Literature review on the evidence for interdisciplinary teams in community-based services

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Statement on Language

In this report, we use the term “children with disabilities” which reflects person first language. This is in line with what is commonly used in disability services and reflects the language used in the UNCRPD (persons with disabilities). We recognise that the term ‘disabled persons or people’ which is considered to be identity first or social model language is preferred by some people. Identity-first language acknowledges the fact that people with an impairment are disabled by barriers in the environment and society and so aligns with the social and human rights model of disability. We also acknowledge that some people do not identify with either term.

For further information on disability-related language and terminology, please refer to the NDA’s Advice Paper on Disability Language and Terminology.[[1]](#footnote-1)

Abbreviations

|  |  |
| --- | --- |
| AOTI | Association of Occupational Therapists of Ireland |
| CDNT | Children’s Disability Network Teams |
| CPAT | Collaborative Practice Assessment Tool |
| CRAICS | Community Rehabilitation and Intermediate Care Services |
| HSE | Health Service Executive |
| IASW | Irish Association of Social Workers |
| IDT | Interdisciplinary Team |
| IMT | Interdisciplinary Management Tool |
| IPEC | Interprofessional Educational Collaborative |
| MDT | Multidisciplinary Team |
| TDT | Transdisciplinary Team |
| PDS | Progressing Disability Services |
| UK | United Kingdom |
| WHO | World Health Organisation |

Executive Summary

Introduction

Across health and social services therapists work within a variety of team configurations. These are dictated by the environment, the nature of the clients and the outcomes required. The most common configurations include multi-disciplinary working, interdisciplinary working and transdisciplinary working.

The Children’s Disability Network Team (CDNT) service model requires that therapists within CDNTs work in an Interdisciplinary team (IDT). IDTs are a method of working in which a number of professionals from different disciplines who work with the child and family, share information, decision-making and goal-setting. This review gathers and presents evidence around the strengths and weaknesses of IDTs in a systematic way.

The aim of this literature review is to examine the evidence base in relation to IDTs for services similar to CDNTs. That is, community-based teams with several disciplines on the team.

Methodology

A systematic search was performed across a number of electronic academic databases, and grey literature sources. Studies were included if they met the following criteria: (a) focused on interdisciplinary teams within health or social care services (b) written in English and (c) available in full text.

The selected studies were screened for relevance based on the titles and abstracts. Full-text articles of potentially relevant studies were retrieved and further assessed for eligibility according to the inclusion and exclusion criteria.

After screening against eligibility criteria, data extraction was performed to capture key information, including the type of article and jurisdiction. A narrative synthesis approach was employed to summarize and integrate findings across the included studies.

Findings

This review found that there is some confusion around terminology, terms can be poorly defined and used interchangeably. The most common confusion is between the IDT, the multidisciplinary team (MDT) and the Transdisciplinary team (TDT).

In multidisciplinary teams members of different professions or disciplines assess or treat a client/patient independently and share only information with each other. The team is focused on the task, not the collective working process. An interdisciplinary team is a number of professionals from different disciplines who work with the child and family, sharing information, decision-making and goal-setting. Whereas TDTs, use an integrative work process and disciplinary boundaries are partially dissolved.

IDTs are different from MDTs in that in an IDT, colleagues work together to plan and produce outcomes, rather than in an MDT where parallel working is the norm. IDTs are distinct from TDTs because in an IDT staff maintain competence boundaries whereas in a TDT therapists share roles and skills across the disciplines.

The review found that IDTs are present in many settings nationally and internationally, including primary care, intermediate care, rehabilitation medicine, geriatric care and palliative care, where the core principles remain the same.

To be effective IDTs require strong relationships, good communication, strong leadership, shared spaces and interprofessional education. Strong relationships allow team members learn from one another, negotiate their roles and maintain a balance of power are vital in IDTs as they foster collaboration creativity and efficiency. Communication is vital, as it helps colleagues exchange ideas and understand each other’s perspectives. IDTs benefit from strong leadership, which promotes shared decision-making and innovation at every level. Shared spaces and joined-up technological infrastructure also encourage active collaboration. Interprofessional education is essential for all IDT members. It helps staff to overcome logistical barriers and become practice-ready. IDTs which are more likely to function as intended are smaller, operate under a clear protocol and engage in shared working practices.

