4 Interdisciplinary Roles and Interface

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4.1 Introduction

Several intertwined acute and chronic problems complicate the delivery of comprehensive psychiatric inpatient treatment: medical conditions with complex medication regimens, cognitive deficits, psychosocial needs, and psychiatric symptoms/behavioral problems. Coordination between disciplines is crucial. The US Health Resources and Services Administration (HRSA) is a resource for understanding the types of clinicians in the mental health workforce in the United States. Table 4.1 lists these disciplines, roles, education, licensure requirements, and scope of practice. In the United States, states control the scope of practice; there is wide variation across states, which may differ in other nations. Figure 4.1 summarizes a recommended interdisciplinary practice during geriatric inpatient psychiatry hospitalization.

4.2 Vignette

A 72-year-old woman with a 20-year history of depression was referred to inpatient psychiatry from the nursing home (NH) for major neurocognitive disorder (MNCD) with behavioral disturbance. The patient was taken to the emergency department for agitation, constant pacing, insomnia, delusions, verbal aggression, and combativeness. Medical history included hypertension, type 2 diabetes mellitus, COPD, chronic kidney disease, and obesity. The NH report indicated that the patient had been eating sweets from other resident's trays, refusing insulin (Lantus 18 units daily), and refusing blood glucose draws. The patient said, "…they are trying to cut me up with a knife."

In the ED, she was irritable and agitated, said that staff stole her money ($25,000) and were trying to stab her to death. She refused to cooperate with a physical exam and threatened everyone, stating she was going to call the police if anyone touched her.

Medication history included antidepressants for at least 10 years, most recently Sertraline 100 mg daily for 3 years.

Upon admission to inpatient psychiatry service, members of the multidisciplinary team (psychologist, psychiatric mental health nurse practitioner, registered nurse, behavioral health specialist, psychiatrist and psychiatry fellow) reviewed the medical record and began treatment planning. Delirium was ruled out and the working diagnosis remained major neurocognitive disorder (MNCD) with behavioral disturbance.

Distribution of work was assigned: the acute psychiatric issues would be managed medically by the psychiatric fellow in consultation with the

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Table 4.1 Licensure requirements and scope of practice in the United States, by mental health provider type

Provider type	Degree	Supervised practice	Exam	Scope of practice
Requires doctoral level degree				
Psychiatrist	Medical Doctorate (MD) or Doctorate of Osteopathic Medicine (DO), both of which typically require 4 years to complete (including 2 years of clinical rotations). Coursework emphasizes physical medicine.	Generally requires 3 or 4 years of post-degree supervised clinical training (residency) in the specialty of psychiatry.	Generally requires a passing score on the United States Medical Licensing Examination (USMLE) for MDs or DOs. DOs can also elect to take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). *To become board certified,* an exam is administered by the American Board of Psychiatry and Neurology.	Diagnose psychiatric disorders. Provide psychosocial treatment for individuals, families, and groups. Can prescribe medication. Can diagnose and treat physical conditions; neuroimaging; perform procedures such as Transcranial magnetic stimulation (TMS) and Electroconvulsive Therapy (ECT)
Clinical Psychologist	Doctoral degree in psychology or a related field, which generally takes between 5 and 7 years to complete and requires academic coursework, clinical training, a dissertation, and an exam.	Generally requires 3000 hours of supervised clinical training, which takes approximately 2 years.	Generally requires a passing score on the Examination for Professional Practice in Psychology (EPPP).	Diagnose psychiatric disorders. Provide psychosocial treatment for individuals, families, and groups. Administer and interpret psychological tests. Generally cannot prescribe medication.
Requires Doctoral Level or Master's Degree				
Marriage and Family Therapist (MFT)	Master's degree (2–3 years), doctoral degree (3–5 years), or postgraduate clinical training (3–4 years) in marriage and family therapy or a related field. Coursework emphasizes the individual's mental health in the context of interpersonal relationships (e.g., family and peers).	Generally requires 2 years of post-degree supervised clinical training.	Generally requires a passing score on the Association of Marital and Family Therapy Regulatory Board's Examination in Marriage and Family or the equivalent California Exam.	Diagnose psychiatric disorders. Provide psychosocial treatment for individuals, families, and groups. Cannot prescribe medication.
Psychiatric Mental Health Nurse Practitioner (PMH-APRN)	Doctoral degree (DNP-practice focus or PhD-research focus) requiring 3–4 years of post-BSN training; DNP requires 1000 or more hours of supervised clinical practice OR Master of Science in nursing (MSN), generally requires 2 years of coursework and 500 or more clinical hours. Coursework and supervised clinical practice.	DNPs generally require 500 or more hours for Master's prepared nurses or 1000 or more hours for Bachelor's prepared nurses.	Requires a passing score on the national certification exam conducted by the American Nurses Credentialing Center for the APRN role; must be renewed every 5 years.	Diagnose psychiatric disorders. Provide psychosocial treatment for individuals, families, and groups. Can prescribe medication (dependent upon the scope of practice allowed in the state).
Requires Master's Degree				
Clinical Social Worker	Master of Social Work (MSW), which typically requires 2 years. Coursework emphasizes human and community well-being. Requires a supervised field practicum (internship).	Generally requires 3200–3400 post-degree supervised clinical hours, which take approximately 2 years.	Generally requires a passing score on the Clinical Exam of the Association of Social Work Boards.	Diagnose mental disorders. Provide psychosocial treatment for individuals, families, and groups. Cannot prescribe medication.

