to care. As there is a great deal of overlap with terms such as cooperation, multi-disciplinary, inter-agency and trans-disciplinary collaboration, studies that address these similar concepts care are included in the analysis.

As mentioned, the largest body of literature available is focused on the need for integrated systems and case management (e.g. (Drake et al., 2001; Hendrickson, Schmal, Albert, & Massaro, 1994; Minkoff, 2001; Mason & Siris, 1992). This literature is most often framed as a debate on treatment models and outcomes, or a discussion of various levels of integration at the organization level. I have reviewed this literature to the extent that it focuses on the inter-disciplinary collaboration needed at the practitioner level within these various integrated models.

Baker (1991) offers some of the earliest and yet most relevant literature pertinent to IDC. Going beyond pointing out the need for integration, Baker highlights a number of ‘mechanisms’ and ‘working principles’ needed to support this IDC environment. He emphasizes the need for a shared ideology that includes collaboration, continued education, and leadership. Luyster and Lowe (1990) also go beyond organizational

design to conceptualize an “inter-professional collaboration” that relies upon communication and appreciation of other professional’s perspectives. These authors readily acknowledge the difficulty in quickly achieving this communication and appreciation, with Baker describing it as a gradual evolutionary process, dependant on continued consensus building and training. Luystor and Lowe further stress that in order to develop these qualities there must be ample opportunities for open case discussion, as well as a willingness to relinquish power in traditional roles to support compromise in treatment plans. These articles are heavily descriptive, and make little mention of the how to handle providers who may be unwilling or unable to relinquish the power of their professional identity, nor do they mention how to support the process during the ‘evolutionary’ stages.

Fox, Fox and Drake (1992) propose a model involving continuous treatment teams, an approach that highlights an inter-disciplinary team working closely with the client and their support system through assertive engagement, with adequate support and training to address both types of problems. They stress that training must be continuous, and suggest monthly peer seminars to provide ample opportunity for cross disciplinary discussion and introduction of current research (Fox et al., 1992). This continuous training serves an important purpose beyond education; it becomes an additional time for relationship-building amongst team members and an opportunity for exposure to cross-disciplinary perspectives outside of specific case files. Ries also highlights these cross-training opportunities as “one of the most effective tools administrators have for bridging gaps between clinicians and services from different fields” (Ries, 1994). Creating space for informal dialogue is equally important, as studies

have shown that this informal reflection can deeply affect clinical behaviour (Soumerai, 1998; Soumerai & Avorn, 1990).

As mentioned by Ries, there is often a need to ‘bridge a gap’ between practitioners from different fields. Cross-training and opportunities for informal dialogue are frequently mentioned as powerful tools supporting relationship-building and an appreciation for alternative professional perspectives. Zweben (1993) also cites communication as an important factor in IDC; she stresses that communication allows for clarification of assumptions present in each discipline, as well as the opportunity for a spontaneous common language to develop that can help bridge the ‘gap‘ between professional discourses. Davidson & White (2007) also acknowledge that this ‘gap’ serves as a barrier to IDC. They propose that this “conceptual” dimension may be what has hampered many of the efforts towards integrated care despite concerted efforts to address the political, fiscal, and structural issues surrounding integration. They argue for an “organizing principle” across the disciplines that allows for a conceptual structure on which to base the working relationship and demonstrate how this concept can be applied across the behavioural health discipline spectrum. Furthermore, they argue that this conceptual organizing principle allows for the patient to more fully participate as an active agent of change within the inter-disciplinary professional team and not as “passive recipients of care” (L. Davidson & White, 2007, p. 114).

While very few studies in the CD literature provide concrete examples of ways to support and sustain IDC, there are many that highlight the barriers and challenges. Howland (1990) cites a number of challenges encountered during a study of service provision: lack of knowledge across disciplines, conceptual differences regarding

primary illness and use of medication, confidentiality issues, and ineffective follow up. However, once documenting the issues with IDC he does little to suggest strategies to handle these difficulties, beyond “fostering a better working relationship between the systems and resolving…conflicts” (Howland, 1990, p. 1135). Minkoff (2001) has a long and prolific body of research on integration of addiction and mental health systems at the organizational level. At the practitioner level he cites a conceptual barrier similar to that discussed by Davidson and White (2007) above. He also cites difficulties arising out of multiple streams of accountabilities. For example, individuals functioning as an integrated unit often have separate funding sources and individual representative management structures that they must return to, each with its own unique leadership style, performance expectations, and administrative components.

### Inter-disciplinary Collaboration (IDC) in the Health Services Literature

Inter-disciplinary collaboration is now a common factor across most different health service arenas. Again, most of the developed literature in this area advocates for, rather than explicates, systems of inter-disciplinary organization and service provision. The purpose of this section of the review is to highlight literature that further describes concepts discussed above. This section focus on mental health services literature. As in the above section, the literature here also overlaps and interchanges many of the key terms, including inter-disciplinary, inter-professional, multi-disciplinary, collaboration, cooperation and integration.

A great deal of literature discussing IDC is found in the community mental health field. Although these articles fail to mention the role of addiction services in their care

focus (and therefore have not been included in the above section), it can be assumed given what we know about concurrent diagnoses rates that many of the clients they serve may also suffer from addiction. As in the section above, many of the authors discuss a conceptual 'gap' between the varying disciplines. Some, such as Pietroni (1991) and Ovretveit (1995) attribute this 'gap' to macro issues such as differences in worldview, while others attribute it to differences in professional identity, resulting from factors including educational backgrounds, professional language or discourse, and status or power (Leathard, 1994a; Peck & Norman, 1999). These differences certainly all influence the dynamic of an IDC group relationship, and too often can incite jealousy and tribalism (Beattie, 1995; J. Ovretveit, 1996). Many of the authors attempt to elaborate the role and function of professional identity in the group IDC relationship. A number of common topics appear in these studies: 1) professional boundaries (Beattie, 1995; Finlay, 2000; Fiore, 2008) 2) blurring of role definitions (Davies, Mannion, Jacobs, Powell, & Marshall, 2007), and 3) goal setting and reflection (Ambramson & Rosenthal, 1995). All of these heavily interwoven factors are said to contribute to the individual team member's ability to function in the IDC environment.

Each profession, and its unique educational and social background, acculturates its members differently in reference to morality, ethics, values and practice. These differences between professions can often be heightened by the current pressure for, and indeed often the expectation, that permeable boundaries and increased flexibility on the part of the individual practitioner are, the path to improved group relations and collaboration (Mattessich & Monsey, 1992). Often this ideal can conflict with the basic fact that individuals with specialized training are often most efficient, and indeed most

comfortable, in the area of their training and expertise. Brown, Crawford and Darongkamas (2000) examine this notion in a study of professional boundaries within community mental health, stating that “in a paradoxical sense…the encouragement of generic working seemed to make some respondents all the more insistent on separate professional identities” (p. 432). Far from arising only out of professional acculturation, Brown et al argues that without effective leadership, goals and support, professional boundaries are often actually promoted through IDC environments, as individuals struggle to maintain a sense of professional worth against a “creeping genericism” that is perceived as a threat to professional history and future autonomy (p. 433). As patient care is ‘spliced’ into portions to each group member, individuals then guard losing this ground and further disengage from the original aims of the collaborative environment (Jones, 2006). Undeniably, this is adverse to the intended outcomes of creating IDC environments and does not improve the working environment or outcomes for the individual, the organization, or the client.

Lankshear (2003) produced a very useful study looking at 55 members of mental health teams from varying professions including nurses, social workers, occupational therapists and other medical professionals. This study was unique in that rather than identifying challenges and barriers, it instead identified a number of ‘coping’ strategies used commonly by members of the teams and did so regardless of the strategy’s outcome. That is, some identified strategies had entirely different outcomes in varying contexts and experiences. For example, one strategy identified by Lankshear was termed fraternization:

> In some cases, workload tensions were resolved because, whatever protocols and procedures were in place, the over-

> riding issue was the need to offer support to overworked people as valued colleagues and friends…for, despite the evident tensions, individual relationships within the teams were reported to be good on the whole (Lankshear, 2003, p. 460).

In other cases, however, fraternization served to frustrate collaboration as a whole when certain team members, despite feelings of sympathy, refused to further burden their own heavy workload to assist others with acute care. Although supported by management, this choice severely hampered group relations and in some cases, resulted in isolation of some group members.

Many of the coping strategies as identified by Lankshear are similar to, or fit within, one of the overarching guiding components of IDC as proposed by Bronstein (2003) in a model developed to guide social workers functioning in an IDC environment. In this model five core components of successful IDC are identified:

**(1) Interdependence**: includes both formal and informal time together, with each dependent on the other in some manner to fully accomplish goals and tasks. In order to function interdependently each professional must have an understanding and knowledge of not only their own professional role and boundaries, but also of those professions with which they are working. Individuals must also believe that there is more to gain than lose through this interdependent relationship. As discussed above in reference to Lankshear's 'fraternalization' often this is not the case and the true aims of the IDC environment are further eroded;

**(2) Newly created professional activities**: refers to collaborative programs, policies, structures or supports that maximize the professional experience and knowledge of each collaborator. The transition to an IDC environment must include also creating

fundamental change in service and/or delivery. Mattessich and Monsey (1992) also noted the importance of this shift in their early work on collaboration and service integration, stressing that collaborators must jointly create unique outcomes that cannot be replicated by the sole individual in order to feel commitment to the value of operating in an IDC environment;

**(3) Flexibility**: As discussed in detail above, the ability to balance both boundaries and the blurring of professional roles is crucial in the IDC environment. Flexibility extends beyond interdependence and refers to "the deliberate occurrence of role-blurring" (Bronstein, 2003). It is characterized by a willingness to engage in constructive conflict, compromise and an adaptability that allows for extension beyond traditional professional roles when the situation calls for creativity (Brown et al., 2000; Lankshear, 2003) .

**(4) Collective ownership of goals**: Much more than simply having common goals, collective ownership involves involvement throughout the continuum of goal setting, problem definition, joint decision making, common strategies, and commitment to the final success of each individual's goal attainment. Abramson and Rosenthal (1995) argue that broad involvement in direction and decision making (as opposed to top-down decision setting) is crucial to developing ownership over the implementation of strategies and action towards the ultimate goal. Graham and Barter (1999) note that this collective ownership of goals and goal setting should optimally include the client and family as a participatory member in order to mitigate possible power imbalances and provide an opportunity for the client to become equally involved and committed to the process and goals.

**(5) Reflection on process**: Reflection on process refers to both the self-reflexivity of

those involved as well as to a group commitment to reflexive practice and incorporating feedback. IDC is not a static process but a fluid and dynamic relational evolution that is always being altered by contextual factors. Time spent thinking and talking about the relationship, ethical issues and current practices provides opportunity to strengthen the collaborative relationship as well as manage latent or rising conflict (Bronstein, 2003; Huntington & Shores, 1983; Jones, 2006).

## Inter-Disciplinary Collaboration (IDC) in the ADR Literature

The research on intergroup conflict is extremely relevant and useful in the study of interdisciplinary collaboration. The process of coming together as an interdisciplinary team or group for successful collaboration demands the ongoing development of effective problem solving and conflict management skills. Creating a successful IDC environment means navigating through a number of common conflict sources as identified in the intergroup conflict literature. This may include conflict arising from factors including 1) collaborative and competitive problem solving processes 2) power differentials 3) (mis)trust 4) dialogue and miscommunication and 5) identity formation, including representativeness and exclusion ((Deutsch & Coleman, 2000; S. Fisher, 2000; Greer, Jehn, & Mannix, 2008; Huntington & Shores, 1983; Jones, 2006; Jormsri, 2004; Mayer, 2004; Medina, Munduate, Dorado, Martíinez, & Guerra, 2005; Rotarius & Liberman, 2000)

.Deutsch states that in inter-group conflict “whether the participants in a conflict have a cooperative [collaborative] orientation or a competitive one is decisive in determining its course and outcomes” (Deutsch, 2000, p.21). He elaborates this idea in

a theory of cooperation and competition that contains two fundamental constructs, critical to my study of IDC. First, Deutsch introduces the construct of interdependence of goals and the nature of action. The interdependence of goals refers to both positive goal interdependence (whereby linked or related goals influence the success of both, or many parties, in goal attainment) and a negative goal interdependence (whereby one party achieving goals directly impacts the chances of another also reaching goal attainment). He suggests that positive goal interdependence is much more than a single common goal but can be the linkage of diverse goals through a number of situations (e.g. rewards for joint achievement, resource sharing, linkage through joint planning, common enemies or authorities, an inability to complete tasks individually, and a common belief in a third party or concept's success). Of course in most IDC environments there is both positive and negative goal interdependence at play and these constructs are meant to offer polar ends of continua. It is the degree of relation, the balance and asymmetry of these factors, that creates a general orientation to the relationship and, according to Deutsch, determines the success or failure of the collaborative endeavour.

The second construct constituting Deutsch's theory focuses on the nature or typology of action and he elaborates three concepts - *substitutability, attitudes,* and *inducibility*. *Substitutabilty* refers to the degree to which one person's actions can satisfy another person's intentions/needs and is central to organizational structure and role definition in most institutional settings. *Attitudes* refer to one's own predisposition to response or reaction type (favourably, unfavourably, evaluatively etc.) when presented with stimuli or action from others. *Inducibility* is the natural complement to substitutability;

and refers to the willingness and flexibility to accept another's influence or action. Inducibility is directly related back to the construct of goal interdependence, in that human behaviour dictates that participants are more willing to accept another's actions if those actions partially achieve or seem to align with your own goal attainment. Likewise, if someone's actions are perceived as harmful to your own goal realization you are likely to reject any requests for assistance or support.