There are many benefits to IDTs, and IDT working is an approach that is valued by families. IDTs have been found to offer better access to care and have been associated with good outcomes across many domains, including task accomplishment and reducing staff burden. The coordinated care offered by IDTs allows staff to be more flexible, building their skills to work towards shared goals in an efficient way. This is especially important for decision-making with complex patients. However, challenges persist, especially where staff do not possess a shared language, or shared information systems. Without the allocation of adequate time and resources, staff may become frustrated by unresolved issues around status or roles and responsibilities. , Some tools exist that may help to quantify changes in IDTs and their impact over time.

Conclusion

This review provided insight into the unique characteristics of IDTs, specifically their composition and approach to workplace boundaries. However, questions remain in the Irish context around issues of clinical governance and professional autonomy. IDTs have many benefits, including better communication, more flexibility and more capacity for joint working with complex patients. Concerns remain about the staff status and the blurring of roles. However, IDTs have the potential to provide a cost-effective way to improve patient outcomes.

This review was limited by the lack of quality empirical studies in relation to IDTs and specific to children’s disability services. The literature highlighted the importance of bridging gaps, creating knowledge and sharing spaces. This should result in unified approach which prevents power imbalances and supports coordinated care. To that end, organisational change should be facilitated at every level. Further research is required to demonstrate the long-term impact of IDTs and their cost-effectiveness. This should be coupled with additional resources for training and infrastructure.

Introduction

There are many different team configurations across the health and social care sector. Three types of teams are most common; multi-disciplinary teams (MDTs), interdisciplinary teams (IDTs) and transdisciplinary teams (TDTs).(1) In practice, the type of team used can depend on the setting and the nature of medical care provided, along with any additional requirements such as educational needs. (2)

The interdisciplinary approach has been identified as a principle and a model of service for the Children’s Disability Network Teams (CDNTs) in Ireland.(3) This decision was based on an endorsement of IDT working by the HSE’s National Reference Group in 2009, as the most effective way to support children with disabilities and their families.(4) Generally, the evidence suggests that an interprofessional approach can result in better quality treatment, better outcomes, improved patient safety, higher job satisfaction, staff wellbeing, lower levels of burnout, cost savings, and reduced staff turnover.(3)

CDNTs provide services to children with complex disabilities. In this context IDTs have been defined as

“…a number of professionals from different disciplines who work with the child and family, sharing information, decision-making and goal-setting.”(3,5) [They]…have common procedures and policies and frequent opportunities for communication. They work collaboratively to meet the identified needs of the child with a joint service plan and see the child separately or together as appropriate.”(5)

The HSE have defined the core principles of IDTs in the CDNT service model as:(3)

* team-based services rather than individual discipline-based services
* sharing information, decision-making and goal-setting across teams
* operating in line with the Policy Framework for CDNTs
* frequent opportunities for collaboration, communication with families and other stakeholders and joint working.

Interdisciplinary team work/training has been presented as the preferred operational method across multiple disciplines.(2,6,7) However, there is a need to review the evidence of the effectiveness of IDTs in a community setting. Lack of consistent terminology can make this more difficult.

Aim

The aim of this literature review is to examine the evidence base in relation to IDTs for services similar to CDNTs. That is, community-based teams with several disciplines on the team.

Methodology

Search strategy

A search was performed using the following electronic databases; Medline, SocIndex, Full Text Finder. A librarian was also consulted on the search terms and executed a search across the database platforms EBSCO and ProQuest. The search strategy utilized a combination of relevant keywords, such as "interdisciplinary team” “health services” (these are fully outlined in Appendix 1). Boolean operators (e.g., AND, OR) were employed to refine the search and maximize the retrieval of pertinent literature.

The reference lists and citation lists of key documents were searched for relevant material. Grey literature sources were also searched through the following electronic databases: Cochrane Library, Social Care Institute for Excellence (SCIE) Trip Database, Global Index Medicus, National Institute for Health and Social Care Excellence (NICE) World Health Organisation, (WHO) Agency for Healthcare Research and Quality, National Quality Forum, Lenus, Health Information and Quality Authority (HIQA), WorldCat.

The research team also contacted organisations of physiotherapists, occupational therapists, speech and language therapists, social workers and psychologists in Ireland, UK, USA, Canada, Australia, and New Zealand to seek out relevant materials. This resulted in some useful position papers.

Inclusion & Exclusion Criteria

Studies were included if they met the following criteria: (a) focused on interdisciplinary teams within community-based health or social care services (b) written in English; and (c) available in full text.

Studies were excluded if they were: (a) related to sectors other than health or social care. (b) did not provide specific or detailed information about the characteristics or effectiveness of the IDT model.