Table 4.1 (continued)

Provider type	Degree	Supervised practice	Exam	Scope of practice
Requires Bachelor's Degree or Associate Degree				
Psychiatric Mental Health Nurse (PMH-NP)	Requires preparation as a registered nurse that can be a 2-year program (Associate Degree Nurse) or 4-year program (Bachelor of Science Degree Nurse); plus 2 years of general nursing practice is required to specialize in psychiatric-mental health nursing.	2000 hours minimum and 30 hours of continuing education in psychiatric-mental health nursing within 3 years to sit for Board Certification.	Requires a passing score on the national certification exam conducted by the American Nurses Credentialing Center for Psychiatric-Mental Health Nursing; must be renewed every 5 years.	Specializes in providing nursing care for patients with psychiatric, mental health, and behavioral health problems. Assesses mental health needs of individuals, families, groups, and communities. Develops nursing diagnoses and care plans. Collaborates with other members of the team.

Adapted from The Mental Health Workforce: A Primer [1]
Sources: U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA); and various professional associations
Notes: The degree, supervised practice, and exam indicated in the table are those generally required to obtain a license for independent practice. Licensure requirements (defined by state boards) and scope of practice (defined by state laws) vary by state. Degree requirements may vary by program. In all cases, the information provided in the table reflects what is generally true in most U.S. states and programs. Elaborating the exceptions is beyond the scope of this report

attending psychiatrist; medical co-morbidities to be addressed by the nurse practitioner in consultation with the hospitalist team; behavioral health specialist and registered nurse to focus on admission and orientation to the unit environment. A dietician was engaged to help develop snacks that were more diabetic-compatible, with some snacks to be used as incentives to improve compliance. Psychologist and nursing staff proposed a non-pharmacological plan to address delusions (Chap. 18: Psychotherapies and Non-pharmacological Interventions).

Over the first 5 days of admission, sertraline was tapered and discontinued. Quetiapine 25–50 mg PRN twice daily and at bedtime was started to treat agitation, insomnia, and mood lability. In consultation with the hospitalist, the dietician encouraged small portions of blueberries and sliced apple as an incentive for blood draws. With gentle coaxing and rewards, within 3 days the patient began to cooperate with lab work ordered to rule out Cushing syndrome, hyperthyroidism, vitamin B12 deficiency, and to determine the status of diabetes. Oral medication was started for diabetes management; blood sugar management improved. Cognitive behavioral therapy attempted to provide an understanding of her diagnosis and need for treatment, but this was not successful. After 10 days of hospitalization, social worker and discharge planners (Chap. 21: Placement) met with NH staff to facilitate a warm hand-off.

4.3 The Mental Health Inpatient Workforce

According to Heisler and Bagalman (2015), no consensus has emerged as to which providers are essential to an inpatient mental healthcare team [1]. This may vary by each geriatric patient's specific needs. But geriatric inpatients with mental health issues often have several acute and chronic health conditions, prompting a range of specialty consultants, from speech-language pathologists (SLP), to neurologists, to physical therapists. These professionals may enter and exit the care team at various times within the hospitalization. The prevalence of medical co-morbidities in geriatric patients, in addition to acute psychiatric conditions, may require an even greater degree of case management and collaborative care [2] (Chap. 7: Acute Medical Events; Chap. 19: Medical Nursing Care and Communication Barriers). Such dynamics underscore the need for excellent communication.