Deutsch also notes that these competitive and cooperative [collaborative] processes are initiated and sustained or entrenched by the characteristic processes of that type of social relationship:

> thus, cooperation induces and is induced by perceived or actual similarity in beliefs and attitudes, readiness to be helpful, openness in communication, trusting and friendly attitudes, sensitivity to common interests and a deemphasise of opposed interests, orientation toward enhancing mutual power rather than power differences, and so on. Similarly, competition induces and is induced by use of tactics of coercion, threat, or deception; attempts to enhance the power differences between oneself and other; poor communication; minimization of the awareness of similarities in values and increased sensitivity to opposed interests; suspicious and hostile attitudes; the importance, rigidity, and size of issues in conflict; and so on. (Deutsch, 2000, p. 31)

Thus, Deutsch’s theory provides an excellent framework for analysis of both individual and group processes that have contributed to a specific cooperative [collaborative] and competitive problem solving environment.

In his study of intergroup conflict and subsequent writing on implications for training, Fisher (2000) attempts to identify a number of practical skill sets that contribute to or facilitate a cooperative [collaborative] group environment, including relationship building skills, sensitivity, leadership, and self-reflexivity. The subjective nature of group relations means that these individual analytic and behavioural skills must be drawn from a wide spectrum of professional practice and social science research areas. He further stresses that intergroup relations and conflict are "both an objective and subjective phenomenon, and that attempts to address only one set of factors or the other are doomed to failure, either immediate or long term" (R. J. Fisher, 2000, p. 186). Therefore, various conflict intervention methods, political, institutional and organizational structure changes, and training that focus on perceptual, attitudinal and relational issues is often necessary for effective change and permanence (R. J. Fisher, 2000; Pruitt & Olczak, 1995).

There is a wide body of research that attempts to conceptualize and define power in operation. Lewicki, Litterer, Minton and Saunders (1994) classify power according to power bases, power uses, and influence, while others, such as Salancik and Pfeffer (1977), define power simply as the ability to motivate certain outcomes. Coleman (2000) describes power as a relational concept, whereby power functions "between the person and his or her environment. Power therefore, is determined not only by the characteristics of the person or persons involved in any given situation, nor solely by the characteristics of the situation, but by the interaction of these two sets of factors" (p. 122). From the location of this research and a social constructivist positioning, power can be thought of as both tangible and perceived, in operation at any

point one has the ability to further one's own goals or positioning, with little to no risk of consequence regardless of negative goal interdependence (Deutsch & Coleman, 2000; R. J. Lewicki et al., 1994). This is extremely important in any sort of study of IDC taking place in an institutional or organizational setting as power is often both medium and outcome; that is, power may often be the process through which structure is created and reproduced (Mumby, 1988).

The concept of trust (including mistrust and the abuse of trust), as we saw earlier in the health services literature, seems to have an important place in the study of IDC. In the conflict field, trust plays a crucial role as a factor in the escalation or management of conflict– if people trust each other; it is much easier to work through problems that may arise. A number of scholars have attempted to break down or categorize the elements of trust formation (including categories such as chronic disposition, situational parameters, and relational history); however, for the purpose of this study and its focus on IDC, it is crucial to recognize the difference between professional and personal trust relationships. Professional trust refers to a task-oriented relationship whose primary focus is on a common, or positively interdependent, goal external to their personal relationship. The latter is concerned with the relationship itself as the primary goal and the development and maintenance of trust serves to strengthen the internal relationship rather than attain an external goal (R. J. Lewicki & Wiethoff, 2000). The developmental movement (or lack thereof) from a professional to a personal trust is crucial within the IDC environment.

The movement from a professional to a personal trust, according to Lewicki and Wiethoff (2000) and based largely upon earlier work by Shapiro, Sheppard, and

Cheraskin (1992), can be categorized into two further developmental stages: calculus based trust and identification based trust. Calculus based trust refers to a deterrence based trust that is grounded in fear of punishment for violating the trust. In this way calculus based trust rests upon an economic calculation, that is, the risks of being perceived 'untrustworthy' are weighed against short term gains. People in this stage of the trust relationship, whether personal or professional, simultaneously prove to each other their trustworthiness through actions while also testing the boundaries of each other's trust. This is therefore a fragile and nonintimate manifestation of a trust relationship and frequently occurs in the early stages of interpersonal relations before the opportunity for evolution or devolution of said relation. Identification based trust however, is based upon identification of each other's desires and intentions. This exists when both, or all, parties effectively understand one another's wants and goals. Lewicki and Wiethoff (2000) posit that "identification based trust thus permits a party to serve as the other's agent and substitute for the other in interpersonal transactions" without the need to regulate or monitor each other in the quest for the realization of interdependent goals (p. 96). A number of activities are noted that strengthen the development of identification based trust including common goal and value setting, joint products, and collocation (R. J. Lewicki & Wiethoff, 2000; Shapiro et al., 1992).

Effective communication is an essential component of any effective intergroup relations, and is central to the development and outcome of conflict (Glick-Smith, 2007; Mumby, 1988; Olekalns, Putnam, Weingart, & Metcalf, 2008). According to Putnam and Poole, "communication constitutes the essence of conflict in that it undergirds the formation of opposing issues, frames perceptions of the felt conflict, translates emotions

and perceptions into behaviours, and sets the stage for future conflict" (Putnam & Poole, 1987, p. 552). As mentioned in the introduction to ADR that opened this study, Deutsch figured communication as a fundamental process involved in conflict, serving roles at times as source, escalation or management process (Deutsch & Coleman, 2000).

While there are many models of communication formulated by a number of social science researchers, Krauss and Morsella (2000) offer a model directly aligned to describe four paradigms or levels of communication as they function in relation to conflict management and collaboration; (1) encoding-decoding paradigm: the simplest form of communication whereby a message is encoded, transmitted and received as a figural replica of the original message (2) intentionalist paradigm: communication that attempts to recognize communicative intentions or what a speaker intended to mean (3) perspective taking paradigm: communication whereby both speaker and listener recognize and attempt to integrate the other's perspective or worldview into the formulation and meaning of a message (4) dialogic paradigm: the recognition that often communication is not a set of sequential independent episodes but rather a highly interactive cooperative activity where "meaning is 'socially situated' – deriving from the particular circumstances of the interaction – and the meaning of an utterance can be understood *only* in the context of those circumstances" (Krauss & Morsella, 2000, p. 153). Principles and pitfalls of effective communication then arise from the four paradigms or levels of communication as described above. Many authors reveal the need to avoid third-party interference, the difficulties communicating ideas across multiple disciplinary audiences, the importance of non-verbal responses and clarification and so on (Deutsch & Coleman, 2000; R. J. Fisher, 1997; S. Fisher, 2000; Glick-Smith,

2007; Huntington & Shores, 1983; Krauss & Morsella, 2000; Olekalns et al., 2008; Swaab, Phillips, Diermeier, & Husted Medvec, 2008).

This chapter has reviewed and presented some of the theoretical and practical foundations and concepts presented in the literature on interdisciplinary collaboration. This review was structured according to three sections: 1) IDC in the Concurrent Disorders Literature, 2) IDC in the Health Services Literature, and 3) IDC in the ADR Literature. This review chapter aims to provide a foundational understanding of the research area and provide a basis for inquiry which emphasizes the need and importance of collaboration in the IDC environment.

# Chapter 3 – Research Design and Methods

## Research Methods

The primary method used to collect data in this research was qualitative semi-structured interviews, guided by the principles of McCracken's Long Interview (1988). This method has been successfully used in other concurrent disorder projects including the recent Centre for Addictions and Mental Health Evaluation of the Concurrent Disorders Systems Model Project. Using this Long Interview method, face to face interviews were conducted with front line health care workers involved in the delivery and management of assessment and ongoing care of addiction and mental health clients. All interviews were digitally recorded and transcribed, with verbatim transcriptions used for both hand, as well as digital, analysis.

## Participant Recruitment and Data Collection

Subjects were recruited from the Vancouver Island Health Authority's Mental Health and Addiction Services department, specifically the Intake and Access division. These services provide initial assessment, diagnosis, and coordination of services for people with severe and persistent mental illness and co-occurring addiction disorders. There are four geographic locations of these services spread throughout Vancouver Island. I was able to succeed in getting permission to recruit participants at two of these four locations. Recruitment was limited to participants demonstrating the following criteria:

- Self-identify as professional in mental health and/or addictions support (this

strategy aimed to draw subjects from multiple disciplines);

- A level of professional training in mental health or addictions of at least one year (this education threshold is designed to allow for inclusion of addiction counsellors and other para or non-professionals that may face power imbalances in the collaborative relationship when considered against the other highly scientific and education based professions such as psychiatrics and medicine).

Data collection consisted of five semi-structured face to face interviews with current employees of the Vancouver Island Health Authority's Mental Health and Addictions Division. Participants were recruited in a two stage process. Ethical review of the research was conducted by the joint University of Victoria and Vancouver Island Health Authority (VIHA) Human Research Ethics Board, and upon approval of the research recruitment posters (see Appendix) were placed in numerous staff only areas at the recruitment sites. After a period of little to no interest being expressed by participants, stage two of recruitment began which included confidentially emailing participants a copy of the recruitment poster and an invitation to participate. This was coordinated using 'all staff' lists and blind carbon copy to ensure confidentiality of potential participants. After an initial invitation in late April 2009 a follow up invitation was again sent in June 2009 to attempt to draw out additional participants. In addition to these two methods of data collection I became aware that I did have a small amount of 'snowball' recruitment; in that one participant waived their own anonymity and discussed their participation with a coworker who then decided to participate.

Despite this two-stage recruitment process, recruitment of participants proved difficult. The initial research design had anticipated 6-10 participant interviews; however

difficulty recruiting participants did eventually limit the research to 5 participants. There were a number of factors limiting participation, cited by those that did choose to participate as well as by those who sent their regrets and declined participation. These included research fatigue (these participants are drawn from a work area frequently involved in research and clinical trials), overwork and extended hours due to fiscal restraints and high need, re-organization of departments and divisions (one potential participant had just recently experienced such re-organization and had been in the new position for a very short period), and difficulty scheduling and coordinating an off work location interview. I think it is important to note that none of the participants or potential participants expressed any hesitance as a result of confidentiality concerns or employment security issues if they chose to participate.

## The Use of Semi-Structured Qualitative Interviews

The choice to use semi-structured qualitative interviews in this study was informed by the need for a method that was both flexible enough for a diverse participant base as well as structured enough to allow for data analysis across multiple professional discourses. Semi-structured interviews were deemed to be the ideal method to allow the participants freedom in describing their own experiences as part of the interdisciplinary group as well as their own successes and challenges therein. Given that much of the research that this project is based on was emergent in nature, the use of semi-structured interviews allowed for participant voice as well as researcher 'control' in order to cover both planned and spontaneous subject matter. Palys states that interviews are pertinent "particularly in exploratory research, when a researcher isn't

entirely clear what range of responses may be elicited" (Palys, 2003, p. 176). When compared to other methods, both quantitative and qualitative, semi-structured interviews seemed the most relevant method to gather authentic and detailed participant experience data.

## Why McCracken's Long Interview?

This four stage process of data collection and analysis is clear, concise, and practical; designed to guide the participant through an interview that is intensive and focused, thereby eliminating any sense of redundancy or indeterminacy (McCracken, 1988). This is especially relevant as it applies to my research participant population. Front line employees operate on a hectic schedule and are apt to lose patience with an interview process that does not appear efficient. While the Long Interview method does demand a time commitment, it only requires a one time commitment on behalf of participants, a strong benefit as opposed to attempting to schedule follow up interviews. Although McCracken's Long Interview technique is frequently used to design exploratory interviews of varying lengths, from one to eight hours, for the purpose and scope of this research study the interviews were designed to be conducted in roughly one to two hours depending on the participant responses and disclosure.

This method departs from other interview methods in that it is precisely structured to gather data not on the individual affective state, but rather on cultural categories and shared meanings or experiences common among participants (McCracken, 1988). McCracken states that this method allows "us into the lifeworld of the individual, to see the content and pattern of daily experience" that in turn provides

an understanding of how the culture in question mediates the human interaction we are studying (McCracken, 1988, p. 9). This aligns well with the research topic, and I believe offers a format for exploration of the inter-group dynamics present and the skills used by the participants to mitigate and navigate these dynamics.

The four stages of McCracken's Long Interview are as follows:

**Stage One: Review of Analytic Categories and Interview Design**

This stage involves a review of the literature in which the literature is treated almost as data, read with a critical eye to ascertain scholarly assumption and deconstruct existing analytic categories in the area which guide the formation of interview questions/areas. This literature review assists in defining problem areas and indicates larger factors that the researcher must be prepared for should they arise in the interview. McCracken takes the position that the literature should be both reviewed and “deconstructed” in order to establish the ground the interview will rest upon as well as allow the researcher to identify preconceptions and scholarly assumptions in operation. A good literature review, McCracken states "makes the investigator the master, not the captive, of previous scholarship" (McCracken, 1988, p. 31).

In this study the literature review provided insights into many of the theoretical and practical foundations on interdisciplinary collaboration, according to research and literature from the concurrent disorders arena, health services and dispute resolution fields. As a researcher, this review allowed me to further refine my own understanding of the area, as well as identify a number of areas of interest to guide the interview process as well as data analysis. Furthermore, the review allowed me to ascertain common beliefs present in the research literature across distinct research fields (for

example, common principles of collaborative relationships present in the health services as well as the dispute resolution literature).