Data Extraction

The selected studies were screened for relevance based on the titles and abstracts. Full-text articles of potentially relevant studies were retrieved and further assessed for eligibility according to the inclusion and exclusion criteria. Data extraction was performed to capture key information.

Synthesis

A narrative synthesis approach was employed to summarize and integrate findings across the included studies. Themes, patterns, and commonalities were identified to highlight the current knowledge and gaps in the literature regarding IDTs.

Findings

An analysis of the literature provides evidence about the relevance of IDTs around four thematic areas:

* Terminology,
* Team settings,
* Characteristics of IDTs, and
* Effectiveness of IDTs

‘Terminology’ highlights the disparities in the language around IDTs in the literature which leaves the potential for confusion. However, strong evidence exists in favour of IDT working. ‘Team settings’ identifies that IDTs whilst not universally used have been found to be a successful method of team operation in a wide range of areas, such as primary care or rehabilitation medicine. ‘Characteristics of IDTs’ outlines the common structures and processes that IDTs require. The area ‘Effectiveness of IDTs’ discusses the advantages and disadvantages of IDTs, the empirical evidence on this topic, and how the impact of IDTs could be improved such as through the use of management or assessment tools.

Terminology

Within the literature there was a lack of clarity and consistency in the application of the term interdisciplinary team and how it is bounded. IDTs are linked to and underpinned by the concept of teamwork. In the healthcare context, where teamwork has been defined as:

“A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organisational and staff outcomes.”(8)

Team working was described in several ways including multi-disciplinary, interdisciplinary, transdisciplinary, interprofessional and multiprofessional. These terms are sometimes used interchangeably in the literature to refer to different team types and processes. (9)

However, each type of team is characterised by a unique approach to working relationships and boundaries (Appendix 2). According to Ellis and Sevdalis[[2]](#footnote-2) the three main team types are defined as follows:

**Multi-disciplinary:** The patient is assessed individually by several professionals (such as nursing, social work, psychiatry, medical etc.) Participants may have separate but integrated roles and maintain their own disciplinary boundaries. The process might be described as additive, not integrative.(1) This is very similar to a Multiprofessional team.(10)

**Interdisciplinary:** Members come together as a whole to discuss their individual assessments and develop a joint service plan for the patient. Practitioners may blur some disciplinary boundaries, but still maintain a discipline-specific base (for instance, aspects of functional assessment may be shared across disciplines.) Teams integrate closer to complete a shared goal.(1) This is very similar to an Interprofessional team. (11)

**Transdisciplinary:** Team members share roles as well as goals. This requires specialist practitioners to share their skills (allowing others to learn new skills) as well as acquire new skills in other areas from other practitioners. The result is a more blended team that shares objectives and many core skills required to achieve the overall goal.(1)

Smith and Nancarrow highlight that team working takes place on a continuum from multidisciplinary through to transdisciplinary with the different terminology representing the extent of team integration. As such, multidisciplinary teams are co-ordinated, but they work in parallel with a focus on the task. Interdisciplinary teams accomplish goals through a collective working process of communication, shared decision-making and responsibility. Transdisciplinary teams work across boundaries through a combination of role extension, role enrichment, role expansion, role release and role support.(12,13)

A review of the literature by Chamberlain-Salaun found multiple definitions of each term. They found four definitions of IDTs, nine definitions of MDTs, and three definitions of interprofessional teams.(14) For example:

* Black takes interdisciplinary to mean “that the team interacts to produce a final outcome on behalf of patients.” (15)
* Delva defined IDTs as “groups of professionals who work collaboratively to develop processes and plans for patients.”(16)
* Goldsmith defines interdisciplinary care as “a process of collaboration among healthcare providers with specialised knowledge from multiple disciplines.” (7)
* Kuder describes an IDT as one that “integrates its various disciplinary perspectives and maintains a network of cooperation and communication.” (17)

In one study different terms were used to distinguish between team elements. That is, some terms related to the team composition and some terms described the workings of the team. For example, multi-professional described a team’s structural composition, while interdisciplinary described the process of intervention.(14)

Nancarrow explains that interprofessional or multiprofessional teams refer only teams that include professionals from different disciplines. While IDTs or MDTs can include all members of healthcare teams, such as administrative support.(9) IDTs have also been reported as including families and carers as team members.(18) Zeiss’ argues that the definition hinges upon the non-hierarchical organisation. of IDTs and how they share collective responsibility.(19) In contrast with MDTs, IDTs are defined by their emphasis on interactions between perspectives.(20) Freedman and Gehret characterise interdisciplinary team members as working in tandem to provide complementary care. (21) While MDTs work in parallel, IDTs share knowledge and expertise, engaging in flexible problem solving.(18)