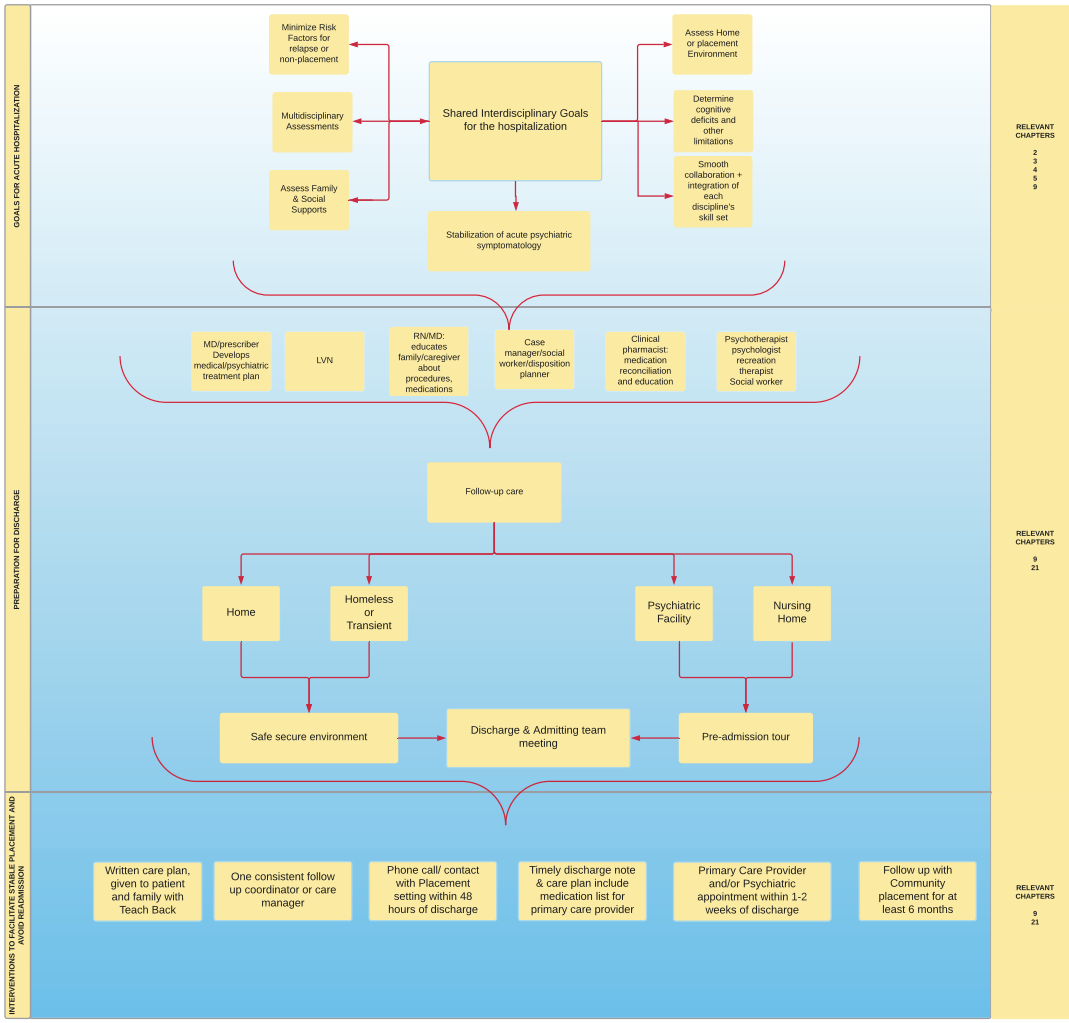

Fig. 4.1 Recommended interdisciplinary practice during geriatric inpatient psychiatry hospitalization

With fewer psychiatric hospitals and institutions, many patients with acute onset or exacerbations of psychiatric symptomatology remain in the emergency department (ED) until an acute inpatient bed is available [3]. The patient in the vignette was fortunate to be admitted within hours, which minimized the need for short-term providers of care.

As noted, several disciplines often participate in the inpatient care of a geriatric patient needing acute psychiatric care. The World Health Organization (WHO) provides a comprehensive summary and definitions of the mental healthcare workforce in various countries, in their Assessment Instrument for Mental Health Systems (WHO-AIMS). Additional professions, not listed in Table 4.1, include the following.

Primary health care worker Provides basic health services and links with other aspects of the healthcare system. This role may be filled by medical assistants, aide-level workers, multipurpose health workers, health assistants, and community health workers, among others. The training and functions vary across countries. Physicians, nurses, and other health professionals may supervise their work.