**Stage Two: Review of Cultural Categories and Interview Design**

This stage involves a self-examination and reflection process, helping to give the researcher a more detailed and systematic appreciation of how personal experience shapes the research topic. Here is the assumption that most researchers are drawn to areas of personal interest and experience. McCracken argues that knowing why you are drawn to an area is an important point to be explicit about in the research process, helping to guide the researcher toward further categories and relationships that inform question formation. The objective here is to give the researcher "a more detailed and systematic appreciation of his or her personal experience with the topic of interest" while at the same time creating a distance, or "defamiliarization" that allows the researcher to establish distance from his or her own deeply embedded assumptions (McCracken, 1988, p. 32).

My own personal review consisted of three separate broad examinations of my experiences with the health care system, addiction and mental health issues, and interdisciplinary collaboration, both in my personal and academic life. Using these I then set out to further explicate connections and relationships I had not previously identified. The exercise was wholly valuable to me as a researcher and allowed me to examine many of my own personal thoughts and connections of which I was previously unaware. This process was extended throughout the research through self-reflective personal journaling designed to keep my position as researcher both illuminated and distanced

from the data collection and analysis. I found this process extremely useful as a way to chronicle my thoughts about the research and process, as well as allowing me to be more fully aware and conscious of how my position as researcher related to participants and to their narratives during interviews and analysis.

**Stage Three: Developing Categories and Conducting Interviews**

This step involves the creation of the questions and the conduct of the interview. Biographical and/or demographical data is commonly used to open the interview, both to allow for data analysis variables as well as to ease the participant into the interview process and develop a small measure of comfort with the researcher. As a form of emergent qualitative inquiry, the formation of the body of the interview which follows must primarily “allow respondents to tell their own story in their own terms” (McCracken, 1988, p. 34). The researcher then, aims to keep an unobtrusive and nondirective position, and creates questions designed to move participants to speak at length without asking questions that supply the terms of the answer solicited. McCracken's process uses open-ended or grand tour questions followed by specific and planned prompts which fit into four general categories: contrast, category, special incident, auto-driving. Contrast prompts position two details or ideas already mentioned by the participant into contrast in order to elicit detail (e.g. what is the difference then between respect and trust?). Categorical prompts allow the researcher to elicit specific detail that surrounds an already mentioned event or activity, including things such as others involved and their roles, significance or outcome, and audience. Many of these details will naturally have been raised by the participant, however these prompts allow for detail that has

been unintentionally omitted by the participant. Special incident prompts are designed to encourage respondents to recall incidents that involve a “counterexpectational reality”; for instance an incident that stands out as exceptional from the normal continuance of social everyday being. These exceptional events may be an opportunity for participants to step away from their assumptions and can provide unique relational and categorical data for the researcher (McCracken, 1988, p. 36). Auto driving prompts involve bringing in external stimuli (such as a video or photograph) and observing participant reaction. Although useful in some research, auto-driving prompts are not used in this study. In addition to these prompts, McCracken identifies key incidents to be aware of and to manipulate by the researcher during the interview in order to further develop meaning in the data, including impression management, topic avoidance, deliberate distortion, minor misunderstanding, and outright incomprehension.

**Stage Four: Analysis of Data**

The most daunting of steps in any qualitative research method, McCracken's process entails an awareness of what "the literature says ought to be there, a sense of how the topic at issue is constituted in his or her own experience, and a glancing sense of what took place in the interview itself" (McCracken, 1988, p. 42). This research was conducted using sequentialled collection followed by analysis, however Glaser and Strauss (1965) point out, there is always a certain amount of intermingling of collection and analysis as a researcher’s subsequent interviews are surely influenced in some way by their participation in, and knowledge of, the previously attained data.

Following verbatim transcription of the interviews, I began the process of coding guided by McCracken's Long Interview process. Initial review of the data aimed at simply recognizing pertinent pieces of text, and paid no attention to the relationships between texts. As the transcriptions frequently contained multiple ideas within a single utterance, I used sentence fragments as a unit of analysis. Two of the participants gave very rich interviews and discussed topics in more detail and depth than the other participants. I found, however, that after sorting the codes into categories, all of the categories contained responses from at least two of the participants, allowing for comment on that category while preserving validity of the analytic method.

In order to draw pertinent data from the text I kept a list of phenomena to one side as a guide to recognizing data that may draw useful information. These included phenomena such as interaction, settings, consequences, emotions, strategies, behaviours, and actions. In addition, I had also developed a list of general questions as part of my record of reflection and analysis that I kept on hand, and continuously added to, in order to focus the coding and develop a reflexive process throughout the analysis. This review generated over 316 relevant pieces of text for coding and review. The pieces of text were then reviewed and organized according to similarities, either in subject matter or phenomena, into contributing factor categories. When carrying out this analysis I chose to use the "inductive method," whereby "data moves from the specific to the general, so that particular instances are observed and then combined into a larger whole or general statement" (Elo & Kyngas, 2008, p. 109).

In choosing the long interview method, I was conscious of the opportunity it holds for self-reflection and analysis of the role of researcher within the study, simultaneously

promoting consciousness of this influence while attempting to distance myself from this engagement and possible influence over the study. McCracken states that:

> "Only by knowing the cultural categories and configurations that the investigator uses to understand the world is he or she in a position to root these out of the terra firma of familiar expectation. This clearer understanding of one's vision of the world permits a critical distance from it...The investigators experiences and biases are the very stuff of understanding and explication" (McCracken, 1988, p. 33)

Ideologically this statement strongly appeals to me as it aligns with my own perspective and goals as a researcher and self location as a professional in the conflict management field. I believe this self-reflection will be crucial throughout data collection and analysis as I attempt to step away from a practitioner role and into that of 'silent' data collector. I think that McCracken's process offers the opportunity to adopt a reflective stance in relation to my own influence and understanding, as well as offering distance and increased clarity of the data away from solely personal interpretation. I believe this method will allow for inquiry that more fully develops the social and institutional context of the research and how this relates to the collaborative relationships present.

## The Informing Role of Critical Incident Technique

Although McCracken's Long Interview Method is the primary method used in this research, certain areas of the interview formation have been strongly influenced and informed by Critical Incident Technique (CIT) (Flanagan, 1954). Critical Incident Technique is "an epistemological process in which qualitative, descriptive data are

provided about real-life accounts" (DiSalvo, Nikkel, & Monroe, 1998, p. 554). Developed by Flanagan, this format aims to generate a comprehensive and descriptive account of an 'incident.' It is crucial to understand that a 'critical incident' within the CIT method does not hold the same connotation as it would within health service. According to Flanagan, a critical incident is "any observable human activity that is sufficiently complete in itself to permit inferences and predictions about the person performing the action" (Flanagan, 1954, p. 327). This technique involves having participants recall an experience (the incident) and detailing their observations around the factors contributing to an outcome. This method aims at pinpointing facts and reducing personal opinion and judgments, and as such is concerned with details of the incident itself, not with generalizations about the individuals involved. CIT is gaining considerable popularity in health services research, particularly in studies assessing level of service and care from both patient and provider perspectives (Kemppainen, 2001). In this study the Critical Incident Technique has been used to inform the creation of grand-tour interview questions (see Appendix) designed to elicit concrete experiences, or 'incidents' of interdisciplinary collaboration. In order for the collection of data in a critical incident study to be effective and useful there are three pieces of information that must always be included a) the description of a situation that led to the experience or incident b) the personal actions or behaviors of the respondent involved in the experience or incident, and c) a description of the results or outcome of the behavior or actions (Anderson & Wilson, 1997). These criteria also helped inform the development of the interview prompts in order to elicit sufficient detail for analysis from all participant experiences.

## Establishing Trustworthiness in Qualitative Enquiry

Lincoln and Guba (1985) posit that trustworthiness of a research project is important in determining the ultimate value of qualitative inquiry. They identify four aspects of trustworthiness in qualitative research including credibility, transferability, dependability, and conformability as well as methods to ensure the trustworthiness of each (Morse, Barrett, Mayan, Olson, & Spiers, 2002). While conformability and dependability present a challenge to a study with this number of participants, there are still a number of available means of ensuring this trustworthiness which are built into the methods of this project. Credibility is established through both peer debriefing and triangulation; that being the use of multiple data sources to enhance understanding. In this study triangulation occurs through a triangulation of data sources. Each participant comes from a unique place in the organizational framework, with unique personal, professional and educational backgrounds and experience. The consistency of the themes that emerge in analysis, despite these differences, provides credibility to the findings and results. Peer debriefing "is a process of exposing oneself to a disinterested peer in a manner paralleling analytical sessions and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308). Peer debriefing has occurred not only with the scholarly review of this study by my supervisor and committee, but has also occurred on an ongoing and informal basis within a peer group who has met monthly to review and discuss each other’s work. Dependability of this study was tested through the external examiner and theses defence process, whereby an external examiner not familiar with

the data has the opportunity to review and assess the adequacy of the findings and results, as well as provide feedback that may lead to the development of stronger findings (J. W. Creswell. Qualitative inquiry and research design, 2007)).

## Chapter 4 – Interview Findings and Analysis

### Contextualizing the Data: The History of Concurrent Care in British Columbia

Before presenting the data it is necessary to explicate some of the relevant history of concurrent care in British Columbia. The integration of addiction and mental health services in our province is relatively new, introduced in 2002. Before this, adult mental health services were regionalized and operated by seven Community Health Service Societies and fifty two Community Health Councils while addiction services were handled by the Ministry of Health, and before this by the Ministry of Labour and Consumer Services (Samra, 2007). In 2002, the mental health and addiction services were integrated, with all leadership and policy direction the responsibility of the Ministry of Health, and all adult service delivery falling to the five regional health authorities.

Before this, individuals needing care for concurrent disorders had to seek treatment through two separate delivery systems that had little or no coordination (Samra, 2007). To this end the integration of addiction and mental health services has been a positive move, and one backed by strong evidence for the efficacy of integrated treatment.

There are two levels to integration, and each has existed in various degrees within VIHA since inception in 2002. System level integration refers to the linkages between services and programs, both within and across diverse treatment systems and units. Program integration, by contrast, refers to an interdisciplinary cast of professionals coming together as a team, continuum, group or unit within a program to deliver treatment. The participants of this study, drawn from the Vancouver Island Health Authority, have operated under an integrated system and program level model since 2002. The actual organization of VIHA's Adult Mental Health and Addiction Services is complex and frequently changing. At the point of this research, organizational service divisions included intake, acute inpatient care, crisis response, urgent short term treatment, addiction services, case management, early psychosis intervention, psychosocial rehabilitation, housing and supported living, and senior's services. However, by the time of completion of this thesis, at least one of these service areas had been renamed, while still another had been transferred entirely out of the Mental Health and Addictions division. This brief history and the complexity of addiction and mental health services in our province is presented here as background to the data and findings, aimed at helping the reader to understand the findings in relation to their surroundings and contextual factors.

## Introduction of Findings

This chapter will introduce and explicate the findings and highlight relevant examples derived from the qualitative interviews conducted. This thesis aims to explore the experience of interdisciplinary collaboration (and inherent conflict) for front line addiction and mental health workers in an integrated environment. In order to reflect lived experience of the participants, questions asked were open ended and designed to allow the participant a large amount of control over choosing which examples or experiences of collaboration they deemed important. In order to focus the data, participants were asked to begin by describing a professional experience or example of 'successful' interdisciplinary collaboration. This yielded rich discussion and as the researcher I found very little need to interrupt or motivate participants to continue or elaborate.

This chapter will describe the themes and categories generated, using relevant data whenever possible to preserve the participant's voice and experience. Figure 1 below illustrates these generated themes and categories, and their interaction as they contribute to the IDC environment.

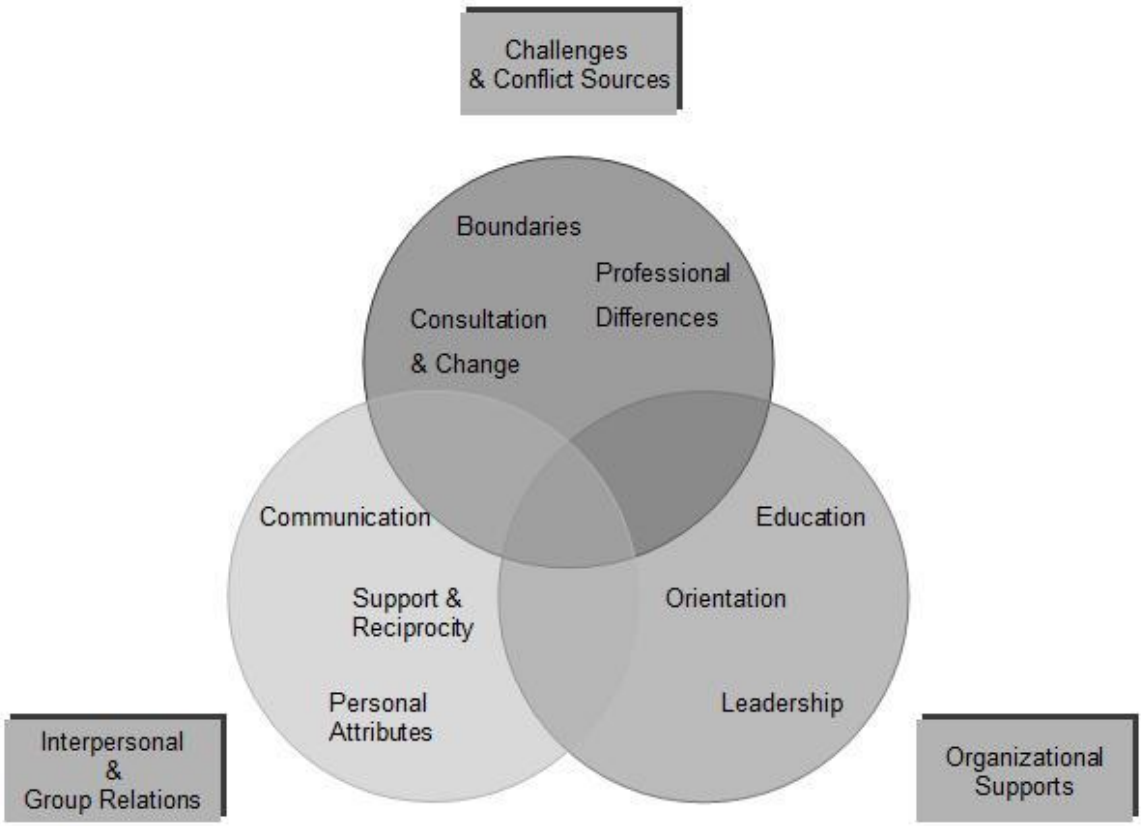


Figure 1.Three Overarching Themes and Nine Categories Generated from the Data

Analysis resulted in the items being collected into nine contributing factor categories (boundaries, education, communication, personal attributes, leadership, orientation, professional differences, consultation and change, and support and reciprocity), which I then organized into three overarching thematic groupings: Challenges/ Sources of Conflict, Interpersonal / Group Relations, and Organizational Supports. The naming of these categories and themes proved very difficult and was an ongoing process throughout the data analysis. The richness of the data, and my desire

to preserve the depth of participant experience, often made it difficult to generate such concise labels.