In the Irish context, the terms to describe the teams are often used interchangeably without any reference to the team definition. For example, page 19 of the Action Plan for Disability Services 2024-2026 discusses Children’s Disability Services. It says “CDNTs are multidisciplinary teams who serve all children in their geographic area with complex needs”. (22) This statement is correct in so far as the teams are constructed of multiple disciplines and incorrect in that the teams are defined by the HSE as interdisciplinary teams. In the Slaintecare report IDTs are listed as a key component of integrated care but a definition of an IDT is not provided.(23)

Team Settings

IDTs were described as being in place in multiple settings including intermediate care for older adults, home settings, rehabilitation medicine, palliative care and primary care.(2,7,13,24,25)

IDTs were found within primary care in Ireland. IDT working in primary care typically took place outside of formal HSE structures, with professionals coming together to initiate programs driven by patient needs. For example, antenatal care, dementia care, fall prevention, and healthy eating on a budget. These teams yielded positive outcomes such as improved quality life and access to coordinated care for patients. Staff noted the cost-effective nature of the programmes and felt they promoted a more holistic approach.(25)

IDTs were found to work well within physical and rehabilitation medicine, where clinicians work to reduce the effects of impairments on activity limitations and a person’s participation restrictions. The IDT approach was found to facilitate rapid information transfer, early intervention and subsequent service discharge. The evidence suggests that IDTs can lead to better survival rates and improved functional outcomes for strokes and various other physiological conditions. In this context, the physician had primary responsibility for patient and team coordination.(2)

Palliative care is yet another domain where interdisciplinary teamwork has become more common. A Canadian study explored the use of a communication framework within IDTs. Discharge outcomes were characterised in terms of improved discharge planning and reintegration into the community. Patient outcomes were also positive, in terms of disease management, satisfaction and achievement of patient goals. (26)

IDTs are not universally used, and MDTs have been reported within Adult Day Services in Ireland and in services catering to the needs of young adults with disabilities. These services cater to the psychological, behavioural, occupational and speech therapy needs of young adults with the aim of providing universal, targeted, and individual supports as required. (27)

Characteristics of IDTs

This section explores the characteristics of IDTs. It describes the pre-requisites, principles, structures and processes which enable IDTs to be developed, maintained, and strengthened over time. This includes what they have in common with other types of teamwork and what makes IDTs unique.

Principles

Nancarrow et al. conducted a comprehensive study of interdisciplinary teamwork through a series of workshops with teams from Community Rehabilitation and Intermediate Care Services (CRAICS) in England as well as a systematic review of the literature. This work established the following principles of good interdisciplinary teamwork (Table 1). (9)

Table 1: Principles of good interdisciplinary teamwork

|  |  |
| --- | --- |
| Theme | Description |
| Leadership and Management | Having a clear leader of the team, with clear direction and management; democratic; shared power; support/supervision; personal development aligned with line management; leader who acts and listens. |
| Communication | Individuals with communication skills; ensuring that there are appropriate systems to promote communication within the team. |
| Personal rewards, training and Development | Learning; training and development; training and career development opportunities; incorporates individual rewards and opportunity, morale and motivation. |
| Appropriate resources and procedures | Structures (for example, team meetings, organizational factors, team members working from the same location). Ensuring that appropriate procedures are in place to uphold the vision of the service (for example, communication systems, appropriate referral criteria and so on). |
| Appropriate skill mix | Sufficient/appropriate skills, competencies, practitioner mix, balance of personalities; ability to make the most of other team members' backgrounds; having a full complement of staff, timely replacement/cover for empty or absent posts. |
| Climate | Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere. |
| Individual characteristics | Knowledge, experience, initiative, knowing strengths and weaknesses, listening skills, reflexive practice; desire to work on the same goals. |
| Clarity of vision | Having a clear set of values that drive the direction of the service and the care provided. Portraying a uniform and consistent external image. |
| Quality and outcomes of care | Patient-centered focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care. |
| Respecting and understanding roles | Sharing power, joint working, autonomy. |

Communications and team Processes

The literature shows that IDTs need regular opportunities to foster communication. This requires regular meetings where staff are encouraged to develop and review shared goals. In an IDT as opposed to MDT, this means that communication should be horizontal rather than vertical, with team members coming together to exchange ideas and influence each other. (2) Nancarrow also reiterates that communication is not only an individual skill, but a two-way process which relies upon appropriate structures. This means that IDT members should be able not only to listen, but to speak out.(9)