Nurse Has completed a formal training in nursing at a recognized, university-level school for a diploma or degree in nursing. Both registered nurses and licensed vocational nurses may work as part of the team.

Occupational therapist Has completed a formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Primary healthcare physician A general practitioner, family physician, or other non-specialized medical doctor consulting to, or is based within, an inpatient psychiatric unit.

Primary healthcare nurse An RN working in the inpatient psychiatric unit.

Psychiatric clinical pharmacists Assist in pharmacological management in patients on multiple medications. Some clinical pharmacists have completed extra postgraduate training in psychopharmacology and are Board Certified Psychiatric Pharmacists (BCPP). A special expertise may be the ability to communicate information about medications in the inpatient geriatric population with psychiatric illnesses, which can enhance the informed consent process.

Case managers Coordinate transition to the community and arrange professional services for individuals with psychiatric conditions; they also monitor patient compliance and symptomatology, reporting information to the provider as well as providing support to families.

Mental health specialists Entry-level mental health professionals without a graduate degree who usually work under the direct supervision of a licensed professional providing crisis intervention, assisting with housing and employment, and arranging for placement and other support services.

Mental health recovery specialists Provide crisis care and support, assist in developing treatment plans for patients, conduct group therapy sessions, and other services. They differ from mental health specialists (described above) in that they have a minimum of a baccalaureate degree in social work, psychology, sociology, or behavioral science and can provide a higher level of care.

Psychiatric nursing assistants/attendants Often have high-school diplomas and have received nursing assistance training or on the job training to assist nursing staff.

Specialty therapists (activities, art, music, recreation) Specialists in recreational and similar activities who lead therapeutic activities and engage patients. On inpatient psychiatry, this role can support many other goals, such as treatment compliance, reduction of agitation, and improvement of nighttime sleep (Chap. 18: Psychotherapies and Non-pharmacological Interventions). An understanding of the specific patient's limitations and symptomatology is inherent in the success of this role.

Mental health teams vary in terms of structure, depending on the type of organization and the patient population. An effective team member understands other members' responsibilities, and facilitates effective communication and collaboration among staff, patients, and families.

4.4 Models of Collaborative Care

Psychiatric care benefits from a model of inpatient care delivery as well as an understanding as to how medical care will be delivered to the patient upon discharge. Conceptual models can translate research into the inpatient environment and provide a roadmap for the context of care, the specific resources available, and the needs of the patient and family.

4.4.1 Collaborative Care Models (CCMs)

An important goal of a geriatric inpatient hospitalization is to stabilize the patient so that

follow-up collaborative care models of care delivery (CCM) can take over upon discharge. Wagner's Chronic Disease Management Model has served as a foundation for most of the CCMs [4]. The model depicts the link between the community resources and the health system along with an informed activated patient and a well-prepared, knowledgeable, and proactive healthcare team. Adaptations of the chronic care model have improved the focus on population health [5] and incorporation of patient-centeredness, timely and efficient care, evidence-based/safe care, and care coordination.

Woltmann et al. (2012) [5] conducted a systematic review and meta-analysis comparing the effectiveness of collaborative chronic care models in mental health and found that the model improves both mental and physical outcomes across a variety of different care settings [6]. Use of CCM applies to the inpatient setting through the following:

1. Patient self-management with enhanced coaching and skill building by encouraging patients to participate in specific education about their illness, problem solving, and shared decision-making with the team;
2. Clinical systems (registries, reminders, decision support) to empower less expert clinicians by providing information about specific conditions;
3. Redefining roles for the various team members to share responsibility through team-based delivery redesign;
4. Experts to support less-experienced clinicians in decision-making, with telepsychiatry or Skype meetings;
5. Coordinating and linking community resources to patients and staff;
6. Providing organizational support for clinicians to receive appropriate levels of training.

The CCM model has been particularly effective for depression, bipolar, anxiety disorder outcomes, and quality of life [6].

4.4.2 Enhanced Primary Care

The enhanced primary care (EPC) model was developed in Great Britain in an attempt to better manage patients with severe and enduring psychiatric illnesses (SMI) [5]. The goal of EPC is to improve recovery and enhance safe discharge to the community. EPC teams consist of general practitioners, consultant psychiatrists, psychiatric nurses, psychologists, and social workers who work as a team to provide care. Liaison between outpatient EPC teams and an inpatient unit staff may provide the safety net to minimize re-admissions. Essential components of EPC are:

- Regular visits to the primary care provider (PCP)
- Enhanced support to PCP from psychiatrists and other mental health professionals
- Additional training and education of PCPs (including nurse practitioners) in how to manage SMI including psychopharmacology and therapeutic depot administration
- Integrating mental health teams (psychiatric registered nurses and behavioral health specialists) into primary care.