## Interpersonal and Group Relations

The first theme that will be presented and discussed is that of interpersonal and group relations. Interpersonal and group relations refers to the specific nature of relationships between one or more people in a given social setting. In this thesis then, this refers to the context of integrated addiction and mental health care, and the given relationships between professionals involved in delivering concurrent care. This theme contains three categories: (1) Communication, (2) Support and Reciprocity and (3) Personal Attributes. The categories present were organized under this thematic heading as they shared commonality as interpersonal skills and conditions necessary for healthy interpersonal and group relations. Jointly these categories represent what the participants identified most often as the most important factor in determining the success of their interdisciplinary collaborative relationship. A large part of the IDC environment is based upon the interpersonal relationships between colleagues jointly responsible for care in an integrated environment; building these relationships require both acquired and natural attributes; open communication, support, reciprocity and flexibility.

### Communication

The data revealed that the most cited factor influencing the interdisciplinary collaborative relationship was communication. Communication refers to the exchange and flow of ideas and information between individuals, and can include both spoken and

written textual representation. Participants stated frequent communication was crucial when handling a collaborative relationship as it allowed “everybody an opportunity to voice their concerns,” thereby reducing ongoing conflict and preventing issues that arose from escalating into entrenched conflict patterns and relationships. In addition, frequent and skilled communication ensured that integrated group members were able to “share information and coordinate a response” regardless of individual professional discourse. One participant noted how taking the time to develop a relationship based on open and frequent communication prevented misunderstanding and allowed for informal education, as both parties could further develop their perspective on concurrent disorders and treatment based on exposure to cross disciplinary ideas and knowledge:

> [speaking about working with colleagues from multiple disciplines and perspectives]
>
> People all have different experience with mental health and addictions and for me; I try to talk to people about that. It’s a trust thing, and being able to have open conversations…I try to talk directly to people…try to get a sense of where they’re coming from. It’s a process where those direct, open conversations can be helpful, and they can help bring a different perspective to me or someone who may not have been aware of the other perspective.

Still another participant reflected that communication, especially across disciplines allowed integrated members of IDC environment to “speak the same language,” that is, to develop a common terminology and language that reaches across disciplinary barriers. Therefore, clear, frequent communication avenues between disciplines allowed for informal education across disciplinary barriers; with each side learning as a result of exposure to alternative perspectives, as well as co-creating new knowledge through

common language and practice terminology. Effective communication skills, and time for this informal communication, are therefore extremely important given the importance of developing cross discipline terminology and language in order to avoid miscommunication, confusion and conceptual conflict as presented in the earlier research literature (Beattie, 1995; Blue & Garr, 2007; Bronstein, 2003; L. Davidson & White, 2007b; Mattessich & Monsey, 1992).

Participants reflected that open communication lines were crucial in order to develop strong and healthy collaborative relationships. They stressed, however, that there were certain imperative skills that created healthy communication. Foremost identified was a communication channel that was free from judgement and operated from a position of mutual respect: “it really comes down to knowing that there’s a nonjudgmental communication line that’s open…maybe that is my bias, but that’s when I’ve seen the strongest growth in myself…not just on the academic front, or the work front, but on the personal front with those relationships.” Consistent attention to frequent and respectful communication allowed for a “professional rapport” even when individuals had yet to have sufficient exposure to one another to develop long term professional and interpersonal relationships. As one participant noted, “it comes down to communication, even if you may not like the person. I’m saying I think that’s what teams come down to, and you know people talk about these words, where they lose their power. But it comes down to actually putting these words into practice.”

Respectful communication that participants felt was free from judgement became especially important during group or team problem solving. Participants stated that a large body of decision making regarding case strategy was handled via informal

consensus driven problem solving. In order to achieve a fair and representative problem solving process, all members of the discussion must feel able to communicate their opinion and perspective, and that this opinion will be given consideration and equal weight with that of their cross disciplinary colleagues. As one participant stated, effective communication allowed the collective to "come together as a team to talk openly about ongoing situations and decide what the response should be." Disagreement and alternative solutions are a constructive component of informal problem solving when individuals possess the skills necessary to respectfully communicate this professional disagreement. Without the ability to communicate effectively, the problem solving and consensus building process can become the avenue for power struggle and further breakdown of communication lines, reinforcing the power and voice of the dominant personalities willing to enter into debate and escalated conflict, while silencing other important perspectives from the discussion.

The data revealed that participants were speaking of two separate 'types' of communication – formal and informal communication. The primary component of formal communication raised was the need for a "formalized process of briefing and debriefing" that allowed group members the time and avenue to discuss shared cases, as well as an allotted time to build rapport and discuss perspectives. Where such time for this formal communication was in place, participants reflected that it allowed them to share and update information in an appropriate way, away from issues of "noise, confidentiality…and the high stress environment." When participants did not have this arranged time and space for formal communication, they reported a "sort of on the fly, informal debriefing" that left additional "questions out of it" and frequently did not convey

needed information to all relevant members.

Informal communication includes any form of communication not scheduled and outside of specific task-driven topic matter. All of the participants mentioned some form of informal conversation as an important component in building the collaborative relationship. For one participant, “informal communication is what a good team comes down to. It is what makes or breaks a good team.” This included informal communication such as “having coffee, talking about what else is going on for people in their lives” with other people frequently part of the inner daily circle, as well as opportunities for informal communication outside of the established working unit, particularly when group members work rotating shifts or in multiple physical settings. Two of the participants reflected that physical space was important in creating an IDC environment that allowed for positive formal and informal communication. As one participant stated, referring to a new physical space that includes private offices surrounding one large common space,: “it gives us an area where we can talk openly about ongoing situations...and, um, just build a little stronger rapport than just people working side by side in offices all day.” Participants noted the availability of common meeting space then played a role in determining the type of interaction and communication possible, especially given noise and privacy constraints in the IDC environment.

**Support and Reciprocity**

The second contributing factor category to be presented is that of support and reciprocity. Support refers to efforts or actions undertaken by one individual for the

purpose of assisting another in the attainment of a goal or outcome. Reciprocity extends beyond this one-way definition of support to include an ongoing, often unspoken, reciprocally supportive relationship, whereby individuals endeavour to offer support to colleagues with an understanding that this support will indeed be offered back given the need. The participants stated a number of ways in which they endeavoured to support colleagues, as well as ways in which they felt supported by others.

Due to the nature of the collaborative environment, frequently participants reported operating outside of their own discipline in order to support the efforts of the collaborative unit, or collective. There seemed to be an unspoken "willingness of team members to help each other out," particularly "when one person's really overwhelmed with work or a situation arises because of a number of case variables." This included participants reporting examples of stepping outside of their own disciplinary role, or "role blurring," and assisting in another professional capacity. This 'role blurring' was brought up by all of the participants as crucial to the success of the collaborative effort, although most participants also were also clear on the need to find a balance between the blurring and respecting of professional boundaries. One participant in particular relayed how the flexibility to blur professional boundaries, here in a cross training capacity, allowed for increased education and communication between disciplines, enhancing professional rapport and providing a better understanding of the collaborative continuum:

> We've recently had a nurse practitioner join our team and her role is very different from a nurse clinician on our team but she is orientating more in the role of a nurse clinician so

> she can get an overview of how the team functions on the continuum, what the entire scope is, the resources, and so she can build rapport and those relationships within the team…eventually yes, she will morph into the nurse practitioner role, a completely different scope of practice…everyone knows this but right now this is more valuable"

This participant's example demonstrates the value of an environment that supports 'role blurring' while also demonstrating the benefits of cross-training, another concept to be discussed later in this chapter.

Given that a large amount of time in the IDC environment is spent on projects and tasks that each individual does not have total control over from start to finish, it becomes important that individuals feel there is an equal and reciprocal basis to the support given by the group. This may include efforts toward joint tasks such as client consultation, assessment and treatment, writing reports and conducting research, new project implementation, as well as consultation and planning across multiple units and departments. It becomes imperative therefore, that individuals trust their fellow colleagues to deliver their own "piece of the puzzle" and one or more individuals do not feel they are offering more than their "fair share" of support towards the attainment of an outcome. The challenge then, is in achieving a reciprocally supportive relationship, whereby members feel supported and supportive, while still trusting the ability of their colleagues to successfully deliver on their contribution to the joint outcome.

Although clearly important to the participants, support from colleagues in the IDC environment is often an intangible or abstract construct, and something participants grappled to explain in words. Various physical actions were mentioned, such as "having

an open door policy," "staying in touch with the team," and understanding or "making allowances" when a colleague was overwhelmed with increased workload or a particular client. Participant's attempts to further detail support included phrases such as "respectful," "a place of understanding," and "flexible." For the participants this often extended beyond task assistance to include receptiveness to problem-solving and how freely group members felt they could divulge their own opinion, even if it was in opposition to the group's consensus. Being able to "problem solve together and even verbalize, you know, what your frustrations are" and "have a forum to talk…to come to some consensus" allowed the participants to feel supported by the collective, which in turn enhanced collective trust in the group's decision making and problem solving strategies:

> "if you feel safe and you feel you're supported and respected then you feel comfortable saying what you need to say or what you feel are the issues and throwing them out there. Then you've said your mind and you can trust the group to come to a good decision."

Despite some apparent struggles to operationalize support that will be addressed later in this chapter, participants were very clear that "support from team members" was tremendously important to the overall collaborative functioning of the group, and easy to identify in practice. As one participant so aptly summarized, "you either leave situations feeling like, yeah, you felt well supported…or you don't. And it's not usually a grey area, it is pretty clear." Another participant relayed an example that demonstrates the human implications of a reciprocal supportive relationship where individuals feel able to call upon their colleagues for support in a challenging situation:

> I saw an individual where they didn't have any

> background [with the medical system], they didn't have a prior history and I was seeing this person for therapy. It quickly became apparent that it probably wasn't the best for them, it wasn't meeting their needs…Over the course of a couple months I had to talk to and involve social work, nursing, EMP, police, outreach nurses, EMHS crew, intake. So there's a lot of triaging and phone work and you know, it really didn't have a lot to do with what I was doing, it had to do with what people where doing from sort of a collective perspective. At any point someone could have basically said no, we are not going to do this…but looking back, I think that without all these different perspectives and disciplines having come together, this person wouldn't be here today…you have to really be able to rely on all these different parts to come together and if one part of this collective fell apart, I think this person wouldn't be here.

This participant demonstrates the importance of the support relationship across the disciplines, but what they also allude to is the importance of a trusted reciprocal relationship; that in an environment of extreme stress and workload it is imperative that each "spoke of a wheel" can be trusted to perform and contribute to the whole.

**Personal Attributes**

The final category to be presented in this theme is the personal attributes of the individuals involved in the interdisciplinary relationship. Personal attributes refers to the distinguishing features, including character traits, aptitudes, skills etc. of an individual. This may include traits such as demeanour, flexibility, warmth, responsibility, positivity etc. The data revealed that personal attributes of the individuals greatly impacted the

ability of the whole to function collaboratively. Much of this can be seen reflected in the earlier categories as well; participants felt collaboration required colleagues willing to develop professional rapport, to cross professional boundaries, and to support and assist one another in the progress towards a common goal. Participants spoke about a number of other personal attributes that they claimed contributed to the success of the IDC environment, including positivity, openness, flexibility, organization, patience, adaptability, respect, enthusiasm, and mental stability.

Participants reflected that personal attributes were very important to developing a functioning collaborative group, while also stating that they were not learned skills but rather inherent characteristics: “number one for me is the ability to work well with others;” “it’s either there or it’s not;” “we know it’s the biggest thing, personality…everything else you can teach to people.” This is not to say that participants expected an immediate personal bond or joviality out of their colleagues, as this is often not the case, but rather that the positive attributes extended or presented by one colleague would be reciprocal and respected across the collaborative environment: “Some people are very gregarious and outgoing and some people are a little more shy. But everyone needs to find their sort of little niche with other people.”