There is a need for clear communication channels within IDTs. This includes setting standards for the type of communication used and the frequency at which it is utilised, for example, recommendations for how often team members should check their email.(26)

Care planning, information exchange, decision making and teaching are all core processes enabled by interdisciplinary communication. Coordination of care is important, especially as specialist teams interact with primary care. Information exchange can occur formally or informally. Teaching involves educating other team members on relevant topics or areas of interest as they arise within discussions. When making decisions, it is vital that interprofessional team members receive input from internal/external stakeholders as required and remain open to feedback from colleagues.(26)

The Interprofessional Educational Collaborative (IPEC) found that cultural humility is important when working with interdisciplinary colleagues. This includes avoiding discipline-specific terminology.(28) Stein indicates that interpersonal skills and relationship building are essential for IDT members, who must shift their mindsets to better engage with each other.(29)

Warren suggests that interdisciplinary care has the potential to improve relationships among medical professionals and patients. Healthcare organisations which mandated interdisciplinary care showed that patient experiences or clinical outcomes did not disimprove. Warren found that the IDT approach promotes an improved experience with regard to timely access, person centred care, quality communication and continuity of care. Indeed, the flow of information electronically between providers (shared records) can lead to better care and lower costs. However, a lack of funding creates conflict, with resources needed for implementation, especially with regard to training and technology. (30)

In terms of interprofessional collaboration, it is important to bridge gaps. That is, to reconcile different perspectives, healing social and communication divisions among team members, as well as well as task divisions. Negotiation is another key process, which is necessary to address overlaps in individual care processes, roles and responsibilities in general. (31)

There are a number of barriers and enablers to interdisciplinary collaborative professional practice. As highlighted by Orchard, team development requires sensitivity to issues of role-socialisation and power imbalances within the overall organisational structure. It is important to both clarify and value the roles which team members occupy, to build trusting relationships, and allow power-sharing.(32)

To work effectively, interprofessional teams should develop clear objectives and shared goals. They should also engage in regular audit processes to evaluate the extent to which a team is working effectively. This can help to identify areas for improvement or to sustain good practices.(33) The evaluation phase can include team processes, team member satisfaction and/or service user outcomes. (32)

Lennox-Chhugani also highlights the importance of relationships within IDTs, describing knowledge creation, identity creation and interdisciplinary power relations as social processes. (18) Knowledge creation is when shared knowledge is transferred and applied within decision-making, for instance, reviewing care plans. Identity creation is when members of IDTs shape their collective identity through interactions and discourse. Power relations are reflected in the hierarchies which remain a reality for many IDTs, with opportunities to act limited by the extent to which pre-existing social rules have been reproduced.(18)

Blackmore suggests that IDTs should have a willingness and capacity to work together long-term. Staff members in functioning IDTs should not experience burnout. This means that quality work will be sustainable. Dysfunctional teams often experience internal divisions. For instance, smaller cliques blaming one another for mistakes made. Within an IDT there should be a culture of mutual respect and trust, strengthened by constructive feedback. Team functioning within IDTs can be improved by providing opportunities for team building, modelling professional relationships, and providing coaching with regard to individual behaviours.(34)

Team Structures

A strong leadership structure is an essential part of an effective IDT It is important that leaders are respected by colleagues, equipped to understand individual perspectives and motivate people to contribute fully. IDTs should have clarity on who their leader is and the extent to which leadership is shared. Responsibilities can shift informally in day-to-day practice, depending on the nature of the situation and the expertise required. Paradoxically, this can only occur if a strong leader is present, to facilitate or manage the process. Research suggests that teams with a specific leader experienced higher levels of satisfaction. (12) Effective IDTs should strike a balance between individual autonomy and team coordination. This requires on-going communication and consultation between staff and leadership. (34)

The utilisation of space is another essential element of team structure. For instance, does the interprofessional team occupy a shared premises? If so, this can contribute to improved integration. Research shows that problems can be solved more quickly when team members were familiar with each other and able to communicate directly. (33) The co-location of team members in a shared office space can result in the improvement of interprofessional relationships. This is because it leads to more frequent, better quality face-to-face communication. (35)

As well as occupying shared spaces, the act of creating space is important for external and internal actors. This can include managing bureaucracy from other organisations or re-creating organisational arrangements to better facilitate collaboration. This is especially important where previous systems did not exist or were insufficient. For example, developing new referral criteria or treatment protocols which reflect a different way of working. (31)

The size of teams was argued as important point for the functioning of IDTS, with In terms of size, smaller teams found to have greater participation, while larger teams were described as “cumbersome.” In terms of composition, more diverse teams were found to be more innovative. (33) However, little detail is available as to what defines a smaller, more diverse team. Concerns were identified that team functioning may be limited due to issues of status. That is, staff of a certain grade level (who hold less senior positions) may feel restricted from providing input to the decision-making process.