This model has been found to improve clinical outcomes, reduce hospital readmissions, and improve satisfaction of patients and clinicians [5] in Great Britain and has been replicated in a number of healthcare systems in the United States [7].

4.4.3 Stepped-Approach Models of Care

Another safety net to minimize re-admission to inpatient units involves a stepped approach to care, based on the concept that evidence-based, low-intensity treatments are the initial interventions and, if not effective, high-intensity treatments can be offered. Low intensity care may not involve healthcare professionals, rather it may involve self-help, including computer education

programs with minimal interaction with trained mental health personnel. In this model, patients have regularly scheduled reviews and are "stepped up" to the next level of treatment if they are not improving.

In the United Kingdom, the National Institute for Health and Care Excellence (NICE) Clinical Guidelines for mental health diseases such as depression and anxiety recommend this stepped approach to care and have had overall positive outcomes in improving access to mental healthcare. (Royal College of Psychiatrists – https://www.rcpsych.ac.uk/members/nccmh/niceclinicalguidelines.aspx). There are now several published studies of this model of care indicating varying levels of success that indicate that further studies are needed [8].

Ness and colleagues (2014), building upon the D'Amour and Oandasan model of Interprofessional Education for Collaborative Patient-Centered Practice (IECPEP), have proposed a model of collaborative practice for community-based mental healthcare [9]. They conceptualized collaborative practice in mental health as an approach to improve the effectiveness of mental health services to patients in community settings by involving collaboration among the professional providers, patients, and families. The model is comprised of the following four components: (1) the framework for service orientation, (2) two interconnected collaborative structures, (3) principles of collaboration, and (4) the processes of collaborative practice (see Fig. 4.2).

Collaborative practice integrates person-centered practice and recovery orientation to enhance mental healthcare in the community environment.

The *first* component of the framework embraces both person-centered practice and recovery-orientation perspectives together to

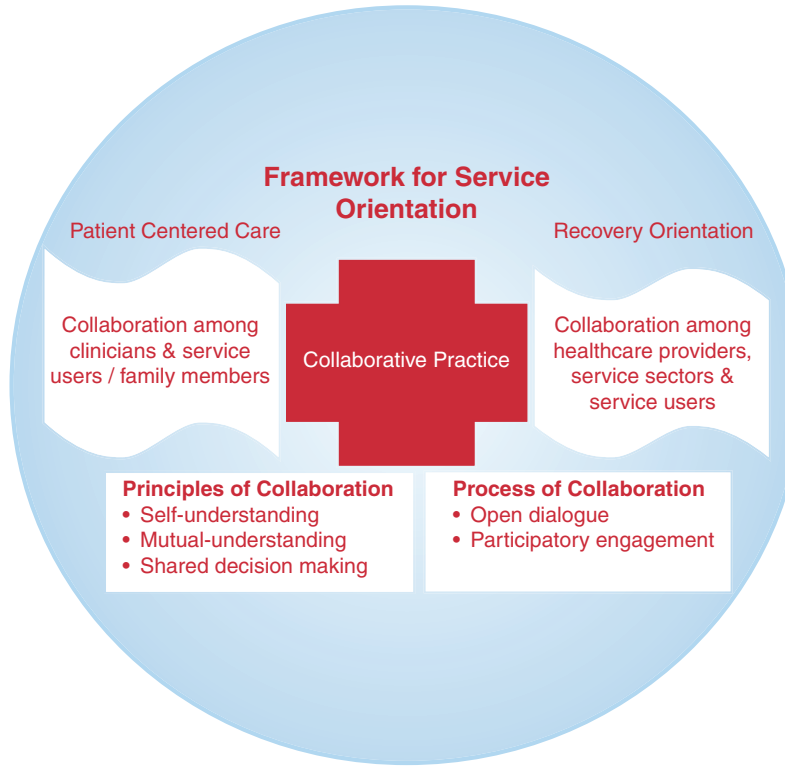

Fig. 4.2 Collaborative practice in community settings

inform the patient and family, placing them in the center of service delivery. Patients and families are equal partners in the planning, developing, and assessing mental healthcare to ensure it aligns with their goals. Person-centeredness, then, drives patients toward self-discovery and transformation and incorporates them into the decision-making processes related to mental healthcare. Recovery-orientation is conceptualized as an individual process but also as a social process that is affected by social conditions such as relationships, life conditions, services, and systems of care.