## Organizational Supports

The second theme presented here is that of organizational supports and their influence on the IDC environment. Organizational supports refer to structural considerations within the IDC environment that contribute to enhanced collaborative potential. This theme is separate and distinct from the earlier categorical mention of

support; where that referred to a relational support capacity between colleagues, here organizational support refers to the policy and structural considerations that provide the context in which collaborative care is delivered. According to dispute resolution theory and practice, it is crucial to examine both the relational and structural aspects of a given situation in order to more fully understand the dynamics of context as it leads to cohesion (or conflict) in the IDC environment. This was strongly reflected in the data, as each respondent commented on various organizational supports and how these supports assisted in, or detracted from, the ability of personnel to create a collaborative environment. The data here have been organized into three contributing factor categories: (1) education, (2) orienting and (3) leadership. These categories were separated into a common theme according to their need for structural consideration, through the creation of policy or the direction of leadership, in order to be realized. As my data collection endeavoured to draw out the positive experiences of participants, most of the items here are drawn from experiences in which the respondents felt these supports were in place and contributed to a successful experience with interdisciplinary collaboration. Within this, however, participants were keen to point out that many of these organizational supports are no longer in place, or only sporadically implemented.

**Education**

Participants identified ongoing education and training as a determinant of success in an IDC environment. While informal education, that being opportunities to learn from others, especially across disciplinary specialities, was mentioned as a positive consideration in earlier categories, this category contains items referencing

formal opportunities, provided through institutional policy and organization, for ongoing professional development. This included ongoing clinical training and cross discipline training as well as opportunities for external “retreats,” “seminars,” and “conferences” with other disciplines. Respondents provided these examples of how opportunities for on-going education enhanced the collaborative relationship:

> I don’t think that [name of participant’s department] would have the same relationship with the addictions staff if it wasn’t for the educational component. It allowed me to create my own philosophy around addiction illness and it gave me a common language with their team;
>
> We had one opportunity to as a team, all of us, to a conference, a mental health national conference. I think that was really important as far as providing some education but also it was just an opportunity for all of the full time people to meet together and to spend time discussing whatever was going on as a team…we work opposite shifts, some of don’t work with, you know, our ‘partners’ at all, so these opportunities are so helpful;
>
> In the past we’ve been very fortunate to be *allowed* [said with distinction] to participate in in-services and educational opportunities that we know were really pertinent to our clinical work and success of the team;
>
> We also had retreats where the team has been able to go, plan, think about the next year and develop some strategies, some goals, as a whole team. To look at the direction we were going and if there were burning issues to problem solve

we could discuss things.

These examples, all from unique participants, demonstrate how opportunities provided much more than educational or clinical skills to the individuals in attendance. As demonstrated, they became a rare opportunity to “pause” the ongoing client care and create “common language,” develop unified strategies and goals, and problem solve issues or latent conflict that had been developing. The demand of being immersed in clinical care, regardless of discipline, often does not allow for the time or space to address these important topics; educational opportunities as a group create a small window for these important actions.

These educational opportunities also allow for more advanced specific training on concurrent disorders, an area where research on best practices and clinical assessments is currently expanding rapidly. Educational opportunities that provided concurrent disorder specific training to an interdisciplinary audience allowed those in attendance to “become committed to the concept together.” Despite this, all members of the IDC environment were often not included or present. One participant expressed regret that the doctors were not often present at educational opportunities. Current policy and organization of personnel is such that despite functioning on a team or as part of an integrated group, physicians are on a contractual status separate from the other employees and as such, receive little or no financial reward for time spent attending educational opportunities. Participants felt that this was detrimental to ongoing learning as a whole; if present prior to educational opportunities, conceptual gaps continued or even expanded between the disciplines. Although the benefits of educational opportunities are abundant, respondents reported a current shortage of these opportunities, in particular during the last fiscal year: “recently VIHA has put a

freeze on any travel and educational opportunities and our experience now has been that it is virtually impossible to get approved to go to any sort of educational."

Another beneficial educational opportunity that arose was interdisciplinary cross-training. Cross training refers to time spent, either in formal training or in a role shadowing position, in a professional capacity outside of one's own discipline. For one participant, who played an additional role on a community based intervention team outside of an institutional setting this meant silently "shadowing" both child and youth care workers and police for a short period of time. The participant felt this was invaluable in helping to understand various "intervention strategies" as well as in providing additional understanding and education of previously unknown areas: "our team had never dealt with children below the age of twelve up to that point…so for the child and youth care to provide education around what mental health looks like in a six or seven year old…was really important."

**Orientation**

The next contributing factor category to be presented as part of the organizational support theme is that of orientation. This refers to the way in which new colleagues are introduced to the IDC environment, and the organizational supports that are in place to handle this transition. This category overlaps with many of the already discussed categories, including education, consultation and change, communication, boundaries, and support and reciprocity. The participants felt that beyond these previously discussed constructs, it was extremely useful to have an orientation or mentoring process in place as care for concurrent disorder clients is such a specialized

and emerging field: “there’s not a lot of people who come to these positions with an extensive history of working where we do so we are often trying to do a lot of training to get them up to speed.” One participant acknowledged that there was currently a system in place whereby the first “number of shifts are kind of, they’re referred to as the confidence building phase” with a decreased amount of task responsibility. The participant felt this was insufficient given the need for “pretty critical decisions, which have quite serious legal and medical consequences.

Participants reported that beyond this brief orientation there was a need for an extended period of shadowing or mentorship. While it certainly appears this attends to a need for more time to understand the task specific role of care, it also appeared that in the absence of a clearly defined organizational model of collaborative care, participants felt the need to observe in order to ‘learn’ best practices for a collaborative relationship. Two participants described what they saw as an effective mentoring relationship:

> In the past, what we were able to do was to have the resources to provide mentoring to new people coming in. When I started on the team, I had tremendous mentoring from the permanent staff. I didn’t have to do anything except observe for many, many interventions, and I just saw how it went. There was no expectation for me to do anything but observe, think about what I would be doing, and watch what actually was occurring. We don’t have that luxury anymore, once people are through their three days of orientation, they’re expected to be up and running;

> Mentoring is key for people in this environment, and I’ve often thought its important regardless of the team, not with supervisory relationships but in just small, small groups…if

> there is someone who has come on board I think there's a stigma attached, you know, like they're being evaluated, right?...so you know, Mr. Smith has just come on board and he's a little freaked out. I think it's important to have somewhere he can go to…just to be able to talk to.

These examples demonstrate many of the inherent benefits to a mentoring relationship, including the opportunity to observe and gather information, the space to consider options and strategies free from immediate consequences, and the development of a trusting relationship with a mentor to turn to for advice and professional opinion. As discussed earlier, there is frequently an absence of time in this busy IDC environment, and a mentoring relationship with new colleagues was thought to provide a crucial window of time in which new group or team members could focus on all of the above mentioned themes – building relationships, observing different perspectives, and learning problem-solving strategies.

**Leadership**

The final category present in this theme is that of leadership. Leadership refers to the entire chain of management responsible for providing direction and guidance to the interdisciplinary unit, from the presence of team leaders through to division management and organizational leaders. At the program level, participants spoke highly of immediate management who gave "excellent support…without the micromanaging" and were able to "allow the team to kind of gel on its own." This item was often raised in relation to the concept of autonomy, whereby participants stated that team leaders and management demonstrated "respect for professional autonomy" by allowing the team to problem solve their own alternative solutions or options for how to

achieve a desired outcome. This was further demonstrated when effective management was referred to as a "gatekeeper of communication," whereby leadership assumed a "facilitator" role that ensured "everybody has an equal opportunity to say their piece and to help with the problem solving." Participants also stated that leadership was viewed positively when their contribution extended beyond directing group goals or outcomes to also involve attempts to acknowledge the individual's contribution to the collaborative effort: "you know, I can work a lot more, I can be a lot more satisfied in my work knowing that there's that acknowledgement a bit. That I'm doing a decent job. I don't need a birthday cake on my birthday; I just need to be respected." A strategic leader, then, observed team practice and took the time to explicitly recognize individual's actions that demonstrated the values of collaborative practice. This was especially in contrast when viewed against respondents perspective on upper management and those not directly connected with the team who were frequently felt to not have "a great understanding" of the efforts and difficulties of the unit or group towards serving concurrent disorders clients. The data also showed that participants perceived management as contributing positively to the collaborative environment when they perceived their management to be acting as "strong advocates" for the success of the team or group. This included advocating for "additional resources", as well as positively representing the unit or group "at higher levels of VIHA." It seems then that in a collaborative environment, where seldom is one name attached to an achievement, it was important to the participants that leadership took the time to understand, appreciate and advocate for the individual's respective contributions, as well as the value of the collaborative unit or group as a whole.

## Challenges / Sources of Conflict

As one participant stated: "*"not every team has to be rainbows and lollypops every day. There's going to be fights and that's part of it."* This theme focuses on the inherent challenges and sources of conflict as experienced by the participants. These are organized according to three contributing factor categories: (1) professional differences, (2) navigating boundaries, and (3) consultation and change. While challenges and conflict can be constructive opportunities for growth and positive change, left unresolved or mismanaged these challenges can significantly influence the cohesiveness and collaborative potential of the IDC environment.

### Professional Difference

A number of participants discussed the challenges that surfaced as a result of professional differences in the IDC group environment. Professional difference refers to the diverse disciplinary backgrounds in which individuals have been professionally acculturated, and with it the resulting differences in values, ethics, ideology and language. Through initial disciplinary education and eventual experience operating within a specific disciplinary perspective, professionals from quite similar health disciplines may in fact hold vary diverse perspectives, particularly as they apply to the conceptualization of certain illnesses and appropriate treatment.

While quite often these professional differences were mentioned in a positive light, professional difference was also mentioned as a frequent challenge and source of conflict, particularly when power differentials were perceived. This included a range of

positions, from feelings of being in a position of lesser power, through to the recognition of having an excess of power in the group. Referring to the prioritization of cases and clients, one participant offered “it’s hard, and sometimes a bit of a conflict for me ‘cause I am [job title] so, you know, I could put them at the top of the list if I choose to”, as well as “we are a team, but in the end, people will say the buck stops with me.” These participants seem to recognize their own power position, and the ability they have to influence the course of action for the group. At other times participants reported frustration stemming from their own lack of power (actual or perceived), particularly when they felt others to be in a position of power, able to influence team direction or “control people” in decision making or problem solving situations.

All of the participants made specific reference to challenges presented by operating on a team or unit that included individuals with diverse educational backgrounds. At times it appeared that a difference in educational background, in particular years of study, led to perceived power differentials within the groups. Doctors, including general physicians and psychiatric practitioners in particular, were mentioned more often as having a power over relationship, with other group members as well as with clients: “they don’t have all the power, I know that, but often they think they do…I think that whole power base thing, we like to pretend it doesn’t matter but it does.” While participants were clear this not the case with every relationship, they still noted a general trend to the power relationship whereby “certainly they may be receptive to taking your observations, but, they still have a ‘my word is the final word’” orientation. These professional power relationships (whether actual or perceived) had direct implications on the ability of team members to handle conflict productively as it

arose.

Participants also mentioned the challenge of operating as a cohesive team with very different conceptual and ideological backgrounds, particularly in respect to addiction and the nature of relapse and recovery. According to participants, certain professions have a background which is "into fixing things" and they felt this to be challenging when navigating a group relationship concerned with addictions care, particularly when a client suffered a relapse: "they take it personally…they have to just let it go, they can't, they can't let that go", "that attitude, it just, it almost destroys all of our good work." Here then, the conceptual gap regarding addiction illness and treatment creates an actual rift in the team responsible for care; "I didn't do a good enough job, I don't want you as a patient, you're a waste of skin, you don't want help, this kind of attitude…whereas, you know, I think relapse is part of the journey, its part of treatment…we just need to keep going." This conceptual difference can be exacerbated by the amount of specific addiction education and training team members have received and the degree to which they believe in and follow the newest research in their practise with concurrent clients. Participants noted that when certain members had a larger share of addiction specific training and education, a splitting of the team could occur: "here we are, going along in this direction and the hospital staff [who had not received the extensive training] are still back here."

**Boundaries**

The second contributing factor category to be presented as a significant challenge and source of conflict in the IDC environment was the role of boundaries. As

discussed earlier in the theme of support and reciprocity, the ability to maintain disciplinary flexibility and stretch traditional professional boundaries is at times extremely useful when supporting colleagues and working towards common goals. At other times however, the expectation that all members of the IDC environment be willing and able to operate in a cross-discipline setting outside of their own expertise seemed to challenge the cohesiveness of group relations, particularly when encountering colleagues less willing or able to take on additional tasks. Throughout the interviews, many of the participants noted that they believed *all* members must be willing to blur professional boundaries in order to create effective group relationships: "it is absolutely essential that everyone can contribute in all areas, be able to cover in certain areas…there is no expectation that they're going to have that level of knowledge that the other person has, but there has to be a sort of minimum understanding…there is an expectation that people will provide a contribution other than their own direct discipline";

> I think that if, and again, purely from my own perspective, that if there wasn't some sort of line crossing or blurring, not in terms of breaking an ethical line, but in terms of crossing a certain you know, work set or union set job description, that that team would not be successful…And they're not breaking any boundaries but personally they are crossing a professional boundary that they don't have to, job wise. They would be well within their rights to say, you know, this is not my case or problem…but they will cross that line. And I need to know, in the back of my mind, that people that I work with are willing to do that.