The model under which an IDT operates can also influence the way in which they work. For instance, in Norway, home-based IDTs providing care to older adults operated under the trust model. (24) The trust model is a system whereby frontline workers have autonomy to allocate additional hours to provide tailored services. In practice, reporting requirements limit the extent to which estimated hours can differ from actual allocation. The deviation must be accounted for and if it persists, the allocation may be changed. This system is further limited by the fact that team members from different disciplines have different working practices and job requirements, which may limit their ability to function effectively as part of an IDT. For example, therapists can place service users on a waiting list and arrange their working day. In contrast, nursing care cannot be postponed if a team member is ill, nor can daily tasks such as medication or personal care be scheduled around IDT meetings.(24)

Issues have arisen in the Irish context in relation to line management and clinical governance.(36) For example, a member of one therapy group who may be used to being managed by a more senior member of their own therapy group, in an IDT may be managed by a more senior manager of a different therapy group. The importance of discipline-specific managers was highlighted in a joint statement by five HSCP organisations, which stressed that the lack thereof caused significant clinical concerns, risks and distress for practicing clinicians. They also stated that this was impacting the recruitment and retention of HSCPs.(36) This and other issues around lack of supervision, have led to dissatisfaction, as indicated by surveys of the Association of Occupational Therapists of Ireland (AOTI) and the Irish Association of Social Workers (IASW) members. (37,38) Examples of this include sporadic, or non-existent line management from colleagues who are unable to provide 1:1 support, and supervisors who are no longer practicing and cannot help with workload management. The issue of clinical governance is being actively addressed in the Irish setting.

Interprofessional Education

It is important to ensure that the principles of IDT working, communication processes, and team structures are embedded within IDTs. Interprofessional education plays a key role in this.

The WHO defines interprofessional education as that which “occurs when two or more professionals learn about, from and with each other to enable effective collaboration and improve health outcomes.” (39) Interprofessional education fosters resilience in the face of global challenges such as staff shortages and it is viewed as a building block for collaborative practice.

There are many mechanisms which allow educators and the curriculum to better accommodate IDT working. For instance, shared learning objectives and considerations with regard to logistics/scheduling for students from different disciplines. Under the Framework for Action on Interprofessional Education and Collaborative Practice, positive outcomes are reflected in the following learning domains:

* Teamwork
* Roles and responsibilities
* Communication
* Learning and critical reflection
* Relationship with and recognising the needs of the patient
* Ethical practice

There are a number of actions which can be taken to prepare the team to be practice ready, which include providing organisational support, allocating adequate funding and time for staff training to develop and deliver interprofessional education. For example, offering incentives for staff who participate and setting aside time for meetings.(39)

The Partnership for Healthy Ageing also identified IDT training as a priority area for those working in the field of geriatrics.(6) They establish a number of goals which should be incorporated into the curriculum for every learner, from students to practicing professionals. They also identify the following factors which enable successful IDT training:

* Attitudes and experience with team care and training
* Faculty support and student participation
* Level of training of students and trainee expectations
* Training context Institutional and financial support for training.

Effectiveness of IDTs

Körner’s comparison of IDTs and MDTs showed that IDTs scored better in all aspects of teamwork. These include objective orientation, task accomplishment, cohesion and willingness to work together, as well as workplace atmosphere, leadership, organisation and communication. This was particularly evident for members of non-psychosomatic rehabilitation teams[[3]](#footnote-3), which may be linked back to different working conditions or expectations among staff.(40)

A review of the CDNT for Kildare West-Wicklow highlighted that families valued the interdisciplinary approach, noting that it allowed for more comprehensive and integrated service delivery. Staff also felt that working in an IDT enabled flexibility and openness, with joint goal-setting, problem solving and skill sharing. It reportedly led to improved case management when concerns arise for children and families.(41)