The *second* component of the framework is conceptualized as collaboration between two structures: the inpatient mental health team providing in-hospital service, and the mental healthcare system in the community. The model is easily adapted to any healthcare team and inpatient psychiatric settings. Coordination between both systems is essential to improve clinical outcomes and enhance the experience of care as well as to provide efficient services across patients, functions, activities, and settings.

The *third* component of collaboration includes three specific principles:

1. Self-understanding
2. Mutual understanding
3. Shared decision-making

Self-understanding requires each person to know her/his own perspectives, knowledge-base, motivations, and biases. Mutual understanding is about the relationship and the effort to communicate with the goal of understanding differences of opinion and focus on achieving truth. Shared decision-making is essential, with shared goals and accepting accountability.

The *fourth* component involves actual collaborative processes. It incorporates the practice of working together to meet the needs of patients and families, with partnering, a team approach, mutual trust, and respect. The authors describe two key processes: open dialogue and participatory engagement. Open dialogue requires team members to value uncertainty so that all are free to bring forth differing opinions, choices, interpretations, and courses of action. Participatory engagement is the willingness to share the group's work without constraints or prejudices, and with appreciation for each team member's strengths.

Inpatient psychiatric units can use this model effectively, as they discharge geriatric patients with residual or chronic psychiatric symptoms to the community. A patient-centered approach incorporates patients and families into the care planning and decision-making processes, and uses different clinicians to provide coordinated care.

Each of these models has theoretical significance and merit; outcomes are likely dependent upon the context of care and who is involved in the team. The principles of a multidisciplinary team with varying levels of knowledge and skill is important in the face of shortages of available resources. The models are based on the concept that a variety of different professions working in concert can provide more comprehensive, person-centered care, and achieve better outcomes.

4.5 Core Competencies for Collaborative Practice

Historically, there has been little attention paid to educating and training different professions and levels of healthcare workers to work as a team. But in 2009, several national health professions accrediting associations representing nursing, medicine, dentistry, osteopathic medicine, pharmacy, and public health formed a collaborative group that would promote and encourage their constituents to advance knowledge and skills in team-based care of patients and to improve population health outcomes. This group, the Inter-Professional Education Collaborative (IPEC), produced *Core Competencies for Interprofessional Collaborative Practice* published in 2011 [10]. It detailed four competencies necessary for successful teams and encouraged health profession schools to educate faculty to develop curriculum based on the competencies.

In 2016, several other health professional organizations joined the group, bringing the number up to 15. More than 60 other profes-

sions have participated in the process including Behavioral and Community Health, Occupational Therapy, Psychology, Rehabilitation Services, and Social Work. During the 2016 session, the core competency document was updated so that competencies would be organized under "Interprofessional Collaboration" with four core subdomain areas [11].

A complete list of core values and core competencies are listed in Tables 4.2 and 4.3. The goals are inherent: better health, better patient experience, and lower cost. The four core competencies are (1) values and ethics, (2) roles and responsibilities, (3) inter-professional communication, and (4) teams and teamwork.

- *Values and ethics*: Shared values and goals, and ways of working respectfully with each other. Issues related to confidentiality, ethical decision-making, equity inclusion, and cultural competence are important topics for the team to agree upon. Team members commit to maintaining high standards of patient-centered, culturally relevant care, acting with honest and integrity at all times, and to maintain their own professional competencies.
- *Roles and responsibilities*: Understanding one's own role and those of the team. Team members must communicate one's own roles and responsibilities within the team and acknowledge one's own limitations in knowledge and skills. It is equally important to fully understand other team members' capabilities, roles, and responsibilities as well and communicate those to patients, families, and other healthcare professionals. Knowledge of members' roles allows the team to use unique and complementary skills to optimize team care and facilitate positive patient outcomes.
- *Inter-professional communication*: Improvement of communication within the team and with patients, families, and other community members. Many patient healthcare-related safety errors result from poor communication skills. Communication must be clear, respectful, informative, timely, and without jargon. Active listening allows other opinions, thoughts, and concerns to be heard (Chap. 19: Medical Nursing Care and Communication Barriers).
- *Teams and teamwork*: Understanding principles of "team" and "teamwork," acknowledging all members of the team as important, and recognizing that leading within the team is context-specific. The team leader should be dependent upon the knowledge, skills, and abilities of the individual and not solely on the professional role. Each discipline at times may lead the team to develop aspects of the care plan. Teams must develop ways to manage disagreements in a professional, respectful, and constructive way. Effective teams share accountability for errors versus placing blame on individuals; think "team" first instead of "me" first.