Navigating the balance between this need for blurred boundaries and a respect for the unique professional capabilities was noted as a challenge: "so there's a time you

need to blur and a time you have to be very clear on that they're not the same, the professions are different and they bring very different skills to the team, you need to be aware of that." Participants noted that navigating a balance of workload in this environment can be challenging and each individual must be willing and able to communicate personal limits, as well as gauge other's limits in order to preserve the group relationship: "I have to know that they will say no when they're, you know, they've reached a limit of capacity." These boundaries then, both in professional role and capacity, can serve as a significant challenge when communication fails and certain parties feel they are taking on an unreasonable share of the workload outside of their professional area. As one participant describes, "its very Shakespearian to me, you know, all the world's a stage and everyone plays their role…its fine as long as people know where other people sit and how much someone can do, it comes down to not assuming but checking in with them, not just taking it on *all* the time."

**Consultation and Change**

The third category identified by participants as a significant challenge and source of conflict I have termed consultation and change. Consultation and change refers to the process of planning and reorganization in the concurrent environment, from program level goal setting and delivery planning, up to regional and provincial decision making and future policy around best practices in concurrent care. All of the participants mentioned change as a contributing to conflict in one form or another, from challenges operating in new delivery paradigms to frustrations over less than smooth re-organizations. I felt that adding consultation to the description of this theme was

necessary in order to highlight that participants did not necessarily have opposition to all change, but rather the manner in which certain changes were decided upon and implemented significantly disenfranchised the group from participation in the process and end result, thereby straining group relations and leaving the IDC environment "without a sense of control" over their own actions and ability to provide care:

> Umm, well I've lost a lot of respect for VIHA and I think that the way that we've recently been re-organized and moved to seniors health in March show it….there was no consultation at all, with even our managers and directors, it was done at the board level and, well somewhere beyond the director of mental health anyway, and I just find that is so disrespectful with no consultation people that are working in the field see the problem areas and can help to work out a plan to go through the process and its, you know, ended up being really chaotic and stressful. There is so much anxiety for a lot of people and it didn't have to be this way…I think that it created more stress between us all in the workplace than was necessary given the structure of what we already do, and the load we have taken on.

The comment above demonstrates the extent to which participants felt that a lack of meaningful dialogue and participation in decision making impacted the IDC environment, creating significant distrust in the overall objectives of organizational leadership. Participants therefore associated most organizational change with additional stress and an imminent breakdown in group cohesion, rather than seeing change in a positive way and with the potential to further enhance their ability to provide effective care for the concurrent client.

Unfortunately, the challenges associated with change and consultation appeared

to extend also to occasions when individuals were actually consulted to assist in the planning, with participants reporting a lack of trust in the consultation process and end result. One participant stated, with uneasy laughter, “what they think of as consultation is often just them telling us what to do, it’s a systemic problem from the get go.” This lack of trust in the planning processes at times seemed to extend back to the initial integration of the addiction and mental health units, with participants stating “VIHA did mandate we had to integrate but I don’t think that did much;” “it’s difficult to change those archaic mindsets that make the decisions;” and “VIHA itself is disconnected, the upper echelon is very disconnected from the arms and legs.” The challenges presented by the change to an integrated environment often appeared to not be wholly inter-personal, but rather influenced by structural considerations:

> Say, for example, the liaison or integration with the psych unit has been much harder….and for very specific reasons. They’re in the hospital, under fire constantly, the stress level, the work level…so for us here at the community level, our expectations don’t really fit. So there is a sense that we’re not on a continuum despite the integration, there’s usually a disconnect unless we make a concerted effort to try and stay connected, but quite often the disconnect stays and things will happen like clients being discharged without the team conference with us, and we’re like “Whoa, here they are, what happened to the communication?”

The participants acknowledged that change does need to occur however, their lack of involvement in changes occurring to the IDC environment often left them feeling weakened in their own ability to function collaboratively and with diminished ownership over the long term cohesiveness of the integrated teams or units.

## Conclusion

The interview data resulted in three central themes being generated, interpersonal and group relations, organizational support, and challenges and sources of conflict. Far from isolated themes and categories, the findings illustrated that the IDC environment is influenced by multiple relational and structural considerations, and that together these considerations play a large role in determining the depth of the interdisciplinary relationship and the potential for collaborative success. The need for attention to both structural and relational considerations is especially relevant given that the IDC environment of concurrent care is rarely static, but rather continuously impacted by diverse contextual factors depending on the level of diversity in both clients and colleagues.

Furthermore, the findings reveal that the environment of interdisciplinary care, while rewarding, contains significant challenges. A dichotomy seems to be present that pervades the IDC environment; the need for an interdependence of tasks and goals while struggling to maintain and identify with diverse professional identities. This is further challenged by blurring of traditional disciplinary roles and tasks in attempts to create the reciprocal support relationships often necessary to handle the delivery of care in such a demanding arena. Successfully entering into and operating in a collaborative interdisciplinary care environment such as this then requires a complex balancing act of reflective practice that seeks to adjust to myriad contextual influences while still preserving specific expertise and professional identity.

Presenting data and the findings of research is a challenging process and one which I believe often fractures the actual reflection of lived experience. It is crucial then,

that in presenting the findings I close with a reminder to reflect upon the experience of the participants as a whole. When examined overall, their experience gives light to the complexity of an interdisciplinary environment, as well as the capacity of the professionals involved to manage these challenges and create meaningful and useful interprofessional relationships across historically significant disciplinary divides. Furthermore, their experience illustrates for us the dedication of those who truly believe in the value of collaborative practice in the care of their concurrent disorder clients.

# Chapter 5 – Discussion and Conclusion

## Introduction

One of the central purposes of this thesis was to investigate and explore the experience of interdisciplinary collaboration in addiction and mental health services, from the perspective of the front line workers involved in care of concurrent clients. This thesis sought to examine the contributing factors that enhanced the collaborative

environment and helped to create a healthier collaborative relationship among the disciplines involved. This includes exploring a variety of linkages in the relationship between disciplines, on both an interpersonal as well as intergroup level, as well as an understanding of the complex challenges that arise in the interdisciplinary relationship. Conducting this exploration from the perspective of a Dispute Resolution student has allowed for a unique understanding of the Inter-Group relationship and the relational considerations that determine the success of an interdisciplinary group relationship. The following chapter will discuss the implications of these findings as they relate to three areas: 1) the implications for practice, 2) the implications for dispute resolution, and 3) the implications for leadership and policy. In conclusion, the limitations of the research, and areas for future research, will be discussed.

## A Note on Fiscal Conditions

The following discussion of implications and recommendations involves discussion of a number of changes or additions to the concurrent care environment. It is understood that changes and additions to practice frequently require additional resources, especially during initial implementation. This study has attempted to steer away from fiscal commentary for the most part, in order to highlight instead the skills and strategies that contribute to a cohesive collaborative group regardless of current fiscal shortages. It must be noted however, that the current fiscal climate in health care is one of extreme budgetary restraint, and therefore resistant to any of the broader changes that require extensive funding allocations. Despite this, it must be stressed that many of the proposed changes, despite an initial expenditure, can result in

improved care pathways for the client through increased collaborative communication and a higher functioning intergroup relationship – factors that cannot be ignored in long range planning given the high cost and associated low outcomes due to employee turnover, stress, and illness relating to continued interpersonal and intergroup conflict.

## Implications for Practice

While the move to an integrated environment has seemed to provide more efficient, improved care for the concurrent client, professionals involved in this area continue to navigate a new arena wrought with complex dynamics. The ability to intuitively navigate and respect the professional boundaries of others appeared to be directly related to the depth of collaborative relationship achieved. Where participants perceived a balance of flexibility and respect for professional boundaries were achieved, the collaborative practice they described moved beyond merely interrelated task actions and towards an interpersonal collaborative relationship that was described as one of "respect," "trust," and "professional fellowship." When this balance was not achieved, the collaborative practice described appeared to lack a relational depth between colleagues and the sense that many of the proposed benefits of a collaborative practice model (for example creative problem solving, opportunities to incorporate alternative disciplinary perspectives for the benefit of patient experience and outcome etc.) were hampered or non-existent. One participant, who felt themselves in conflict with the opinion of a colleague from another discipline and unable to find a way to address the issue, summarized this deficit as a shift to care whereby "you end up falling back on just what works...so it's over." This is clearly a statement of significant impact given the IDC

environment demands repeated interaction between colleagues. A move away from collaborative practice to simply managing professional interaction is sure to have long term impacts on the interpersonal relationships present, as well as individual's belief in the value of their collaborative practice.

This appears to confirm some of the earlier discussion around professional boundaries in IDC environments, as presented in the health services literature review section. Despite the espousal by researchers, policy makers, and professionals that interdisciplinary collaborative practice is an ideal model (Baker, 1991; Barreira, Espey, Fishbein, Moran, & Flannery, 2000; Bronstein, 2003; Harbaugh, 1994; Leathard, 1994a; Luyster & Lowe, 1990; Mohr et al., 2002), many of the actualities of collaborative practice can be perceived to in fact create further professional difference when conflict arises. When, as in the above example, an individual feels pressured to assume the opinion or decision of another disciplinary perspective, they can withdraw from the group dynamic and cling to their disciplinary difference as an identity defining feature. It is clear that when the balance of respecting and maintaining professional boundaries is not achieved, one may feel the need to guard professional disciplinary identity against further erosion. This then further damages the group relationship as one individual now has disengaged from many of the collaborative aims in an effort to maintain a unique professional identity. When this occurs, the presence of disciplinary difference is only reinforced for the group.

**Recommendations for Practice**

How then do professionals navigate these complex boundaries? A number of

recommendations arise out of this research. Given that inter-professional relationships seemed to be extremely important to the depth of collaboration achieved, the majority of these recommendations focus on the ongoing development of intergroup relationships and interpersonal skills. These recommendations may be achieved through both formal and informal avenues. From a formal training perspective, education opportunities should not only include current theory and practice on the care for concurrent disorders, but should extend to seminars, in-services and/or training modules that focus on the capacity building skills necessary for healthy intergroup dynamics. This can include areas of focus such as communication skills, respectful listening, handling value based difference, and conflict management.

Informally, I would recommend that when possible, opportunities be created for ongoing interdisciplinary discussion, both formal and informal. These sorts of opportunities are often addressed in the literature on collaborative practice. Brown bag lunches are a common strategy, whereby short educational events are hosted that provide education as well as time for interdisciplinary exposure and discussion (Drake et al., 2001; Luyster & Lowe, 1990; Mohr et al., 2002). While certainly useful, I feel that the value of time for education and informal discussion warrants additional consideration than is clearly possible within the short and rushed hour given in the 'brown bag' concept. Furthermore, given the multiple locations of care (community, institutional etc.) this model can be very difficult to implement. Individuals already facing heavy work demands may resist or become resentful of an additional work related obligation that must be attended to, particularly one that is expected to occur within an employee's "downtime."

It is crucial then, that time for interdisciplinary exposure and discussion extends beyond these brief organized sessions and extends also to integration within the workplace daily culture. When collocated, increased integration can be achieved through the addition of formal activities such as round tables, group morning briefs, role shadowing and cross-training; all activities which allow for increased exposure to interdisciplinary perspective and valuable discussion. These discussions can be especially valuable when guided by what Lankshear terms 'reflection on process' (Lankshear, 2003). This refers to creating an environment that values a self-reflexive process for the individual, as well as a group commitment to reflexive discussion. As discussed in the preceding findings chapter, the IDC environment is far from static; it is a complex, dynamic, and relational practice environment. It is constantly influenced by changing contextual factors. This often requires extreme flexibility and ongoing adjustment of practice from the professionals involved. Moving beyond discussion of immediate task related principles, such as current case files, to the integration of reflexive discussion around the group relationship, ethical complexities and strategies for success, not only provides valuable opportunity for communication and exposure to interdisciplinary perspective, but also further solidifies the interrelatedness of goals and outcomes for the entire group. On this note, it is important that a culture of communication and reflexivity strives to be inclusive of all the disciplines involved, despite differing employment situations (for example, physicians who are on contract status) and / or status or power within disciplinary hierarchy (for example, the equal inclusion of paraprofessionals).

On an individual basis, professionals currently in or new to, an IDC health

environment should strive for, and be supported to develop, a self-reflective practice; aware of the changing dynamics and non-static nature of the environment and continuously striving to be aware of their own contribution to the group dynamic. This includes an effort towards self-reflection of personal values around addiction and mental illness, an examination of their own disciplinary ideology and past power influence (or lack thereof) and how these factors influence personal contribution to a collaborative practice environment. An awareness of the importance of interpersonal relations is also crucial, and with this the associated actions to forge and create stronger inter-group dynamics. A number of practical actions that contribute to these relations emerged from the study and were presented earlier. Key among these was frequent and open communication between colleagues; “checking in,” “touching base” and “keeping those communication lines open” in an ongoing effort to strengthen professional rapport and therefore respect, trust and belief in the collaborative relationship regardless of disciplinary difference.

## Implications for Dispute Resolution

According to Dispute Resolution perspective and theory, positive interdependence of goals is a foundation for cooperative orientation towards an inter-group relationship (Deutsch & Coleman, 2000). Interdependence is a concept strongly reflected in this thesis; success in the IDC environment was reported when respondents felt achievement of personal or group goals was best attained through interdisciplinary care. When asked to identify a successful experience of interdisciplinary collaboration, every one of the participants responded with an experience demonstrating how the

attainment of a positive result would not have been possible without the input and coordination of multiple disciplines. This was also reflected in the discussion of education and goal setting. Participants perceived that time as an interdisciplinary group in education or retreat settings allowed for discussion of future direction and goal setting; the outcome of which was a more cohesive group rapport and an increased interdependence through conjoined goals and outcomes.