Schofield-Faulkner’s review found many benefits to IDTs. These include a better appreciation by staff for one’s own discipline, as well as a greater respect for the work of other professionals. These are coupled with better access to care for patients, improved engagement with self-care, as well as a reduction in premature hospital admissions, and a shorter length of stay. Other benefits included relieving the treatment burden upon staff, with IDTs allowing more objectivity than working alone, and facilitating work with complex patients. The IDT model has been characterised as allowing the professionals to better empathise with the patient and one another. (42)

The American Geriatrics Society argued that IDTs deliver optimal and cost-effective care for older persons. IDT training supports this because it enables professionals to deal with complex health needs in a coordinated way. Where team members provide care independently, this can lead to a fragmented approach which fails to meet an older person’s overall needs. On the other hand, interdisciplinary evaluations lead to needs-based interventions, thus reducing the impact of age-related impairments or disability.(6)

Schofield highlighted several challenges to IDT implementation, these relate to issues of the unequal status and participation among team members, and are based on career stages and qualifications.(42) Confusion or blurring of roles was identified as a problem. There were also issues around jargon, technology and a lack of administrative support. Schofield recognised that the IDT approach requires additional time input, but did not specify what this extra time is needed for.(42) Nancarrow found that the extra time can be attributed to providing necessary documentation, such as care plans. (13) Kuziemsky noted, the additional time requirements could be associated with a lack of electronic record-keeping. For instance, one study found that team members spent a lot of time searching for data and questioning its accuracy, because they lacked shared electronic records.(26)

Notably, the value of IDTs can be seen at a grassroots level, with ad-hoc communication enabling the design and delivery of programmes in areas such as fall prevention for older adults.(25)

Research shows that interprofessional teams who receive organisational support are more likely to effectively deliver healthcare. They are also more likely to be radically innovative and/or open to change. But without the right kind of organisational support to implement changes, teams may feel discouraged and revert back to previous practices.(33)

Strengthening the Evidence Around IDTs

Schofield-Faulkner explored some of the evidence in relation to the effectiveness of IDTs. Their review of the literature indicated that analyses of IDTs were either descriptive, process-focused, outcome-focused or empirical across the domains of patient care, personnel or management. (42) The vast majority of the articles in Schofield’s review were descriptive or process-focused. That is, they were typically anecdotal or tended to lack formal research methods. Empirical articles used some quantitative methods, while outcome articles measured the impact of IDTs in terms of an external goal. Examples of these include improved functioning in terms of activities of daily living, improved reliability of patient assessments, improved care-giver wellbeing or improved patient care planning. However, it is unknown the extent to which any of these were objectively achieved. Especially as many studies lacked a control group or pre/post study testing. (42)

In terms of assessing the impact of interprofessional collaboration, a review of the literature by Schot found that most studies (63%) did not report on the effects of professional contributions. Those that did had conclusions that were largely inferred rather than based on empirical data. Examples of statements made without linkage to findings include the notion that active consultation results in higher quality care, or indeed that this results from informal communication channels. This tendency to infer rather than prove suggests a need for further research. (31)

Nancarrow et al. found that teamwork comprises multiple factors, including the setting of care, skill mix, service organisation, individual relationships, and management structures. They suggest that these variables compound the lack of evidence with regard to interdisciplinary teamwork. This is because most research investigates the impact of one or two components, rather than examining the relationship between a range of factors and their impact on staff and patient outcomes.(8)

There are a number of tools which may help to measure the effectiveness of IDTs. For instance, the Collaborative Practice Assessment Tool (CPAT) was developed by Queen’s University in 2009 to determine professional development needs. The survey questions relate to the following domains: (43)

* Mission, Meaningful Purpose, Goals
* General Relationships
* Team Leadership
* General Role Responsibilities
* Autonomy
* Communication and Information Exchange
* Community Linkages and Coordination of Care
* Decision-making and Conflict Management
* Patient Involvement.

The CPAT has been found to be a reliable tool for assessing collaborative practice within teams.(44)

Smith et al. developed an Interdisciplinary Management Tool (IMT).(11)(13) This is part of a structured change management approach, implemented through workshops with facilitators.