Team leadership may help improve skills that incorporate various competencies by asking:

1. How does this discussion reflect any one of the competencies?
2. Are there any barriers to achieving this competence in the team?
3. How can we improve on this competence?

Team meetings ideally are open, transparent, and not threatening; a natural hierarchy exists in teams and may preclude some team members from participating. A mental health aide may feel inadequate to comment on a patient situation in the presence of the psychiatrist, even though he or she may be the team member who sees the patient most often. It is important that the team leader specifically asks for their input and reinforces their value as a team member.

A team culture that embraces *psychological safety* is optimal. This concept was originally explored by William Kahn (and further advanced by Amy Edmondson, a professor at the Harvard School of Business) [12]. Psychological safety means that all members of the team believe that it is safe to take interpersonal risks (such as suggesting a change in care) without fear of ridicule

or negative consequences. Edmondson advocates that high-performing teams need psychological safety to be able to admit mistakes, express gaps in knowledge, share concerns, and verbalize beliefs; this is critical in environments that are high risk and complex such as exists in healthcare. At the same time, individuals and teams must also be accountable for their actions. Teams that are both accountable and ensure psychological safety provide a learning culture in which teams can innovate and improve their team-based processes.

Figure 4.3 provides a summary of the Psychological Safety Framework [12]. The four quadrants range from low to high (left to right and bottom to top). On the horizontal axis, there is the pressure to be accountable and on the vertical axis is the degree that individuals feel psychologically safe in that environment. Individuals with low psychological safety and low accountability fall into the "apathy zone" during which the team member may simply do what needs to be done to get ahead but with relatively minimal effort. Individuals with low psychological safety but who feel highly accountable fall into the "anxiety zone" and typically feel anxious and stressed about their position on the team. Team members who experience high levels of psychological safety but demonstrate low accountability are in the "comfort zone." These team members are often complacent in their role and do not feel any pressure to do more than what is minimally expected. A highly functioning team balances between high psychological safety and high accountability, where the team members are in the "learning zone." Team members then feel safe to admit they do not know everything and are willing to innovate but also are willing to be responsible and accountable for their actions. Only in this zone can there be a high degree of organizational or team learning.

Edmondson and colleagues advocate for three building blocks essential for a learning organization: (1) supportive learning environments, (2) concrete learning practices and processes, and (3) leadership reinforcement of learning. Highly functioning and successful teams should strive to incorporate these structures and processes.

Tables 4.2, 4.3, 4.4, and 4.5 show core competencies for international collaboration, including ethics, roles and responsibilities, communication, and team work.

Values/ethics sub-competencies Work with individuals of other professions to maintain a climate of mutual respect and shared values. Table 4.2 lists values/ethics for inter-professional practice.

Roles/responsibilities sub-competencies Use the knowledge of one's own role and those of

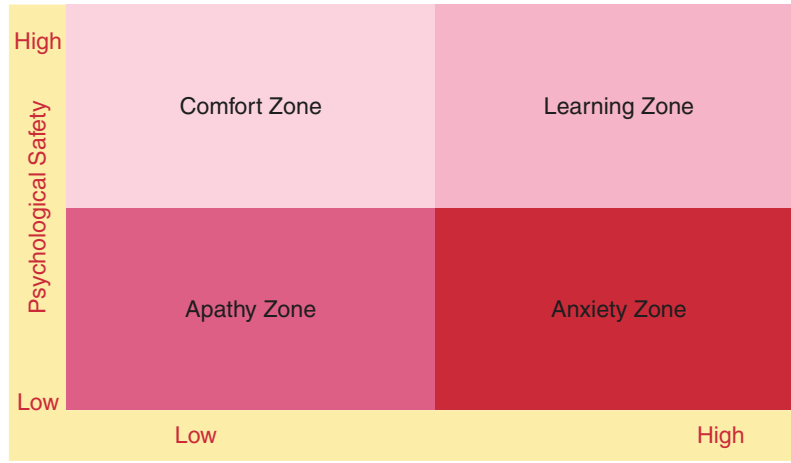

Fig. 4.3 Psychological safety framework [12]

Table 4.2 Values/ethics/sub-competencies to retain mutual respect between different professions