Deutsch (2000) states that an inter-group relationship that has a cooperative, or collaborative, orientation (where the goals of the parties are interdependent) in turn demonstrates a number of positive characteristics that further solidify the intergroup relationship. These include effective communication, an increase in the value of other's beliefs, willingness to enhance another's power, helpfulness, and a redefining of conflicting interests as a mutual problem to be solved through collaborative effort (Deutsch & Coleman, 2000). This can be seen in the data as many of these characteristics were identified by the participants as contributing to the success of the IDC environment. This thesis has shown that the interdependence of goals then not only positively contributes to the attainment of a desired outcome for the group, but also creates a cyclical environment where the very characteristics that contribute to collaborative cohesion are more likely to be displayed.

While the results of this research clearly show that interdependence across disciplinary boundaries is important, it also poses a number of difficulties. When the achievement of a goal depends upon the interaction of a number of variables and individuals, there are increased opportunities for challenges and conflict through misunderstandings, miscommunications, and differing opinions on the ideal course of

action or care pathway. Managing these challenges, and preventing them from escalating to latent or manifest conflict, requires adept conflict management and problem solving skills. As mentioned in the preceding chapter, frequent communication is key to avoiding conflict escalation in many cases. According to the participants, conflicts were handled primarily via informal dispute resolution strategies; through both interpersonal discussions, as well as through group problem solving. While participants spoke of this process in a positive light, there appeared to be, at times, a troubling in-group/out-group struggle occurring in the informal problem solving dynamic. According to participants, when a problem was brought to the group there was discussion of options, a period of discussion, and an attempt at reaching consensus. While consensus driven problem solving is an important component of informal group decision making, power conflict can occur when one 'side' attempts to maximize influence and control in order to reach a dominant consensus of the whole. This was at times apparent in the problem solving strategies brought forward by participants; with one participant reporting that particularly when conceptual gaps on the nature of addictions were present, "you have to spend all this time and energy, you know, to really bully them into the whole concept." While those involved may be genuinely attempting to succeed in situating what they believe is superior care for the client, to pressure or "bully" the minority who ascribe to different care philosophies undermines the legitimacy of the group consensus process and can situate the consensus process as the vehicle through which intergroup division is further expressed and reinforced.

Furthermore, the use of group pressure to seek conformity in decision making can lead to concurrence seeking and groupthink behaviours (Johnson, Johnson, &

Tjosvold, 2001). Concurrence seeking occurs when individuals seek to avoid disagreement and therefore silence their own contribution and any discussion of alternatives (Di Salvo, Nikkel, & Monroe, 1989; Johnson et al., 2001). It can be expected that professionals who feel they have been repeatedly 'bullied' into conforming to the majority perspective are more likely to inhibit interdisciplinary discussion and less likely to bring forward alternative solutions or opinions. There is a similarity here to Janis's concept of groupthink, whereby individuals involved in decision making undervalue their own doubts about the course of action being favoured by the majority in consensus in order to preserve consensus and harmony in the group relationship (Johnson et al., 2001). The fundamental basis of these two phenomena is that individuals will go to great lengths to preserve a harmonious intergroup relationship, especially when dependent upon colleagues for goal attainment and support in crises. This can be seen as a significant danger given the informal problem solving used in this IDC environment, especially given that support from colleagues and the maintenance of a healthy intergroup relationship were described by participants as items of significant importance in the practice environment.

**Recommendations for Dispute Resolution**

There are a number of dispute resolution skills and mechanisms that could be introduced to the IDC environment in order to facilitate improved communication and problem solving. The addition of capacity building or training in joint problem solving strategies could further expand the strategies used to reach consensus when disagreement occurs, as well as offer empowering skills to those currently in minority

opinion positions and looking for constructive ways to integrate their opinion into group decision making. In addition, the development and application of dispute resolution guidelines should be considered in order to provide the group with a clear and consistent framework with which to address emerging interpersonal or intergroup conflict. This is especially important in the community setting where the interdisciplinary teams are more often composed of individuals from multiple governing bodies with diverse accountabilities and are therefore more likely to encounter conflicting conflict management styles and / or organizational practices. The introduction of a framework applicable to all disciplines, one that offers a structured and step based pathway with which to handle intergroup and interpersonal conflict as it arises, could aid in preventing unintended conflict escalation through incompatible conflict management styles and/or strategies.

It is particularly important that the implementation of additional dispute resolution skill sets into the IDC environment address both relational and structural aspects of the intergroup dynamic. As demonstrated through this study, there are both relational and structural, or organizational, constructs that contribute to the cohesion of an interdisciplinary group. Therefore, in order to create longstanding change to the intergroup relationship, both the objective and subjective nature of conflict must be addressed. Fisher states that:

> The objective and subjective mix of conflict also implies that change is required in both process or relationship qualities and substantive or structural aspects for intergroup conflict to come to an enduring resolution. That is, clearing up misattributions and rebuilding trust, for example, need to go hand in hand with developing decision-making procedures

> and allocation systems that address the basic incompatibility. Thus, conflict resolution is prescribed not simply as a mechanism for dealing with difficult differences…but also as an approach that can facilitate constructive change toward a more responsive and equitable system (R. J. Fisher, 2000, p. 187).

Given the complexity of implementing these relational and structural considerations, often the individuals directly involved are simply unable to immerse themselves in the level of unbiased analysis and implementation required. Thus, the application of a third party perspective is often required; ideally this would be through the involvement of a trained dispute resolution practitioner, with the skills and experience to be able to thoroughly analyze the specific context and setting in an effort to develop tailored relational and structural recommendations that address the motivations and constraints of all the disciplines involved in a fair and impartial manner.

## Implications for Leadership and Policy

A number of interesting considerations can be made in relation to implications for leadership and future policy in the concurrent care interdisciplinary environment. While much of the immediate leadership of the interdisciplinary groups was reported as successful and useful “facilitation,” the lack of trust and feelings of disenfranchisement from the overall organizational leadership is disconcerting at best. As discussed in the preceding dispute resolution section, the cohesiveness of a collaborative relationship depends not only on relational factors at the group level, but also upon the organizational structures that have built a platform for interaction that addresses the basic incompatibilities and historical separation of the disciplines involved. A lack of

policy and leadership that reflects these principles could be seen both in program and system level policy decisions. This was reflected in the comments of two participants who offered that "they *told* us to integrate, but I don't think that does much on its own," as well as " VIHA hasn't continued to support us [referring to the integrated unit]…it starts off great guns but then they just fizzle out." When these structural supports and policy choices do not accurately address the needs of 'ground level' groups, overall mistrust and disassociation from organizational identification quickly pervades into daily practice, creating another ingroup / outgroup dynamic between individuals involved in care and those charged with creating the policies needed to successfully deliver said care.

**Recommendations for Leadership and Policy**

There are a number of recommendations for leadership and policy that can be made given the findings of this research. These include recommendations at both the system and program level. Common throughout all of these recommendations is the importance of genuine involvement by those with the history, experience, and knowledge to comment upon what is needed to deliver the most effective care for the concurrent client, that being the professionals and clients themselves. Without the participation of the direct stakeholders in these policy decisions, the resulting decisions, however well intentioned, are likely to be viewed as further evidence of dislocated and misguided upper leadership. This can be seen in the views expressed by the participants around recent re-organization of departments and divisions; despite delineating the need for change in many of the organizational divisions they operate

within (such as the difficulty integrating static community and institutional divisions) they immediately view reorganization as a further difficulty and a move away from integrated care. Had they been provided with a voice in the process, from initial consultation through to a stakeholder place in decision making, therefore creating faith in the decision making process and resulting policy, they would have felt increased ownership over the change and held belief that the reorganization could indeed provide a more suitable situation for the delivery of client care. Inclusive decision making processes that move beyond brief consultation towards participatory decision making are more likely to result in decisions and policy that accurately reflect the needs of those involved in care, ultimately increasing the odds of successful implementation and outcomes, while working to slowly rebuild trust across organizational divisions and hierarchical separations.

One such effort to address historical inequalities between disciplines could begin with reexamining the current location of physicians in the IDC environment. Significant research has pinpointed the difficulties integrating doctors, including physicians, psychiatrists etc., into an interdisciplinary environment, as well as the challenges presented by conceptual differences on the nature of addiction care (Brown et al., 2000; L. Davidson & White, 2007a; Howland, 1990; Lemieux-Charles & McGuire, 2006). The results of this study confirm much of this research, in that challenges arose for the participants when trying to delineate care plans for clients together with physicians and psychiatrists, as often differences arose in care philosophy and values. The current positioning of the physician and psychiatric disciplines as contractual employees, separate and distinct from the other members of the interdisciplinary unit who are

employed under VIHA, creates a positional barrier that reinforces any perceived disciplinary separation. Furthermore, the contractual basis of employment means there is little financial or professional incentive to attend educational events, from informal 'brown bag' lunches to other more formal seminars and retreats. Not being present means the associated benefits discussed earlier, including increased knowledge of concurrent best practices, a commitment to group goals and the development of common language, occur for only a portion of the interdisciplinary group. This results in a further widening of any conceptual gaps that may be present and a splitting of the group according to the values held around the best practices for concurrent care. Both the provincial, as well as the regional health authority, levels need to strive for increased education and reorganization to address this positional separation in order to achieve a more genuine integration of all the disciplines involved.

Another area that warrants discussion is the need for improved training programs and policies. Even when coming from a background of extensive experience in mental health, participants reported that the complex needs of the concurrent client, as well as the shift to collaborative interdisciplinary practice, resulted in a difficult learning curve and periods of additional stress and uncertainty. Given the complicated structure of an interdisciplinary working group, often with multiple leadership structures depending on discipline, there can be significant challenge in locating where trusted guidance can be sought. Furthermore, given the demanding work load of this care arena, there is often little time to seek guidance from other, more experienced members of the care team. Restricted time, especially when coupled with a fiscally restricted environment, means that collaborative support can not be assumed as present simply because the context in

question is an integrated environment, but that these supports must be built in through policy and structure that creates designated time and avenues to access support. As one participant summarized:

> We are in a time when finances are tight, time is tight, people are worked very hard, and is it even fair to put this down to something that is based on a monetary value? How do you make time for just talking, even when you need it? I mean, someone's going to want to code that.

Despite the collaborative arena, time and fiscal restraints can produce pressures that restrict interprofessional guidance and support. Given this, there appears to be a significant need for clear leadership and policy structured to provide both increased initial training, as well as a system that allows for guidance and leadership beyond this initial phase. This could be accomplished through a variety of practical implementations, many of which were suggested by the participants themselves:

- Cross-training: As discussed earlier, cross training allows for the development of a professional rapport and provides valuable interdisciplinary perspective while also exposing those new to the concurrent care environment to knowledge of various programs, supports and avenues of care they may not have otherwise encountered;
- Mentorship: A formalized period of mentorship following initial training, whereby an experienced colleague is available for guidance and nonjudgmental discussion around ethical dilemmas, best practices and strategies to manage difficulties as they arise. Separate and distinct from leadership and management, a mentor relationship ideally provides an open and nonjudgmental

avenue for support;

- Interdisciplinary Leadership Committees: Given the relatively new arena of concurrent care, it can be expected that some challenges will resist immediate solution, particularly given the lack of evidenced based research in certain areas. The creation of an inclusive interdisciplinary committee comprised of individuals across the concurrent care spectrum who have demonstrated education, knowledge, and experience specifically in concurrent illness and care, could create a foundation of knowledge and leadership across current organizational boundaries. This committee, very similar in operation to a formal ethics committee, could then be turned to for impartial assistance when significant new situations or challenges arise for which there is little research or best practice information.

At times it appeared that navigating interdisciplinary care was further complicated by the lack of a clear care model or pathway for all disciplines involved to follow. This could be seen in the importance participants placed upon ongoing communication to avoid confusion, mentorship and leadership to provide direction, and initial time in training to observe "how everyone else does it." Given that integrated, concurrent care is still very much a new arena, some of this deficit can be understood as unavoidable. There is still the need, however, for further research and development of significant policy that provides clear direction of care pathways and best practices, particularly important to those new to an integrated, interdisciplinary environment. Without policy in place that delineates clear care pathways, there is currently significant room for disciplinary power dynamics and historical hierarchy to influence the decision making

process in the choices made on client care, restricting the intended aims and outcomes of collaborative practice.

## Areas for Future Research

As there are few studies that examine the interdisciplinary collaborative environment through the lens of ADR there are a number of areas for future study and research that this study raises for future consideration. For example, studies that attempt to focus further in on a specific conflict item or factor (for example, boundaries), or attempt to further explicate the role of a specific institutional and organizational support and determine its effects on the interdisciplinary relationship. There is also a need to further examine the problem solving and informal dispute resolution processes used in the collaborative environment, with the aim of further developing both informal and formal ADR mechanisms or processes for support and intervention in the ongoing management of intergroup conflict in this environment.

Further research may be usefully directed to additional study within addictions and mental health departments and divisions, or may extend to other collaborative health environments with the possibility of comparison and cross evaluation in order to further measure the validity and transferability of the research. One such study could further expand upon this body of research, by examining the collaborative environment as present for addiction and mental health professionals who work primarily in an institutional setting, as opposed to the community based setting from which the majority of participants were drawn. These comparative studies may also aim to develop a

typology of intergroup relations, looking for similarities and differences in what considerations contribute to or distract from a healthy collaborative environment across various contexts.