The use of the IMT in an intermediate care setting had several positive outcomes relating to:

• Communication

• Leadership

• Personal development

• Focus on goals and outcomes

• Team working

• Team clarity

• Team reputation

• Understanding of the change process

The negative aspects included time taken away from patient care, time required to complete the documentation, lack of goal completion by teams and the uncertainty affecting team direction and morale. There was some qualitative indication that the IMT improved team integration, but this was not reflected in the quantitative data. (38)

Unfortunately, Smith’s study did not find a positive impact on patient outcomes or cost-effectiveness. One possible explanation is that insufficient time was allowed for cultural change to occur.(38) This suggests that further long-term research is required to establish the long-term impact of IDTs

The literature suggests that when measuring the success of the interdisciplinary approach (and the effectiveness of any tools) it may be useful to measure the level of care required at admission/discharge, as well as any therapy outcomes or changes to quality of life, in addition to patient satisfaction.(12)

Limitations

This paper has one key limitation that should be considered when appraising the findings. The majority of the research was from community services such as primary care or rehabilitation medicine but was not specific to services for children with disabilities. In addition, the review was limited by the lack of quality empirical studies in relation to IDTs. However, there was sufficient evidence of the effectiveness of IDTs in community settings and this is likely to also to apply to children’s disability services. However, more research and publications of implementation experiences is required.

Conclusion

This paper highlighted the difficulties with the interchangeable use of terminology around the various methods of team working that can lead to confusion. The paper established that IDTs can be clearly defined from other methods of team working in that the teams uses collaboration and maintains discipline boundaries as opposed to parallel working or sharing skill sets. However, the concept is not used universally and variations in terminology exist within the different sectors of health and social care. It is important therefore that services using IDTs are clear what that means in their setting.

Over time, interprofessional education has developed to reflect the interdisciplinary nature of the work carried out by health and social care professionals. Enablers of IDTs include encouraging open communication and building strong relationships. It is important to schedule regular meetings and engage with audits to monitor effectiveness. The literature shows that IDTs function best when appropriate structures are in place. For example, organisational policies and leadership, coupled with co-location of team members and a mindful approach to participation and reporting procedures.

The literature demonstrated several benefits of IDTs. These include more easily facilitating work with more complex patients, effective communication, and flexibility within a positive work atmosphere. However, there were concerns about staff status and the blurring of roles. IDTs have the potential to improve patient outcomes and may prove cost effective, provided that organisational change occurs at every level. This includes a shift in education and training, coupled with resources to support training and strengthen team infrastructure. To this end, tools such as the IMT and CPAT may help IDTs to reflect upon and measure their effectiveness over time.

There were certain areas that were touched on in the literature but that were not as prominent as may have been expected. Notable examples include issues around clinical governance and professional autonomy.

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Appendix 1: Search Terms Used

This review primarily searched the terminology “interdisciplinary teams” “interdisciplinary working”, “IDTs” or variations thereof. However, additional terms were also searched to a lesser extent, especially where relevant results were lacking. This enabled the research team to find out which terms (if any) were more commonly used. This also helped the research team to define the various concepts and establish any common ground with regard to structures, processes and settings. Where a finding refers primarily to a different search term, this has been specified in text.

For team type the following were used:

* Interdisciplinary team
* Multidisciplinary team
* Transdisciplinary team
* Interprofessional team
* Multiprofessional team

In terms of setting, the search terminology focused exclusively on IDTs based in the context of community-based health and social care. The following is a non-exhaustive list of search terms used in conjunction with the phrase “interdisciplinary teams.”

* Disability services
* Children’s disability services
* Primary care
* Community care
* Health services
* Geriatric care
* Palliative care
* Intermediate care

Appendix 2: Terminology Comparison

|  |  |  |  |
| --- | --- | --- | --- |
| Concept | Composition | Working Process | Outcome |
| Multidisciplinary | Multiple team members from different backgrounds. | Individual assessments, separate roles (distinct boundaries) | Teams members work alongside one another, on a limited basis. |
| Interdisciplinary | Multiple team members from different backgrounds. | Shared goals, shared roles (blurred boundaries) | Team members interact on an on-going basis as part of joint service plan(s) |
| Transdisciplinary | Multiple team members from different backgrounds. | Shared goals, shared roles, shared skills (dissolved boundaries) | Team members re-configure working practices to promote a blended approach. |
| Interprofessional | Multiple professionals from different disciplines | Shared goals, shared roles (blurred boundaries) |  |
| Multiprofessional | Multiple professionals from different disciplines | Individual assessments, separate roles (distinct boundaries) |  |

1. <https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology> [↑](#footnote-ref-1)
2. A singular paper is referenced, as it proved extremely difficult to source clear, consistent definitions of each term that distinguished between each term without contradiction. [↑](#footnote-ref-2)
3. Non-psychosomatic therapists include for example physical therapist, dietician.

   Psychosomatic therapists include psychologist, social worker, art therapist, music therapist or occupational therapist. [↑](#footnote-ref-3)