Values ethics/sub-competencies: work with individuals of other professions to maintain a climate of mutual respect and shared values (values/ethics for inter-professional practice)	
VE1	Place interests of patients and populations at center of inter-professional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span
VE2	Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care
VE3	Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team
VE4	Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes
VE5	Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs
VE6	Develop a trusting relationship with patients, families, and other team members (CIHC, 2010)
VE7	Demonstrate high standards of ethical conduct and quality of care in contributions to team-based care
VE8	Manage ethical dilemmas specific to inter-professional patient-/population-centered care situations
VE9	Act with honesty and integrity in relationships with patients, families, communities, and other team members
VE10	Maintain competence in one's own profession appropriate to scope of practice

Table 4.3 Core competencies for international collaboration: roles and responsibilities

Roles/responsibilities sub-competencies: use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations	
RR1	Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals
RR2	Recognize one's limitations in skills, knowledge, and abilities
RR3	Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations
RR4	Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease
RR5	Use the full scope of knowledge, skills and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable
RR6	Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention
RR7	Forge interdependent relationships with other professions within and outside of the health system to improve care and advance learning
RR8	Engage in continuous professional and inter-professional development to enhance team performance and collaboration
RR9	Use unique and complementary abilities of all members of the team to optimize health and patient care
RR10	Describe how professionals in health and other fields can collaborate and integrate clinical care and public health interventions to optimize population health

Table 4.4 Core competencies for international collaboration: communication

Inter-professional communication sub-competencies: communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease (interprofessional communication)	
CC1	Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function
CC2	Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible
CC3	Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity, and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies
CC4	Listen actively, and encourage ideas and opinions of other team members
CC5	Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others
CC6	Use respectful language appropriate for a given difficult situation, crucial conversation, or conflict
CC7	Recognize how one's uniqueness (experience level, expertise, culture, power, and hierarchy within the health team) contributes to effective communication, conflict resolution, and positive inter-professional working relationships (University of Toronto, 2008)
CC8	Communicate the importance of teamwork in patient-centered care and population health programs and policies

Table 4.5 Core competencies for international collaboration: team work

Team and teamwork sub-competencies: apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient-/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable (teams and teamwork)	
TT1	Describe the process of team development and the roles and practices of effective teams
TT2	Develop consensus on the ethical principles to guide all aspects of teamwork
TT3	Engage health and other professionals in shared patient-centered and population-focused problem solving
TT4	Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/preferences for care
TT5	Apply leadership practices that support collaborative practice and team effectiveness
TT6	Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among health and other professionals and with patients, families, and community members
TT7	Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care
TT8	Reflect on individual and team performance for individual, as well as team, performance improvement
TT9	Use process improvement to increase effectiveness of inter-professional teamwork and team-based services, programs, and policies
TT10	Use available evidence to inform effective teamwork and team-based practices
TT11	Perform effectively on teams and in different team roles in a variety of settings

other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations. Table 4.3 lists roles/responsibilities.

Inter-professional communication sub-competencies Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible

manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease. Table 4.4 lists core competencies for inter-professional communication.

Team and teamwork sub-competencies Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable. Table 4.5 lists core competencies for team work.

4.6 Summary

The several clinical disciplines who comprise an inpatient psychiatry team collaborate best when roles are defined and respected and the ultimate goals of patient stabilization and safety are shared. The four competencies needed to work effectively in a high-quality collaborative team environment include: (1) values and ethics, (2) roles and responsibilities, (3) inter-professional communication, and (4) teams and teamwork. It is critical that team leaders promote these competencies by ensuring psychological safety so that the team can work within the learning zone. In that environment, team members can feel safe to ask for help, admit errors, and suggest innovations without feeling threatened or belittled. Teams that work within the learning zone are much more likely to ensure they are incorporating *all* valuable evidence into their care.

Understanding models of outpatient healthcare delivery can help prevent early readmission. The inpatient team can facilitate a smooth and lasting transition by anticipating the strengths and limitations of the outpatient teams, and adhering to good communication, which fosters collaboration. Each inpatient team member can support the overall team goals of patient stabilization and transition, by using her/his unique skills.

Take-Away

- Providing care to geriatric inpatients with acute psychiatric symptomatology and maladaptive behaviors, along with co-morbid medical conditions, requires an effective team of collaborating professionals from several disciplines.
- Each professional member of the team communicates and demonstrates her/his areas of expertise as well as limitations. This fosters respect and coordination.
- Each professional applies her/his expertise to support the goals for the patient, as well as engages the skills and expertise of other disciplines. This enhances an understanding among each discipline about what each can best offer, and it promotes effective collaboration.
- The healthcare delivery models practiced by an inpatient psychiatric team can foster a smooth transition to outpatient care.

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