A range of goals for collaborative practice—levels or bands of collaboration

This is a rough sketch only—not a precise depiction! Take in the gestalt—don't quibble about "fit" to the categories.

From Peek, C.J. "Integrated Care: Aids to Navigation" (2007)

Model	1	2	3	4	5
	Minimal collaboration	Basic collaboration from a distance	Basic collaboration on-site	Close collaboration in a partly integrated system	Close collaboration in a fully integrated system
Doherty, McDaniel, & Baird (1995)	• Separate systems • Separate facilities • Communication is rare • Little appreciation of each other's culture; little influence sharing	• Separate systems • Separate facilities • Periodic focused communication mostly by letter, occ phone. • View each other as outside resources • Little understanding of each others culture or sharing of influence	• Separate systems • Same facilities • Regular communic.-- occasionally face-to-face • Some appreciation of each others roles and general sense of larger picture, but not in depth • Medical side usually has more influence	• Some shared systems • Same facilities • Face-to-face consultation, coordinated tx plans • Basic appreciation of each others role & culture. Share biopsychosocial model. • Collab. routines difficult-- time & operations barriers • Influence sharing-- some tensions	• Shared systems & facilities in seamless biopsychosocial web • Pts & providers have same expectation of a team • Everyone committed to biopsychosocial; in-depth appreciation of roles & culture • Collaborative routines are regular and smooth • Conscious influence sharing based on situation & expertise
handles adequately	Routine, w little biopsychosocial interplay & mgmt challenges	Moderate biopsychosocial interplay, e.g, diabetes & depression with mgmt of each going reasonably well	Moderate biopsychosocial interplay requiring some face-to-face interaction & coordination of tx. plans	Cases with significant biopsychosocial interplay & mgmt complications	Most difficult and complex biopsychosocial cases with challenging mgmt problems
handles inadequately	Cases refractory to tx or w significant biopsychosocial interplay	Significant biospsychosocial interplay, esp when mgmt is not satisfactory to either MH or medical providers	Signif. biopsychosocial interplay, esp those with ongoing & challenging mgmt problems	Complex w multiple providers & systems; esp with tension, competing agendas or triangulation	Team resources insuffficient or breakdowns occur in the collaboration with larger service systems.
Seaburn, Lorenz, Gunn, Gawinksi, Mauksch (1996)	Parallel delivery: Clear division of labor not flowing into each other significantly	Informal consultation: MH professional helps physician deal with a clinical problem, but usually no contact with the patient	Formal consultation: MH professional has direct contact with pt. in typical relationship as a consulting specialist	Co-provision of care: Patient care is shared and the professionals may see the patient or family together	Collaborative networking: Provider team is extended to include family and other medical specialists, educators, community resources
Org. literature Strosahl, Peek & Heinrich, others	Traditional referral-between-specialties models		Co-location models	Organization integration or "primary care mental health" models	
MH provider might say--	"Nobody knows my name"	"I help your patients"	"I am your consultant"	"We are a team in the care of our patients"	"Together, we also teach others how to be a team in care of pts. and design of the care system"
Medical prov. Might say--	"Who are you?"	"You help my patients, but not me"	"You help me as well as my patients"		

Doherty, McDaniel, & Baird (1996). Five levels of primary care/behavioral healthcare collaboration. Behavioral Healthcare Tomorrow, October 1996. Also appears as Doherty (1995), The why's and levels of collaborative family healthcare. Family Systems Medicine, 1995, Vol 13, No.3/4.

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