## Limitations of the Research

There are several limitations to this study in its current form. The first limitation in this research pertains to the methodological choice. McCracken's long interview was especially useful in preserving the experience of research participants throughout the collection, analysis and reporting of findings. The participants are experts in their respective fields of practice and their perspective and opinion regarding navigating an interdisciplinary environment should be considered both valid and useful for others experiencing an introduction to this form of collaborative care. This being said, the methodological choice limits extensive researcher inference and strives to allow the participants a certain amount of control over interview direction. There were certain topics and areas that we simply could not cover in the interviews as they were not raised by the participant during our time together. In addition, the use of a single interview meant that after analyzing the data as a whole, I had additional questions or areas I would have liked to able to explore further with participants. For example, I would have been interested in further exploring the informal problem solving strategies employed by the participants, as well as what formal problem solving methods they have been exposed to or have received training in. Despite this, I felt the interviews resulted in abundant data and allowed for a great amount of understanding regarding the collaborative environment.

Second, the data represents one particular moment in time. As mentioned, the ongoing change and reorganization of addiction and mental health care in British Columbia means that similar research conducted at another moment in time may garner data that differs in some areas, particularly that which depends on organizational and institutional settings for actualization. In addition, participants also represented a number of disciplines active in concurrent disorder care however, there are other disciplines involved not represented in the study that may have presented other important contributing factors. Finally, because of ethical considerations the options for recruitment were limited. Due to the need to preserve anonymity and ensure there was no pressure or coercion involved, every effort was made to restrict the role of management in assisting in recruitment. This meant that recruitment strategies were limited to poster and blind email requests, rather than direct introduction of the research to captive audiences. Therefore, the participants who made contact with me and subsequently participated in the research are likely to be individuals who felt committed to the concept of interdisciplinary care and therefore wanted to share their experience. There may be alternative perspectives from those not as committed to interdisciplinary care that have not then been represented in this thesis. I believe however, that this is a strength of my study, as the participants came into the interview process eager to share their experiences and believing they had much to share and contribute to the knowledge on interdisciplinary collaboration.

## Conclusion

This research sought to answer the question, “What do mental health and

addiction professionals report as determining the success of an Inter-Disciplinary Collaborative environment?" Five experienced, dedicated and passionate professionals shared their time and experiences of working in an interdisciplinary environment. The knowledge derived from these individuals was explicated in the preceding chapter, organized according to three central themes: 1) the role of interpersonal and group relations, 2) organizational supports, and 3) challenges and conflict sources. In this chapter I discussed the implications of these findings as they relate to three areas: practice, policy and dispute resolution.

The findings suggest that participants strongly believe in the value of collaboration, despite its inherent challenges, and can identify a number of important variables that contribute to its success in the concurrent care environment. I believe there is immense value in the past experiences of others, and qualitative research such as this can provide guidance and key factors to consider for others entering into, or designing policy around, the concurrent care arena. I hope this paper serves as support for others navigating the complex dynamic of interdisciplinary relationships, and that the application of a dispute resolution perspective that places significant value on intergroup relations has indeed elucidated useful detail on the nature of interdisciplinary professional relations and managing conflict in the intergroup relationship in this context. Integrated mental health and addiction care is indeed a new arena, wrought with challenges and barriers. The creation of healthy interdisciplinary relationships capable of effective collaboration and supported by ongoing relational and structural considerations, can only contribute positively to the future of this critically important arena.

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## APPENDIX A – LETTER OF INFORMATION AND CONSENT

### Inter-disciplinary Collaboration in Addiction & Mental Health Services

You are being invited to participate in a study entitled **Inter-disciplinary Collaboration in Addiction & Mental Health Services** that is being conducted by Amber Mitchell. I am a Graduate student in the department of Public Administration at the University of Victoria and you may contact me if you have further questions by telephoning 250-758-0822 or by email at arisha@uvic.ca

As a Graduate student, I am required to conduct research as part of the requirements for a degree of Masters of Arts, Dispute Resolution. It is being conducted under the supervision of Dr. Mary Ellen Purkis, Dean of Human & Social Development. You may contact my supervisor at 250-721-8050.

This research is being funded by a Pacific Leaders Graduate Fellowship. The purpose of this research project is to explore inter-disciplinary collaboration. Specifically, the objectives are to explore the dynamics of the inter-group relationship present in front line service workers handling concurrent disorder clients and to examine the skills used by the participants that foster the collaborative relationship and improve group dynamics among the inter-disciplinary team members. This research is taking place at two Vancouver Island Health Authority locations, Victoria and the Cowichan Valley. You are being asked to participate in this study because you have self-identified as a mental

health and/or addictions professional involved in an inter-disciplinary work environment.

If you agree to voluntarily participate in this research, your participation will include one meeting, at a mutually agreed upon location, of a maximum 1.5 hours, during which time you will be asked to speak about your experiences with inter-disciplinary collaboration. Your responses will be digitally recorded and analyzed together with the other 6-10 participants for common responses, skills, and general themes.

Participation in this study may cause some small inconvenience to you, including the time necessary for participation, as well as travel to and from the location of participation.

There are some small potential risks to you by participating in this research. These may include emotional or psychological risks brought on by reflection of past experience. The researcher believes that this risk is very small and unlikely to occur as the study will focus primarily on the positive experiences of the participants, including their own skills and collaboration techniques. However, to deal with this small degree of risk all participants will be given contact information for counselling services offered through employee assistance and/or organizational dispute resolution.

Research of this type is important and provides many benefits to the participant, society and the state of knowledge. Individually, this research provides an opportunity for participants to reflect upon their successes and valuable skills. Wholly, this research aims to enhance the collective understanding and knowledge of collaborative inter-group relations. This enhanced understanding may help to improve future policy and provide direction to institutional support for collaborative work relations.

As a way to reimburse you for any inconvenience related to your participation such as travel, parking or childcare, you will be given a $25 gift card. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. Your decision to withdraw will not influence the nature of your relationship with the University of Victoria or VIHA either now, or in the future. If you do withdraw from the study your data will not be used unless you give signed permission at the time of withdrawal. If you should decide to withdraw at any time you will still receive the above mentioned compensation in full.

As this is a personal interview, you will not be anonymous to the researcher herself. However, all data recordings will be anonymized and every effort will be made to maintain your confidentiality and the confidentiality of your data. This will include no identifying data used in the research writing, secure locked and /or password protected data storage in the researchers private office, and no one but the researcher herself

having access to personally identifiable data including recordings, notes, or consent information. If transcription services are used for audio recordings a signed confidentiality agreement from the transcriptionist will be obtained and no identifying consent information will accompany the audio files.

There are some limits that must be made known to participants as part of this consent process. Due to the nature of the topic, there are some interview areas that may naturally involve 3rd parties. Limits to 3rd party disclosure will be maintained by the interviewer through topic redirection in an effort to restrict the disclosure of private unauthorized 3rd party information. Due to the relative size of the target populations, there may also be a small chance that some responses used in the final thesis may be recognizable to other readers through shared common experience or situation. Every effort will be made by the researcher to minimize this risk, including anonymized responses as noted above, as well as topic redirection during the interview and care during the research write-up to not include direct quotes that may be recognizable to others involved. As noted, this chance is relatively small, however it is still important to note that full confidentiality cannot be guaranteed by the researcher.

Data from this study will be disposed of before a maximum of two years from the date of consent. All paper records will be commercially shredded and all digital data will be digitally shredded using a commercial grade digital shredder erasing program.

It is anticipated that the results of this study will be shared with others through a final thesis and defence, as well as through presentation to scholarly and government audiences. The results of this study will also be available to participants, and the public, electronically through the University of Victoria's electronic thesis portal and/or the Library and Archives Canada theses portal.

To discuss anything in this information and consent letter, or for further questions, please refer to the researcher's contact information on the first page. In addition to being able to contact the researcher you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca and the VIHA Research Ethics office at 250-370-8620.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

| _____ | _____ | _____ |
|---|---|---|
| *Name of Participant* | *Signature* | *Date* |

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

**APPENDIX B – Copy of Transcription Confidentiality Agreement**

**Confidentiality Agreement:**
**Barriers and Bridges: Interdisciplinary Collaboration in Addictions and Mental Health Care Study**

1. Confidential Information

The researcher, Amber Mitchell and the University of Victoria, hereby confirms that she will disclose certain confidential and proprietary information to their interview transcriptionist, Kirsten Parks .
***Confidential information*** shall include all data, materials, products, technology, computer programs, specifications, manuals, software and other information disclosed or submitted, orally, in writing, or by any other media, to **Kirsten Parks** by A. Mitchell.

2. Obligations of Transcriptionist
A. **Kirsten Parks** hereby agrees that the material contained in the research study is confidential and is to be used solely for the purposes of said study. Said confidential information should only be disclosed to employees of said research study with a specific need to know. **Kirsten Parks** hereby agrees not to disclose, publish or otherwise reveal any of the Confidential Information received from researcher (A. Mitchell), research assistants or other participants of the project to any other party whatsoever except with the specific prior written authorization of A. Mitchell.
B. Materials containing confidential information must be stored in a safe location so as to avoid third persons unrelated to the project to access said materials. Confidential Information shall not be duplicated by **Kirsten Parks** except for the purposes of this Agreement.

3. Completion of the Work
Upon the completion of the work and at the request of A. Mitchell, **Kirsten Parks** shall return all confidential information received in written or tangible form, including copies, or reproductions or other media containing such confidential information, within five (5) days of such request.
At **A. Mitchell's** option any copies of confidential documents or other media developed by **Kirsten Parks** and remaining in her possession after the completion of her work need to be destroyed so as to protect the confidentiality of said information. Kirsten shall provide a written certificate to Owner regarding destruction within ten (10) days thereafter. With his/her signature, Kirsten shall hereby adhere to the terms of this agreement.

_____ _____

Transcriptionist Signature and Date Researcher Signature and Date

## APPENDIX C – DRAFT INTERVIEW GUIDE

Stage I: Information & Consent

The initial stage of the interview is an opportunity to build rapport and answer all the questions a participant may have. I will explain who I am and how I got involved in this research project. I will explain the purpose of the project, why participants were selected, and approximately how long the interview is anticipated to last. I will pass a copy of the consent form to the participants, giving them time to read it and answer any questions, either about the study itself or the consent document.

Stage II: Transition & Demographic Information

After the question/answer period and consent, I will use a transitional phrase that informs the interviewee that the interview is beginning:

**"Now if we can, let's begin to talk about your job. Can you tell me what your professional role is?"**

The purpose of the stage is to ease the participant into discussion, in an area they feel confident and knowledgeable about, themselves. Demographic information will be gathered about professional role, duties, education etc.

Prompts here may include:
**"How long has this been your profession?"**
**"Have you always worked in this area?"**
**"What education or training has been a part of your role?"**
**"Could you tell me more about what you consider your primary duties?"**
**"What other disciplines or professions do you frequently work together with?"**

Stage III: Interview

At this point, participants will be asked to recall a successful experience of inter-disciplinary collaboration.

**"As you know, this research is concerned with inter-disciplinary collaboration. I will give you a moment and I would like you to try and recall a specific example or experience you have had that you would classify as successful inter-disciplinary collaboration. Take your time, and begin whenever you like."**

The goal here is gather details of the incident recalled that include the setting, time range and context of the event, what occurred in both the incident and outcome, and why the participant considered it to be a success.

Prompts will attempt to elicit detail on the strategies or skills that the participant identifies as contributing to the successful outcome. These prompts may include:

**"Can you tell me more about the context of this? Was this a typical arrangement or situation?"**
**"Can you tell me why this stands out for you as a success? What about the outcome was important?**
**"Was their anything significant leading up to this example that you consider important to the outcome?"**
**"How do you feel you contributed to the successful outcome?"**
**"How did you learn to do this/that?"**
**"Do you find that is an important skill/technique outside of this example, perhaps in your other inter-disciplinary experience?"**
**"**

Generic prompts and/or redirections throughout the interview will be used to guide the participants towards relevant detail or explication and away from 3rd party disclosure. These may include:

**"Tell me more about…"**
**"What did you do then?"**
**"What happened after this?"**
**"I don't quite understand, could you explain it to me in a different way?"**
**"What makes you say that?"**

**"Take your time; you can think for awhile if you want."**
**"What other choices or actions do you think you could have made?"**
**"I'm going to have to stop you for a minute, could we talk about…"**
**"Do you think you could tell me about what you chose to do instead?"**

After the participant seems to have concluded on details of the above example, they will be asked if there are any other experiences that have come to mind and they would like to share before concluding.

Stage IV: Conclusion

During the concluding phase, participants will be able to ask any questions and make any comments they deem relevant. I will discuss how these interviews contribute to the success of this project and detail the next stage of transcription. I will offer all participants the opportunity to review their transcript, either by mail or in person, if they so wish. Finally, participants will be thanked for their contribution and the interview will come to a conclusion.

## APPENDIX D – RECRUITMENT POSTER

# Inter-disciplinary Collaboration

Do you self identify as a professional with a minimum one year specialized education or training that is currently involved in addiction and mental health care and/or treatment?

Do you frequently work with others from outside your own professional discipline?

University of Victoria researcher looking for participants from across multiple disciplines (ex. nurses, physicians, counselors, social workers, management, care aides etc.) to be included in a study on inter-disciplinary collaboration in addictions and mental health care and treatment. Your participation is voluntary. All effort will be made to protect and maintain confidentiality of participants and limits will be placed on 3rd party

disclosure. Depending upon the number of potential participants, not all interested individual may be selected. Participation will take approximately one hour and will take place at the location and time of your convenience. Share your opinion, reflect on your skills and highlight your successes.

## Questions? Want to Participate?

Please take one of the attached contact slips and contact the researcher for a letter outlining information and consent process.

Researcher Contact:
Amber Mitchell
MADR Candidate
University of Victoria
(250) 216-2181
ARISHA@UVIC.CA.

This study has been approved by the joint UVIC/VIHA ethics committee, as well as by the department management for posting. Any questions or comments, Amber Mitchell at arisha@uvic.ca.